

the Behavior Therapist

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President's Message

Greetings From Nebraska

Debra A. Hope, *University of Nebraska, Lincoln*



In my first column writing as President, I would like to thank the membership for the opportunity to serve ABCT, the association that has been my professional home for the past 25 years. (Yes, I received my fifth gold star on my name badge at the meeting this year!) Serving as your President is a tremendous privilege and a highlight of my professional life.

As I write this in early January, I am hearing stories in the news media about the various governors who are taking over states in deep budget crises. Although not the fodder of national news, I know a similar story line is occurring at many professional membership organizations. I feel fortunate to come into this role at a time when our association is very healthy. We ended the year with a rosy budget picture, thanks in part to the success of the New York City conference in 2009. While other similar organizations experienced declining membership, we reached a long-standing membership goal of over 5,000 members in 2010 (5,088 to be exact). As the Board comes to the Strategic Planning Retreat this May, we can focus on what we would like to achieve, not how are we going to survive.

Each November the Board meets for a full day on the Thursday of the convention. Under the able leadership of Frank Andrasik, we had a productive meeting in San Francisco. In part, we focused on the basic functioning of the association, including hearing committee reports and assessing our progress towards the goals that

[continued on p. 19]

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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
 - Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
 - Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
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were set the previous year. Many people work very hard to get our business done. If you click on "Governance" on the ABCT Members tab of our website, you will see a list of many of these people, including Board members, central office staff, coordinators, journal and web editors, committee chairs and committee members. Nearly all committee reports had a long list of "tasks accomplished" in the previous year—a list far too long to enumerate here. My thanks to everyone who contributes at every level to our shared mission.

As good behaviorists, we know the importance of having observable, measurable outcomes, so each November we set a list of priorities for the coming year. For 2011, the priorities are to:

- plan and conduct a productive Strategic Planning Retreat;
- lead the development of a model CBT predoctoral training curriculum via our Dissemination Task Force on Training;
- continue development of our web site;
- increase our endowment to \$2 million;

- strengthen and enhance our member base; and
- help grow our next generation of leaders.

These goals are not in a particular priority order—we see all of them as very important. The last four are continuations of goals from last year as we have identified the next step towards these larger outcomes.

One of my first tasks as President has been to develop an agenda for our Strategic Planning Retreat. I will work with the Board and Executive Director Mary Jane Eimer to plan our time well. We have had some preliminary discussions of topics, including what we could do next on dissemination and where to go with our use of the web and social media. Watch for a later column devoted to retreat topics, but I would welcome thoughts now from any member regarding where the association should be going and/or what are our greatest needs—e-mail me at dhope1@unl.edu with *ABCT Strategic Plan* in the subject line. I hope to foster a retreat with a good balance of cre-

ativity, wisdom (about where CBT is going or should go), and practicality.

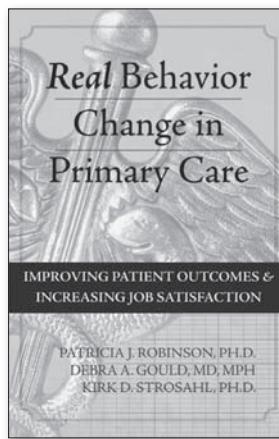
Finally, I would like to thank Frank Andrasik for his excellent service as President in 2010. Thank you, Frank, for your good judgment, sense of humor, and tireless devotion to the association. Stefan Hofmann also ended his term as Representative-at-Large in 2010. He was an active participant in our monthly Board calls, providing astute comments on many issues. George Ronan ended his term as Secretary-Treasurer. George's understanding of our budget and investment strategies is truly amazing. Many thanks to Stefan and George for your service. Welcome to our new Board members: Denise Davis, Secretary-Treasurer; Lata McGinn, Representative-at-Large; and Bob Klepac, President-Elect. I look forward to working with all of you.

...

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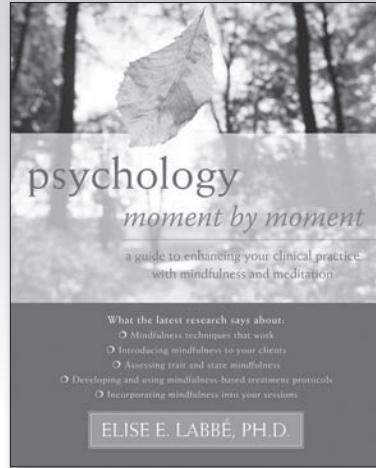
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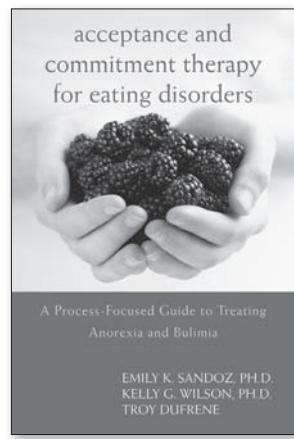
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The Therapeutic Relationship in Prolonged Exposure Therapy for Posttraumatic Stress Disorder: The Role of Cross-Theoretical Dialogue in Dissemination

Jay A. Morrison, University of Mississippi Medical Center

Prolonged exposure therapy (PE) for posttraumatic stress disorder (PTSD) achieves symptom reduction by extinguishing the classically conditioned association between traumatic memories and physiological responses to fear through the use of repeated imaginal exposure to the traumatic event. While exposure to additional cues in the environment that have come to trigger the fear response through similar classical conditioning mechanisms is also a part of the treatment, instructing and guiding patients in the imaginal exposure technique constitutes the majority of the time spent in therapy (see Foa, Hembree, & Rothbaum, 2007, for a full description).

Numerous investigations have demonstrated the effectiveness of PE and imaginal exposure (see, for example, Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010, for review), including data demonstrating the following: equivalent dropout rates to other active treatments (Hembree et al., 2003); that symptom exacerbation occurs only in a minority of patients and is neither related to retention nor posttreatment outcome (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002); the equivalence of a 30-minute versus a 60-minute dose of in-session imaginal exposure for successful posttreatment outcome (van Minnen & Foa, 2006); expansions of the efficacy of imaginal exposure with alcohol-dependent populations (Coffey, Stasiewicz, Hughes, & Brimo, 2006) and cocaine dependent populations (Brady, Dansky, Back, Foa, & Carroll, 2001); and modifications of the approach in challenging community settings (Henslee & Coffey, 2010).

In spite of this large and accumulating body of evidence in support of PE, systematic investigations of its implementation by practitioners treating PTSD are few (Becker, Zayfert, & Anderson, 2004; Cahill, Foa, Hembree, Marshall, & Nacash, 2006; van Minnen, Hendriks, & Olff, 2010). However, this literature suggests that PE

and imaginal exposure, in spite of their demonstrated effectiveness, are, in fact, greatly underutilized. Several general factors associated with therapists' implementation of PE are noted in this literature, including lack of adequate training and supervision, concerns regarding iatrogenic effects, and the complicating impact of comorbid diagnoses. In addition to these concerns is a stated preference by therapists for *individualized* over *manualized* treatments (Cahill et al., 2006).

This distinction between *individualized* and *manualized* is certainly worth greater scrutiny and more careful discrimination. It implies a dichotomy between a personalized treatment, which accommodates to the individual and responds to his or her unique needs, and a less flexible, mechanically applied, and perhaps even dehumanizing technology on the other. The idea that manualized treatments are reductionistic, that they do not capture the full complexity and nuance of human experiencing, and are particularly incapable of responding to life-altering traumatic experiences, is an idea that may be held, to some degree, by many of those delivering mental health services to traumatized individuals today. The thought that manualized treatments prevent the development of a therapeutic relationship that is critical for symptom improvement, and that individualized treatments do, may be a significant barrier to the utilization of exposure therapies.

