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Contents

President's Message

Awareness and Dissemination

Dean McKay, ***Fordham University***

You have all likely heard how important it is that cognitive-behavioral methods are disseminated widely. The reasons for this are fairly evident, but to highlight just a few justifications one could look to protection of the public when they seek empirically grounded therapy; ensuring that practitioners are equipped with the best methods of intervention and the means to acquire newly developed approaches derived from the theoretical base of CBT; and to provide the means to further the development by having a well-informed base of researchers. Under past ABCT leadership, in collaboration with other training stakeholders, recommendations were developed that would foster an educational environment to ensure sound doctoral training in cognitive-behavioral methods (Klepac et al., 2012). The teaching of empirically supported methods more generally is already emphasized in the Commission on Accreditation of the American Psychological Association guidelines for accrediting doctoral training programs (Commission on Accreditation, 2009). These are excellent developments in the profession. It appears it is also not enough.

Getting to the training centers is of course critical in promoting cognitive-behavioral methods. But what of the practitioners who are already out there, possibly engaging in non-empirically-supported methods? Research has shown that while practitioners trained in a wide range of theoretical and scientific traditions can learn specific empirically based treatments, the

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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.
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- 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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likelihood that these approaches will continue to be used after a program of intervention ends (i.e., a short clinical intervention program, a research protocol) is very low (McHugh & Barlow, 2010). Residency programs in psychiatry, psychology, and social work to a very large degree offer didactic training in cognitive-behavioral methods (Weissman et al., 2006), but this is hardly akin to ensuring sound implementation, or even likelihood of adoption in providing client care. Additionally, didactic training covers a very wide range of professional training activities.

One other way may be to address this at the level of other professional referral sources. Many of our colleagues are referred clients regularly from pediatricians, cardiologists, neurologists, dentists, general practice doctors, and other medical specialists. If these professional groups had a clear understanding of the empirical support for cognitive-behavior therapy, they would likely suggest this specific approach to treatment. Since these same groups are likely to see the same client again over the course of, or immediately after a course of, cognitive behavioral treatment, they would also likely recognize the benefits.

Our colleagues in behavioral medicine already know this. A number of empirically supported interventions aimed at promoting psychological health associated with a range of health and medical procedures have shown that our interface with colleagues in other medical disciplines has been instrumental in disseminating CBT (for examples of evidence-based behavioral medicine approaches, visit www.ebbp.org). While this works quite well for psychological adjustment due to medical illness, what of psychological distress unrelated to acute or chronic medical illness?

Mental illness is presently cast by not only psychiatry but by major funding agencies as diseases of the brain. Indeed, the development of the Research Domain Criteria (RDoC) that informs most funding decisions by the NIMH rests on this as a major assumption, as follows:

> RDoC classification rests on three assumptions. First, the RDoC framework conceptualizes mental illnesses as brain disorders. In contrast to neurological disorders with identifiable lesions, mental disorders can be addressed as disorders of brain circuits. Second, RDoC classification assumes that the dysfunction in neural circuits can be identified with the tools of clinical neuroscience, including electrophysiology, functional neuroimaging, and new methods for quantifying connections in vivo. Third, the RDoC framework assumes that data from genetics and clinical neuroscience will yield biosignatures that will augment clinical symptoms and signs for clinical management. (Insel et al., 2010, p. 749)

This medicalization of mental illness will contribute to what is already a significant emphasis on medicine in the treatment of psychopathology. This means that in light of the emphasis on conceptualizing mental illness as medical in nature, medical practitioners can expect a significant increase in the number of patients seeking treatment for emotional distress. The research suggests that utilization of medical services due to psychopathology is already high. For example, research has shown that individuals with anxiety disorders have higher levels of medical utilization than the general population (Deacon, Lickel, & Abramowitz, 2008). Individuals with depressive disorders visit doctors far more than the general population, even following remission of symptoms at 10-year follow-up (Holahan et al., 2010).

Medical doctors of all specialties have a built-in incentive to address mental health problems with great seriousness, if for no other reason than their bottom line. Research has shown that mental health problems adversely affect satisfaction with medical care. For example, anxiety was a significant factor in satisfaction with inpatient hospital care (although age was the greatest predictor; Rahmqvist, 2001). Jackson, Chamberlin, and Kroenke (2001) found that anxiety and depression were associated with lower satisfaction with medical care at 2-week and 3-month post medical care. These are but two examples, but it appears that (a) clients are bombarded with information to suggest that their emotional distress is medical in nature, (b) mental health problems are associated with higher levels of medical utilization, and (c) these very same mental health problems are associated with lower medical care satisfaction. This is where dissemination comes back into focus. While many medical doctors may agree with the conceptualization of mental illness as a brain disease, they may also rue the day that very same conceptualization became an official policy statement. Increasing the awareness of the efficacy of CBT among medical professionals is worthy for lowering utilization and improving satisfaction. As one more avenue for "getting the word out" about empirically supported treatment, it would appear that there is a vast professional group that would welcome this approach.

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I am again indebted to Brett Deacon for very helpful comments on an early draft of this column.

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Science Forum

Conducting Reviews for Scientific Journals: A Guide for New Reviewers, and Suggestions for Old Hands

Dean McKay, ***Fordham University***

Reviewing manuscripts for scientific and professional journals is an important activity. The act of reviewing a manuscript requires several important skills to be brought to bear. It calls for critical (sometimes very critical) evaluation of other researchers' work; it requires diplomacy (typically), even if the work is poor; and it requires that constructive suggestions be offered, even if you think the paper should be rejected. In addition to these things, a good reviewer knows methodology, statistical approaches, and the content of the literature that the research is based upon.

If you have been asked to review a manuscript, it is because the editor has recognized your work or your expertise and has deemed you an expert suitable for providing feedback on someone else's work. Accordingly, this should be regarded as an honor. Recognition by one's peers is a high form of flattery, so consider it as such. However, reviewing a manuscript is also viewed by some as a burden. Additionally, some reviewers are so prolific at the craft of offering peer commentary that their reputation becomes well known among editors. This means that these highly prolific reviewers likely perform a disproportionate number of reviews. So consider this plea: if you are asked to review, please consider doing so in order to ensure a wider range of scholarly recommendations become part of the final published products in our scientific publications. While it is generally an uncompensated professional activity, it is also one that typically comes with difficult-to-quantify rewards. For example, you will now be privy to some of the most current research activities of your colleagues. You will play a small part in shaping the research literature. You will also have a chance to gain a deeper understanding of your own area of inquiry. Finally, it will also likely improve your own writing and research as you are exposed to a wide range of approaches others employ as you are forced to engage in a very close reading of the research.

Getting Oriented

When you accept the role of reviewer for an article, it is expected that you offer commentary on the paper. This means that the paper will be read far more closely than it is likely to be when and if it is finally published. Now, occasionally a manuscript comes along that is so well written and tightly developed that it warrants little comment. This is rare, and issuing reviews without remark or recommendations may be a flag for the editor that the review was not taken with the seriousness it deserved. In short, if you think the manuscript is flawless, you likely missed something. Remember that the task of the reviewer is not only to determine if a manuscript is suitable for the journal, but it is also a service to the profession by ensuring quality science is published, and a service to the author(s) since regardless of how you recommend (accept, accept pending revisions, revise and resubmit, or reject), the author should benefit from your feedback for the ultimate acceptance in the journal for which it was reviewed, for when it is resubmitted elsewhere if it was rejected, or as feedback for their next manuscript. In the case of rejections, it is very possible that when the authors resubmit elsewhere you will be asked to review the same paper again (see details on handling reviews of resubmissions below). In one extreme example, in my role as Associate Editor for a journal, a prospective reviewer complained to me that the same paper had been reviewed by this same person for five previous journals.

A good review evaluates the entire manuscript, from formatting and style, to content and conceptualization, to analyses done and not done. The structure of the review is up to the individual reviewer, but it should touch upon each of the major sections of the manuscript.

Matters Big and Small

Reviewers of manuscripts need to evaluate the degree the manuscript fits with the theme of the journal. Usually an editor screens a manuscript to be sure it is appropriate and will deny the review if it is out of scope. This is not always the case. It is therefore important that reviewers be acquainted with the mission and aims of the journal. For articles submitted to a professionally oriented journal (i.e., in our profession, one that is more directed at service delivery), attention to matters such as psychometric properties of scales employed is not necessarily the most important aspect of the manuscript. On the other hand, reviews for journals that publish the results of clinical trials warrant attention to the scale properties, construct validity of the experimental design, generalizability, and all the other usual aspects of good methodology.

As manuscripts become more complex in the questions addressed, there is greater risk that the authors and/or the readers will become confused regarding the conceptual and/or theoretical goals of the paper. There are several red flags that can help a reviewer identify such potential confusion. First, authors who are conceptually unclear often rely on vague and/or general statements about the issues to be tested. If you are not sure what the author is intending to test, this is important to point out and clarify. This could simply be a case of poor writing, but it can also mean something more substantial regarding the conceptual basis of the manuscript. The confusion around the ideas being conveyed can sometimes be discerned in the discussion section, where the implications of the conclusions are beyond the scope of the data or literature reviewed. When this happens, the manuscript is in big trouble, particularly if the true implications are not particularly meaningful.

