

# *the* Behavior Therapist

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### President's Message

## (Still) Standing on the Right Side of History

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



As I write this, President Obama has recently signed the certification that the U.S. military is prepared for the end of the Don't Ask, Don't Tell (DADT) law that prohibited gays and lesbians from serving openly in the U.S. military. At our November meeting in Toronto, I will ask the ABCT Board to review our nondiscrimination policy to see if changes are needed in light of the end of DADT.

Our nondiscrimination policy has a short history but one that is entwined with DADT. In 2005, in response to an inquiry from the special interest group (SIG) on the Study of Lesbian, Gay, Bisexual, and Transgender Issues, the Board discovered that ABCT did not have a nondiscrimination policy. As Representative at Large, I was appointed by the Board to lead an ad hoc committee (which included Christopher Martell, Steve McCutcheon, Bob Klepac, and Alan Peterson) to develop a policy. Here is the policy that the Board approved on November 16, 2006:

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

[continued on p. 99]



Writing the overall policy was easy. The tricky part was how to handle recruitment for military internships in our publications and at the convention. There was an incredible tension between the desire to affirm lesbians and gays who were excluded from open military service under the DADT law and yet provide access to much needed cognitive behavioral treatment for service members in a time of war. ABCT members associated with the armed services who communicated with me were clear that they did not agree with the military's discriminatory policy but argued strongly to keep the recruiters and advertising in ABCT. Some gay members painfully spoke of the need for ABCT to make a strong statement for equality. Facing discrimination in many aspects of their lives, at the very least they wanted their beloved professional home to stand up for them. Many called for ABCT to lobby Congress to change the law but, under the rules of our incorporation, we could not do that as an association. Ultimately the Board required that all advertisers and recruiters review our nondiscrimination policy and explicitly state any ways in which their own policies differed from that of ABCT. It was an awkward compromise but I think the best we could do. Thankfully, soon it will be unnecessary.

Gays and lesbians have an uneasy history with mental health professionals, including behavior therapists. Early in the history of behavior therapy, some of the "interventions" to "cure homosexuality" that have been most reviled by the gay community came from what we now understand to be misapplications of learning principles. As DADT is repealed and wedding bells toll for gay and lesbian New Yorkers who are celebrating their now legally recognized marriages, it seems like a good time to look at some of our brighter moments in gay history.

Recently I heard someone say that their finest memory of ABCT was when our then-president Gerald Davison declared in his 1974 Presidential Address that the existence of interventions for changing sexual orientation implied that being a sexual minority was pathological and increased the stigma experienced by clients (Davison, 1976). He argued that the therapies posed an ethical dilemma, regardless of their efficacy, which he clearly doubted even then. Davison went on to say that individuals seeking to change their sexual orientation could not freely give informed consent for

treatment because they were surely responding to antigay societal messages that they should change. I urge you to read Davison's full article and recommend it to your students as it is still relevant today.

A quick look at the daily news reveals that a lot is changing in attitudes towards sexual minorities and on the legal front for gay rights in the U.S. and around the world. (Although this November when we are in Canada, those of us from the U.S. might realize how far ahead of us our northern neighbors are.) As in 1974, ABCT is on the right side of history. We have an active SIG focused on the study of lesbian, gay, bisexual, and transgender (LGBT) issues. Our website (abct.org) has two LGBT fact sheets – one for clients and one for therapists. Several presentations from rigorous programs of research that focus on topics especially relevant to sexual minorities are on the Toronto convention program (as has been true for a number of years). Our members are writing influential books on culturally sensitive cognitive-behavior therapy with gays and lesbians (e.g., Martell, Safren, & Prince, 2003).

These days, gay and behavior therapy fit comfortably in the same sentence. Thank you, Past-President Davison, for shining a bright light on this path for us.

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## Reflections on Mentoring

Richard J. McNally, *Harvard University*

Last May, I received an e-mail message from Shelley Robbins bearing the subject line “ABCT’s Outstanding Mentor Award.” My first thought was that our association was polling its members about possible nominees for this honor. Upon opening the message, I realized that Shelley had written to say that I was to receive the award at the 2010 conference in San Francisco. I was very touched and surprised; I had no idea that my past and current graduate students had nominated me. Mary Jane Eimer later contacted me, checking to see whether I would be present at the conference. There was no question that I would be there, award or not. Like one of Konrad Lorenz’s ducklings, I imprinted on ABCT many years ago, having missed only two meetings since my first conference in Chicago in 1978. When I have mentioned this to my graduate students, they often remind me that they were not even born in 1978.

Late this winter, Kathleen Guntherth asked me to write an article on mentoring for *the Behavior Therapist*. I have no special qualifications for doing so, other than having mentored Ph.D. students since 1984 and having learned a great deal from my own mentors, Steven Reiss and Edna Foa. Steve was my advisor in graduate school, and Edna was my internship and postdoctoral supervisor.

Mentoring is more than the explicit teaching formalized in the classroom, clinic, or laboratory. It also includes the informal transmission of practical, tacit knowledge—the tricks of the trade that seldom figure as topics in the graduate curriculum itself. Among the many possible mentoring topics, I concentrate on only three of them in this article: presenting at conferences, writing, and interacting with media. I summarize lessons that I have learned and that I transmit to my graduate students.

### Presenting

Our Ph.D. program in clinical psychology at Harvard University has a clinical science emphasis. My colleagues and I aim to produce researchers who are also equipped to provide evidence-based interventions. Hence, we emphasize the importance of

students presenting and publishing their research.

I provide feedback to students developing their first posters, stressing the importance of simplicity. A good poster is a visual sound bite. Hence, students need to use bullet points, not complete sentences, and figures, not tables. The objective is to stimulate discussion and make it easy for people to grasp the key points of the study.

Unfortunately, the vast majority of conference posters contain far too much material, producing a serious information overload for attendees. Presenters cram too many details into their posters to ensure that the facts are handy should someone ask them an obscure question about the research. A better strategy is to have a hard copy of the study available as a resource for answering such questions.

Many students speak on symposia. When mine have an upcoming presentation, I work with them as they go into rehearsal. I have them develop an initial Powerpoint presentation, emphasizing that I do not expect their first practice talk to be anything other than a very rough draft. In the presence of me and other supportive listeners, usually fellow graduate students, the student rehearses the talk four or five times over the course of a week or so, revising the slides and the oral delivery itself.

I tell students that I was so nervous during my first talk that my hands were vibrating so much that I thought I would spill the water in my Styrofoam cup whenever I tried to take a drink. Everyone is anxious before talks early in their careers. Yet despite feeling very anxious, people can still learn to give fine talks. Moreover, the more one speaks the more fun it becomes.

### Writing

Like most professors, I provide detailed feedback to students on their writing, and I urge them to study everything from the relevant section of the American Psychological Association’s (2010, pp. 61-86) *Publication Manual* to Strunk and White’s (1979) classic with its famous admonition, “Omit needless words” (p. 23). I emphasize that the more one writes, the easier it gets. Fluency comes with practice.

Mentors need to provide clear, constructive feedback without demoralizing students. If students become overly anxious about their writing, they can become paralyzed by perfectionism and never accomplish anything; perfectionism leads to procrastination. I have often told students that I expect that their first draft will be “junk,” and that’s okay. I tell them that my first drafts are always junky, even today.

Some years ago, I handed an undergraduate several folders containing articles and papers on phobias relevant to his honors thesis. He was delighted to discover a term paper on the topic that I had written in 1979 for a class taught by my advisor, Steve Reiss. It was covered with highly critical comments about my writing. I thought I had written a great paper. Steve disagreed. He was right. I took Steve’s comments to heart, and continued to work on my writing. A substantially revised version of the term paper appeared several years later in *Psychological Bulletin* (McNally, 1987).

Because I was a much lousier writer than my students are today, I make a point to give them a copy of my old term paper. It puts things in perspective for them, reducing worry about their own progress.

As a postdoctoral fellow, I had the good fortune to discover Robert Boice’s (e.g., 1983a, 1983b) empirical work on fostering the productivity of academic authors, later summarized in several masterful books (Boice, 1990, 1994, 2000). As a faculty development officer, Boice devised and tested intervention programs that enabled professors to counteract procrastination and overcome writer’s block. He drew on behavioral principles, such as stimulus control, self-monitoring, and contingency management, noting how the great novelists had used these same tricks to ensure their steady productivity (Wallace & Pear, 1977).

Through his research, Boice identified the best methods for establishing consistent output, and he debunked many myths about writing along the way. He found that productive authors schedule relatively brief periods to write each workday, ranging from about 15 minutes to 2 hours. Moreover, they record their data. Indeed, professors and graduate students who do not record their writing behavior will inevitably overestimate how much time they actually spend writing versus taking coffee breaks, daydreaming, and checking their e-mail.

Boice also found that people who block out one entire day per week to write or who write in binges lasting for many hours are rarely as productive as those who commit an



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hour or so every workday to their writing. The bingers encounter two problems. Their postmarathon exhaustion makes it hard for them to write again for days or weeks later. When they do attempt to resume their writing, they feel rusty and experience difficulty picking up where they left off. The successful academics, Boice learned, block out moderate amounts of writing time in their busy research, teaching, clinical, and administrative schedules.

I am a “Boicean.” Since 1983, I have kept a wall calendar near my desk that I use solely to record the amount of time that I write each day. I activate the stopwatch on my wristwatch whenever I begin to write, and I stop it when I take a break. I try to squeeze in at least 15 minutes of writing per day, and I try to avoid exceeding 2 hours. Self-monitoring can be sobering. For example, I may spend three hours at my desk, yet rack up only 1 hour and 15 minutes of actual writing, with the remaining time spent thinking about what I want to say next, double-checking an article that I am citing, or getting coffee.

Although I strive to complete five writing sessions per week, unavoidable emergencies occasionally occur, resulting in missed sessions. For these days, I enter a zero on my calendar. I have found Boice’s behavioral methods very effective, and I recommend them to my students.

Contrary to Romantic myths about authors requiring the inspiration of their Muse, great writers have been great behaviorists when it comes to creative work. Inspiration is often the consequence, not the antecedent, of writing. Examples abound. Ernest Hemingway counted the number of words he wrote each morning, recording the data on a chart, so as not to kid himself about his productivity (Plimpton, 1965). His publisher, Charles Scribner, ridiculed him, apparently because Hemingway’s methods violated Scribner’s concept of The Artistic Genius. In a 1944 letter to his editor, Max Perkins, Hemingway bluntly dismissed Scribner, saying the publisher knew nothing about how writers actually work (Hemingway, 1984, p. 56).

Other authors used different dependent variables. Goethe (1836/1984, pp. 202–203) recorded pages completed per day. Anthony Trollope (1883/1999, p. 271) counted pages and tracked time, writing from 5:30 to 8:30 each morning before heading off to his day job working for the post office.

Writing on a schedule and tracking output are methods of nonfiction authors, too.

When the great 20th-century political journalist Walter Lippmann was an undergraduate at Harvard, he got to know William James quite well. The psychologist gave him great writing advice. As Lippmann’s biographer wrote, “James also taught him discipline—that every writer should set down at least a thousand words a day, whether or not he felt like it, even whether or not he had anything to say” (Steel, 1980, p. 18). James followed his own advice; despite being a late bloomer, dying relatively young, and suffering repeated bouts of debilitating depression (Simon, 1998), he still managed to produce 307 publications (Simonton, 2002, p. 38).