It is here that cross-theoretical dialogue may be useful to the dissemination of PE for PTSD. A consideration of the therapeutic relationship and processes postulated by other orientations might allow CBT proponents to communicate even more effectively how the quality work that CBT practitioners perform in developing and using relationships parallels closely, or is not exclusive of, many of the relational processes proposed by other therapeutic schools. This might also lead to innovative new ways in which to approach the many misconceptions that

continue to exist regarding PE (see Feeny, Hembree, & Zoellner, 2003, for a discussion of some of these misconceptions).

In spite of the fact that the perceived absence of a relational dimension to the therapy may impede dissemination efforts, remarkably little conceptual or empirical work has addressed the therapeutic relationship in PE for PTSD. A handful of studies have examined the therapeutic relationship using the 12-item version of the Working Alliance Inventory (WAI; Tracy & Kokotovic, 1989). The working alliance as operationalized by this measure defines the therapeutic relationship from a CBT perspective: the extent to which the client and therapist agree on goals and therapeutic tasks, and the extent to which the client has confidence in the therapist. Although this limits the usefulness of this literature for cross-theoretical dialogue in some ways, it remains an important literature in need of expansion, and is worth brief review here.

Keller, Zoellner, and Feeny (2010) reported stronger working alliance scores as assessed by the WAI earlier in treatment in a sample of women randomly assigned to PE compared to those assigned to sertraline treatment. A stronger early alliance was associated with higher rates of homework compliance in PE, and modestly associated with number of sessions completed equally in both treatments. A history of positive trauma-related social support was also associated with stronger early alliance in PE, and, based on this, the authors propose that additional time solidifying the working alliance or adding procedures for developing stronger social networks for patients who did not receive positive trauma-related social support may be useful. This, however, seems to suggest the need for augmentations to PE, and strong data in support of this idea are presently lacking (see Hembree & Brinen, 2009, for a discussion of PE augmentation).

Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) examined the effect of a two-phase treatment in a sample of women with a primary diagnosis of PTSD and a history of childhood physical or sexual abuse. Phase 1 consisted of 8 weeks of skills training in affect and interpersonal regulation and Phase 2 consisted of 8 weeks of a modified PE procedure (STAIR/MPE). A stronger working alliance was associated with greater posttreatment symptom improvement, and this association was mediated by the patient's capacity for negative mood regulation in Phase 2. However, the lack of a comparison group in this study

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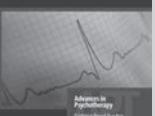


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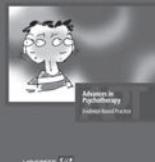


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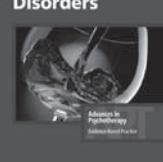


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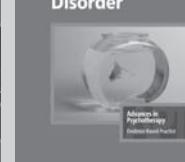
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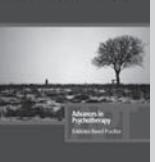
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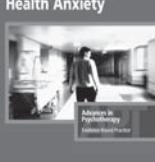
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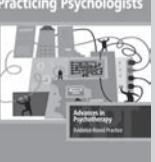
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prevents speculation about the role of the alliance in PE versus modified procedures, as has been noted elsewhere (Cahill, Zoellner, Feeny, & Riggs, 2002).

Although not specific to PE treatment, findings from two other investigations may be informative regarding the working alliance in exposure therapy for PTSD. Kendall and colleagues (2009) found that, in a sample of 86 children receiving treatment for separation anxiety disorder, generalized anxiety disorder, or social phobia, the introduction of exposure exercises did not alter the trajectory of growth in the therapeutic alliance over the course of treatment, nor was this trajectory different from a comparison treatment in which no exposure exercises were included, as assessed by a modified version of the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992), a measure conceptually similar to the WAI. Meyerbröker and Emmelkamp (2008), in the only study examining the alliance in virtual reality exposure therapy, found that a stronger alliance as assessed by the WAI was associated with greater improvements in those in treatment for fear of flying, but not for acrophobia. Overall, while there is certainly a need for more research in this area, there seems to be no evidence that exposure approaches have a negative impact on the therapeutic alliance.

The following discussion aims to expand the discourse on alliance in PE by noting ways in which elements of the therapeutic relationship espoused by other therapeutic orientations are relevant to a systematically and rigorously applied exposure therapy for PTSD. Three theorists within the history of psychotherapy who, over time, have emphasized the importance of the therapeutic relationship may be especially useful to the present discussion: the self-psychology of Heinz Kohut; the person-centered therapy of Carl Rogers; and the Stone Center's relational-cultural theory, as described by Jean Baker Miller and Judith V. Jordan. A brief review of their principle positions with respect to the therapeutic relationship and its role in symptom amelioration will be provided here and compared with the therapeutic relationship in exposure therapy for PTSD.

The Self-Psychology of Heinz Kohut

The principle therapeutic technique of Kohutian self-psychology is that of empathic immersion, or *vicarious introspection*. While scholars have critiqued the originality of Kohut's theory and its uniqueness from other theorists in the object-relations

schools of thought overall (Greenberg & Mitchell, 1983), his particular emphasis on the importance of the analyst's use of introspection to guide accurate articulations of the patient's experience was historically quite influential. Kohut articulated this process in the following way:

The core area of [self psychology]...is defined by the position of the observer who occupies an imaginary point *inside* the psychic organization of the individual with whose introspection he empathically identifies (vicarious introspection). (Kohut, 1971, p. 219, italics original)

For Kohut, the analyst's ability to imagine her- or himself into the subjective world of the patient facilitates the gradual strengthening of the patient's sense of self as the analyst reflected back the patient's perspective with accuracy. The increasing internalization of the relationship with the analyst, in which the patient experiences being accurately understood, leads to the reunification of the patient's otherwise fragmented or fragile self-structure and an establishment of the capacity for healthy interdependence with others.

At first it is difficult to perceive the relationship between the use of vicarious introspection in Kohutian self-psychology and the technique of prolonged exposure therapy for PTSD. The similarity appears when considering carefully the role of avoidance in traumatic stress, and the difficulty many patients have initially in reexperiencing, in the fullest sensory and emotional detail possible, their traumatic experiences. It is not uncommon for patients to offer elaborate descriptions of one aspect of the trauma, even aspects that may seem to be the most emotionally charged from an outside perspective, only to gloss over, rush through, or omit entirely the portion of their experience that was, in fact, the most difficult for them. The therapist's capacity to notice the more subtle manifestations of avoidance during imaginal exposure is important to the facilitation of the fullest activation of the patient's fear network, and subsequent achievement of the extinction of the conditioned link between fight or flight physiological responses and intrusive memories of the trauma. As the patient describes the traumatic event, it is important for the therapist to imagine him- or herself, to some degree, in that situation as *the patient*, in order to generate hypotheses about what the patient may be omitting from the narrative as an avoidance strategy, and to heighten the vividness of the description of the traumatic

experience for the patient. In exposure therapy, this begins first with sensory details—for example, if I were the patient in an identical situation, what would I be seeing, touching, smelling, hearing, and tasting? Are these elements present in the patient's description? What would I be thinking and feeling emotionally, at various points in the experience? Are these elements present as well? This introspective process on the part of the therapist becomes communicated to the patient simply through the use of reflective questions during imaginal exposure, and through the process of discussing with the patient places in the trauma narrative where full vividness has not been achieved. Although the mechanisms of symptom reduction are certainly different in exposure therapy from those theorized utilizing a self-psychological approach, the therapist's use of self in this way remains an asset in the administration of exposure therapy.