Second, for any manuscript, the "so what?" question should be clearly answered. There are a lot of manuscripts out there that seem designed to pad someone's CV, and that is fine, but, especially if reviewing for a very high-level journal, the "so what?" question should be answered early and often. Some authors fail to answer the "so what" question, but it exists in the manuscript. Savvy reviewers can help authors find the "so what" question and help guide them to answer it as part of the request for revisions.

Third, minor technical items that require attention include: Does the manuscript have the correct formatting? Is it arranged in a logical manner? Are the authors attentive to the proper formatting for reporting statistics? These are all relatively minor but nontrivial items that will be a headache for the editor. You will be doing the authors and the editor a favor by identi-

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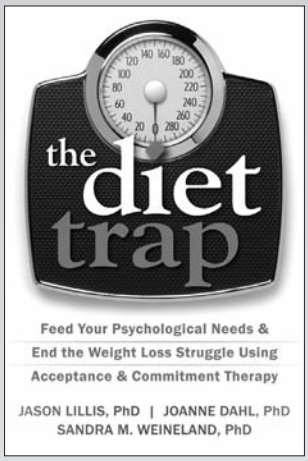

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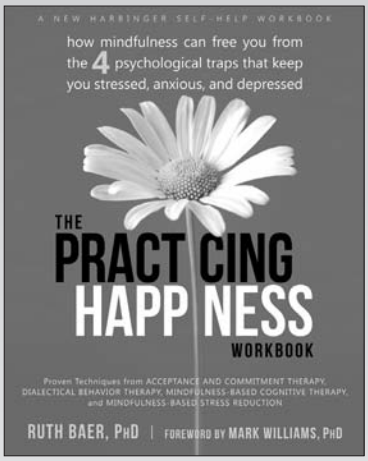

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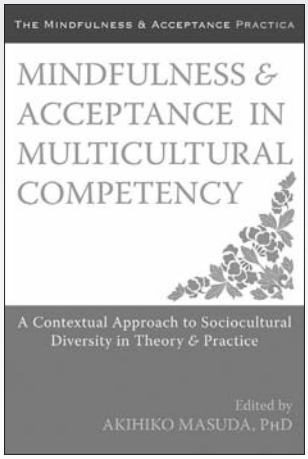

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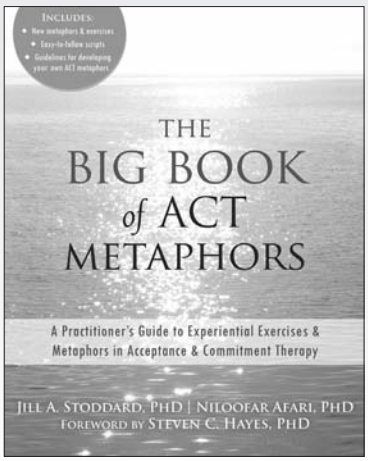

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fying any formatting problems and recommending changes accordingly in your review.

The Structure of the Review

Everyone has their personal preferences and style, and there is no accepted standard for how reviews are structured. As an editor and reviewer, I have often favored the following format:

- *Brief summary of the manuscript*: This shows the editor and author that you read and understood the paper. It also provides an opportunity for you to put the rest of the manuscript in its proper context for the comments that follow.
- *Overarching comments about the manuscript*: This would be the place to discuss some broad themes that were present in the manuscript that might warrant clarification or elaboration. It is also the place to call attention to more general limitations of the paper, if there are any. This can range from conceptual clarity to writing style.
- *A critique of each major section of the manuscript*
- *Abstract*: Review to be sure the information matches the conclusions in the paper. Oddly, the mismatch between the abstract and the data is not too unusual. Also, be sure the author has a sentence or two from each of the major sections of the manuscript represented here.
- *Introduction*: the big questions for this section are: Did the authors develop the idea well enough to justify the hypotheses tested? Is the literature representative of the prevailing sentiment in the research? Perhaps more than any other section, this portion of the manuscript requires the reviewer to be familiar with the domain of the research as well as matters of style.
- *Method*: Each subsection of the method deserves careful scrutiny. Is the population studied appropriate to the research question? Are participant recruitment procedures clearly described? Are the measures adequate for testing the hypotheses? Is there adequate statistical power? Have the measures been described in enough detail, and adequately? These questions should be satisfactorily answered.
- *Results*: The first question you should ask is, Did they in fact test the hypotheses? While it would seem obvious that a manuscript would do this, it is also oddly not uncommon to see that the analyses fail to evaluate the hypotheses adequately. Further, it is possible for authors to commit Type IV errors—namely, conducting the right statistical test for the hypotheses but draw the wrong conclusion (Levin & Marascuilo, 1972). Finally, are there additional analyses that could be reasonably conducted to more fully evaluate the phenomena studied? You are in a position to recommend additional analyses for the author(s) at this point in the review.
- *Discussion*: This is where authors get to draw their conclusions, raise additional questions, and humbly state the limitations in their research. These three elements should be in this section. If there are no limitations, in my book there is no recommendation to publish. Authors need to recognize the limitations, and occasionally a contributor is so awestruck with their own work that they fail to note any ways the research is inapplicable to specific situations. This level of self-adulation should not be rewarded. In this section, authors should also make an effort to clearly describe the implications of their research findings. This is the place where authors can offer additional hypotheses for future evaluation and applications of the findings. The reviewer has the task of either suggesting additional ways the implications can be described, or indicate where the findings may have been overgeneralized.
- *A section with minor comments*: These are usually items like grammatical or spelling errors; format problems; errors in fully blinding the manuscript (for journals that rely on blind review); superfluous tables and figures, or comments on structure of tables and figures; and adequacy of any appendices.

Types of Manuscripts for Review

The Empirical Paper

The most common type of manuscript review, the empirical paper most readily lends itself to the format described above. These are the ones early reviewers and graduate students are best equipped to review since it is in their professional lingua franca.

The Review Paper

There are some very high-level journals that only publish review papers (for example, *Clinical Psychology Review*, which as of this writing has an impact factor of 8.40). When reviewing for a journal such as this, the big question is whether the literature reviewed was thorough (as opposed to selective for supporting the thesis) and covers the existing literature accurately. That is, are the papers represented properly? This calls for a more detailed familiarity with the scientific literature within the specific domain reviewed. These reviews are often far more demanding to complete.

The Meta-Analysis

A hybrid of a data-based investigation and a review paper, the meta-analysis calls for a fairly in-depth knowledge of the literature as well as a sound knowledge of statistical methods that both underlie the area being summarized as well as meta-analytic methods per se. There are some very good sources to help guide a reviewer in these kinds of reviews (see Card, 2012; Rosenthal, 1995). A notable issue in meta-analyses is whether the author engaged in a selective review of studies, which in turn distorts the effect sizes and conclusions drawn in these studies. Further, authors of meta-analyses should pay particular attention to the adequacy of the methodologies involved in the body of research reviewed. These limit the extent of any conclusions that may be drawn. The manner of conducting meta-analyses is described in Card, and the APA has developed standards for reporting (meta-analysis reporting standards, in the APA publications guide).

The Invited Paper

Journals routinely solicit for special issues, and the papers contained therein are typically invited by the editor or guest editor(s). These papers receive a different type of treatment in the review process for many midlevel journals, but undergo the same level of rigorous review for top-tier journals. Usually reviewers invited for these reviews are given some additional instructions about the theme of the special issue and background on any guiding principles that contributor authors were given before preparing their manuscripts.

You Are Invited to Review the Revision

After the initial review, the journal will typically send you, the reviewer, the decision letter as well as the review you completed, along with the reviews of the other reviewers. If the author has an opportunity to revise and resubmit, for most high-level journals the original reviewers will be invited to evaluate the second version. The revision should include a cover letter that the author uses as an opportunity to describe, in point-by-point detail, how the recommendations you and your colleagues made at the initial review were handled. It is your

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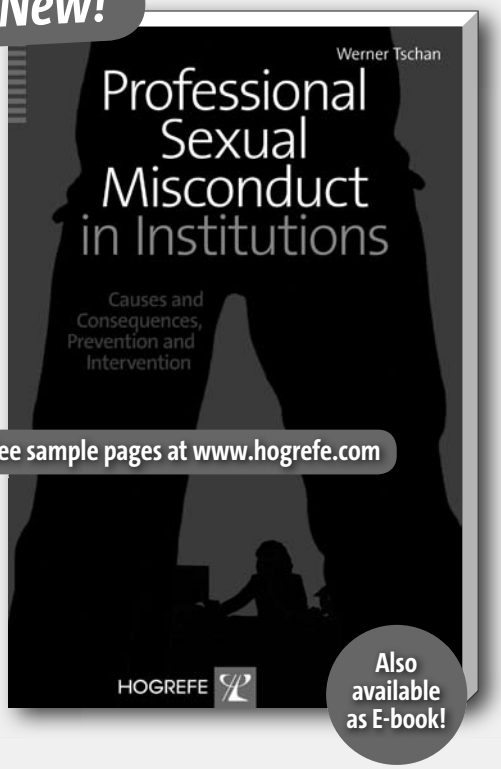

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job now to determine how adequately these changes were carried out.