Will structured writing periods boost productivity while sacrificing creativity? Will quantity trump quality? For several reasons, these concerns are unfounded. First, behavioral self-management methods foster creative ideas as well as increase the number of manuscripts completed (Boice, 1983b). Second, although quantity does not ensure quality, authors who produce the best work almost always produce the most as well. The notion that the giants of science and literature produce only a handful of masterpieces is incorrect. High quality is almost always accompanied by immense productivity, even though the latter does not guarantee the former (Simonton, 1984, pp. 81–83). As Simonton (2002, pp. 37–38) observed, the number of publications of history’s giants is impressive: Albert Einstein (607), Wilhelm Wundt (503), Sigmund Freud (330), Francis Galton (227), and Charles Darwin (119), to name but a few. As W. H. Auden once remarked, the chances are that “the major poet will write more bad poems than the minor” (quote in Simonton, 1984, p. 83) because the great poets produce more poems overall than the minor poets ever do. Yet we forget the lousy poems, and remember the good ones.

In addition to scheduling regular writing periods and recording words, pages, or time, authors have used other tricks to maintain their creative output. For example, it is helpful to end one’s daily session in the middle of a paragraph rather than working to closure by finishing a section of the manuscript. By doing so, it makes it much easier to pick up where one left off the

day before. As Hemingway (1964) put it, “I always worked until I had something done and I always stopped when I knew what was going to happen next. That way I could be sure of going on the next day” (p. 12).

Victor Hugo used contingency management methods while writing his novel, *Notre-Dame of Paris*. He had been down in the dumps, finding it difficult to get started. Hugo then hit upon the idea of confining himself to his writing room after having his valet lock away his formal clothes “so that he would not be tempted to go out,” as his wife put it (p. 7, quoted in J. Sturrock’s Introduction; Hugo, 1831/1978; Wallace & Pear, 1977). Lacking any suitable clothing until he finished his daily writing session, Hugo had no choice but to work on the book instead of goofing off and procrastinating.

Most authors arrange their writing environment to minimize distractions and maximize their productivity. Yet sometimes their stimulus control methods border on the bizarre. Consider Friedrich Schiller’s, as described by his friend and colleague, Goethe. Goethe had dropped by Schiller’s house one day. Although not at home, Schiller was soon to return, and his wife invited Goethe to have a seat in her husband’s writing room. Immediately thereafter, Goethe began to experience intense malaise. As he recalled, “At first I did not know to what cause to ascribe this wretched, and to me unusual, state—until I discovered that a dreadful odour issued from a drawer near me. When I opened it, I found to my astonishment it was full of rotten apples. I went to the window and inhaled fresh air, by which I was instantly restored” (Goethe, 1836/1984, p. 189).<sup>1</sup> When Schiller’s wife returned moments later, Goethe asked her why her husband stored rotting garbage in his drawer. She explained that Schiller was able to write only when he could smell the aroma of rotting apples.

As a struggling young author, F. Scott Fitzgerald submitted many short stories for publication, receiving over 100 rejection slips in the process. To motivate himself to try harder, he pinned them to a wall in his apartment (Mizener, 1965, p. 105). Aware of Fitzgerald’s motivational trick, I adapted

<sup>1</sup> For some strange reason, my copy of the English translation of this marvelous book is incorrectly entitled *Conversations with Eckermann*. The correct title is *Conversations with Goethe*. Eckermann is the author. Johann Eckermann was a young author who worked as Goethe’s secretary during the final years of Goethe’s life. After work, Eckermann would share a bottle of wine (or two) with Goethe, getting the great man to expound on all sorts of topics. Eckermann took copious notes of these conversations, later transforming them into a book. Because I quote from my copy, the title in the reference list corresponds to the incorrect one.

it during my first year on the academic job market. I received dozens of rejection letters in response to my job applications, enabling me to “wallpaper” my writing room with them as a reminder to work harder.

I mention these anecdotes to illustrate how authors maintain their productivity. I don’t necessarily recommend that graduate students have someone lock away their clothes until they finish their daily writing session or store rotting garbage in their desks to stimulate creativity. Rather, I aim to demystify writing, and to urge budding authors to apply behavioral methods in their daily work.

### Educating the Public via the Media

Psychologists can use the media to help educate the public about our field. There are two ways of doing this. One is to write Op-Ed essays and evidence-based trade books for general readers. The second is to serve as a resource for journalists. The second route is by far the most common, and I help students learn how to do this.

I have had several students whose research caught the attention of the media, enabling them to explain complex or controversial issues to the public. When stu-

dents have an interview scheduled, I brainstorm with them about the questions they are likely to receive and the answers they might provide. I sometimes play the role of the journalist, doing practice interviews with my student. I emphasize that they must “remember their ABCs” when interacting with the media. What students say must be accurate, brief, and clear. Accuracy entails sticking close to the data and avoiding careless generalizations about one’s findings.

Brevity is likewise essential. Editors can print only short replies from interviewees. They must abbreviate long-winded answers, sometimes inadvertently distorting their meaning. This is especially true for television. In my experience, a typical prerecorded (not “live”) interview lasts about 1 hour, yet producers choose only a few sound bites of several seconds duration to air on the show. Accordingly, effective interviewees must distill the essence of their message in a sentence or two, and do so accurately.

Finally, clarity entails avoidance of jargon. During a live interview for BBC television several years ago, I used the phrase “psychophysilogic reactivity.” My inter-

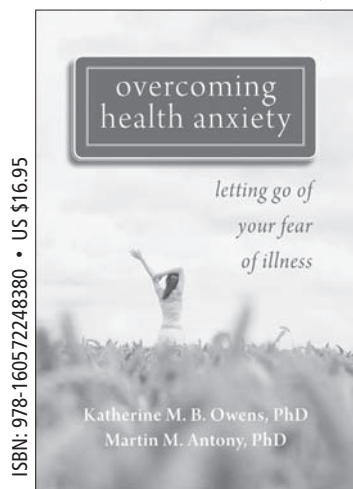
viewer winced off camera, signaling me to translate this phrase into ordinary language to avoid befuddling the viewers. I quickly clarified, “That is, an increase in heart rate and sweating on the palm of the hand, associated with an increase in anxiety.” I should have thought my replies through ahead of time to ensure that I had ready translations for any jargon.

Many psychologists grumble about journalists, blaming them for garbling the facts, exaggerating findings, or seeking to write something sensational as a way to sell newspapers and magazines or to boost television ratings. In my experience, this cynical view is inaccurate. Most journalists are highly responsible individuals who want to get the facts straight. Moreover, they do not want to anger and alienate their sources in our field by distorting what we say. By remembering the principles of accuracy, brevity, and clarity, we can avoid misunderstandings of our work in the media and help educate the public.

### Conclusion

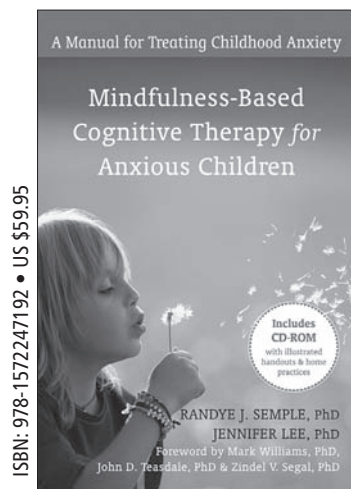
In this article, I focused on only three topics that figure in my mentoring of graduate students. Accordingly, I close by rec-

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ommending two superb books that provide essential information about academia that rarely appears in the formal graduate curriculum (Boice, 2000; Darley, Zanna, & Roediger, 2004). Yet both books are more than just survival guides; they teach graduate students and new faculty members how to flourish as well.

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## Clinical Forum

# The Mobile Revolution and the DBT Coach

Linda A. Dimeff, *BTECH Research, Inc., Seattle*

Shireen L. Rizvi, *Rutgers University*

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Whether we know it or not, we are in the midst of a radical paradigm shift that is changing how we detect, prevent, and treat behavioral problems. We have argued elsewhere that this seismic transformation is propelled by the rapid acceleration in technology, aided by the now ubiquitous Internet (Dimeff, Paves, Skutch, & Woodcock, 2011). Barely 16 years old, the Internet has changed every aspect of how we live—so much so that it is hard to remember what life was like before it existed. How did we communicate, shop, pay our bills, find our friends and our mates, conduct research, and store precious information (Kelly, 2007)? With the rest of the developed world, we are now wirelessly “wired,” so much so that we forget our con-

nectivity until access is interrupted. Then we remember. Our actions come to a grinding halt. We cease to function.

The Internet era has created the conditions for the relatively recent emergence of “the mobile revolution.” According to Stanford professor and technology expert B. J. Fogg, within 10 years, no other medium—from television to the Internet to word of mouth—will exert more influence on our behavior than our mobile phones (Fogg & Eckles, 2007). Fogg highlights what we implicitly know: We simply love our mobile phones! We spend more time with them than we do our loved ones, they are always within arm’s reach regardless of where we are, and we become terribly anxious when we cannot find them. Why?

Because these super-charged devices facilitate our work, our play, and our relationships. We connect with loved ones, get directions to remote destinations, transact business, make travel arrangements, track calories, watch videos, and play games through them. As “smart phones” get increasingly “smarter,” they further become extensions of our frontal lobes—providing context-specific prompts that help us achieve our goals. The power, diversity, and complexity of the tasks performed by today’s mobile phones have led to its renaming. The once “mobile phone” has morphed into “mobile devices” or “mobile screens” (Spitznas, 2010).

The rapid surge in mobile technology is illustrated by the ascendant course of Apple’s iPhone. The iPhone was first introduced as a prototype just 3 years ago, on January 9, 2007. The intention to support third-party applications (apps) using its own Internet browser (Safari) was announced 5 months later, and the first iPhone was sold to the public starting in June 2007. Within 2 years of its release, 50,000 apps had been produced, and over a million downloaded. The exponential growth of this surge has continued. By January 2011, over 400,000 iPhone apps were available for the iPhone, and over 10



billion have been downloaded (Apple, 2011). Apple's commercial success propelled innovation and fierce market competition among the major smart-phone makers, all of whom now offer apps created by third parties covering a wide range of content. With regard to the domain of psychology, we have identified over 65 apps that currently exist across mobile platforms for a variety of mental health and behavioral problems, including anxiety, depression, overeating, and insomnia, to name a few. Despite the plethora of these omnipresent apps, we know of none that are supported by efficacy data. As a field, we are forced to acknowledge that the rate of dissemination of these apps is far exceeding our ability to evaluate them.

Mobile devices are also being used to prevent, assess, diagnose, and treat a number of behavioral and health problems. For example, simple text messaging is the platform being used to promote sexual health and decrease the transmission of sexually transmitted diseases among inner-city youth (Levine, McCright, Dobkin, Woodruff, & Klausner, 2008), help individuals stop smoking (Haug et al., 2008; Obermayer, Riley, Asif, & Jean-Mary, 2004;

Riley, Obermayer & Jean-Mary, 2008; Rodgers et al., 2005; Whittaker et al., 2008), facilitate weight loss (Joo & Kim, 2007; Kubota, Fujita, & Hatano, 2004; Morak et al., 2008; Tanguy & Heywood, 2007), promote proper prenatal care among pregnant women (Bornstein, 2011), and improve physical activity (Damen, 2007; Hurling et al., 2007). In the area of remote diagnostics, mobile technology is being used to monitor and facilitate treatment of chronic diseases, including severe asthma (Ryan et al., 2005) and diabetes (Carroll, Marrero, & Downs, 2007; Quinn et al., 2008); diagnose pneumonia (Microsoft, 2009); provide real-time adherence monitoring of HIV antiretroviral therapy in Uganda (Haberer et al., 2010); and monitor blood alcohol levels in concerned drinkers (Chmielewski, 2008). Innovations soon to be released include an easily digestible smart pill (with a tiny transmitter and antenna) that tracks medication adherence when swallowed (Maqbool, Parkman, & Friedenberg, 2009) and a wearable body sensor that communicates real-time health status information to your mobile device in the form of a conversation. For example, a person quitting smoking might receive the

following message from his or her "lungs": "Don't even think about smoking. It's been 8 hours since your last cigarette. Carbon monoxide in your blood has already dropped by half, and I'm pinker already" (Unicef, 2010). A comprehensive overview of the emerging mobile technology-based inventions can be found in the recently released "Future of Health" report (PSFK, 2010).