The Humanistic Psychotherapy of Carl Rogers

Carl Rogers' "necessary and sufficient" conditions for therapeutic change are well known (Rogers, 1961). While certainly the generally nondirective approach of Rogerian humanistic psychotherapy is distinct from exposure-based treatments, similar to Kohutian self-psychology, certain capacities and skills emphasized with this method deserve mention, as they apply to the relationship in PE. As did Kohut, Rogers emphasized the critical importance of remaining as close as possible to the phenomenological world of the patient, and, similar to the process of empathic immersion described above, this technique may reasonably aid in the identification and supported confronting of previously avoided aspects of traumatic memories during exposure. Two qualities of the therapeutic relationship in Rogerian therapy deserve mention for the present discussion: therapist authenticity and unconditional positive regard. In elaborating on the important qualities of the therapeutic relationship and its creation, Rogers advised considering several questions. Perhaps with the most bearing on therapist authenticity, he noted,

Can I be strong enough as a person to be separate from the other? Can I be a sturdy respecter of my own feelings, my own needs, as well as [the patient's]?...Am I strong enough in my own separateness that I will not be downcast by his depression, frightened by his fear, nor engulfed by his dependency? (p. 52)

During the course of exposure, therapists also experience the extinction of the physiological arousal that accompanies any initial fear or horror that may be experienced upon hearing the stories that some patients tell. However, this can only occur if therapists can model the strength, consistency, and courage necessary to remain fully engaged and focused with the imaginal exposure process and not avoid themselves, and as a consequence, collude with the parts of patients that wish to continue to avoid. Rogers' authenticity, rather than merely a component of a passive therapeutic process, represents a considerably active and challenging stance to maintain during the course of imaginal exposure.

This previous point becomes closely related to the role of unconditional positive regard during the process of imaginal exposure. As noted previously, imaginal exposure is a method through which the therapist encourages the graphic depiction and actual reexperiencing of events, which of course involves intense fear, helplessness, or horror, but also shame, guilt, grief, and a host of other negative emotions typically perceived to be unbearable on the part of

the patient. And, in conducting imaginal exposure, it is the therapist's role to hear these descriptions, enquire about additional sensory details, and, at the conclusion of the telling, to ask the patient to tell the story again, with warmth, compassion, and gentle firmness. It is obviously essential that, whatever material the patient presents, the patient continue to be accepted fully by the therapist, and that this acceptance is clearly communicated in all aspects of the therapist's stance. In the absence of this, the therapist runs the risk of communicating in subtle ways what the patient has likely heard from multiple sources before: that the experience is too much for people to hear, that sharing the traumatic event will alienate others, and, potentially, that their particular story is even too much for someone who is a mental health professional to tolerate. The therapist's cultivation of an attitude of openness and acceptance to the full reality of patients' experiences, and thus allowing for the continued unflinching engagement with the exposure process, is critical in assisting patients to overcome what are in some cases long histories of avoidance.

The Stone Center's Relational-Cultural Model

Mutual empathy and connection lie at the core of therapeutic change in Relational-Cultural Therapy (RCT; Jordan, 2010). Rooted historically in the theorizing of Jean Baker Miller (1976), RCT sees oppression and marginalization in relationships as central to the etiology and maintenance of what is considered psychopathology. Through the process of building mutual recognition and empathy between therapist and client, the client's isolation, maintained through hierarchical social and political structures in which individuals and groups gain power through competition and the establishment of dominance over others, is alleviated and her or his capacity to generate growth-fostering and sustaining connections beyond the consultation room is restored.

Similarly to other relational perspectives mentioned here, it might seem, at first pass, that there is actually little in common between the therapeutic relationship in RCT and that in PE. Central to the theory of change in RCT is the process through which the client, by "seeing, feeling, and know-



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ing” the experience of the therapist and the ways in which the therapist is impacted by him or her, is provided with a corrective relational experience (Jordan, 2010). Through this process, the client has increasing feelings of mattering to another person, and the client’s sense of mastery in being able to maintain an authentic connection with another in the context of inevitable, periodic disconnections grows. In order for this to occur, the therapist strives to increase egalitarianism within the therapeutic relationship, and to openly acknowledge and explore sociocultural inequalities and controlling images that limit the client’s experience. By contrast, PE could be seen as maintaining a relationship hierarchy in which the therapist has expert knowledge and the patient is the recipient of that knowledge, thereby maintaining the patient’s sense of isolation as they remain in subordinate relationship to an essentially unknown, yet expert, other.

However, while the processes of change are indeed theorized to be quite different in RCT and PE, the values and goals of RCT are not at all incompatible with the process of conducting exposure therapy for PTSD. As noted above, in the discussions of both self-psychology and humanistic psychotherapy, therapist authenticity, presence, and capacity to immerse him- or herself in the phenomenological world of the client are very useful in the successful implementation of imaginal exposure, as the therapist continues to note dimensions of the traumatic experience that may continue to be avoided. Further, unconditional

positive regard, or the acceptance of experiences and events that the client has previously perceived as shameful and therefore kept from relationships with others, are key elements of both humanistic and relational-cultural approaches. These qualities are also valued within RCT.

In addition, and perhaps most importantly, the goal of RCT is to assist the client in moving from a state of chronic disconnection to increasing connection and community. While not an explicit goal or stated mechanism of change in PE, a similar dynamic typically occurs. For example, consider the case of Jane, a woman who as a child witnessed the repeated and severe abuse of her mother at the hands of her mother’s boyfriend. She focused on one particularly severe incident when she was 7 as she completed a course of PE, while also in inpatient substance abuse treatment. Following her second 45-minute exposure session, she realized that throughout her life she believed that in order to maintain her connection with her mother that she could not let go of her symptoms. Her symptoms of PTSD and substance dependence served to bear witness to the violence her mother experienced. As she became increasingly comfortable confronting, rather than avoiding, her memories of her traumatic experience, this insight emerged, and she noted that she felt the desire to talk to her mother about this, and ask her mother what impact her recovery would have on their relationship. Further along in the process of exposure, she described a situation in which one of her friends had a black eye from a household

injury unrelated to violence. Seeing her so injured, however, activated her memories of her mother’s abuse, which her friend did not know of previously. The patient noted the urge to avoid and disconnect herself from her friend to avoid the pain of these memories. But, having more success confronting these experiences in therapy, she instead allowed herself to become tearful in front of her friend, and risked disclosing elements of her childhood experiences. The result was that her friend felt closer to her, and her to her friend. The reduction of acute physiological arousal through PE allowed more complex thoughts and associated emotions related to her traumatic experiences to emerge. Avoidance, from an RCT perspective, may easily be conceptualized as a strategy of disconnection. The therapist, by serving as a supportive guide through the exposure process, affirms, simply through the process of consistently and patiently attending to the trauma narrative, that this strategy of disconnection is unnecessary. And, with new capacities for sharing her traumatic experiences with others in regulated and considered ways, Jane was able not only to enhance her connections with others but to advocate for their health and healing as well.