This leads to some interesting outcomes. Typically authors execute the revisions with skill and manage this task well. Some are unable to do so, and in these cases it does not work out well for the author(s). It is up to you to determine if (a) it should be again reconsidered, in a third review following additional revision, or (b) the author should seek publication elsewhere, with your additional comments to help guide them in further strengthening the paper.

One other phenomenon will become known to you if you begin to review a lot of manuscripts. You may recommend rejection of a paper from one journal only to be asked to review a modified version of the same paper for a different publication. In some instances it becomes evident that the author(s) disagreed with your evaluation as well as that of the other reviewers and submit the paper unaltered from the other occasion you reviewed it. The way you respond to this state of affairs is at your discretion. Some reviewers take umbrage at this, and will excoriate the author(s) for ignoring professional recommendations. Some reviewers just review it anew, with fresh eyes, and offer additional sage comment. Some take a moderate approach and inform the author(s) in their review that they previously reviewed the same manuscript for a different journal, see no substantial change, and then proceed to reissue the same review offered for the other publication. In my personal experience I handle this based on how substantially I disagreed with the author(s) on the first occasion I reviewed the manuscript, and after I have had the benefit of seeing how substantially other reviewers disagreed as well. If there seems to be a consensus among the reviewers, then my approach to the review will be more demanding than if the other reviewers made a cogent argument for the quality in the first pass and they diverged from my assessment. In this latter instance, I will then review again with the other reviewer's comments in mind to see if I stand by my initial evaluation or have a more forgiving attitude.

Unmasking

Reviews for journals are typically anonymous. In some instances you may wish to unmask yourself. Before you do this, consider a few things. What is your motivation for doing so? Is it to curry favor with the author and the other reviewers (in the case of a very good review)? Is it to make your point known, publicly, in the case of a bad review? Are these reasonable justifications for unmasking? At the end of the day, typically little is gained by unmasking, and in my humble estimation, the harm may be greater than any potential benefit. So, when in doubt, don't unmask, and when there is very little doubt, sleep on it and ask a colleague before going through with it. This, incidentally, is the subject of some discussion at present. One opinion suggests that offering potentially unmasked reviews creates conditions where reviewers are fairer and less likely to use incendiary language in their reviews. I personally advocate simply never using a demeaning tone, no matter what the opinion of the paper reviewed. As an editor, I try also to be on the watch for inflammatory language by reviewers and ask for reconsideration of tone when it occurs.

Unintentional Unmasking

Caution is offered against unintentional unmasking. This can come about in a few ways, but two prominent means are noted here. First, the paper you are reviewing may have been one you saw at a conference. You may have even discussed the findings with the author. That conversation may have been noteworthy to the author, but not integrated into the manuscript. Raising issues in your review that you specifically discussed at the conference may tip the author off as to your identity. This is not necessarily bad, but you may not want your identity revealed, so "bury" your conference discussion in the review with other comments so as to potentially throw the author(s) off the scent. The second way you may unmask yourself is by referring to your own research in the review, to the exclusion of other papers. For me at least, as soon as I decide that a paper I authored should have been cited or is offered as a guide to the contributor, I will also cite several additional papers of relevance that were not in the manuscript and to which I was not a contributor.

Issuing Judgment

Do not "feel the power." When you write your review, you will have opinions about the suitability of the manuscript. However, in the body of the review, it is not your job to state outright whether it should be published, revised and resubmitted, or rejected. You will have a place to do that in the reviewer score sheet, but editors tend to take a bit of offense at reviewers making strong statements about manuscript suitability in the actual review. It is all too possible that the paper you think is a stellar monument to the profession is simultaneously viewed by another reviewer as so flawed it should not even appear in a county-level professional association newsletter. Your message about the adequacy or inadequacy will be felt in the content and tone of your review.

This brings me to my last, but by no means least, important aspect to conducting a review. Remember that the paper you review is that of a colleague. Would you want to be on the receiving end of the feedback you are about to issue? It is always better to be diplomatic, even if you are recommending rejection, than to be mean-spirited. Some reviewers take the cloak of anonymity as an opportunity to say things they would never say in polite company. Authors will notice, editors are supposed to keep that in check, and it is in poor form. In only the rarest of circumstances should the tone of the review be discouraging, and when that rare occasion does occur, stop and ask if this is truly that rare occasion.

Reviewing is a critical professional activity. Good reviewing is a task that requires time and attention, and since it is uncompensated, we may feel it is difficult to make the commitment to perform this job. Please consider that you would want your own paper to receive the attention it deserves, and that reviewers will see your work as worthy of their attention when you are yourself asked to review. Ultimately, doing this task can be quite rewarding and serves as a way to sharpen one's own skills in other ways.

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All Access Pass to the 2014 NIMH Research Agenda

Todd B. Kashdan, ***George Mason University***

On January 23, 2014, I had the opportunity to sit in on the 236th policy session agenda meeting of the National Institute of Mental Health (NIMH). During this 1-day meeting, NIMH staff and related mental health associations provide an update on recent accomplishments and discuss their research priorities for the upcoming year. Each year, ABCT receives an invite and sends a representative. This is my attempt to describe the most important details to ABCT members.

Overview of Activities by NIMH

Dr. Thomas Insel, Director of NIMH, started the meeting with an overview of recent NIH and NIMH activities, showcasing larger initiatives. Much of his discussion centered on the global burden of diseases. In a 2013 article in the *Journal of the American Medical Association* (Murray et al., 2013), researchers examined 291 diseases and injuries in 187 countries from 1990 to 2010. By calculating the years of life lost to diseases and premature death, you end up with a metric referred to as Disability Adjusted Life Years (DALYs). The number-one category of costly disorders are neuropsychiatric in nature, led by major depressive disorder and followed by drug use, anxiety, and alcohol use disorders. How have we fared since 1990, with the enormous financial investment in understanding and treating neuropsychiatric disorders? Not good, as the years lost to depression increased (from #7 to #5 on the global burden list), anxiety disorders (from #12 to #13) and self-harm (remained at #14) barely moved over the past 20 years, and schizophrenia only showed a small improvement (from #32 to #27). Based on these sobering numbers, Dr. Insel discussed plans for how to invest money more effectively and efficiently.

NIMH is thinking much more about explicitly addressing functional impairment, which is not synonymous with the presence of distress or psychiatric symptoms (McKnight & Kashdan, 2009). A statement made by Dr. Insel should be considered a mantra for those of us interested in securing grant funding: future RFAs will be directed to move the DALYs dial, and we can think of this as "Dollars for DALYs." To make this happen, Dr. Insel is planning to be directive. He is projecting a bump from 20% to 30% for investigator-initiated funding (set-asides) in 2014. He is investing much more in science that has immediate public health impact, where difficult problems are solved.

Dr. Insel acknowledged that 2013 was an unusual year as the 19% funding line was a drop from 22% in fiscal year 2012, but not as bad as the worst fiscal year ever in 2011, when the funding line was at 17%. In response, there are plans to address the heterogeneity among review groups. Specifically, careful consideration is being given to the following issues: (a) science is changing faster than the selection of who belongs on review groups, (b) not all review groups receive equal quality or quantity of applications, (c) not all review groups are of equal quality in terms of rigor and fairness, and (d) for many institutes, percentiles determine the payline even though assumptions that percentiles are equivalent and are an appropriate proxy for quality have been violated. Another issue that was raised was that the mean age of a researcher's first R01 grant remains at 42 years, unchanged for the past decade. For the last decade, two to three times as much funding has been given to researchers over 65 years compared with 36 and younger. Are we missing the most creative years of scientists? It is unclear why younger scientists are being rejected. No answers were provided at the meeting but, importantly, great thought is going into how to fix these problems.

One solution has been the NIMH BRAINS Program—biobehavioral research for innovative new scientists. You can think of these as smaller pioneer awards. NIMH is soliciting highly innovative, creative, ambitious research proposals from early-stage investigators who are tenure track but without tenure or any prior R01 support. The goal of this program is to break the innovation inhibition of the tenure process and support high-risk/high payoff research programs that address highest NIMH priorities. In 2013, the success rate stood at 20%, a much better payline than other initiatives, with 34 awards given to researchers ranging from 0 to 10 years post-Ph.D.

Following Dr. Insel's remarks, a discussion ensued with the rest of the council. Dr. Steve Hyman spoke of the trouble with any organization in that study sections lead to cottage industries that stifle creativity. His suggestion was to carefully address study section renewal. Dr. Insel was open to a more flexible approach about how one is on a study section and how and when are they removed.

Dr. Nancy Kanwisher spoke of the near-zero correlation between grant funding percentiles and impact (such as citation rates of grant-funded research). Dr. Insel agreed that more needs to be done to fund meaningful, high-impact research. He met with his leadership team to determine the most important breakthrough in each research topic area over the past 5 years. Upon reverse-engineering these breakthroughs, he found that some of the most important science was the most expensive and Pioneer awards have been particularly valuable. Thus, from this exercise, it appears that simply increasing the number of R01s and R03s might not be the answer.