Given the vast advances that have been made in the field of mobile technology, together with the ubiquitous nature of mobile devices, we wondered whether mobile technology could be leveraged as a therapy adjunct for individuals with borderline personality disorder (BPD) and substance use disorders (SUD) who are receiving Dialectical Behavior Therapy (DBT). Specifically, would clients with BPD, many of whom are exquisitely emotionally and interpersonally sensitive (Linehan, 1993), tolerate the use of a mobile device as a stand-in for a call to their therapists? Would DBT therapists be open to the use of mobile devices as stand-ins for themselves? Could we build an app that might actually bolster DBT treatment outcomes and potentially



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reduce the cost burden associated with delivery of DBT for BPD (McMain, 2010)?

### Mobile Technology Innovations in DBT: The DBT Coach

For the past 2 years, we have been actively developing and evaluating a mobile app for use as a therapy adjunct by clients with BPD, including those with co-occurring SUD, receiving DBT (Rizvi et al., in press). Because of the relative importance of DBT skills in the treatment of individuals with BPD (Koons et al., 2006; Linehan, 2010; Neacsiu, Rizvi, & Linehan, 2010), we decided to focus our initial efforts on building and evaluating a therapy adjunct mobile app (DBT Coach) that would further facilitate use of DBT skills in one's natural environment. The primary purpose of the DBT Coach is to aid clients in using DBT skills in the context of their lives outside the therapy session. The remainder of this article will focus specifically on the DBT Coach: what it is, the iterative process of development, efficacy research, and the vision for the future. It is hoped that this information will be useful for those seeking to develop evidence-based CBT apps of their own.

#### Development of the DBT Coach Prototype

Telephone consultation has always been a central treatment modality in standard outpatient DBT, intended to facilitate generalization of DBT skills to clients' natural environments—from the therapy room to the real world (Dimeff & Koerner, 2007). Rather than calling one's clinician after en-

gaging in dysfunctional behavior, DBT encourages clients to call for skills coaching if they encounter difficulty applying the skills in order to promote engaging in alternative, functional behaviors. Although skills coaching is an essential DBT treatment mode, many obstacles interfere with clients actually receiving coaching from their therapist when it is most needed. For example, clinic policy may require that all after-hours calls are routed to centralized mobile crisis phone centers (rather than a particular clinician), or therapists may be unwilling to accept calls outside of work hours or after they retire for the evening. In other instances, therapists may be willing to take calls 24/7, but may not always be available at the moment when coaching is needed. Finally, some DBT clients choose not to call their therapists for outside-of-session coaching when needed because they do not want to disturb them. We envisioned the DBT Coach app as an additional resource for clients, to be used before and/or instead of calling their primary clinician for coaching.

The first phase of this project involved developing a prototype of the DBT Coach mobile phone app using an iterative process of development with extensive feedback from DBT experts, DBT clinicians, and target end-users, namely individuals with BPD and co-occurring SUD receiving DBT. This initial version provided coaching in the DBT skill of opposite action (OA; Linehan, in press). OA, an emotion-regulation skill, is a behavioral approach to changing unwanted negative emotions in the moment by behaving in ways that are counter to the emotion's action urge.

Feedback across multiple iterations of the DBT Coach prototype was provided by four groups of individuals: (a) clients with BPD-SUD ( $n = 26$ ); (b) DBT clinicians ( $n = 31$ ); (c) DBT trainers employed by Behavioral Tech, LLC ( $n = 46$ ) attending the annual Trainers' Meeting in May 2009; and (d) DBT researchers ( $n = 34$ ) attending the annual DBT Research Strategic Planning Meeting (October 2009). Feedback from this iterative process was used to further develop the app until a prototype was created that was ready for evaluation. To ensure the clinical safety among individuals with BPD during the development phase, we purposely recruited clients from strong DBT programs known to the authors in the event that unforeseen, unintended negative consequences occurred following exposure to the DBT Coach.

All discussions with the group of BPD clients occurred in the context of focus groups that were attended by at least one DBT clinician. Eight groups were held, each lasting an average of 60 minutes. The majority of DBT clinicians were interviewed individually ( $n = 21$ ); the remaining 10 DBT clinicians participated in one of three therapist focus groups. Participants were 18 years or older and currently part of a DBT program, either as clients or therapists. The majority of therapists and clients were female (81% and 75%, respectively) and Caucasian (96% and 75%, respectively). The majority of therapists held a master's degree (52%) or a Ph.D./Psy.D./M.D. (41%) and worked in an outpatient setting (53%). They reported having worked as a clinician for 9 years on average. The majority of clients had completed college (75%) or post-college education (20%) and had never married (45%) or were divorced (30%). On average, clients had been in DBT for approximately 4 months.

Qualitative and quantitative approaches to data collection and analysis were applied to determine usability and acceptability. Using a grounded theory approach to qualitative data analysis (Glaser & Strauss, 1967), notes from the interviews were categorized into common themes and were then verified for accuracy by the product development team. Hypotheses generated from one user were tested with subsequent users, and global concerns generated during the first series of usability interviews and first focus groups were revisited during subsequent individual interviews and focus groups. Themes were then sorted into one of three a priori categories: (a) essential usability problems requiring immediate revisions or improvements that could be easily

Table 1. Satisfaction Data ( $N = 137$ )

Selected Relevance/Satisfaction Items	<i>M</i> ( <i>SD</i> )
How relevant was the program to the treatment of individuals with BPD-SUD? 1 = <i>not relevant</i> ; 5 = <i>extremely relevant</i>	4.00 (.93)
How easy was the material to understand? 1 = <i>not easy</i> ; 5 = <i>very easy</i>	4.55 (.96)
How likely would you be to use this tool in your treatment? 1 = <i>not likely</i> ; 5 = <i>extremely likely</i>	4.05 (.90)
Given that this is a prototype, would you recommend we continue to develop it? 1 = <i>not at all</i> ; 5 = <i>yes, absolutely</i>	4.68 (.65)
If this tool were available for use by you in your treatment, would you make use of it on your own initiative?	100% yes

incorporated; (b) nonessential but promising changes to consider in subsequent versions; and (c) not relevant/possible (given scope of project aims and/or state of technology). As anticipated, a number of essential themes emerged that were corrected in the final prototype. Examples include: initial language intended to validate client was perceived as disingenuous and unnecessary, font size was too small, and the text was too lengthy. Nonessential themes included the desire for a skill to help reduce extreme distress before being able to use OA, personalized messages from therapist, and greater specificity in coaching responses. Not relevant/possible themes included: desire for an option for clients who do not have “smart” phones and/or who are not “tech-savvy,” and for individuals with cognitive impairments. Clients and therapists were generally in agreement regarding their critique of the DBT Coach’s merits and problems across iterations. A number of positive comments were expressed by clients: “The definitions are great and would definitely be helpful when I’m dysregulated because it’s a very difficult time to remember skills”; “There are times when I feel too awful to call my therapist, but I would use the phone”; “I love this app, it was so helpful to me”; “It’s very helpful because you can do it in private”; and “It felt really natural and conversational.” As illustrated in Table 1 ratings from end-user testing and focus groups were consistently higher than the a priori criterion we had set to determine whether usability and acceptability had been achieved (a score of 3.5 on a 5-point Likert scale).

### *The Final DBT Coach Prototype*

We installed the DBT Coach app on Nokia Series 60 smart phones. To activate, users would select a DBT Coach icon on the phone’s home screen. Once launched, the DBT Coach assessed emotional intensity and urges to use drugs on a 0 to 10 scale; users were then instructed to identify the emotion they were currently experiencing, which then led to an emotion-specific branching of possible DBT Coach responses. To ensure that users were motivated to use OA, the DBT Coach next asked if they were willing to work on changing the emotion. If they indicated yes, users were directed to specific coaching in the use of OA (Linehan, in press). If they indicated no, users were invited to evaluate the pros and cons of changing the emotion. Users who remained uninterested in working to reduce their emotions were encour-

aged to call their therapists. Those who were willing were asked to indicate a specific action urge they experienced in response to the emotion from a list of emotion-specific choices. Users were then presented with emotion-specific OA behaviors and encouraged to select an action. Before completing the session, users again rated their emotional intensity and urge to use drugs.

To facilitate its use, the DBT Coach provided definitions and additional as-needed information on important concepts and terms by means of pressing a soft-key. For example, if users opted to receive a definition for the term “effective,” a new screen would be produced with its definition (“An emotion is effective if having it is doing something good for you in both the short AND the long-term. Sometimes an emotion can be justified but the intensity of it is too high to be effective”).

The “Follow-Up DBT Coach” was available to assess progress in applying OA after a user-specified period of time. The Follow-Up DBT Coach would again assess the user’s level of emotional intensity. If the emotional intensity had decreased since the last use, a positive statement was provided (e.g., “That’s good news” or “Great job

being effective”). If the emotional intensity was equal to or higher than their initial coach use, the program would generate a follow-up statement such as, “So you’re still feeling [emotion]” or “OK, it may help to try opposite action again,” and users would be invited to review the OA content. Those who opted for this review advanced to the emotion-specific OA list. If not, the program stated, “Sorry this isn’t more helpful right now. Please come back if you want to try the Coach again later. You can always call your therapist for help” before exiting.

### *Evaluation of the DBT Coach Prototype*

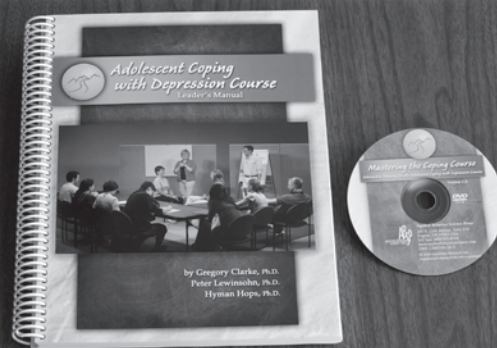
Following completion of the prototype, we then evaluated its feasibility over the course of a 2-week pilot trial using a within-subjects pre-post design ( $n = 22$ ; Rizvi et al., in press). BPD-SUD clients receiving DBT were again recruited to participate. Participants were provided with a Nokia phone with the DBT Coach app installed and all other features disabled for 10 to 14 days. Results from this small uncontrolled trial were favorable and supported the feasibility of the DBT Coach. Briefly, participants liked the phone ( $M = 3.32$ ,  $SD = 1.21$  on a 1.5 Likert scale), used it an aver-

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age of 15 times over the course of the trial, and rated it helpful in decreasing their emotional intensity and urge to use drugs in the moment of coaching. Additionally, participants reported a significant decrease in depression and general distress over the short trial, as measured by the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, & Erbaugh, 1961) and the Brief Symptom Inventory (BSI; Derogatis, 1975). Full quantitative analyses from this trial are described elsewhere (Rizvi et al.).