Conclusion

The principle components of the therapeutic relationship in each of these theories, and their relationship to PE, are summarized in Table 1. However, there are, of course, several limitations to the above discussion. There are a host of studies on the comparative efficacy and effectiveness of psychotherapeutic approaches, and this discussion is not meant to minimize or ignore the fact that therapeutic methods differ with respect to their ability to achieve symptom reduction in PTSD (e.g., Foa et al., 2005; Gilboa-Schechtman et al., 2010; Powers et al., 2010; Resick et al., 2008; Schnurr et al., 2007). Nor should this discussion imply support for a type of haphazard eclecticism, in which important differences among schools of psychotherapy are minimized and elements of each approach selectively chosen that only appear similar when taken out of context. Further, no other curative mechanisms other than the extinction of the classically conditioned link between physiological arousal and traumatic memories, and subsequent operantly conditioned avoidance, in exposure therapy for PTSD are meant to be suggested. However, a consideration of the therapeutic relationship in PE remains im-

Table 1. Components of the Therapeutic Relationship in Prolonged Exposure for PTSD and Three Divergent Relational Psychotherapeutic Schools

Theoretical School	Therapeutic Component	Relevance for Prolonged Exposure
Self-psychology	Vicarious introspection	Attunement to avoided components of trauma narratives
Humanistic psychology	Authenticity	Consistent encouragement of fear and distress
	Unconditional positive regard	Affirmation of the essentially tolerable and benign nature of memories and resulting associated emotions; reduction in patient shame over traumatic events as they are shared
Relational-cultural psychology	Connection	Consistently bearing witness to traumatic experiences over time, allowing natural desires for connection to emerge as avoidance diminishes

portant, as explicitly defining its qualities and acknowledging its relevance may lead to innovation and advancement in dissemination. When more connections can be drawn between existing approaches and new methods, then perhaps the adaptation of new technologies will be met with less hesitancy and cross-theoretical dialogue enhanced. The conducting of imaginal exposure, the systematic facilitation of the reexperiencing of what is often among the most profound events in patients' lives, can, in fact, be one of the most deeply personal ways of engaging with patients. The fact that a similar (i.e., manualized) methodology works across patients in no way diminishes this fact. Encouraging an examination of the rich humanity inherent in exposure procedures will hopefully increase the number of practitioners willing to seek training and supervision in this method for the treatment of patients suffering from posttraumatic stress disorder.

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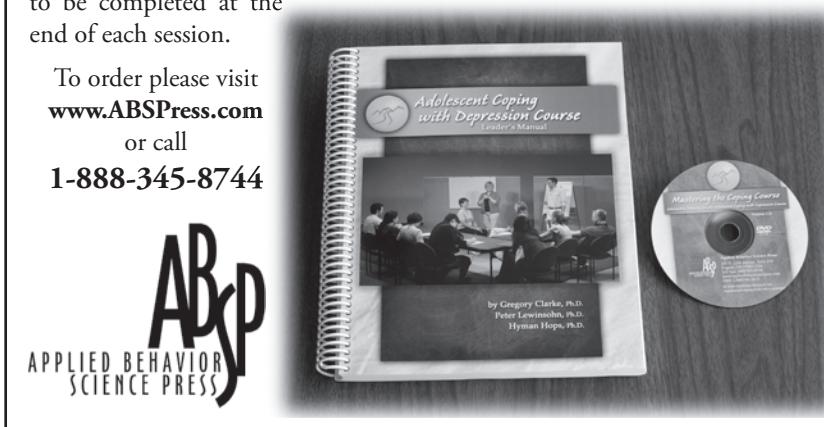
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Clinical Forum

Clinical Competency and Case Presentation From the Behaviorist's Perspective

Ashley B. Tempel, Amanda H. Costello, and Cheryl B. McNeil, *West Virginia University*

Clinical competency has long been an essential component of professional development in the field of clinical psychology (Fouad et al., 2009). Historically, initiatives have suggested shifts in training philosophies, formats, and structure to meet the needs of graduate and internship programs and the field as a whole (Schulte & Daly, 2009). Recent authors have proposed that yet another shift towards a "culture of competency" is key for the development of proficient psychologists (Roberts, Borden, Christiansen, & Lopez, 2005). Comprehensive competency assessments use a range of assessment tools not only to foster learning and determine curriculum and program effectiveness, but also to progress the field and protect the public (Kaslow et al., 2009). The clinical case presentation is one such tool that is commonly used for teaching and evaluating competency within various clinical settings (Donovan & Ponce, 2009; Kaslow et al.). This article will review, from a behavioral perspective, the utility of clinical case presentations in building and evaluating recommended competencies. Our aim is to stimulate and challenge further discussion regarding the role of case presentation in comprehensive assessments of professional skill.

Case presentation is a broadly used tool at both the student and professional levels. As a clinical tool, case presentations are commonly utilized during preliminary examinations, clinical training teams, hiring processes, and as a specific tool to educate and share knowledge with professionals in multidisciplinary settings. With increased range in the purposes and use of case presentations across settings, no single strategy will prove best in the assessment of all components or competencies. Case conferences that serve as a teaching tool may inform practice for the professional audience and have utility in shaping broad professional behavior (e.g., Kravet et al., 2001; Price & Felix, 2008). Case conferences used for competency evaluations often establish performance contingencies for the presenting

clinician and have utility in shaping individual practice. For example, at West Virginia University, clinical doctoral students are required to provide two case conferences that are evaluated by faculty and students and considered when conducting annual evaluations and recommendations for doctoral candidacy. Please see Table 1 for a case conference evaluation form created by Kevin Larkin, Ph.D., the Director of Clinical Training at West Virginia University, in collaboration with faculty from the clinical and clinical child programs. When preparing case presentations for the purpose of competency evaluations or teaching, behavior therapists may find the topic areas outlined on this evaluation form useful.

Background Information

The first step in many effective case presentations is identifying the client's background information. This may include describing the client's referral to the agency and any information gathered in the referral process. The referral can often be a discussion point, as many clients who come to a clinic for one set of target behaviors display vastly different presenting problems during the intake session. The client's relevant medical, psychological, occupational, and social history may also be reviewed to provide others with details relevant to the client's prior and current levels of functioning. For example, within the client's medical history, general medical conditions and medications may be discussed; this gives the presenter an opportunity to discuss possible medical or biological causes of the target behavior. Elements of the psychological history may include prior or current diagnoses, as well as treatments and services provided; therapists may find this information useful in conceptualizing treatment approach and addressing treatment resistance. Occupational and social histories often assist in the identification of psychosocial stressors such as employment status and social supports. Background information of the client provides other professionals an introduction to the case being presented.

Assessment

An important aspect of behavioral therapy practices is creating an idiographic approach to assessment. Ideally, clinicians will use and present multimodal assessment techniques (for more complete description see Cone, 1978). The inclusion of both direct (e.g., behavioral observations in a natural or analog setting) and indirect (e.g., physiological, self-report, collateral report) assessments of behavior may provide a fuller clinical picture. It may also be helpful to report behavior across contexts; this information is necessary for many clinical diagnoses

and may inform aspects of the individual's environment that trigger or maintain behaviors. When using indirect measures such as self-report measures, a behavior therapist should not only rely on normed scores and clinical cutoffs but also become familiar with the specific items endorsed; a client's reporting behaviors are also a sample of behavior and may be considered for presentation. In addition, consultation and communication with other professionals (e.g., physicians, teachers, psychologists, or therapists) may be important to present if information regarding behavior change or consistency over time is noted. Inclusion of

behavior graphs from frequent assessment of target behaviors across treatment may also demonstrate the course of treatment and time points in which both statistically and clinically significant changes (e.g., removal of diagnosis, increased functioning) occurred during the treatment process.