NIMH Strategic Planning

In the next part of the day, Dr. Kevin Quinn, Acting Director, Office of Science Policy, Planning, and Communications, and Dr. Brent Miller, Office of Science Policy, Planning, and Communications, spoke about the 2014 strategic objectives. After a careful review, they agreed that a "tune-up, not an overhaul" is needed in 2014. The same structure, first designed in 2008, will be kept with the following objectives: (a) promote discovery in the brain, (b) chart mental illness trajectories, (c) develop new and better interventions, and (d) strengthen the public health impact of NIMH-funded research. The strategic research priorities that align with these objectives are available on their website.

Both Drs. Quinn and Miller addressed the changing scientific landscape that NIMH must address: (a) mental disorders can be seen as brain disorders, (b) how we conduct research and treat patients (such as mobile technology), (c) health care policy, (d) societal events and needs, and (e) global thinking. A few of the opportunities or challenges, depending on your perspective,

are implementing mental health parity and dealing with the early prediction and prevention of psychiatric disorders. One of the homework assignments for council members, prior to this day's meeting, was to reflect on so-called "paradigm shifts in science and practice" such as clinical genomes, epigenetics and behavior, neurolaw, and augmented cognition, and to think about what areas are ready for grant initiatives, what are the next provocative research questions, and what do we want to prepare for in 2019.

Following the opening remarks, a discussion ensued with the rest of the council. The majority of the council felt strongly about the importance of the first strategic objective of promoting discovery in the brain via themes such as (a) understanding factors acting on brain and emotional development that influence mental health outcomes; (b) increase the ability of the scientific community to collect, deposit, and use "big data" in real time, as well as use it more broadly; (c) understand genetic variation in the brain; (d) take advantage of a new age of targeted neuropsychopharmacology that is on the horizon; (e) understand the neural basis of resilience in mental disorders; and (f) develop the next generation of neuromodulation technologies that leverage new advances in engineering and chemistry. One of only three people to challenge the imbalance toward neurobiology was Dr. Mary Jane Rotheram, who noted that thinking of mental health as a brain disorder goes against sociology, anthropology, and cultural research funded by NIH in the past. Dr. Deanna Barch mentioned that scientists have been dissuaded from looking at common causes and risk factors. This is a problem because common factors offer the "biggest bang for dollars" spent by NIH. Dr. Insel in turn asked, "Are there others besides genetic risk factors?"—to which Dr. Barch replied that there are several, including family environment, poverty, social support, and nutrition. None of these factors are specific to specific outcomes; rather, they are general toxic factors that require more research into the underlying mechanisms and how to alter or prevent them. Dr. Marsha Linehan stated that there is nothing human that is not biological. We need to emphasize how we change but we do not always have to understand them fully to change them. How do you best change the brain? We don't know why behavioral treatments work, and what is the fastest way to the part of the brain to change. Behavioral treatment might be best because you target exactly what you want to change. If we can sell behavioral treatments as those that change the brain, we call sell them better and reduce pharmacological treatment reliance.

Psychologists don't like to hear this but you don't always need a therapist to treat people. We can translate behavioral interventions into computerized platforms. More research is needed on how well these can be created and on how to disseminate them for large numbers of people. Dr. Deanna Barch mentioned that during the development of interventions, we need to consider what the consumer is interested in using. As an example of her point, she mentioned training programs that address neuroplasticity. These technologies have great value for assessment, for what drives a mental illness, and could be useful targets for treatment. Yet, we do not know much about how well they work. Research is required in areas that have consumer momentum.

Several council members spoke on the topic of "big data." How do we reduce the friction cost of the best minds getting access to the data? This is going to require a radical departure for how we handle collaborations. It has clear implications for specifying investigators on initial grant applications and financial support for secondary data analyses. Dr. J. David Sweatt reiterated that there is medical and psychiatric comorbidity, and several common risk factors. If we want to have a huge impact on DALYs, we need an institute where we address both medical and psychiatric problems. Our ability to acquire data exceeds our ability to analyze them. We need to reach out to psychometricians and mathematicians. A point extended by others in that we are going to need integrative centers where the latest innovations in cellular biology, cognitive neuroscience, epigenetics, etc., can be understood and synthesized into meaningful, high-impact work. In response to these points, Dr. Insel stated that a big priority of NIH is to figure out how to move from big data to knowledge.

Patient-Centered Outcomes Research Institute

Dr. Grayson Norquist, Chair, Patient-Centered Outcomes Research Institute (PCORI) Board of Governors, discussed often-neglected funding opportunities. Part of the 2010 Affordable Care Act was to "develop and improve the science and methods of comparative clinical effectiveness research." This led to three strategic goals: (a) comparisons of outcomes that matter to patients, (b) increase quantity, quality, and timeliness of research information, and (c) speed the implementation and use of evidence. Essentially this institute fits with the recent surge of interest in personalized medicine. Given my personal characteristics, conditions, and preferences, what will work best and what are the potential side effects?

Proposals are evaluated to assess the impact of a condition on the health of individuals, the potential for improving care and outcomes, technical merit, patient centeredness, and patient and stakeholder engagement (5 criteria for merit). This is not about developing interventions in terms of efficacy, this is an institute interested in effectiveness. Patients are involved in the research design. Patients are talking about what matters to them and partners right from the beginning. This level of communication between investigators and patients continues throughout the research project. Other priorities include an attempt to create psychometrically sound measures that everyone uses and an interest in co-funding projects with other agencies such as NIH. By collecting data on large patient groups in the real world through networks, we will be able to ask questions that cannot be addressed in small clinical research trials such as heterogeneous clinical profiles and outcomes, and mechanisms and moderators.

Why should you consider PCORI? As of January 2014, they funded 279 projects committing $464.4 million. Mental-health-related issues are central to 31 projects and over $50 million dollars of committed funds. There is one legislation rule: PCORI is not allowed to do any economic analysis on grants. Money is not allowed to be taken into consideration when evaluating proposals. It is also noteworthy that there are no limits on the number of times you can submit, and because this is not a federal institute, they can make decisions and change quicker. More information can be found at http://www.pcori.org/funding-opportunities/funding-center/

NIMH FAST Workgroup

The next speaker was Dr. Jill Heemskerk, Deputy Director, Division of Adult Translational Research, who spoke about a new direction in clinical trials. NIMH is trying to address several problems with conventional clinical trials—unfortunately, the current focus is limited to pharmacological treatments. The typical design is a convenient drug, convenient dose, small sample size, and the primary outcome is efficacy.

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Getting Grief Back on Track: An Introduction to Complicated Grief and Its Treatment

Katherine Shear, M.D.

About 2.5 million people die every year in the United States alone, and 60 million worldwide. Estimating an average of three very close friends and relatives means at least 7.5 million people are bereaved yearly in the United States and 177 million people are bereaved every year around the world. The death of a loved one is a uniquely challenging life experience—one of the most difficult a person can face—yet most people find a way to come to terms with the loss, reshape their relationship with the person who died and restore a sense of meaning and purpose in their own lives. However, for an important subgroup mourning is derailed, leading to development of complicated grief (CG). CG can be reliably identified and is associated with substantial distress and impairment, including a high risk for suicidal ideation and behavior. Research suggests that people suffering in this way respond to a targeted treatment that addresses grief complications and also supports and revitalizes the natural healing process. The purpose of this webinar is to describe CG, discuss ICD11 and other criteria for the condition, and to outline the development and testing of a targeted psychotherapy, along with some study results.

M. Katherine Shear, MD, graduated with honors from the University of Chicago and attended Tufts University Medical School. After completing residencies in Internal Medicine and Psychiatry and a research fellowship in psychosomatic medicine, she joined the faculty in the Department of Psychiatry at Cornell University Medical College. During her tenure at Payne Whitney Clinic she established the department's first clinical research program in Anxiety Disorders. In 1992 Dr. Shear moved to the University of Pittsburgh where she served as Professor of Psychiatry until January, 2006. Her work focused on the development and implementation of funded research in anxiety disorders, depression, and grief, primarily in the area of psychotherapy studies. She has conducted studies and provided mentorship for research using a wide range of different psychotherapy methods including psychodynamic psychotherapy, cognitive behavioral therapy, Rogerian reflective listening treatments for panic disorder, and IPT for depression with panic spectrum features.

Most recently, Dr. Shear has worked in the area of bereavement and grief. She recently developed a novel composite psychotherapy for the syndrome of complicated grief. Her work culminated in the publication of the first randomized controlled treatment study for complicated grief in June 2005. In September 2007, Dr. Shear received a $2.6 million five-year grant from the National Institute of Mental Health to conduct the first clinical study to determine the effects of two different models of treatment for complicated grief in older adults. In August 2009, Dr. Shear received a $1.8 million 5 grant for a complicated grief multisite treatment study examining the relative merits of antidepressant medication with and without complicated grief treatment.

Dr. Shear is currently the Marion E. Kenworthy Professor of Psychiatry at the Columbia University School of Social Work and Columbia University College of Physicians and Surgeons. She is also the Director of the Center for Complicated Grief at Columbia University School of Social Work.

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Theory of Mind Impairments in Social Anxiety Disorder

"Accordingly, individuals with SAD are neither unable nor unwilling to make inferences about the thoughts of others. Rather, they read too much into how others are feeling, thereby misunderstanding social situations."

Hezel & McNally
Behavior Therapy
doi: 10.1016/j.beth.2014.02.010

archive

"Honesty as a strategy can be extraordinarily effective."