Extensive qualitative data were also collected from BPD-SUD participants and their therapists upon completion of the trial. Specifically, we conducted a 30-minute post-trial interview with participants to gather feedback about their experience with the DBT Coach. Participants were asked what they liked and disliked about the app, the ways in which the app was helpful to them, if there were any barriers that interfered with their use of the app, and suggestions to improve it. Salient themes were distilled from the interview notes using a grounded theory approach to qualitative data. A summary of these themes and the number of participants that identified them is reported in Table 2. In order to provide a fuller picture of users' experiences with the DBT Coach, vignettes were created based on the data we received and are presented in Appendix A.

### The Future of the DBT Coach

Encouraging results from the first phase of our development and testing suggest that there is merit in moving forward with the DBT Coach app. We envision that the hub of DBT Coach will be the interactive skills coaching feature itself, which will eventually contain information about the major DBT skills and instructions on their use. Upon activating the device, clients will be able to choose whether to be guided in a step-by-step fashion to select a specific skill to try given the specific context (just as they might when calling their individual clinician for skills coaching) or proceed directly to a specific skill for information, just as they might flip through their DBT skills notebook. In addition, the DBT Coach will include a number of other features designed to facilitate skills use and generalization. These include a Skill of the Day feature, an electronic skills use log, an area to upload uplifting favorite messages, and "survival tools" (e.g., favorite games the client can access to help distract from a crisis when urges to engage in dysfunctional behaviors are high).

### The Mobile Revolution and the Future of Clinical Psychology

In a relatively brief period, the Internet has made possible a kind of connectedness and sharing of information that was inconceivable just a generation ago. Mobile phones and mobile technologies, already

ubiquitous in our lives, are expected to play an even greater role in shaping and influencing behavior. Mobile technologies are already being used to promote a number of health behaviors. Our own work adds to their potential by providing in vivo coaching to promote skills generalization among individuals with BPD and SUD. The exponential growth of technology makes it difficult to envision fully what is around the corner or the limitless ways in which mobile technology will impact the practice and scope of clinical psychology in the years to come. For certain, these advances will put the clinician as well as therapy itself in the palm of the client's hand (and in her or his pocket, purse, backpack) 24/7.

As the mobile revolution continues to unfold and change the nature of treatment, new challenges will emerge. First, how do we evaluate the efficacy of a technology-based intervention that is moving faster than our ability to submit and receive a grant, let alone conduct and publish our research findings? By the time a grant proposal is funded, the original concept, if it involves mobile technology, will already be out of date. Second, how much emphasis should be placed during the grant review process on technology innovation (vs. research innovation)? Is it enough to add any form of mobile technology into a treatment intervention in order to meet the threshold for innovation, even if the technology is outdated? Or is it important that technology and research innovation are both on the cutting edge? Third, where do we set the bar in terms of the degrees of mobile complexity? Specifically, should we confine our mobile interventions to the lowest common denominator—what most individuals have access to now worldwide (e.g., text messaging), or do we "shoot for the moon" and innovate for the future, where all or most will have *really smart* smart phones? Finally, how do we address issues of security, privacy, and confidentiality as therapy moves into the Ethernet? This much we do know: We are now just at the tip of the iceberg for what promises to be a rich, complicated, and powerful mode for influencing health and human suffering.

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Table 2. Themes From User Feedback (N = 22)

Themes	Frequency
<i>Pros</i>	
Good reminder to practice DBT skills	4
Step-by-step guide to Opposite Action	3
Increased practice of DBT skills	3
Private and discrete	3
Allows to get coaching without downsides associated with reaching out to a therapist	3
Gives something to do in moments of distress (reaching for phone; going through coaching)	3
Easy to use	3
Portable (accessibility)	3
<i>Cons</i>	
Not enough variability in reinforcers	2
Not salient enough during a big crisis	2
Limited content (just one DBT skill)	2

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## Appendix A: Case Vignettes

### Alisse

Alisse is a 32-year-old Caucasian woman who meets diagnostic criteria for BPD, SUD, posttraumatic stress disorder (PTSD), and bipolar disorder (BD). She is a single mother of two children and does not work outside the home. Both children are currently in the custody of child protective services. She had received comprehensive DBT for 5 months for methamphetamine ("meth") dependence. Alisse finds that she can behave skillfully and avoid using meth just before and during her visitations with her children. However, the moment the visitation ends, she struggles with anger, sadness, and high urges to use drugs to regulate her emotions. Alisse's participation in the trial happened to overlap with a visitation. As the visit came to an end, she stated that her reliance on the DBT Coach to help manage her painful emotions and high urges to use increased. Self-described as "paper-challenged," Alisse instead relied on the DBT Coach to walk her through OA in a step-by-step fashion, which she reported to be very helpful.

### Sean

Sean is a 35-year-old Caucasian male diagnosed with BPD, BD, alcohol abuse, and schizoaffective disorder. He had received comprehensive outpatient DBT for 2 months for self-injury and alcohol abuse. Sean rarely calls his therapist for coaching,

even when he feels he needs it, because he does not want to feel like a burden to him. Sean stated that the DBT Coach was extremely helpful as he could get the coaching he needed without having to call his therapist.

### Jaclyn

Jaclyn is a 55-year-old Caucasian woman diagnosed with BPD, major depressive disorder (MDD), and generalized anxiety disorder (GAD). She has obtained some graduate education and currently works part time. Jaclyn had received comprehensive outpatient DBT for 6 months. One of Jaclyn's therapy goals was to decrease her cigarette smoking. Overall, Jaclyn stated that she did not like the prototype because it lacked the complexity of information she needed to interact meaningfully with it. Specifically, she continues having difficulty identifying her emotions—a prerequisite before applying OA—which interfered with her use of the DBT Coach. However, the few times she was able to properly identify her emotion, she reported that the DBT Coach was very helpful in decreasing the intensity of the unwanted emotion.

### Julie

Julie is a 20-year-old Japanese American female diagnosed with BPD, MDD, alcohol and pain killer abuse, and GAD. Julie had received comprehensive DBT for 1 year and

2 months in a private DBT center in Seattle, WA. She stated that she "loved the app and it was very helpful," especially with regard to the day-to-day intense emotions she experiences. During the course of the research trial, Julie broke up with her partner and as a result was homeless for several days. Julie said she relied on the DBT Coach during this difficult time to walk her through OA and was able to avoid engaging in dysfunctional behaviors as she would have in the past.

### Antonia

Antonia is a 41-year-old Spanish-Filipino American female diagnosed with BPD, alcohol abuse, and BD. She has some college education and is unemployed. Antonia had received comprehensive outpatient DBT for 8 months. Antonia stated that her intense jealousy often leads to arguments with her husband, which then results in intense anger and eventually a relapse. Antonia was pleased with the DBT Coach and stated that it was very helpful in regulating her intense emotions. Regardless of the fact that Antonia does not own a cell phone, she stated that the DBT Coach was very user-friendly and the interface was intuitive. She also valued how discrete and nonintrusive it was, and that the language was calming and natural.

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- Dr. Linehan is the owner of BTECH Research, Inc. Dr. Dimeff is Vice President and Chief Scientific Officer of BTECH Research, Inc. Drs. Rizvi, Dimeff, and Linehan anticipate receiving royalties from the eventual completion and sale of the DBT Coach. Drs. Dimeff and Linehan currently receive royalties for other products developed at BTECH Research, Inc. and distributed by Behavioral Tech, LLC. Drs. Dimeff and Linehan also receive royalties from Guilford Press. Drs. Rizvi, Dimeff, and Linehan provide workshops on DBT for Behavioral Tech, LLC.

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## Classified

**UNIVERSITY AT BUFFALO, THE STATE UNIVERSITY OF NEW YORK.** The State University of New York at Buffalo's Department of Psychiatry currently has a fulltime position for an Academic Emergency Psychiatrist interested in teaching, research in outcomes of emergency psychiatric treatment and the development of systems of health care delivery. Experience working in emergency psychiatry and with students and residents is required. Rank dependent

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DISSEMINATION IN THE 21ST CENTURY

# TORONTO

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45th Annual Convention  
November 10–13, 2011

# Welcome

David DiLillo, ABCT Program Chair, *University of Nebraska, Lincoln*

*Welcome to Toronto* and the 45th Annual Convention of ABCT! We are thrilled to have the convention in Canada for the first time in several years. Toronto is a vibrant and diverse city with many excellent cultural, dining, and sightseeing opportunities.

ABCT is a growing organization, with approximately 5,000 members (including almost 300 in Canada). The convention has expanded over the years and has taken on an international flavor. This year we received over 1,800 submissions from the U.S. and 19 other countries. To accommodate this growth, for the first time, events are scheduled in two hotels: the Sheraton Centre Toronto and the Toronto Hilton. The walk between them takes a brief 4 minutes and may be done underground in inclement weather in about 10 minutes.

This year's theme is *Dissemination in the 21st Century*. We return to that theme after a decade that has brought advances in theory and research on models of dissemination, innovative technological approaches to treatment delivery, new ways of assessing dissemination outcomes, and novel methods of disseminating proven interventions through education and training. These themes are reflected in many of the excellent presentations at this year's convention.

Other highlights of the meeting will include Debra Hope's

Presidential Address and our four Invited Addresses (Thomas Bradbury; Zindel Segal; Bonnie Spring; and a special panel, chaired by Linda Sobell, honoring the late Alan Marlatt's life and research).

In addition to the tried-and-true presentations we have come to expect, this year brings the introduction of a new presentation format: Spotlight Research Presentations. These 60-minute sessions will allow researchers to debut especially innovative or groundbreaking findings and offer a more in-depth research presentation than is permitted by symposia or other formats.

A successful convention is the product of many people's hard work. I would like to thank the coordinators and members of the Convention and Education Issues committees; Mary Ellen Brown at ABCT, who works tirelessly behind the scenes to make the convention happen; Assistant Program Chairs Rosy Maldonado and Laura Watkins, who worked many hours scheduling, responding to inquiries, and handling numerous details. I also appreciate the many members of the Program Committee who each reviewed a large number of submissions. Finally, I thank Deb Hope for entrusting me with the privilege of serving ABCT as this year's Program Chair.

Best wishes for a stimulating and productive convention!

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## ABCT's Online Convention Itinerary Planner

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### *About the Itinerary Planner*

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2011 convention in Toronto. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner.

The purpose of ABCT's Itinerary Planner is to help you locate presenters, sessions, and topics quickly and easily. The Itinerary Planner is accessible on ABCT's website at [www.abct.org/conv2011](http://www.abct.org/conv2011). To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can *search* by session type, or you can *browse* by day. (Keep in mind, the ABCT convention program book will only be mailed to those who preregister by **October 3**. Programs will be distributed on-site to all other registrants.) After reviewing this special Convention 2011 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

[www.abct.org/conv2011](http://www.abct.org/conv2011)



**Search | Plan | Find**



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

# Clinical Intervention Trainings

## **2-Day: Wednesday & Thursday**

▷ 8:30 a.m. - 5:00 p.m.

### CLINICAL INTERVENTION TRAINING 1

**Deepening Your Work as a Contextual  
Cognitive Behavior Therapist:  
Applying the Psychological Flexibility Model**  
Steven C. Hayes, *University of Nevada*

## **1-Day: Thursday**

▷ 8:30 a.m. - 5:00 p.m.