Case Conceptualization

It is important for behavioral formulations to demonstrate how the data were used to both guide the treatment and determine treatment completion. The presenter's case conceptualization should be

Table 1. Feedback Summary: Clinical Case Presentation

	Excellent	Good	Satisfactory	Unsatisfactory	NA
Background Information					
<ul style="list-style-type: none"> • Case description and identifying information • Description of presenting problem • Description of referral source • Description of social/educational/occupational hx • Description of hx of psychological problems and/or tx • Description of pertinent medical hx • Description of current and hx of medication and substance use 					
Psychological Assessment					
<ul style="list-style-type: none"> • Choice of assessment measures • Rationale for choice of assessment measures • Description of assessment findings • Discussion of assessment findings 					
Case Conceptualization					
<ul style="list-style-type: none"> • Description of case conceptualization • Accuracy of diagnosis • Rationale for diagnosis (differential diagnosis) • Discussion of case conceptualization 					
Intervention					
<ul style="list-style-type: none"> • Choice of intervention (including overview of the evidence base) • Rationale for choice of intervention (including consideration of strengths and weaknesses of approach chosen) • Description of intervention (including pertinent process and/or outcome data) • Discussion of intervention 					
Ethics					
<ul style="list-style-type: none"> • Adherence to ethical standards • Confidentiality of the client protected during the presentation 					
Presentation					
<ul style="list-style-type: none"> • Preparation for presentation • Organization of presentation • Clarity of presentation • Level of interest generated by the presentation • Use of audiovisual material • Oral presentation skill 					

established from the discussion of the initial assessment measures and relevant background information. The case conceptualization should include a theoretical explanation of the case that is sufficiently thorough and specific to enable the audience to understand the presenter's clinical choices and rationale. Regardless of whether the chosen conceptualization is supported or opposed, the discussion of the case conceptualization is often an element in case presentations that sparks conversation and dialogue among audience members. It is not only important that presenters are able to demonstrate the building of a case conceptualization on solid rationale, but also that they display flexibility in their conceptualization and that they implement continued reevaluation of treatment based on frequent assessment. Inclusion of relevant elements used to distinguish between differential diagnoses is also beneficial in assisting other professionals with conceptualizing the client's presenting problem behaviors.

Intervention

In the introduction of the treatment of choice, it is important to provide a rationale and briefly discuss treatments that were not chosen. When providing rationalization for chosen treatments, a presenter may discuss conceptualization factors that influenced their practice. For example, the literature may be referenced as it plays a large role in making informed treatment decisions. Also, a clinician may reference elements of the functional assessment that indicated the utility of the chosen intervention. Regardless of whether a clinician is implementing an empirically supported technique or a combination of techniques (e.g., relaxation and exposure and response prevention or even manualized treatments such as dialectical behavior therapy or parent-child interaction therapy), unexpected or novel elements of the intervention process are also important to report. A conceptualization of why a specific technique was or was not effective may also be important to include. Inclusion of the implemented intervention process, in combination with data derived before, during, and after treatment, serves to provide a picture of the overall treatment process.

Ethics

Throughout the presentation it is essential for clinicians to maintain confidentiality of protected health information and to display professional demeanor. Clearly, clinicians must adhere to the clinical standards

and guidelines of the American Psychological Association (see Barnett & Johnson, 2008). For example, clinical standards require the deidentification of sensitive case information (e.g., names of client, family members, schools, place of employment, or other affiliations), and clinical guidelines recommend obtaining a client release of information prior to the presentation. It is helpful to include information in the case presentation about ethical issues that arose while working with the client and to discuss the problem-solving steps that went into the ethical decision-making. Finally, the presenter of a case conference should take great care to be respectful of the client when discussing the case. Humor and sarcasm about the individual can be demeaning of the client's dignity and should be avoided or used with caution to maintain a sensitive and professional atmosphere throughout the presentation.

Presentation

Professionals are expected to provide thoughtful consideration of clinical cases through logical organization and balance in the level of detail reported. Clinicians may also find it beneficial to anticipate and prepare potential questions or areas of discussion. Furthermore, it is important to troubleshoot technical elements of the presentation (e.g., PowerPoint, microphones) to ensure that they do not detract from discussion points. Although every behavior therapist would love to be able to present on the "perfect" case (i.e., the client whose graphs show treatment gains or who calls the clinic following treatment to report positive feedback), these cases are rare in actual clinical practice. Often, the most interesting and educational case conferences involve real-life complicated cases with a mixture of successes and challenges, as opposed to the "perfect" case with "perfect" data. Case conferences focusing on barriers to treatment or clients with little treatment success can be highly effective in building or evaluating competencies. Clinicians who are able to carefully evaluate the strengths and weaknesses of their treatment approach are most successful in presenting a case conference. Important to effective case conferences is a clinician's ability to assess his or her own treatment methods and draw conclusions for future treatment processes. Additionally, as one of the most informative components of the presentation is the answering of audience questions, it is beneficial to time the talk so that at least 10 minutes is preserved at the end for thought-

ful responses to audience inquiries. In conclusion, the case presentation is an important educational opportunity for clinicians to iteratively evaluate their treatment approach with both successful and unsuccessful clinical cases, and to educate and collaborate with other professionals to refine and advance assessment and treatment planning.

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At ABCT

Minutes of the Annual Meeting of Members

Saturday, November 20, 2010, San Francisco

Call to Order

President Andrasik welcomed members to the 44th Annual Meeting of Members, saying, "I appreciate you all coming." Notice of the meeting had been sent to all members in September.

Minutes

Secretary-Treasurer Ronan asked for any comments or corrections on the minutes from last year's meeting. M/S/U: The November 21, 2009, minutes were unanimously accepted as distributed.

Expressions of Appreciation

President Andrasik thanked the Board members for their hard work this year. He thanked Bob Leahy, rotating off as Immediate Past President. He thanked George Ronan for his work as Secretary-Treasurer from 2007-2010, noting that he hates to see a member of the Finance Committee with such long service go. He said it was a pleasure to get to know Stefan Hofmann, Representative-at-Large, 2007-2010, and expects to see him doing other things in the near future. He also thanked Art Freeman, who is concluding his term of office as the Coordinator of Convention and Education Issues and for his many years of service to the Association.

President Andrasik also thanked Amy Wenzel, Professional Issues Committee Chair, 2008-2010; Steven C. Hayes, International Associates Committee Chair, 2007-2010; Kelly Wilson, Deputy to World Congress Committee, 2007-2010; Drew Anderson, Editor of *the Behavior Therapist* for Volumes 31 through 33; Bryce McLeod, Public Education and Media Dissemination Committee Chair, 2007-2010, and Chair of the Publications Committee's Journal Task Force in 2009-2010; Art Freeman, Convention and Education Issues Coordinator, 2007-2010; John D. Otis, 2010 Program Chair, whose expertise and dedication were amply demonstrated here; Sandra Pimentel, Continuing Education Issues Committee Chair, 2007-2010; Patricia M. Averill, Institutes Committee Chair, 2008-2010; and Bruce Zahn, Master Clinician Seminar Series Chair, 2010.

President Andrasik thanked the members of the Program Committee, noting, "We all know that putting together a program of this size takes a lot of time and dedication. This year we had 128 members help review program submissions. Please accept my heartfelt appreciation for the 2010 Program Committee members." He thanked Anne Marie Albano, Drew Anderson, Margaret Andover, David Atkins, Sonja Batten, J. Gayle Beck, Debora J. Bell, Kathryn Bell, Jennifer Block-Lerner, Timothy Brown, Steven Bruce, Annmarie Cano, Cheryl Carmin, Corinne Cather, Eunice Chen, Mari Clements, Meredith Coles, Dennis Combs, Jonathan Comer, James V. Cordova, Lisa Coyne, Rudi De Raedt, Ronda L. Dearing, Tamara Del Vecchio, Patricia DiBartolo, Ray DiGiuseppe, David DiLillo, Keith Dobson, Greg Dubord, Jill T. Ehrenreich, Susan Evans, Todd Farchione, Edna Foa, Patti Fritz, Richard Gallagher, Scott T. Gaynor, Brandon Gibb, Kathryn Grant, Kim Gratz, Amie Grills-Taquechel, James Gross, Gordon Hall, Melanie Harned, Tae Hart, Trevor Hart, Joseph Himle, Stefan Hofmann, Flora Hoodin, Debra A. Hope, Curtis Hsia, Jennifer Hudson, Melissa Hunt, Emily Johnson, Barbara Kamholz, Robert Kern, Nancy Keuthen, Muniya Khanna, Jacqueline Kloss, Robert H. LaRue, Jennifer Langhinrichsen-Rohling, Jean-Philippe Laurenceau, Erika Lawrence, Robert Leahy, Penny Leisring, Gabrielle Liverant, Luana Marques, Lata McGinn, Dean McKay, Elizabeth A. Meadows, Douglas Mennin, Alicia Meuret, Catherine Michas, Alec Miller, Todd Moore, Sandra Morissette, Katherine Muller, James Murphy, Douglas Nangle, Lisa Napolitano, Tara M. Neavins, Karl Nelson, Conall O'Cleirigh, Roisin O'Connor, K. Daniel O'Leary, Phyllis Ohr, Bunmi O. Olatunji, Camilo Ortiz, John Otis, John Pachankis, Suzi Panichelli-Mindel, David Pantalone, Sandra Pimentel, Donna Pincus, Donna Poslusny, Sheila A.M. Rauch, Simon Rego, Sarah Reynolds, Lorie Ritschel, Shireen Rizvi, Patricia Robinson, Ronald Rogge, Kelly J. Rohan, M. Zachary Rosenthal, Kristen Sanderson, Steven L. Sayers, Mitchell Schare, Brad Schmidt, Kathleen J.