Marsha M. Linehan
Cognitive-Behavioral Treatment of Borderline Personality Disorder
(1993, p. 324)

{continued from p. 88}

When negative results arise, they are often meaningless because we cannot determine if the dose is too low, there are too few patients, or the "wrong" patients were studied. This describes nearly everything in the NIH current portfolio that receives good scores in peer review.

The new direction is personalized or experimental medicine, which is where the NIMH FAST workgroup comes in. Not only will we learn about clinical trials, we will learn about the mechanisms of disease/disorder. The funded trials will show that the drug reaches the target (e.g., receptor occupancy) and show that the drug affects the target (e.g., does the drug change brain function? is change dose dependent?). The current contracts are for studies of the mood and anxiety spectrum, psychotic spectrum, and autism spectrum. One of the unique features is the Research Domain Criteria (RDoC) study design. For instance, in the first trial in mood and anxiety, inclusion was based on anhedonia measure scores, and people could possess DSM diagnoses across the anxiety and mood spectrum. In the FAST workgroup, they are not enrolling anyone in any trial based on DSM diagnosis. This is the new model of experimental therapeutics trial designs. They are starting with drug targets but in the future, this will be relevant to behavioral targets. Notably, this was the first time that the RDoC was mentioned during the entire day of activities.

Recommendations

Based on my experience throughout the day, I can offer a few suggestions for what appears most promising to psychosocial researchers. First, NIMH is very invested in meaningful real-world outcomes. Each of us thinks what we study is important and meaningful, but NIMH is clearly invested in objective measures of impairment and, on the other side of the spectrum, healthy functioning. Being able to alter people's thoughts and feelings (i.e., psychological distress) simply does not carry the same weight as concrete changes in physical and social activity (e.g., DALYs). There is great utility in adopting this in basic and applied research. This dovetails nicely with PCORI's mission to fund clinical trials where the outcomes are of paramount importance to clients, who will be partners in the research design. It would behoove us to think like human beings first and scientists second, adopting the perspective of how people want their lives to look like if treatment worked out exactly as desired. These individuals would behave differently and this would be observable, thus, there is no reason to rely on crude assessments via global self-report surveys that ignore social context. Second, for better or worse, NIMH has a strong biological stance toward mental illness. This does not mean we need to abandon cognitive, behavioral, interpersonal, and cultural levels of analysis. What this means is that researchers will benefit from grant proposals that address multiple levels of analysis, and including biobehavioral markers as one level will help in the grant process. One of the benefits is the potential for interdisciplinary collaborations that will enable us to get closer to comprehensive models of human behavior. Third, with the strong interest of NIH in big data, there is great promise in mobile technology for collecting data on assessment, intervention, and prevention. There has been a big upswing in the use of experience sampling with smartphone and cellular phone technology and there are a large number of researchers with the data analytic expertise to best take advantage of these data. Think about the usefulness of this technology in younger adults who are more likely to view these innovations as simple and nonintrusive. We are not limited to intensive repeated self-report assessments, as we can get autonomic data and use this information to target transdiagnostic problems such as suicidality, loneliness, and social avoidance. Combining this technology with interview and laboratory designs in longitudinal designs, we may be able broaden our focus beyond main effects to social interactions and environmental exposures that influence the presence or absence of pathology.

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Science Forum

The Dodo Bird Verdict: Status in 2014

Scott O. Lilienfeld, ***Emory University***

The Dodo Bird, a flightless creature from the island of Mauritius, was hunted to extinction in the closing decades of the late 17th century. In contrast, the Dodo Bird verdict—named after the mythical character in Lewis Carroll's *Alice in Wonderland* who declared (following a race) that "everyone has won, and all must have prizes"—remains alive in the early 21st century. Alert readers will note, incidentally, that I wrote "alive," not "alive and well." The Dodo Bird verdict, as psychotherapists and psychotherapy researchers are aware, refers to the conclusion that all psychological treatments are equal in their effects (Luborsky, Singer, & Luborsky, 1975; Seligman, 1995). Despite strenuous efforts to relegate the Dodo Bird verdict to the same oblivion that befell its feathered namesake (e.g., Beutler, 2002; Chambless, 2002; Chambless & Ollendick, 2001; Hunsley & Di Guilio, 2002), some prominent authors continue to insist that the null hypothesis of therapeutic equivalence cannot be rejected (e.g., Bohart, 2000; Duncan, 2002). For example, Shedler (2010) entitled a section of his influential *American Psychologist* article "The Flight of the Dodo," and after reviewing the early evidence for psychotherapeutic equivalence, concluded that "subsequent research has done little to alter the Dodo bird verdict" (p. 105).

In this brief and highly selective commentary, I survey recent findings bearing on the Dodo Bird verdict, and summarize this verdict's current scientific status. I will argue that this verdict (a) is and always has been a straw person (or should I say "a straw bird"?) and (b) has for all intents and purposes been falsified, and that it is high time to consign it to the dustbin of paleontology once and for all. At the same time, important questions regarding the nature and magnitudes of specific and nonspecific effects in psychotherapy certainly remain (e.g., Wampold, 2001).

Terminological and Conceptual Confusion

Before examining the evidence bearing on the Dodo Bird verdict, we should address several terminological and conceptual issues that have contributed to all manner of confusion in the psychotherapy literature. The original meaning of the Dodo Bird verdict, introduced by psychologist Saul Rosenzweig (1936) nearly eight decades ago, did not refer to the precise equivalence of all psychotherapies. Instead, it referred to a broad equivalence in effectiveness across different "schools" (orientations) of therapy, such as psychodynamic, behavioral, and the like. Over time, however, this verdict has transmogrified into the far more radical claim that all therapies are equivalent in their outcomes. In this contemporary incarnation of the Dodo Bird verdict, all or essentially all of the variance

in therapeutic outcomes is attributable to nonspecific factors, such as the therapeutic alliance. It is worth noting, incidentally, that even the term "verdict" is a misnomer; the modern Dodo Bird is a hypothesis, albeit a dubious one.

For starters, the assertion of exact equivalence across all treatments is highly implausible on at least two grounds. First, a highly conservative and somewhat dated estimate places the total number of psychotherapies at 500 (Eisner, 2000), and even this figure omits many of the more bizarre interventions, such as equine-assisted therapy for eating disorders (Christian, 2005), future life progression therapy (http://www.the-healing-practice.com/id32.htm), and trampoline therapy for autism spectrum disorder (and no, I'm not making that one up; see http://www.komonews.com/news/health/trampoline-216671201.html). The conclusion that there are no differences in outcome among any of these 500+ interventions strains credulity. Second, as many authors (e.g., Cohen, 1994; Lykken, 1968; Meehl, 1978) have noted, in the social sciences the null hypothesis of no differences across interventions is essentially always false. The null hypothesis, which is more precisely the "nil hypothesis" (Cohen) of zero differences across all treatments, almost certainly cannot be true in literal form. It would imply, inter alia, that all psychological techniques are correlated zero (yes, that's r = .0000000, etc.) with the effective deployment of common factors, such as therapeutic rapport, that are themselves tied to positive client outcomes.

At this juncture, some thoughtful readers may balk. The claim of precise therapeutic outcome equivalence, they may understandably insist, must be a straw bird. Surely, no serious scholar adopts such an extreme a position, right? *Au contraire*. Take Duncan (2002), who referred to "the minuscule number of studies that have demonstrated superiority of one model over another" (p. 43) and even likened the comparisons among treatments to "the competition among aspirin, Advil, and Tylenol." "All of them," he wrote, "relieve pain and work better than no treatment at all" (p. 43). Or take Assay and Lambert (1999), who argued that "Curiously, the findings of no differences between treatments go largely unheeded" (p. 40).

Fueling the confusion, various writers have used the Dodo Bird verdict to refer to two quite different assertions, namely, (a) a main effects hypothesis or (b) an interactional hypothesis (moreover, in many cases, authors have not made clear which version of the verdict they are endorsing). The main effects hypothesis posits that collapsing across most or all psychological disorders, all psychotherapies are equal in their effects. In contrast, the interactional hypothesis proposes that there are no treatment-by-disorder statistical interactions: No therapy is preferentially better for any disorder than for any other. Such interactions, it is worth noting, provide the primary raison d'etre for the impetus to develop empirically supported treatments (ESTs; Chambless & Ollendick, 2001). Taken to its logical (illogical?) extreme, this interactional hypothesis implies that, conservatively speaking, the 500 (approximate number of treatments) × 300 (approximate number of DSM diagnoses) = 150,000 treatment-by-disorder interactions are precisely equal in magnitude.

Needless to say, this hypothesis is so patently absurd that we can safely reject it on a priori grounds. Does anyone seriously believe that rebirthing therapy, for example, is as effective for obsessive-compulsive disorder as is exposure and response (ritual) prevention (ERP), or that Thought Field Therapy is as effective as applied behavior analysis for autism spectrum disorder? Even Bruce Wampold, an outspoken advocate of the position that differences among therapies are generally minimal, has been careful to note that this conclusion holds only for bona fide therapies, namely, well-established interventions that are characterized by plausible theoretical rationales (Lilienfeld, 2007; Wampold et al., 1997). Said Wampold (see DeFife, 2010) in an interview:

> From my reading of the research evidence and my own research, it seems that the differences among treatments in terms of benefit to patients are small, if not negligible. This observation applies, however, to treatments that are intended to be therapeutic, are delivered by competent therapists, have a cogent psychological rationale, and contain therapeutic actions that lead to healthy and helpful changes in the patient's life.