### CLINICAL INTERVENTION TRAINING 2

**Bringing Exposure Procedures Into Dialectical  
Behavior Therapy**  
Marsha M. Linehan and Melanie S. Harned,  
*University of Washington*

# Invited Addresses

### PRESIDENTIAL ADDRESS

**Exploring the Interaction of Learning, Culture and  
Hormones in Anxiety**  
Debra A. Hope, *University of Nebraska-Lincoln*

### INVITED ADDRESS

**Relationship Science and the Improvement of  
Preventive and Educational Interventions for  
Couples**  
Thomas Bradbury, *UCLA*

### INVITED ADDRESS

**What's Next for Mindfulness-Based Cognitive  
Therapy? Moving Beyond Efficacy to Mechanisms  
and Dissemination**  
Zindel Segal, *University of Toronto*

### INVITED ADDRESS

**Evidence-Based Practice: What's New and How It  
Can Help You**  
Bonnie Spring, *Northwestern University*

### INVITED PANEL

***A Tribute to Dr. G. Alan Marlatt***

MODERATOR: Linda Sobell, *Nova Southeastern  
University*

- **Effects of Alcohol Using the Balanced Placebo  
and Taste-Test Procedures**  
Dennis Donovan, *University of Washington School  
of Medicine*
- **Relapse Prevention**  
Katie Witkiewitz, *Washington State University*
- **Harm Reduction**  
Mary Larimer, *University of Washington*
- **Mindfulness**  
Sarah Bowen, *University of Washington*



# Workshops

ticketed sessions

Workshops provide participants with up-to-date integration of theoretical, empirical, and clinical knowledge about specific issues or themes.

## Friday

▷ 9:00 a.m. - 12 noon

### WORKSHOP 1

#### **Working With Bipolar Disorder in Children and Adolescents: Clinical Presentation, Assessment Strategies, and Treatment**

Eric Youngstrom and Melissa Jenkins, *University of North Carolina at Chapel Hill*

### WORKSHOP 2

#### **Enhancing Treatment Outcomes in Dialectical Behavior Therapy for Borderline Personality Disorder**

Shireen Rizvi, *Rutgers University*

### WORKSHOP 3

#### **Designing Contingency Management Interventions for Health Behaviors**

Jeremiah Weinstock, *St. Louis University*, and  
Carla Rash, *University of Connecticut Health Center*

### WORKSHOP 4

#### **Brief Management of Suicide Risk**

Craig Bryan, *University of Texas Health Science Center*

### WORKSHOP 5

#### **An Integrated CBT Approach for Anxiety and Depression Comorbidity**

Neil Rector, *University of Toronto*, and John Riskind, *George Mason University*

▷ 1:30 p.m. - 4:30 p.m.

### WORKSHOP 6

#### **Modern Cognitive Behavior Therapy**

Stefan Hofmann, *Boston University*

### WORKSHOP 7

#### **Assessment and Treatment of Late-Life Depression**

Dimitris Kiosses, Jo Anne Sirey, and Victoria Wilkins, *Weill-Cornell Institute of Geriatric Psychiatry*

### WORKSHOP 8

#### **Treating Narcissistic Personality Disorder: The Patient That We Like to Dislike**

Arthur Freeman, *Midwestern University*

### WORKSHOP 9

#### **Civil Commitment: Ethical Breach or Prudent Care?**

Wayne Bowers, Arnold Anderson, and Janeta Tansey, *University of Iowa*

### WORKSHOP 10

#### **Facilitating the Development of Emotion Regulation Skills for Youth with Autism Spectrum Disorders: Focusing on Therapy Readiness and CBT Interventions**

Shana Nichols and Samara Tetenbaum, *ASPIRE Center for Learning and Development*

# Saturday

▷ 9:00 a.m. - 12 noon

## WORKSHOP 11

### **Interpersonal Psychotherapy for Depressed Adolescents: Techniques and Implementation**

Laura Mufson, *Columbia University*, and Jami Young, *Rutgers University*

## WORKSHOP 12

### **Acceptance and Change in Couple Therapy: Integrative Behavioral Couple Therapy**

Andrew Christensen, *UCLA*

## WORKSHOP 13

### **Psychotherapy for the Interrupted Life: An Evidence-Based Treatment for Adult Survivors of Childhood Abuse**

Tamar Gordon and Christie Jackson, *New York University*, Susan Trachtenberg Paula, *Martha K. Selig Institute*, and Marylene Cloitre, *New York University*

## WORKSHOP 14

### **Silence to Sound: Understanding and Implementing a Treatment Approach for Selective Mutism**

Sandra Mendlowitz and Suneeta Monga, *University of Toronto*

## WORKSHOP 15

### **Empirically Based CBT Supervision: Making Supervision More Effective**

Robert Reiser, *Palo Alto University*, Donna Sudak, *Drexel University*, and Derek Milne, *Newcastle University*

▷ 1:30 p.m. - 4:30 p.m.

## WORKSHOP 16

### **Exposure Therapy for Anxiety: Basics and Beyond**

Jonathan Abramowitz, *University of North Carolina at Chapel Hill*, Brett Deacon, *University of Wyoming*, and Stephen Whiteside, *Mayo Clinic*

## WORKSHOP 17

### **Regulation of Cues for Childhood Overeating: The Regulation of Cues Intervention**

Kerry Boutelle, *University of California, San Diego*

## WORKSHOP 18

### **New Thinking in Treatment-Resistant Depression: Targeting Emotional Overcontrol**

Thomas Lynch, *University of Exeter*

## WORKSHOP 19

### **Paradigms for Disseminating Contextual Cognitive Behavioral Therapy Strategies**

Patricia Robinson, *Mountainview Consulting Group*

## WORKSHOP 20

### **Introduction to Cognitive Behavioral Therapy for Insomnia**

Michael Perlis, *University of Pennsylvania*, Donn Posner, *Brown University*, and Robert Meyers, *St. John's University*

## WORKSHOP 21

### **Difficult to Treat? Not Anymore! Cognitive Therapy for OCD**

Adam Radomsky, *Concordia University*

# Master Clinician Seminars

ticketed sessions

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

## Friday

▷ 8:00 a.m. - 10:00 a.m.

### MASTER CLINICIAN SEMINAR 1

#### **Cognitive-Behavior Therapy for Children and Adolescents With Obsessive-Compulsive Disorder**

Dean McKay, *Fordham University*, and Stephen Whiteside, *Mayo Clinic*

▷ 10:15 a.m. - 12:15 p.m.

### MASTER CLINICIAN SEMINAR 2

#### **Problem-Solving Therapy for Depression: Recent Revisions**

Arthur Nezu and Christine Nezu, *Drexel University*

▷ 12:30 p.m. - 2:30 p.m.

### MASTER CLINICIAN SEMINAR 3

#### **Integrating Sexual Interventions Into Couple and Individual Cognitive Behavioral Therapy**

Barry McCarthy, *American University*

▷ 2:45 p.m. - 4:45 p.m.

### MASTER CLINICIAN SEMINAR 4

#### **Case Conceptualization Approach to Insomnia for Non-Sleep Specialty Treatment Settings**

Rachel Manber, *Stanford University*, and Colleen Carney, *Ryerson University*

## Saturday

▷ 8:00 a.m. - 10:00 a.m.

### MASTER CLINICIAN SEMINAR 5

#### **Improving Your Socratic Savvy**

Priscilla Schulz, *Uniformed Services University of the Health Sciences*, and Candice Monson, *Ryerson University*

▷ 10:15 a.m. - 12:15 p.m.

### MASTER CLINICIAN SEMINAR 6

#### **Using Exposure Strategies in Acceptance and Commitment Therapy**

John Forsyth, *SUNY-Albany*

▷ 12:30 - 2:30 p.m.

### MASTER CLINICIAN SEMINAR 7

#### **Buried in Treasures: The Treatment of Compulsive Hoarding**

David Tolin, *Institute of Living and Yale University School of Medicine*, and Randy Frost, *Smith College*

▷ 2:45 p.m. - 4:45 p.m.

### MASTER CLINICIAN SEMINAR 8

#### **Treating Tourette's Syndrome and Trichotillomania Across the Developmental Spectrum**

Nancy Keuthen, *Massachusetts General Hospital and Harvard Medical School*, Douglas Woods, *University of Wisconsin-Milwaukee*, and Martin Franklin, *University of Pennsylvania School of Medicine*

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

## Thursday

▷ 8:30 a.m. - 5:00 p.m.

### INSTITUTE 1

**Introduction to Motivational Interviewing**  
Daniel McNeil, *West Virginia University*

▷ 8:30 a.m. - 5:00 p.m.

### INSTITUTE 2

**The Inclined Heart: A Mindfulness and Values Focused Institute**  
Kelly Wilson, *University of Mississippi*,  
and Emily Sandoz, *University of Louisiana*

▷ 1:00 p.m. - 6:00 p.m.

### INSTITUTE 3

**Behavioral Activation for Treating Depression: Putting Guided Action Into Action**  
Christopher Martell, *University of Washington*,  
and David Pantalone, *Suffolk University*

▷ 1:00 p.m. - 6:00 p.m.

### INSTITUTE 4

**Concurrent Treatment for Alcohol Dependence and Posttraumatic Stress Disorder**  
David Yusko and Edna Foa, *University of Pennsylvania*

▷ 1:00 p.m. - 6:00 p.m.

### INSTITUTE 5

**Dialectical Behavior Therapy for Emotion Dysregulation and Nonsuicidal Self-Injury in Adolescents**  
Lorie Ritschel and W. Edward Craighead,  
*Emory University School of Medicine*

▷ 1:00 p.m. - 6:00 p.m.

### INSTITUTE 6

**Mindfulness- and Acceptance-Based Behavioral Therapies in the Treatment of Anxiety and Related Disorders**  
Susan Orsillo, *Suffolk University*, and  
Lizabeth Roemer, *University of Massachusetts, Boston*

▷ 1:00 p.m. - 6:00 p.m.

### INSTITUTE 7

**Pushing Past Perfectionism: Using Cognitive-Behavioral Strategies to Treat Perfectionism Across the Anxiety Disorders in Children and Adolescents**  
Deborah Ledley and Lynne Siqueland, *Children's Center for OCD and Anxiety*

▷ 1:00 p.m. - 6:00 p.m.

### INSTITUTE 8

**OCD and ERP in the Real World: Sources of and Solutions for Treatment Compliance/Resistance Issues**  
Jonathan Grayson, *Anxiety and OCD Treatment Center of Philadelphia*



Advanced Methodology and Statistics Seminars (AMASS)  
are for applied researchers, presented by renowned  
research scientists

## Thursday

▷ 8:30 a.m. - 5:00 p.m.

### AMASS 1

#### **Developing Dynamic, Sequential Interventions That Optimize Mental Health Outcomes: Novel Clinical Trial Design and Data Analysis Strategies**

Susan Murphy and Daniel Almirall, *University of  
Michigan*

▷ 2:00 p.m. - 6:00 p.m.

### AMASS 2

#### **Item Response Theory: Fundamentals and Application of Modern Psychometric Analysis**

James Henson and Abby Braitman, *Old Dominion  
University*

## Sunday

▷ 8:30 a.m. - 12:30 p.m.

### AMASS 3

#### **An Introduction to Modern Missing Data Handling Techniques**

Craig Enders, *Arizona State University*

# Spotlight Research

no ticket required

These 60-minute sessions are intended for in-depth presentations  
of especially innovative or groundbreaking findings.