Sexton-Radek, Tamara Sher, Sandra Sigmon, George Slavich, Jasper Smits, Jennifer Snyder, Diane Spangler, Susan Sprich, Eric Storch, Gregory Stuart, Dennis Tirsch, Kimberli Treadwell, Matthew Tull, Cynthia L. Turk, Risa Weisberg, Robert Weiss, Amy E. Wenzel, Kamila White, Shannon Wiltsey Stirman, Robert Zeiss, and Michael J. Zvolensky.

President Andrasik thanked the Local Arrangements Committee for a terrific job and making us all feel very welcome in San Francisco. He thanked Allison Harvey, Local Arrangements Committee Chair, and her committee's members, Kate Kaplan, Jen Kanady, and Adriane Soehner.

Appointments

President Andrasik noted that it was a pleasure to announce the appointments for the coming years. Sandy Pimentel will serve as 2010-2013 Convention and Education Issues Coordinator; Muniya Khanna as 2010-2013 Continuing Education Committee Chair; David DiLillo will serve as the 2011 Program Chair for the Toronto meeting; Jeffrey Goodie will serve as 2012 Program Chair for the Washington meeting; Cynthia Crawford will serve as 2011 Local Arrangements Committee Chair for Toronto; Scott Compton will serve as 2010-2013 AMASS Committee Chair; Kevin Chapman will serve as 2010-2013 Master Clinician Seminar Chair; Anne Marie Albano will serve as 2010-2013 International Associates Committee Chair; George Ronan will serve as Chair of Specialization in Behavioral and Cognitive Therapies Within Various Professions; and Kate Gunthert begins her term as Editor of the Behavior Therapist starting January through December of 2014.

Finance Report

Secretary-Treasurer Ronan reported that ABCT is in solid financial shape and our financial future looks good. The Finance Committee oversees the fiscal health of ABCT; monitors income, expenses, and projections; ensures funds are available for achieving specified goals; makes recommendations regarding personnel; ensures funds are invested prudently; and evaluates financial considerations related to ownership of permanent headquarters. The Finance Committee is comprised of the Secretary-Treasurer, also known as the Finance Committee Chair, two members selected by the Chair (Judy Favell and Mike Petronko) and the President-Elect (for the moment, Debra Hope, but soon to become Bob Klepac). He noted that the Finance

Committee monitors approximately 400 budget lines and maintains frequent communication with the Auditor, our Investment Adviser, and the Executive Director as well as participates with the Board calls. The Finance Committee meets face-to-face each year in November and in the Central Office each spring.

Secretary-Treasurer Ronan reported that the Association's net income for fiscal 2010 is \$392,607 and was distributed across Conventions, Publications, and Membership; the short-term investment of operating funds is \$1,077,797 and has experienced a 1.9% return rate since inception (July 2010); Special Project and Capital Expenditure funds are at capped levels; and Fund the Future has a balance of \$685,466 with a return rate of 10.41% since inception (July 2009). He reminded the members that ABCT's fiscal year is November 1 to October 31 and that these numbers could change slightly once all the final bills are received and our accountant completes the 2010 fiscal audit. The fiscal projections for 2011 through 2013 are in the black.

He reported that the Association is fiscally sound; we pass yearly independent audits; we follow accepted accounting principles (GAAP); we are compliant with all state and federal regulations; our budget is transparent; staff time and task allocations are congruent with our stated goals; and we have lots of people who have worked hard to get us in this very positive financial position. Secretary-Treasurer Ronan reported that the Association renovated its office space for the first time since its acquisition in 1993. He also said that the future looks especially bright given that he is now handing over the reins of the Finance Committee to Denise Davis, our incoming Secretary Treasurer.

Coordinator Reports

Academic and Professional Issues

Joann Wright, Coordinator of Academic and Professional Issues, noted that the Professional Issues Committee is dormant, pending direction from the May 2011 Strategic Planning Retreat. She expects that Lata McGinn, the incoming Representative-at-Large and liaison to Academic and Professional Issues, should have some good ideas for that committee and others. The Research Facilitation Committee, under chairmanship of Michael Twohig, has shown some fresh ideas on assisting in developing early research that will be publicized through *tBT* and our website. Kristi Salters-Pedneault, chairing the Academic

Training Committee, is working on ways to promote the Mentor Directory, a wonderful easy-to-use resource that has seen its usage more than doubled since last year. Her committee also launched the CBT Medical Educators Directory and continues to update the course syllabi on our website.

Coordinator Wright announced the slate of award winners: G. Alan Marlatt for Career/Lifetime Achievement; Steven D. Hollon for Outstanding Researcher; Gail Steketee, Michael W. Otto, Sabine Wilhelm, Stefan Hofmann, and Mary Ellen Brown for Outstanding Service to ABCT; Richard J. McNally received the Outstanding Mentor Award; Paul Ekman was named Distinguished Friend to Behavior Therapy; Matthew T. Tull was named the President's New Researcher; Margaret Sibley received the Virginia Roswell Dissertation Award; and Shari Steinman received the Leonard Krasner Student Dissertation Award. Brooke Marie Huibregtse, Abby Jenkins, and David Hillel Rosmarin were this year's Elsie Ramos First Author Poster Award winners. We also acknowledged 32 books receiving ABCT's Self-Help Seal of Merit designation. The authors and titles will be listed soon on our website. She thanked Rochelle "Shelley" Robbins and the Awards and Recognition Committee for another heartwarming and delightful awards ceremony. Dr. Wright encouraged all ABCT members to nominate their colleagues for the 2011 awards program.

Coordinator Wright said she was pleased that Anne Marie Albano was taking over as Chair of the International Associates Committee; she knows that Anne Marie will make the international members feel welcome; and pleased that George Ronan was taking over as Chair of Specialization in Behavioral and Cognitive Therapies Within Various Professions, given all the important work that looks to be developing.

Convention and Education Issues

Sandy Pimentel, the incoming Coordinator for Convention and Education Issues, reported there were 3,310 attendees. She asked people to look around: there's a conference happening here. She said she loves the program book cover, commenting, "It's so cool; thanks, Stephanie [Schwartz, ABCT's Managing Editor]." Coordinator Pimentel noted some new initiatives made this year by her committee chairs. She said, for the second consecutive year, program books were sent in advance only to those who had registered by October 1 to save both trees and to encourage early registra-

tion. She also noted many of the ticketed sessions had, for the first year, handouts available online. She noted this is a work in progress. She was happy to see David DiLillo as our Program Chair for Toronto and to see that Jeffrey Goodie is getting a good head start for his work as 2012 Program Chair for the Washington meeting. The year following Washington will be Nashville; locations beyond this have yet to be determined. She also noted that the CE group will be concentrating on additional ways to serve our members and consider online offerings and adding social media components.