Regrettably, this crucial caveat appears to have been cavalierly ignored by some proponents of the Dodo Bird verdict. As a consequence, the conclusion that "the differences in outcome among therapies that have a reasonable theoretical rationale and that all work reasonably well to begin with are often minimal" has in many cases become "the differences in outcome among all therapies are minimal." This semantic slippage is potentially dangerous, as it can contribute to the erroneous belief that the techniques implemented by therapists are irrelevant to client outcomes.

Three Strikes Against the Dodo Bird

These key conceptual issues aside, the past decade has not been kind to the Dodo Bird. Several sources of research evidence have converged to raise serious questions regarding the blanket assertion that all treatments, even bona fide treatments, are approximately (let alone precisely) equal in their effects. I briefly summarize three of them here:

- There is growing evidence that at least some psychological treatments, such as Scared Straight interventions for conduct disordered adolescents and critical incident (crisis) debriefing to trauma-exposed individuals, can be harmful (Dimidjian & Hollon, 2010; Lilienfeld, 2007). For example, in a meta-analysis of randomized controlled trials for the prophylaxis of posttraumatic stress disorder symptoms, Litz, Gray, Bryant, and Adler (2002) found that critical incident stress debriefing displayed a slight negative effect size (d = –.11) compared with no treatment or alternative treatment control conditions. Needless to say, the presence of negligible or even negative effect sizes in meta-analyses raises serious questions regarding the Dodo Bird verdict.

- In a meta-analysis of 26 randomized controlled trials (N = 1,981), Tolin (2010) compared cognitive-behavioral therapy (CBT) with other bona fide treatments, such as psychodynamic, interpersonal, and supportive therapies. For anxiety disorders (d = .43) and mood disorders (d = .21), but not for other conditions, CBT was significantly more efficacious than comparison interventions, with the difference attaining statistical significance for the comparison with psychodynamic treatment. CBT exerted significant effects not only on target symptoms, but also on general psychological functioning, dispelling the oft-cited claim that CBT gains often do not generalize beyond directly treated signs and symptoms (see Brewin, 1996, for a broader discussion). Although the authors of a smaller, follow-up meta-analysis (Baardseth et al., 2013) reported no significant differences between CBT and alternative interventions, Tolin (in press) argued persuasively that their null results were a consequence of introducing excessive "noise" into the analyses. Specifically, when the analyses are

limited to studies with high methodological quality (e.g., random assignment, evaluator blinding to condition) and to global symptom measures, the clear-cut superiority of CBT over other interventions for panic disorder and generalized anxiety disorder emerges (Tolin, in press).

• Bell, Marcus, and Goodlad (2013) conducted a meta-analysis of 66 dismantling and additive studies of psychotherapy, namely, those in which full therapeutic protocols were compared with components of these protocols. Although there were no significant differences among treatments in dismantling studies, the differences among treatments in additive studies were statistically significant, albeit small in magnitude, for targeted symptoms (but not nontargeted symptoms) at termination ($d = .14$) and follow-up ($d = .25$). Although these differences are modest in size, they suggest that the addition of specific ingredients to an extant psychotherapy protocol typically yields enhanced outcomes. This finding runs counter to claims of psychotherapy outcome equivalence, which imply that only nonspecific factors are of consequence.

Strike Four

More recently, another strike against the Dodo Bird verdict came from a stunning study, published in *American Journal of Psychiatry*, by Poulsen et al. (2014). The authors randomized 70 patients with bulimia nervosa to either CBT or to psychoanalytic psychotherapy. Outcomes, measured using the Eating Disorder Examination interview, were assessed at 5 months and at 2-year follow-up by evaluators blind to condition assignment. Both therapies were implemented using treatment manuals developed by the study authors, with treatments delivered by well-trained therapists. Client dropout was addressed using intent-to-treat analyses.

Notably, the dice in this study were loaded heavily in favor of psychoanalytic therapy. Clients randomized to CBT received only 20 sessions of treatment over 5 months, whereas clients randomized to psychoanalytic therapy received 2 years of weekly treatment. Moreover, if any allegiance effects (see Luborsky et al., 1999) were present, they should have worked in favor of psychoanalytic therapy: the study's two lead authors were proponents of this treatment and the study was carried out at a clinic that specializes in this treatment (Hollon & Wilson, 2014).

Still, the findings unambiguously favored CBT. At 5 months, 42% of bulimic patients who received CBT had ceased bingeing and purging, compared with only 6% of patients who had received psychoanalysis. At 2 years, these numbers were 45% and 16%, respectively.

Yes, this is only one study (Coyne, 2014), and we should be cautious about overhyping findings until they have been independently replicated (Pashler & Wagenmakers, 2012). At the same time, the methodological rigor of the study, conjoined with the magnitudes of the group differences, which easily surpass the hoary "inter-ocular trauma test" of statistical significance (see Savage, 2009), should suffice to give even dedicated Dodo devotees considerable pause.

Concluding Thoughts

Clearly, a growing body of data indicates that previous assertions of strict equivalence across all therapeutic modalities have been essentially falsified. None of this implies, of

course, that a host of crucial questions regarding psychotherapy specificity and nonspecificity do not remain to be resolved. Wampold (2001) and others may well be correct that the outcome differences among bona fide treatments have frequently been overstated, and that further attention should be accorded to the role of nonspecific effects in therapy. In particular, it will be essential to ascertain whether certain psychological conditions marked by generalized demoralization (e.g., major depression) may be responsive to a broad range of interventions, whereas conditions characterized by a less pronounced demoralization component (e.g., obsessive-compulsive disorder) may require much more targeted treatment, such as ERP. Wampold and other proponents of treatment nonspecificity have also raised constructive questions regarding the overriding emphasis on ESTs given that sizeable treatment-by-disorder interactions may be harder to come by than many of us (myself included) had once supposed. In the coming decade, a heightened emphasis on empirically supported principles of change that cut across many treatments, such as exposure, behavioral activation, and positive reinforcement of adaptive behaviors (Rosen & Davison, 2003), as well as on transdiagnostic therapeutic protocols (Barlow et al., 2010), should contribute to a thoughtful reconsideration of the relative roles of specific versus nonspecific factors in treatment processes and outcomes.

In the meantime, scholars on both sides of the debate should be able to find common ground on one central point. As my colleague Marshall Duke has noted, the Dodo Bird has become an albatross. It has increasingly impeded progress in psychotherapy research, and it has outlived its scientific utility. The verdict of strict outcome equivalence across all psychotherapies, whether in its main effect or interactional form, should at long last be declared extinct and, like its feathered counterpart, forever banished to the exhibit halls of museums.

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■ **CALL *for* PAPERS**

President's New Researcher

ABCT's 2013-2014 President, Dean McKay, Ph.D., invites submissions for the 36th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. Submissions must include the nominee's current curriculum vita and one exemplary paper. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or post-residency); and (b) have been published in the last two years or currently be in press. Submissions will be judged by a review committee consisting of Dean McKay, Ph.D., Stefan G. Hofmann, Ph.D., and Jonathan D. Abramowitz, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 5, 2014, and must include four copies of both the paper and the author's vita and supporting letters if the latter are included.

Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

DEADLINE: August 5, 2014

Call *for* Applicants

The **Association for Behavioral and Cognitive Therapies** (ABCT, www.abct.org) invites applications for a Director of Outreach and Partnerships, with a likely start date in summer 2014. This full-time position with competitive salary and benefits reports to the Executive Director. ABCT is a 4,600 member-strong professional organization committed to the advancement of scientific approaches to the understanding and improvement of human functioning. Responsibilities include the development, implementation, and coordination of membership growth and retention strategies; building partnerships with other professional and allied organizations to advocate for and advance shared goals such as federal funding for behavioral research, recognition/funding of evidence-based approaches to prevention and treatment; and advancing ABCT's dissemination goals. The successful candidate will be outgoing, dynamic, collaborative, and energetic; possess excellent communication skills and passion for the mission of ABCT; and be able to represent ABCT well to diverse constituents.

***Required qualifications*:**

1. Doctoral degree in psychology or related field + ≥ five years' experience
2. Licensed or license-eligible
3. Knowledge and passion about ABCT: cognitive-behavioral orientation and commitment to science and evidence-based principles
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***Preferred qualifications*:**

1. Experience with professional organizations
2. Experience with outreach, membership, and marketing
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4. Experience building partnerships
5. Experience with information technology including social media
6. An academic background in population-based approaches to dissemination (e.g., MPH)

ABCT is an Equal Opportunity/Affirmative Action Employer. Send CV, contact information for five references, and a letter addressing the alignment of your experience with the qualifications to **DirectorofOutreach@abct.org**. Review of applications will begin on March 24, 2014 and continue until the position is filled.