## Friday

### SPOTLIGHT 1

#### **Reaching the Underserved: An Adapted CBT Treatment for Postpartum Depression in Early Childhood Prevention Programs**

Moderator: Robert T. Ammerman, *Cincinnati  
Children's Hospital Medical Center*

### SPOTLIGHT 2

#### **Emotion Regulation Therapy for Complex and Refractory Presentations of Anxiety and Depression**

Moderators: Douglas S. Mennin, *CUNY-Hunter*  
David M. Fresco, *Kent State University*

## Saturday

### SPOTLIGHT 3

#### **Transdiagnostic CBT for Anxiety: Efficacy, Acceptability, and Beyond**

Moderator: Peter J. Norton, *University of Houston*

### SPOTLIGHT 4

#### **Bounce Back: Reclaim Your Health—A New Provincewide, Telephone-Supported, CBT-Based Self-Help Program for Primary Care Patients With Mild to Moderate Depression**

Moderator: Mark Lau, *University of British Columbia*

# General Sessions

no ticket required

**Clinical Round Tables** and **Panel Discussions** feature discussion by experts on a current important topic. **Membership Panel Discussions** emphasize training or career development. **Symposia** are presentation of data, usually investigating efficacy of treatment protocol or particular research.

## Clinical Round Tables

### ▷ AGING

#### **Disseminating Behavioral and Cognitive Interventions for Older Adults to Providers in a Continuum of Care Settings**

*Chair:* Ann Steffen

*Panelists:* Jeffrey Buchanan, Leah Dick-Siskin, Sean Lauderdale, Kristen Sorocco

### ▷ COGNITIVE PROCESSES

#### **Transdiagnostic Cognitive Vulnerability Factors: Where Have We Been and Where Do We Go From Here?**

*Chair:* Alison McLeish

*Panelists:* Gordon J. Asmundson, Norman Schmidt, Wendy Silverman, Jasper Smits, Carl Lejuez, Bunmi Olatunji

### ▷ DISSEMINATION

#### **Bridging the Gap: Dissemination of Evidence-Based Practices From the Lab to the Clinic**

*Chair:* Marissa Morris-Jones

*Panelists:* Melissa Grady, Erica Eugenio, Jennifer Bellamy, David Klonsky, Andrew Ekblad, Bruce Chorpita

### ▷ EDUCATION AND TRAINING

#### **Seven Questions for Highly Effective Trainers: Learning How They Train Student Therapists to Deliver Mindfulness-Based Approaches Competently**

*Chair:* LeeAnn Cardaciotto, Jennifer Lerner

*Panelists:* Nikki Rubin, Cara Fuchs, Kelsey Schraufnagel, Dennis Tirsch, Steven Hickman, Elizabeth Roemer

### ▷ HEALTH PSYCHOLOGY

#### **Treatment Dissemination in Health Care Settings: Innovations and Outreach Practices**

*Chair:* Kathy Sexton-Radek

*Panelists:* Christina Nash, Jacqueline Kloss, Shelby Freedman Harris, Lisa Uebelacker, Jason Ong

### ▷ OCD/OCD SPECTRUM

#### **Animal Hoarding: Characteristics, Commonalities, and Clinical Challenges**

*Chair:* Simon Rego

*Panelists:* Daniel Moran, Randy Frost, Gail Steketee

#### **Issues in Managing Treatment Resistant OCD and Spectrum Disorders in Children and Adults**

*Chair:* Cheryl Carmin

*Panelists:* Meredith Coles, Bradley Riemann, C. Alec Pollard, Randy Frost, Martin Franklin, Jonathan Abramowitz, Gail Steketee

### ▷ SEVERE MENTAL ILLNESS

#### **Innovative Applications of CBT for Psychosis in Practice: Working Across Different Levels of Symptoms and Functioning**

*Chair:* Kate Hardy

*Panelists:* Kate Hardy, Dimitri Perivoliotis, Sally Riggs, Neal Stolar

### ▷ TREATMENT

#### **I Know They Work, but How Do I Do It? Strategies for Integrating Evidence-Based Treatments Into Your Practice**

*Chair:* Simon Rego

*Panelists:* Keith Dobson, G. Terence Wilson, Stefan Hofmann, Martin Antony

#### **Models of Successful Dissemination of Evidence-Based Therapies for PTSD in U.S. Department of Defense Clinics**

*Chair:* Priscilla Schulz

*Panelists:* David Mather, Marjorie Weinstock, Carrie Rodgers, Kelly Crowe, Bradley Wolf, Suzanne Dundon

#### **When Thinking Changes Your Mind, That's Philosophy. When God Changes Your Mind, That's Faith. When Facts Change Your Mind, That's Science**

*Chair:* Simon Rego

*Panelists:* G. Terence Wilson, David Barlow, Christopher Fairburn

## Membership Panels

### MEMBER PANEL DISCUSSION 1

#### **Getting in and Succeeding in Graduate School in Clinical Psychology**

*Panelists:* Karen Christoff, Debora J. Bell, Lauren Cox, David Hansen, Richard G. Heimberg, Mitchell Prinstein, Jennifer Veilleux, and Sheila Woody

### MEMBER PANEL DISCUSSION 2

#### **What Professionals Look for When They Hire New Employees**

*Panelists:* Hilary Vidair, Martin Antony, Mitchell L. Schare, Anne Marie Albano, Antonette M. Zeiss, and Kristine Doyle

## Panel Discussions

### ▷ ADDICTIVE BEHAVIORS

#### **The Reorganization of Addictions Research at NIH: What Does it Mean for Behavioral Research?**

*Chair:* Barbara McCrady

*Panelists:* Dennis Donovan, Peter Monti, Linda Sobell, Kenneth Leonard

### ▷ ADULT DEPRESSION/DYSTHYMIA

#### **Lessons Learned in Treatment-Resistant Depression: Where Do We Go From Here?**

*Chair:* Thomas Lynch

*Panelists:* Steven Hollon, Michael Thase, Zindel Segal, Jacqueline Persons

▷ COUPLES/CLOSE RELATIONSHIPS

**Forgiveness: An Emotionally Challenging, Often Rewarding, and Potentially Controversial Process**

*Chair:* Kristina Gordon

*Panelists:* Susan Johnson, Julie Exline, Rebecca Cobb

▷ DISSEMINATION

**Consultation to Improve Implementation: How Is It Being Used, and What Is Working?**

*Chair:* Suzanne Decker

*Panelists:* Patricia Resick, David Kolko, Adam Weissman, Tara Mehta, Rinad Beidas, Bradley Karlin

**Dissemination of CBTs to the Public on a Shoestring Budget: Old Problem, New Solutions?**

*Chairs:* Amanda Russo, Kristin Herzberg

*Panelists:* Harold Robb, Matthew McKay, John Forsyth, Jason Luoma, Stefan Hofmann, James Herbert

**Dissemination With and Without Technology: How Can We Better Reach the Masses?**

*Chair:* Beverly Fortson

*Panelists:* Lisa Ware, Shannon Self-Brown, Georganna Sedlar, Lisa Witter

**Leaders in Dissemination Reflect on the Past Year's Conferences and Look Ahead to the Future of Our Field**

*Chair:* Cara Lewis

*Panelists:* Jacquie Brown, David Chambers, Robert McMahon, Katherine Comtois

**The Growth and Evolution of CBT Over the Past 35 Years**

*Panelists:* Gerald Davison, Marvin Goldfried

**Transporting CBT From the Research Clinics to the Providers and Consumers Who Want and Need Them: What We Have Done and What We Still Need to Do**

*Chair:* Maureen Whittal

*Panelists:* Mark Lau, Chris Williams, Steven Hollon, Larry Lynd

▷ EDUCATION AND TRAINING

**Practice-Based Research: How to Conduct Meaningful Research in Clinical Practice**

*Panelists:* Kelly Koerner, Travis Osborne, Jason Luoma, Jacqueline Persons

**Training a New Generation of Dissemination and Implementation Scientists**

*Chair:* Ann Garland

*Panelists:* Ryan Beveridge, Marc Atkins, Erin Accurso, Timothy Fowles, Adele Hayes, Lauren Brookman-Freeze, Rinad Beidas

▷ PERSONALITY & BORDERLINE PERSONALITY DISORDER

**BPD and Emotional Dysfunction: Translating and Disseminating the Science to Improve Health Care**

*Chairs:* M. Zachary Rosenthal, Nathaniel Herr

*Panelists:* Paul Links, M. Zachary Rosenthal, Alexander Chapman, Kim Gratz

▷ PROFESSIONAL ISSUES

**Careers in Clinical Psychology: Which Path Makes Sense for Me?**

*Chair:* Jedidiah Siev

*Panelists:* Simon Rego, Sabine Wilhelm, Matthew Nock, Randy Frost, Antonette Zeiss

**"Get a Life": Or Does Being a CBT Professional Allow for One? Thoughts From Dual-Career Couples**

*Chair:* Arthur Nezu

*Panelists:* Linda Craighead, Edward Craighead, Keith Shaw, Patricia Resick, Robert Zeiss, Antonette Zeiss, Christine Nezu

▷ RESEARCH

**Assessing Sexual Orientation and Other Methodological Issues in Research With Sexual Minority Participants**

*Chairs:* Luis Morales Knight, Debra Hope

*Panelists:* Miriam Smith, Steven Safren, Trevor Hart, Gary Gates, John Pachankis

▷ SEVERE MENTAL ILLNESS

**Disseminating Behavior Therapies in Institutional Settings for Patients With Severe Mental Illness: Methods, Challenges, and Successes**

*Chair:* Daniel Hoffman

*Panelists:* Nadine Chang, Michael Merritt, Rochelle Robbins, Alicia Michelle Marsh, Bradley Riemann, Mitchell Schare

**Dissemination of Cognition-Targeted Treatment Techniques for**

**Schizophrenia-Spectrum Disorders**

*Chair:* Will Spaulding

*Panelists:* Robert Drake, Volker Roder, Alice Medalia, David Penn

**When Stabilization Is Not Enough: Dissemination of Best Practices for Recovery in Serious Mental Illness**

*Chair:* Jason Vogler

*Panelists:* Mary Sullivan, Jennifer Snyder, William Spaulding

▷ TREATMENT

**Art of Exposure Therapy: Reality Beyond the Guidebooks**

*Chair:* Mitchell Schare

*Panelists:* Jonathon Grayson, Dean McKay, Jonathan Abramowitz

**CBT in the Age of Telehealth: Can Videoconferencing Increase Access to Care?**

*Chairs:* Debra Hope, Brandon Weiss

*Panelists:* Amy Przeworski, Jodi Polaha, Nathan Miller, Stephane Bouchard, Brandon Weiss, Brandon Weiss

**Legal and Clinical Perspectives in Using Teleconferencing in CBT**

*Chair:* Katia Moritz

*Panelists:* Jeff Szymanski, Junko Tanaka-Matsumi, Jonathan Hoffman, James Herbert

**Psychophysiology, Neuroimaging, and Neuropsychology for the Clinic: How Close Are We?**

*Chairs:* Christen Deveney, Greg Siegle

*Panelists:* Adam Weissman, Jan Mohlman, Thilo Deckersbach

**When Speaking to Our Clients More Directly Isn't Working: Using Stories, Metaphors, Paradox, and Analogies to Increase the Clinical Impact of Newer and More Traditional CBTs**

*Chairs:* Kristin Herzberg, John Forsyth, Simon Rego

*Panelists:* Dennis Tirsch, Joanna Arch, Susan Orsillo, Robyn Walser, Michael Otto, Steven Hayes, Christopher Fairburn, G. Terence Wilson, David Barlow