Membership Issues

Kristene Doyle, Coordinator for Membership Issues, announced that we had 5,088 members in 2010, an all-time record. She reported that 38 active SIGs presented 316 peer-reviewed and accepted posters last night at the ABCT Welcoming Cocktail Party and SIG Expo. The SIG program is growing and it is exciting to see. This convention had numerous offerings and sessions for students and young professionals, including "What Employers Look for in New Professionals" and "NIH Loan Repayment." The third and final student survey is on the web and we are finding that students are overwhelmingly satisfied, and that many intend to upgrade their status from Student to New Professional. She noted that Ray DiGiuseppe is developing a new Leaders' Workshop to help mid-career and new professionals get involved and, if involved, move up the leadership ranks. She stressed that there is plenty of room in our governance for new members, and fabulous staff and member resources to help anyone interested in getting involved. She also noted that the Clinical Directory and Referral Committee is brainstorming ways to improve the Expanded Find-a-Therapist Directory, including possibly adding participant photos. She noted the list-serve continues to get more use and ever more interesting content. Social networking remains a work in progress. She encouraged all members to nominate colleagues and vote during the 2011 election of ABCT Officers.

Publications

David Teisler, Director of Communications, reported on behalf of Dave Haaga, Publications Coordinator, that Tom Ollendick, Editor of *Behavior Therapy*, has doubled manuscript flow and increased printed pages by half; moreover, *BT*'s im-

pact factor increased to 2.74. Editor of *Cognitive and Behavioral Practice*, Maureen Whittal, has also increased manuscript flow, by almost 50% in the last year, and has more than a dozen invited special series and case conferences coming. Her streaming videos are among the most viewed articles. Steve Safran has been selected as the incoming editor of *Cognitive and Behavioral Practice*, and officially starts January 2013. Kate Gunthert officially kicks off her editorship of the *Behavior Therapist* January 1, 2011, and has introduced new sections, including one on Medical and Health Care Settings. Mr. Teisler also noted that ABCT's web hits continue to increase and its ranking in Google searches continues to rise. Most significantly, he said, is the increase in number of referrals from other sites and the low bounce rate, meaning that a high number of people who come to the site stay for more than a second or two. He thanked Mitch Prinstein, the web editor, for his work on the site. Susan White, who heads the Public Education and Media Dissemination Committee, is adding links to Wiki definitions that feature CBT and will begin developing podcasts to help expand the website's list of symptoms. He noted that Brad Schmidt, Chair of the Media Production Committee, is reviewing existing archives and clinical grand rounds with an eye to developing promotional clips for the website.

Finally, he noted that next year print journals will be unbundled from member subscriptions. They will continue to be available as an option. The electronic versions of both journals will be available to all members.

Executive Director's Report

Mary Jane Eimer, ABCT's Executive Director, said it has been a phenomenally busy and productive year, again, fresh off

Classified

POSTDOCTORAL FELLOWSHIP, POST-TRAUMATIC STRESS DISORDER. The University of Central Florida Anxiety Disorders Clinic has 2 postdoctoral fellowship positions (1 position is available immediately and the 2nd in summer 2011) to participate in a Department of Defense funded research program to treat veterans of the Iraq and Afghanistan conflicts who are suffering from posttraumatic stress disorder (PTSD). Applicants should have a Ph.D. in clinical psychology and completed a predoctoral clinical psychology internship, both from programs accredited by the American Psychological Association. Experience providing exposure therapy and other behavioral treatments to individuals with anxiety disorders is required. The postdoctoral fellow will be responsible for the as-

our NYC convention; we brought in 2010 with a new record membership and co-hosted the World Congress in addition to our regular duties and commitments. It's exciting to begin planning for next year and our triannual strategic planning retreat. We are blessed to have a leadership committed to this thoughtful process that helps define the Association's strategic and tactical goals for the next 3 years. She thanked George Ronan for the phenomenal term of office and an outstanding final year of service as our Finance Committee Chair: more than \$300,000 income over expense, or what the rest of the world calls profit. Other organizations are having trouble keeping their members and paying their bills, and we are setting records and building our reserves.

She reminded the membership that they have an amazing staff: Stephanie Schwartz, who edits our journals and *tBT* and designs many of the covers and much of promotional material; Damaris Williams, who handles the books and the money so capably; Keith Alger, who is a great can-do or just-did kind of guy; Tonya Childers, who solves the convention problems, manages our exhibits, and processes membership dues with aplomb; Lisa Yarde, who is the database guru and queen of technology; David Teisler, who does wonderful things in publications and who has transformed the web; and Mary Ellen Brown, who has done nothing but thrive and shine in her 35 years here. It was wonderful to see the Association acknowledge Mary Ellen's contributions to the Association during the Awards Ceremony.

President's Report

President Andrasik said he always has a warm comfortable feeling when he's working with M.J., and that he's honored to have had the opportunity to have served the

essment and treatment of veterans with PTSD, implementing individual treatment sessions using virtual-reality exposure therapy and conducting group treatment sessions using social skills training and behavioral therapies. Additionally, the fellow may participate in data analysis and manuscript preparation, and provide supervision of graduate and undergraduate research assistants. The position is available immediately (1/7/2011). Interested applicants may contact Deborah C. Beidel, Ph.D., ABPP at dbeidel@mail.ucf.edu or apply online at www.jobswithucf.com/applicants/Central?quickFind=75748. The University of Central Florida is an equal opportunity, equal access, and affirmative action employer.

membership as their President. "Why do you serve?" he remembered being asked, and stated, "Because I believe that ABCT is doing something important." He believes this even more as he ends his term as President.

Transition of Officers

President Andrasik announced that, as of now, Bob Klepac loses one "elect," moving up from President-Elect-Elect to President-Elect; Lata McGinn, who just last year was Program Chair, effortlessly moves to Representative-at-Large; and Denise Davis takes over Secretary-Treasurer with the ultimate goal of amassing a full year's operating expense in reserve.

President Andrasik said he could not feel more confident that ABCT is in "good competent hands" than to turn over the gavel and the Association to Debra Hope, our new President.

New Business

President Hope thanked all who work so hard on all our behalf. She thanked John Otis, Frank Andrasik, and Mary Ellen Brown for the wonderful conference; she thanked Mitch Prinstein for the ever-improving website, noting that we will need to replace him this year; and she thanked the staff, especially M.J. Eimer, with whom she is already in constant contact.

Adjournment. There being no further business, the meeting was adjourned at 12:57 P.M. Pacific Time.

— *Respectfully submitted,*

George F. Ronan, Ph.D.

2007–2010 Secretary-Treasurer

Resources for researchers

- Grants
- Links to government funding agencies
- Data collection tools
- Statistical software
- *tBT* articles related to professional development in research
- Links to international scientific organizations

 <http://www.abct.org>

[ABCT Members Only](#) 

[Helpful Resources](#) 

Preparing to Submit an Abstract

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

- **Presentation type:** Please see “Understanding the ABCT Convention” (right-hand column) for descriptions of the various presentation types. For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and a minimum of three and a maximum of five papers. Although the chair may present a paper, the discussant may not. For Panel Discussions and Clinical Roundtables, please have one moderator and between three and five panelists.

- **Title:** Be succinct.

- **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT category. Possibilities are current member; lapsed member or nonmember; postbaccalaureate; student member; student nonmember; new professional; emeritus member.