ABCT

The Lighter Side

NIMH Mad Libs

Brett J. Deacon, ***University of Wyoming***

INSTRUCTIONS: *A fictitious, familiar, yet incomplete NIMH press release appears below. Choose one term from each parenthesis to fill in each blank. You may select answers that reflect the positions of NIMH and/or assumptions of the biomedical model (listed first in each parentheses), or alternative answers based on science and/or reality (listed second). It's up to you!*

On the Verge of Revolutionizing Precision Medicine by Hopefully Transforming Diagnosis

Since the publication of DSM-III in 1980, biomedical research has demonstrated that mental health problems are _____ (disorders of brain circuits[1]; psychological problems with largely unknown biological causes). Indeed, it has become an NIMH mantra to describe mental disorders as _____ (brain disorders[2]; caused by the complex interaction of biological, psychological, and environmental factors). Advances in neuroimaging and other cutting-edge biomedical technologies have revolutionized our understanding of the brain, thereby _____ ("completely alter[ing] the way we approach diagnosis[3]"; having no effect on how diagnoses are made) and leading to _____ (the development of safer and more effective biological treatments; no meaningful advances in biological treatments[4]). Mental health outcomes in the United States have _____ (improved; worsened[5]) alongside NIMH's support of biomedical theories and treatments in preference to evidence-based psychosocial approaches. To illustrate, dramatic increases in the use of "antidepressant," "antipsychotic," and stimulant medications have witnessed a _____ (decrease; marked increase[6]) in the prevalence of Americans on federal disability for the mental disorders these medications treat. Newer antipsychotic, antidepressant, and "mood stabilizing" medications are _____ (more effective; no more effective[7]) than first-generation versions of these drugs discovered by accident in the 1950s. Mental health stigma has _____ (improved; not improved[8]) as Americans have come to adopt our position that mental health problems are biologically based brain diseases. One mental disorder listed in DSM-IV, Rett's Disorder, has even been conclusively shown to have a biological cause.[9] As a result, Rett's Disorder has been _____ (heralded as proof in principle that mental disorders are biologically based diseases; removed from the DSM-5 as a mental disorder and reclassified as a genetic disorder[10]).

Despite these developments, reliance on the DSM diagnostic system is limiting our progress. Now that DSM-5 has been published, it is clear that DSM diagnoses are _____ (not valid[11]; neither reliable nor valid[11, 12]). Mental disorders are diagnosed based solely on symptoms, and objective laboratory measures for DSM diagnoses do not exist. In the rest of medicine, symptom-based diagnosis is not credible and has been largely replaced by diagnosis based on objective laboratory tests. Our declaration that DSM diagnoses lack validity because they cannot be diagnosed with objective tests has been previously asserted by _____ ("anti-psychiatry" forces who "don't want to improve mental healthcare"[13]; well-informed critics whom we have spent half a century vilifying as "anti-psychiatrists" for making this same point[14]). Given that the DSM system provides the foundation for nearly all mental health diagnosis, billing, coercive treatment, forensics, and research in the United States, its lack of validity is a serious problem for _____ (biomedical researchers only[15]; our entire mental health system). Our admission that DSM diagnoses do not have established biomarkers ____ (dictates that we redouble our efforts to discover the biological causes of mental health problems rather than consider the consequences of pursuing a failed paradigm; directly contradicts our long-standing position that mental disorders are brain disorders with recognized biological causes[16]).

Patients with mental disorders deserve better. That's why NIMH has launched the Research Domain Criteria (RDoC) project. We are committed to _____ (demonstrating that mental disorders are real medical diseases that can be diagnosed with objective laboratory measures[11]; meeting the needs of Americans with mental health problems). Although science has not advanced to the point where a neuroscience-based classification is possible, we must nevertheless proceed as if genetics and neuroscience will someday inform diagnosis.[17] Therefore, _____ (we are funding the creation of a new diagnostic system that will hopefully lead to the discovery of as-

yet unknown biological causes[17]; mental health problems may not be brain diseases after all). The RDoC initiative assumes that psychological problems are disorders of brain circuitry, and that the tools of clinical neuroscience will identify dysfunctions in neural circuits.[18] This initiative will support research designed to achieve the failed goal of DSM-5: "translat[ing] basic and clinical neuroscience research relating brain structure, brain function, and behavior into a classification of psychiatric disorders based on etiology and pathophysiology."[19]

RDoC is a necessary first step toward precision medicine in which assessment of "molecular signatures, neuroimaging patterns, [and] inflammatory biomarkers"[20] may lead to "cures" for "brain diseases" like depression and anxiety disorders.[21] Understanding the true nature of mental health problems will require contributions from many sources, such as _____ ("genomics, epigenetics, electrophysiology, animal models, [and] clinical psychiatry"[22]; scientists from a variety of disciplines who study biological, psychological, and environmental contributions to mental health problems). Given that we estimated the arrival of "biodiagnosis" and "treatment of core pathology" in 2015,[23] the need to uncover the biological causes of mental disorders is urgent if we are to retain our credibility.

The NIMH is optimistic that additional decades of biomedical research following the RDoC project will _____ (renew dwindling pharmaceutical industry interest in psychiatry[24] and bolster psychiatry's image as a clinical neuroscience discipline[23]; perpetuate the opportunity cost associated with dramatically underfunding empirically supported psychosocial approaches). Our confidence is based on the track record of biomedical research in the modern DSM era, which demonstrates that we are _____ (currently; perpetually[25]) "on the verge"[26]/"on the cusp"[27]/"on the brink"[28]/"on the threshold"[29]/"facing a tipping point"[30] of transformative breakthroughs that might revolutionize mental health treatment. Under the leadership of biological psychiatrist Thomas Insel, the NIMH is committed to a future in which all patients with mental disorders undergo expensive biological testing administered by psychiatrists in medical settings to facilitate the use of personalized biological treatments provided by psychiatrists.

The RDoC initiative is symbolic of the NIMH's commitment to disproportionately support biomedical research over evidence-based psychosocial approaches like cognitive-behavioral therapy that are often at least as effective as medications in the short term and more effective in the long term, have no adverse biological effects, are less expensive, and are strongly preferred by patients. Psychological scientists are encouraged to submit grant proposals for the RDoC initiative, provided that their research facilitates the "power of biology to identify illnesses linked to pathophysiology" and "the development of more specific [biological] treatments."[17] Psychologists interested in having their research supported by NIMH in the current funding climate must understand that _____ ("to be a leading clinical psychologist, you have to know cognitive science, you have to know the biological basis of behavior, you have to know neuroscience, you have to know a fair amount of genetics"[31]; psychological research is not valued unless it is intended to demonstrate the biological underpinnings of psychological processes). We leave it to the profession of psychology to deal with the consequences of our virtual requirement that psychological scientists must conduct neuroscience research if they wish to be supported by the NIMH.

Although three decades of NIMH biomedical research funded by billions of taxpayer dollars have failed to discover reliable biomarkers, produce safer and more effective biological treatments, or improve mental health outcomes, we are confident that additional decades of biomedical research will validate our faith in this approach. Indeed, we have just allocated $40 million in 2014 to the BRAIN initiative, which focuses on "advancing our technological capabilities for understanding how circuits of interacting neurons function to create behavior, with the ultimate goal of improving our scientific foundation for the diagnosis and treatment of brain disorder."[32] The NIMH looks forward to a future in which advances in biomedical research lead to biological tests and cures for brain diseases. In the meantime, we ask that individuals with mental health problems who have difficulty accessing safe, effective, and affordable interventions wait patiently while neuroscientists go about their work.

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Clinical Forum

My Third Star: Reflections on 15 Years of Attending ABCT Conventions

Jennifer Block-Lerner, ***Kean University***

Perhaps it is because this was a "light" year for me, with no talks and thus no last-minute slide edits, room checks, anticipatory anxiety, and lengthy debriefing conversations. Perhaps it is because I traveled alone, without my family, for the first time in many years. Perhaps because I have an amazing roommate/friend/colleague, with whom I can process experiences large and small. Perhaps it can be attributed to the fact that, as a friend and I checked in at the conference and were offered gold stars to put on our name tags (one for every five years of membership), I was a bit shocked when I calculated that this was my 15th year attending the annual event. And, perhaps it is all of these things and also just because I am getting older and have the benefit of some hindsight and perspective. For whatever combination of reasons, it seems that I have been able to navigate this ABCT conference more intentionally, consciously, and reflectively than in years past. In so doing, I am finding myself immensely grateful for so many elements of my experience "here" and in and with the organization more generally.

I distinctly remember my graduate school mentor, Elga Wulfert, and more advanced labmates coming back from AABT back in 1997, the year I began the clinical psychology doctoral program at the University at Albany. They spoke with such enthusiasm and excitement about their time in Miami Beach. It was an almost unspoken assumption that I would join them the following year with a poster to present in hand. I don't remember if I did indeed carry a poster to that conference, but I do very fondly recall a symposium on the clinical utility of John Cone's functional assessment matrix that my classmates and I put together under the direction of John Forsyth, the instructor of our first-year behavioral assessment course. While few people attended the early-morning talk, the camaraderie and learning that came of the preparations, shared traveling and—much to our delight—conversation with John Cone himself over coffee in the underground mall in Toronto after the event, were extremely influential. Of course, there were the "celebrity" sightings in the elevator that allowed us to, with awe, put faces to the names of those whose work we were absorbing in classes and other training contexts. That conference and those over the next few years brought life-changing introductions to therapeutic frameworks and many opportunities to grow as I nervously embraced opportunities to ask questions of those I so admired, designed, and presented on various research projects, and connected with those who generously gave of their time to support my work and/or who paved the way for my professional path ahead. I so clearly remember the deep excitement of the moment that I spoke with Sue Orsillo at the internship "meet and greet" event during my fourth year, knowing I had just submitted my application to the Boston VAMC and hoping with great fervor that I would be selected to interview at the site.