**Why Did You Say That? Why Not Say This, Instead? Comparing Verbal Interventions in ACT, CT, and REBT**

*Chair:* Stevan Nielsen

*Panelists:* Robyn Walser, Raymond DiGiuseppe, Robert Leahy

▷ VIOLENCE/AGGRESSION

**Addressing Violence Against Women Through Advocacy: A Multilevel Approach for Psychologists**

*Chairs:* Katie Edwards, Susan Wilson  
*Panelists:* Erika Kelley, Christine Gidycz, Susan Wilson, Katie Edwards

## Symposia

▷ ADDICTIVE BEHAVIORS

**Disseminating Brief Interventions to College Student Drinkers**

*Chairs:* Christopher Correia, James Murphy  
*Discussant:* Kate Carey

▷ ADHD

**Advancing the Guidelines for Evidence-Based Assessment of ADHD**

*Chairs:* Julie Owens, Yuko Watabe  
*Discussant:* Gregory Fabiano

**Co-Occurrence of Mood Disturbances and ADHD: Patterns, Explanations, and Treatment**

*Chair:* Courtney Beard  
*Discussant:* Richard McNally

**Gender Differences in the Clinical Presentation, Treatment, and Outcome of Children With ADHD**

*Chair:* Erika Coles  
*Discussant:* Cynthia Hartung

▷ ADOLESCENT DEPRESSION

**Innovative Cognitive-Behavioral Family-Based Approaches for the Prevention and Treatment of Adolescent Suicidal Behavior**

*Chairs:* Kim Gratz, Alexander Chapman  
*Discussant:* Thomas Lynch

▷ ADOLESCENT DEVELOPMENT

**The Validity of BPD in Youth: Evidence From Real-World Settings**

*Chair:* Carla Sharp  
*Discussant:* Jennifer Tackett

▷ ADULT ANXIETY

**Attentional Biases and Anxiety: Data From Treatment Outcome Research**

*Chairs:* Erin Tone, Page Anderson

**Cross-Cultural and Racial Variants**

**in Social Anxiety and SAD**

*Chair:* Ashley Howell  
*Discussant:* Lynn Alden

**Delineating Core Mechanisms Associated With Disgust and Its Disorders**

*Chair:* Bunmi Olatunji  
*Discussant:* David Tolin

**Exploring Disgust and Its Role in the Pathogenesis of Clinical Disorders**

*Chair:* Danielle Maack  
*Discussant:* Kevin Connolly

**Implicit Cognition in Anxiety Disorders: Development, Maintenance, and Treatment**

*Chairs:* Allison Ouimet, Adam Radomsky  
*Discussant:* Rudi de Raedt

**Mechanisms of Change in CBT for Anxiety Disorders**

*Chair:* Carmen McLean  
*Discussant:* Edna Foa

**Prospective Examination of the Self-Medication Hypothesis: How Drinking to Cope Is Associated With Traumatic Stress, PTSD Symptom Clusters, and Risk for Sexual Assault**

*Chair:* Terri Messman-Moore  
*Discussant:* Sherry Stewart

**Psychophysiological Biomarkers of Distress Disorders: Improving Diagnostic Classification and Informing Treatment**

*Chairs:* Jessica Flynn, David Fresco  
*Discussant:* Stefan Hofmann

▷ ADULT DEPRESSION/DYSTHYMIA

**From Cortex to Context: New Strategies and Refined Targets in the Interventions of Mood Disorders**

*Chairs:* Amanda Calkins, Thilo Deckersbach  
*Discussant:* Michael Otto

**Investigations of the Role of Perceived Burdensomeness on Variables Associated With Risk for Suicide in Adults**

*Chair:* Kelly Cukrowicz  
*Discussant:* Tracy Witte

▷ ASSESSMENT

**Dimensional Classification of Psychopathology: Proposals for the**

**Emotional, Externalizing, and Personality Disorders**

*Chair:* Anthony Rosellini  
*Discussant:* David Barlow

**Dissemination of Evidence-Based Assessment: Progress and Challenges**

*Chairs:* Michael Southam-Gerow, Cassidy Arnold  
*Discussant:* Marc Atkins

▷ AUTISM

**Co-Occurring Psychological and Behavioral Problems in Adolescents and Adults With Autism Spectrum Disorder: Assessment and Characteristics**

*Chairs:* Nicole Kreiser, Cara Pugliese  
*Discussant:* John Richey

▷ BIPOLAR DISORDER

**Bipolar Disorder: Current Hot Topics in Psychological Research**

*Chairs:* Thilo Deckersbach, Louisa Sylvia

**Bipolar Disorder: From Childhood Risk Factors to Prevention and Intervention**

*Chair:* Dina Hirshfeld-Becker  
*Discussant:* Michael Otto

**Psychological Treatment and Assessment of Bipolar Disorder in Children and Adults: Effective Translation From Research to Clinical Practice**

*Chair:* Steven Jones  
*Discussant:* Steven Hollon

▷ CHILD

**Longitudinal Explorations of the Therapeutic Alliance and Other Treatment Processes in Youth Psychotherapy**

*Chair:* Marc Karver  
*Discussant:* Brian Chu

**Perceptual Bias of Competence in Externalizing Disorders: Clinical Presentation, Theoretical Explanations, and Treatment Implications**

*Chairs:* Thorhildur Halldorsdottir, Thomas Ollendick  
*Discussant:* Laura Seligman

**Bringing Evidence-Based Behavioral Interventions to Head Start: Lessons Learned in Developing,**



**Implementing, and Evaluating Evidence-Based Behavioral Practices in a National Early Childhood Setting**

*Chairs:* Katie Hart, William Pelham  
*Discussant:* Christopher Lonigan

**Early Life Stress and Trauma**

*Chairs:* Pia Pechtel, Randy Auerbach

**How to Keep From Getting Schooled: Dissemination and Implementation of Empirically Based Programs for Children and Adolescents in Educational Settings**

*Chair:* Richard Gallagher

▷ CHRONIC MENTAL ILLNESS

**New Developments in Neurocognitive Enhancement: Novel Treatment Strategies and Challenges Across Mental Disorders**

*Chair:* Christopher Bowie  
*Discussant:* Will Spaulding

▷ COGNITIVE PROCESSES

**Cognitive Bias Modification: Dissemination and Expansion to New Populations**

*Chair:* Courtney Beard  
*Discussant:* Richard McNally

**Distress Tolerance and Substance Use: Recent Findings and Treatment Implications**

*Chair:* Alison McLeish  
*Discussant:* Stacey Daughters

**The Relationship Between Cognitive Biases and Rumination**

*Chairs:* Blair Wisco, Lori Hilt  
*Discussant:* Lauren Alloy

▷ COUPLES/CLOSE RELATIONSHIPS

**Five-Year Follow-Up Data on a Comparison of Two Couple Therapies**

*Chair:* Lisa Benson  
*Discussant:* Douglas Snyder

▷ COUPLES/FAMILIES/RELATIONSHIPS

**Beyond Satisfaction: An Examination of the Associations Between Depression, Stress, and New Domains of Relationship Health**

*Chairs:* C. J. Eubanks Fleming, Katherine Williams Baucom  
*Discussant:* Sarah Whitton

**Disseminating Couple Interventions in the 21st Century: Harnessing Technology to Intervene on a Large Scale**

*Chair:* Brian D. Doss  
*Discussant:* James Cordova

**Positive Factors That Promote Relationship Well-Being**

*Chair:* Cameron Gordon  
*Discussant:* Douglas Snyder

**Translating Research Into Practice: Empirically Validated Family Prevention Programs**

*Chair:* Melinda Morrill

**Intimate Partner Functioning and Health**

*Chair:* Mark Whisman

▷ DEPRESSION/ DYSTHYMIA

**The Role of Meditative Practice in Mindfulness-Based Treatment for Depression**

*Chair:* Lance Hawley  
*Discussant:* Zindel Segal

**Novel Interventions for Perinatal Depression**

*Chair:* Cynthia Battle  
*Discussant:* Mark Whisman

▷ DISORDERED EATING

**Comorbid Anxiety and Disordered Eating: Research Findings and Implications for Treatment**

*Chair:* Cheri Levinson  
*Discussant:* Bethany Teachman

**Ecological Momentary Assessment in the Study of Eating-Disordered Beliefs and Behaviors**

*Chair:* Corby Martin  
*Discussant:* Patrick O'Neil

**Manifestations of Body-Checking Behaviors Across Diverse Populations**

*Chair:* Brooke Whisenhunt  
*Discussant:* Corby Martin

**Sex Differences in the Manifestation, Diagnosis, and Treatment of Eating Pathology**

*Chair:* Courtney Warren  
*Discussant:* Brooke Whisenhunt

**Understanding Eating Pathology Utilizing Experimental Methodologies**

*Chair:* Courtney Warren  
*Discussant:* Marisol Perez

▷ DISSEMINATION

**Brief Psychotherapy Outside the Mental Health Clinic: Evidence and Innovations for Expanding Access to Care**

*Chair:* Jason Nieuwsma  
*Discussant:* Carolyn Pepper

**Building a Two-Way Bridge Between Research and Practice:**

**Disseminating Clinical Experiences in Conducting Empirically Supported Treatments**

*Chair:* Jeffrey Magnavita  
*Discussant:* Linda Sobell

**Comparing Usual Care and Evidence-Based Care for Children and Adolescents: Advancing Dissemination in the 21st Century**

*Chair:* Charmaine Higa-McMillan  
*Discussant:* Ann Garland

**Consultation: A Critical Component of Dissemination and Implementation of ESTs**

*Chair:* Jeremy Pettit  
*Discussant:* Peter Jensen

**Getting the Word Out: Dissemination and Clinical Application of Findings From Contemporary Women's Health Research**

*Chair:* Pamela Geller  
*Discussant:* Heather Flynn

**Measurement in Dissemination and Implementation Science**

*Chair:* Rinad Beidas  
*Discussant:* Sonja Schoenwald

**Mental Health Service Utilization in Youth: Deficiencies of Availability, Awareness, and Use of Evidence-Based Treatments**

*Chairs:* Rebecca Blais, Matthew Jakupcak  
*Discussant:* Sonja Batten

**Moving Outside the Ivory Tower: The Learning Collaborative Approach to the Implementation of Best Practice in Community Settings**

*Chair:* Rhea Chase  
*Discussant:* Esther Deblinger

**New Developments to Increase Access to CBT for Primary Care Patients With Depression**

*Chair:* Mark Lau

*Discussant:* Steven Hollon

**Novel Interventions for Perinatal Depression: Improving Dissemination by Addressing Issues of Treatment Acceptability and Accessibility**

*Chair:* Cynthia Battle

*Discussant:* Mark Whisman

**TAU Factors Affecting Evidence-Based Practice Dissemination and Implementation**

*Chair:* Cameo Borntrager

*Discussant:* Gregory Arons

**Using Stakeholder Input to Refine Evidence-Based Treatments for Dissemination**

*Chair:* Joshua Langberg

*Discussant:* Joel Sherrill

▷ DIVERSITY ISSUES

**But Words Will Never Hurt Me? The Impact of Microaggression on Mental Health and Health-Risk Behaviors**

*Chair:* Debra Kaysen

*Discussant:* Steven Safren

**Developing Culturally Attuned Evidence-Based Practices With American Indian and Alaskan Native People**

*Chairs:* Alicia Mousseau, Carrie Winterowd

*Discussant:* Daniel McNeil

**New Advances in Minority Stress Conceptualizations of Sexual Minority Individuals' Well-Being**

*Chairs:* Brian Feinstein, John Pachankis

*Discussant:* Marvin Goldfried

**Nonsuicidal Self-Injury in Underrepresented Populations: Issues of Ethnicity, Gender, and Psychopathology**

*Chair:* Katherine Bracken-Minor

*Discussant:* Kim Gratz

▷ EDUCATION AND TRAINING

**Addressing the Theory-Practice Gap in CBT: A Perspective From All Three Waves**

*Chair:* Brian Pilecki, Dean McKay

**Beyond Train and Hope: Active Learning, Supervision, and Consultation to Improve Clinical Skills**

*Chair:* Charmaine Higa-McMillan

*Discussant:* Kimberly Hoagwood

**Design and Implementation of Web-Based CBT Training: Identifying Critical Elements in a Randomized Intervention Study With Veterans Administration Mental Health Providers**