- **Affiliations:** The system requires that you enter affiliations before entering authors. This allows you to enter an affiliation one time for multiple authors. DO NOT LIST DEPARTMENTS. In the following step you will be asked to attach affiliations with appropriate authors.

- **Key Words:** Please read carefully through the pull-down menu of already defined key words and use these if appropriate. For example, the key word “military” already on the list should be used rather than adding the word “army.” Do not list *behavior therapy*, *cognitive therapy*, or *cognitive behavior therapy*.

- **Goals:** For Symposia, Panel Discussions, and Clinical Round Tables, write 3 statements of no more than 125 characters each, describing the goals of the event. Sample statements are: “Described a variety of dissemination strategies pertaining to the treatment of insomnia”; “Presented data on novel direction in the dissemination of mindfulness-based clinical interventions.”

- **Overall:** Ask a colleague to proof your abstract for inconsistencies or typos.

Understanding the ABCT Convention

The ABCT Convention is designed for practitioners, students, scholars, and scientists. All of the ABCT members involved in making the Convention have as their central goals the provision of opportunities to meet the needs of the diverse audiences interested in the behavioral and cognitive therapies. Attendees have varying disciplines, varying levels of experience, varying theoretical CBT orientations, as well as special clinical concerns. Also important are the opportunities to meet people with similar interests for social as well as professional networking.

Some presentations will offer the chance to learn what is new and exciting in behavioral and cognitive work from our dynamic and vibrant presenters. Other presentations will address the clinical-scientific issues of how we develop empirical support for our work.

The Convention consists of General Sessions and Ticketed Events. There are between 150 and 200 general sessions each year competing for your attention.

GENERAL SESSIONS

Invited Addresses. Speakers share their unique insights and knowledge on a broad topic of interest to attendees.

Symposia. Presentations of data, usually investigating efficacy of treatment protocol or particular research. Symposia are either 60 minutes or 90 minutes in length. They have one or two chairs, one discussant and between three and five papers.

Panel Discussions and Clinical Round Tables. Discussions (sometimes debates) by informed individuals on a current important topic. These are organized by a moderator and have between three and six panelists who bring differing experience and attitudes to the subject matter.

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

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

Clinical Grand Rounds. Master-level clinicians give simulated live demonstrations of therapy.

Clients are generally portrayed by graduate students studying with the presenter and specializing in the problem area.

Spotlight Research Presentations. New to the 2011 Convention, this format provides a forum to debut new findings considered to be truly groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute Q&A period will allow a more in-depth presentation than is permitted by symposia or other formats.

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

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

TICKETED EVENTS

In addition to a 250-word description, several goals, and recommended readings, these listings include a level of experience to guide attendees.

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

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

Advanced Methodology and Statistics Seminars. Designed to enhance researchers' abilities, there is generally one offered on Thursday and one offered on Sunday A.M. They are 4 hours long and limited to 40 attendees.

Institutes. Leaders and topics for Institutes are taken from previous ABCT workshop presentations which need a longer format. They are offered as 7-hour or 5-hour session on Thursday, and are generally limited to 40 attendees.

Clinical Intervention Training. One- and 2-day events emphasizing the “how-to” of clinical intervention. The extended length, either 7 hours or 14 hours, allows for exceptional interaction.



CALL for PAPERS © ABCT

45th Annual Convention | Toronto

November 10–13, 2011

DISSEMINATION in the 21st Century

Dissemination of our proven interventions has been a theme of the annual meeting several times over the years. As we return to that theme this year, we do so in a new climate of interest and acceptance of cognitive-behavioral approaches on many important fronts. Increasingly, consumers and their families understand that the best hope for relieving their suffering comes from our work. Yet, in many cases, we still cannot transport our best treatments out of our research clinics and into the hands of payers, providers, and consumers who want and need them. At the 45th Annual Convention, we will turn our focus to 21st century dissemination.

We are particularly interested in theory and research on models of dissemination from all disciplines, innovative practices including technological solutions and novel venues for service delivery, and assessment of dissemination outcomes. We are also interested in presentations on curricula and other training strategies to help us prepare the next generation of ABCT members to continue to meet the challenge of dissemination.

Submissions may be in the form of symposia, clinical round tables, panel discussions, and posters:

Symposia: Presentation of data, usually investigating efficacy of treatment protocol or particular research.

Panel Discussions and Clinical Round Tables: Discussion (sometimes debate) by informed individuals on a current important topic.

Poster Sessions: One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees.

PROGRAM CHAIR: David DiLillo, Ph.D.

Check ABCT's website, www.abct.org, for the on-line submission portal, which will open in early February.

The deadline for submission is March 2, 2011

Additional information can be found at www.abct.org



CBT Medical Educator Directory

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

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.
2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.
3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

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

How to Submit Your Name

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

Descriptions of training programs, teaching outlines and/or syllabi, and other supplemental teaching materials for courses specific to medical training that can be shared with others (i.e., through posting on ABCT's website or via the list-serv) are also welcome. Please submit syllabi and teaching materials

Syllabi for traditional CBT graduate and postgraduate courses outside the medical community may be sent to Kristi Salters-Pedneault at saltersk@easternct.edu.

<http://www.abct.org>

[Professionals, Educators, & Students](#) ↗
[CBT Medical Educator Directory](#) ↗

An Invitation to Reykjavík, Iceland, for the

EABCT 2011 CONGRESS

THEME

Prevention

AUGUST 31–SEPTEMBER 3, 2011

www.eabct2011.org

Authors } Please include this form when you submit work to *tBT*. You can also access an electronic version of the Copyright Transfer Form on ABCT's website:
http://www.abct.org/docs/Members/copyright_transfer_2011.pdf

the Behavior Therapist | KATHLEEN GUNTHERT, Ph.D., Editor

Copyright Transfer

Manuscript Title: _____

Manuscript # (for office use): _____

Authors: _____

I hereby confirm the assignment of all copyrights in and to the manuscript named above in all forms and media to the Association for Behavioral and Cognitive Therapies, effective if and when it is acceptable for publication by ABCT. (For U.S. government employee authors, this provision applies only to the extent to which copyright is transferable). I also confirm that the manuscript contains no material the publication of which would violate any copyright or other personal or proprietary right of any person or entity, and I acknowledge that the Association for Behavioral and Cognitive Therapies is relying on this letter in publishing this manuscript.

I have read *the Behavior Therapist's* publication guidelines and have included any relevant information required.

Signature: _____

Print name and title if not author: _____

To be signed by at least one of the authors (who has obtained the assent of the others, if any). In the case of a "work for hire" (a work prepared by an employee within the scope of his or her employment or commissioned as work for hire under a written agreement), an authorized representative of the employer should sign.

PLEASE NOTE: Manuscripts cannot be processed for publication until the Publisher has received this signed form. If the manuscript is not published by the Association for Behavioral and Cognitive Therapies, this letter will not take effect.

Please email* this form as an attachment (as a PDF, jpeg, or scanned image) to gunthert@american.edu.



*If you are unable to transmit this form via email, please make a note in your submission email and we will send you alternative mailing instructions.

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Questions? Contact Shelley Robbins, Awards & Recognition Chair: srobbins@holystfamily.edu

Call for Award Nominations . . .

- ◆ Outstanding Researcher
- ◆ Outstanding Mentor
- ◆ Lifetime Achievement
- ◆ Distinguished Friend to Behavior Therapy
- ◆ Outstanding Service to ABCT

STUDENT AWARDS:

- ◆ President's New Researcher
- ◆ Virginia A. Roswell Student Dissertation
Leonard Krasner Student Dissertation
- ◆ Elsie Ramos Memorial Student Poster Awards

NOMINATE ON-LINE: www.abct.org ◆ DEADLINE: March 1, 2011