The next year brought a most memorable journey to the conference, with almost half of my large internship class renting a van and driving from Boston to Philadelphia with some shopping adventures along the way. Then came several years of co-chairing symposia and speaking with pride on experimental studies, conducted during postdoc and as a Visiting Assistant Professor, that contributed to the forging of long-term collaborations and friendships. During these years, I became keenly aware of the "small world-ness" of ABCT and how interconnected the circles really were (e.g., my internship classmate's grad school classmate was on internship with my grad school classmate . . . and so it goes). I loved this.

As I assumed a faculty position in a relatively small Psy.D. program after several years of teaching at a liberal arts college, I was once again grateful to be heading to the conference with so many from "home." I enjoyed spending time with current colleagues and students in a new context, getting to better know each other as whole people. I tried to emulate my mentors' styles of integrating students into the fold, introducing them to colleagues and friends from other institutions and enthusiastically promoting their work. At the same time, I became more and more appreciative of the opportunities to reconnect with mentors, colleagues, friends from earlier chapters in my life. A shared breakfast or cup of tea, lab dinner, quick though meaningful conversation in a hallway—these were opportunities to catch up on lives—professional positions, specific responsibilities, relationships, and then often the expansion of families as many colleagues and/or their spouses became pregnant and had children. A special kinship was forged with those who had little ones around the same time as I did; we have continued to swap stories, celebrate, and share the challenges of various stages on a yearly basis as those children have grown.

So many moments throughout the years have shaped who I am as a professional and whole person more generally. I remember bringing my older son, Ben, to students' poster sessions and program social gatherings; feeling the challenges and joy of wearing multiple hats simultaneously. I recall, from only last year, experiencing deep pride in and respect for a doctoral student, sitting alongside some of the most well-known experts in our field, holding very high levels of anxiety and beautifully contributing to a panel discussion on mindfulness and ACT-based interventions in higher education. I remember, as a more advanced graduate student, being approached by someone at a poster session, marveling at the challenging questions he was asking me about my pilot study and only later learning that he was a co-developer of the very treatment approach I had implemented. I fondly think back on the time that my graduate school classmate, husband-to-be, and I arrived at the conference hotel late at night to be told that there were no more regular rooms available; shortly thereafter we were escorted to the "prime minister's suite," formal dining room, club-level privileges, and all and collapsed on the floor laughing at the irony of meager graduate students being granted such special treatment. On a much more serious note, it was at ABCT that an internship classmate/dear friend shared news of symptoms that were shortly thereafter attributed to Stage 4 colon cancer; it was also at the conference 6 years later that close friends and colleagues gathered together for a moving and heart-wrenchingly bittersweet memorial service. It is also at the conference that we come together year after year to speak with sadness and gratitude about the lessons that Deb continues to teach us.

While some are unique and personal, I know that elements of these stories are universal to all of us who have been coming to the conference for many years (and I recognize that while I am marveling over my 15 years, there are many who have earned double, triple, and maybe even quadruple the number of stars). As I prepared to head back from the conference, back to my home institution, I found myself wanting to help the students I work with to feel similarly connected to the organization and similarly committed to attending the annual convention, for the gifts that such involvement promises to continue to provide. I have also come to realize that many members of the cohorts of which I have been part attend only very sporadically or not at all. This has led me to reflect on various individuals' experiences with the organization and ways of thinking about conference attendance and led me to consider whether this might not be a valuable larger "conversation" to have, thus prompting the writing of this article.

It is easy when thinking about conference experiences and considering whether or not to attend to focus on workshops, symposia, panel discussions, and poster sessions. Of course, these can offer invaluable learning opportunities and the chance to hear, see, and otherwise experience those who are shaping our field. Conference attendance might also offer the promise of seeing a new city or experiencing an old favorite (although I have personally found it hard to find the time to get out into the "world" [especially challenging, and perhaps necessary, in the city of a hotel in Nashville!]). However, if this is all or even most of what the decision to attend is based on, I believe that we miss some of what can be the richest and deepest gifts of regular attendance. I say this recognizing that for some groups of professionals, especially those in predominantly clinical positions who face not only the high costs of attendance (including hotel, transportation, and food, in addition to registration fees) but also the loss of salary based on cancelled sessions, it is not an easy choice. And, I am continually humbled by the wisdom and "theory in action" that the full-time clinicians I interact with demonstrate and also the possibilities for collaboration across professionals in various roles. Similarly, as a wise committee chair at a meeting I attended recently stressed, members of allied health professions need to be part of our conversations and committee work over the long haul to truly be able to "harness the synergy." Thus, these are important questions to explore as we continue to build membership and, related but not one and the same, potential lifelong connections to the organization.

Some of the value of regular conference attendance might come from attending any professional convention on an annual (or other regular) basis. Connecting with old friends; developing new collaborations and friendships; appreciating the interconnectedness of circles; seizing outstanding opportunities to hear from experts in the field and to share and get feedback on one's own work; wanting to be in three places at once and using that awareness to make very conscious choices about which talk to attend, which friend to meet, or how long to go back to one's room to regroup, while likely still mourning untraveled paths; experiencing new scenery and a pause in daily/weekly routines that might allow for a fresh perspective or just a much-needed break—these can likely be experienced at conferences with any number of acronyms and their own versions of alphabet soup. However, I do believe that some of what I have come to deeply appreciate about regularly attending ABCT is indeed unique to ABCT. Serving as chair of the Academic Training Committee for several years and as a committee member thereafter helped me to become aware of the governance structure of the organization (really felt like a secret world I was suddenly becoming privy to; I don't think it is anyone's intention to conceal it and with the expansion of the website it probably isn't nearly as "hidden" as it seemed to me at the time) and how much opportunity there really is to have an impact. Further, I came to know and deeply appreciate the people who run the ship, year in and year out, as leadership changes with each election and committee chair term. MJ, David Teisler, and others I haven't worked with as closely but whose names are familiar and comforting—in my experience, these individuals truly form the backbone of all of the great work that happens within the organization; we are very blessed.

I also think that a tremendous part of what makes ABCT special is that all of the convention presentations, journal articles, and other means of dissemination are ultimately, most basically, about the alleviation of human suffering. We can dispute the best ways to approach this undertaking (and often lively such disputes are memorable and clarifying in their own right, making the breadth of the organization, the largeness of the umbrella of "CBT," powerful). And, as Skinner (e.g., 1945) so aptly conveyed, even the behavior of the scientist is amenable to analysis. So, *how* we dispute, *how* we conduct our empirical research, *how* we decide how many clients to see and where and how much to charge, *how* we mentor our students, *how* we form and behave within consultation groups, *how* we serve and otherwise engage with the organization, *how* we decide which sessions to attend and which colleagues or friends to have lunch with—all of these can themselves be explored through our theoretical frameworks and subject to empirical study—and we know this. It may be this notion, this awareness in our very bones, that is humbling and that allows us to be productive workers (e.g., through making use of stimulus control techniques to foster our writing), committed partners, and perhaps effective parents to our children or pets (e.g., with keen awareness of the dangers of the negative reinforcement trap; Patterson, 1986) and, related, prompts so many of us to be intentional and values-driven in our choices as much of the time as possible. Personally, coming to ACT and other mindfulness and acceptance-based behavioral approaches—with my first formal exposure through ABCT (I will never forget the impact that Steve Hayes' presidential address in 1998 had on me; I purchased the audio tape and listened over and over) and then through my wonderful good fortune of training with Sue Orsillo and Liz Roemer, have given me a powerful framework in which to develop as a professional and a whole person, indeed blurring the lines between professional and personal, across all of the many hats that we all wear (I love Kelly Wilson's, 2005, "one life" notion here). It is what makes it easy and delightful to come together with like-minded others over coffee or on an airplane to or from a conference and to forge what feel like enduring friendships in a matter of hours or even minutes. It is what allows me to sit with important questions about the extent to which I am writing a paper or working on a book because it is important for me to add lines to my CV or those of students working with me, because I believe that I might have something meaningful to say, and/or because of a variety of other contributing factors. It is what makes all of us passionate lifelong learners.

In conclusion, I thank you for traveling down memory lane with me and listening to my musings. Again, I share specifics of my own journey in large part because I strongly suspect that many elements of these experiences are universal to those of us who bear multiple "stars" and might speak to the potential big-picture value of conference attendance and organization involve-

ment. I am very grateful to all who have shaped my experiences within ABCT (including those who have "held down the fort" at home so that I might be able to attend each year) and hope that this piece might play a small role in contributing to decisions about conference attending and the *how* of navigating the days to come in Philadelphia, Chicago, New York, and wherever else the years take us, should we be so fortunate.

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