*Chair:* Josef Ruzek

*Discussant:* G. Terence Wilson

▷ EMOTION REGULATION

**Early Changes in Emotion Regulation Processes During CBT for Emotional Disorders: Psychological Markers of Treatment Success?**

*Chairs:* David Moscovitch, Jonathan Huppert

*Discussant:* Zindel Segal

**Emotion Dysregulation in Suicide: Evidence of a Robust and Paradoxical Relationship**

*Chair:* Michael Anestis

*Discussant:* Matthew Nock

**Getting Clear About Emotional Clarity: Construct, Measurement, and Implications for Emotion Regulation and Psychopathology**

*Chair:* Vera Vine

*Discussant:* Lizabeth Roemer

**Innovative Investigations of Emotion Regulation as a Mechanism of Change in Treatments for BPD and Related Pathology**

*Chairs:* Candice Chow, Courtney Weiner

*Discussant:* Brian Chu

▷ FAMILY RELATIONSHIPS

**When a Parent, Child, or Partner Has BPD: Understanding the Impact on Families and Improving Interventions**

*Chair:* Nathaniel Herr

*Discussant:* M. Zachary Rosenthal

▷ HEALTH CARE SYSTEM

**Mental Health Care Utilization in OEF/OIF Veterans: Understanding Treatment Barriers and Mechanisms of Treatment Engagement**

*Chairs:* Rebecca Blais, Matthew Jakupcak

*Discussant:* Sonja Batten

▷ HEALTH PSYCHOLOGY

**Exercise for Physical and Mental Health: Targets for Intervention and Dissemination for CBT Therapists**

*Chairs:* Michael Otto, Jasper Smits

*Discussant:* Matthew Martens

**Expanding the Application of Anxiety Sensitivity to Health Behaviors: Enhancing Treatment Across Diverse Domains**

*Chair:* Bridget Hearon

*Discussant:* Jasper Smits

**Laying the Groundwork for Dissemination: Developing Evidence-Based Behavioral Interventions for HIV/AIDS**

*Chair:* David Pantalone

*Discussant:* Steven Safren

**Understanding Psychological Distress in View of Dissemination: Social and Cognitive Factors Cutting Across Medical Illness**

*Chairs:* Stacey Hart, David Pantalone

*Discussant:* Frank Andrasik

▷ INFORMATION PROCESSING

**Integrating Cognitive and Genetic Models of Psychopathology: Addressing the "Missing Heritability" Problem**

*Chair:* Brandon Gibb

*Discussant:* Valerie Knopik

▷ NEUROSCIENCE

**CBT for Anxiety Disorders: Utilization of Neuroimaging as a Treatment Outcome Assessment Tool**

*Chair:* Steven Bruce

*Discussant:* Richard McNally

▷ OCD/OCD SPECTRUM

**Believed-In Imaginings in OCD: New Experimental and Clinical Findings**

*Chair:* Kieron O'Connor

*Discussant:* Adam Radomsky

**Diagnostic Considerations in the Classification of Body Dysmorphic Disorder: Symptoms Across Anxiety Disorders**

*Chair:* Cassidy Gutner

*Discussant:* Sabine Wilhelm

**Family Members of Those With OCD: Accommodation, Attributions, and Treatment**

*Chairs:* Keith Renshaw, Catherine

Caska

*Discussant:* Steffany Fredman

**Highlights From Recent Advances in Understanding Hoarding: A Focus on Phenomenology and Treatment**

*Chair:* Kiara Timpano

*Discussant:* Gail Steketee

**The Persistence of Compulsions**

*Chair:* Christine Purdon

*Discussant:* Gail Steketee

**Understanding and Treating Religious and Sexual Obsessions**

*Chair:* John Dehlin

*Discussant:* Jonathan Huppert

▷ PARENT TRAINING

**Implementing Home-Based Parent-Child Interaction Therapy: Clinical Considerations, Adaptations, and Outcomes**

*Chairs:* Amanda Costello, Cheryl McNeil

*Discussant:* Sheila Eyberg

**Methodological Approaches for Examining the Dissemination and Implementation of Behavioral Parent-Training Programs Targeting Child Maltreatment Prevention**

*Chair:* Shannon Self-Brown

*Discussant:* John Lutzker

▷ PARENTING

**Interventions for Depression in Parents or Children at Risk: Relations Among Observed and Self-Reported Parenting, Parental Depression, and Child Outcomes**

*Chair:* Mark Whisman

▷ PERSONALITY & BORDERLINE

**Findings From a Randomized Controlled Trial of DBT for BPD: Treatment Response, Cost Effectiveness, and BPD Subtypes**

*Chair:* Shelley McMain

*Discussant:* Alexander Chapman

▷ PTSD

**Anxiety Sensitivity in PTSD: Specificity, Incremental Validity, and Treatment**

*Chair:* Frank Farach

*Discussant:* Jonathan Abramowitz

**Beyond Fear: Understanding Negative Emotion in the Psychopathology and Treatment of PTSD**

*Chair:* J. Beck

*Discussant:* Patricia Resick

**How Does Change Work? Exploring Mechanisms of Treatment Change in PTSD**

*Chairs:* Aileen Echiverri-Cohen,

Michele Bedard-Gilligan

*Discussant:* Sheila Rauch

**Novel Treatments for Comorbid PTSD and Substance Use Disorders**

*Chair:* Seth Gillihan

*Discussant:* Edna Foa

**Patient and Therapist Factors in the Dissemination and Implementation of Evidence-Based Treatment for PTSD**

*Chair:* Shannon Kehle

*Discussant:* Edna Foa

▷ RESEARCH

**Doing More With Less: Increasing the Efficiency, Impact, and Reach of CBT Through Processes of Change Research in ACT and Mindfulness-Based Stress Reduction Outcome Trials**

*Chairs:* Sean Sheppard, John Forsyth

*Discussant:* Steven Hayes

**Examining Differences Between Research and Clinical Samples: Should We Be Concerned About the Generalizability of Evidence-Based Treatments?**

*Chair:* Amanda Jensen-Doss

*Discussant:* V. Robin Weersing

**Exploration of the Relationship Between Physiological Arousal and Treatment Outcome in Anxiety Disorders**

*Chair:* Kristy Benoit

*Discussant:* Stefan Hofmann

**Longitudinal Models for Clinical Research: Overview and Recommendations**

*Chairs:* Aaron Fisher, David Atkins

*Discussant:* Scott Baldwin

**Measuring Associative Networks Over the Course of CBT: New Methods for Studying the Process of Change**

*Chairs:* Adele Hayes, Keith Dobson

*Discussant:* Christopher Beevers

**Studying the Nature and Course of Anxiety Disorders in African American, Latino, and Caucasian Samples: The Harvard/Brown Anxiety Research Project-Phase II**

*Chairs:* Risa Weisberg, Courtney Beard

*Discussant:* Angela Neal-Barnett

▷ SEVERE MENTAL ILLNESS

**Implementing Culturally Sensitive Interventions for Latinos With Schizophrenia**

*Chair:* Irwin Rosenfarb

*Discussant:* Shirley Glynn

**Is CBT Really Just for Outpatients? Examining Treatment Outcomes in Acute Psychiatric Settings**

*Chair:* Megan Hughes

*Discussant:* Edmund Neuhaus

▷ SLEEP

**Perspectives on Treating Insomnia in the Context of Comorbid Disorders**

*Chair:* Christopher Fairholme

*Discussant:* Charles Morin

▷ SOCIAL PHOBIA/SOCIAL ANXIETY

**Embracing the Digital Age: Methodological Innovations in the Study of Social Anxiety**

*Chairs:* Katya Fernandez, Cheri Levinson

*Discussant:* Stefan Hofmann

**Eye-Tracking Studies of Attention Biases in Social Phobia and Depression**

*Chair:* Casey Schofield

*Discussant:* Brandon Gibb

**Social Anxiety and Health-Risk Behaviors in Adolescents and College Students**

*Chair:* Amie Schry

*Discussant:* Deborah Beidel



**Understanding Social Anxiety's Role in Risky Alcohol and Marijuana Use: Clinical Implications of Research Data**

*Chair:* Julia Buckner  
*Discussant:* Sherry Stewart

▷ SUBSTANCE USE

**Understanding Substance Use Among Medically Vulnerable Populations**

*Chair:* Alison McLeish  
*Discussant:* Carl Lejuez

▷ TECHNOLOGY

**Disseminating Mindfulness-Based Interventions in the Workplace: Using the Internet or Telephone to Increase Access to Mindfulness-Based Cognitive Therapy and MBSR**

*Chair:* Mark Lau  
*Discussant:* Zindel Segal

**Dissemination Efforts in Behaviorally Focused HIV Prevention Among High-Risk Youth: From Bench to Desktop to Africa and Beyond**

*Chair:* Carla Danielson  
*Discussant:* Lisa Marsch

**Internet-Based Psychological Services: Legal, Ethical, and Clinical Issues**

*Chairs:* James Herbert, John Forsyth

**Technology's Role in the Dissemination of Parenting Programs**

*Chair:* Jessica Cuellar  
*Discussant:* Robert McMahon

▷ TRANSLATIONAL

**A Transdiagnostic Examination of the Biosocial Model of Emotion Dysregulation: Evidence From BPD and Beyond**

*Chair:* Ann Haynos  
*Discussant:* Kim Gratz

**How We Think About How We Feel: Beliefs About Emotions and Emotion Regulation**

*Chairs:* Katherine Dixon-Gordon, Amelia Aldao  
*Discussant:* Robert Leahy

▷ TREATMENT

**Examining Treatment Trajectories: Predictors, Outcomes, and**

**Implications for Child and Adult Samples**

*Chairs:* Halina Dour, Jennifer Regan  
*Discussant:* Kimberly Hoagwood

**Homework Compliance and Treatment Enactment in Mindfulness-Based Relapse Prevention for Addictive Behaviors: Does it Happen and Does it Matter?**

*Chairs:* Sarah Bowen, Katie Witkiewitz

**Moderators and Predictors of Psychosocial and Pharmacological Treatments for Anxiety Disorders and Depression**

*Chairs:* Alicia Meuret, Kate Wolitzky-Taylor  
*Discussant:* Michelle Craske

**Moderators of Success of Mindfulness-Based Interventions**

*Chair:* Moria Smoski  
*Discussant:* Clive Robins

**New and Novel Approaches to Exposure Therapy**

*Chair:* Dean McKay  
*Discussant:* Martin Franklin

**New Directions in the Treatment of Adolescents With Mental Health Disorders**

*Chairs:* William Pelham, Margaret Sibley  
*Discussant:* Joel Sherrill

**Partnering with Healthcare Settings to Improve Mental Health Services for Children and Adults**

*Chair:* Denise Chavira  
*Discussant:* Michael Murphy

**Understanding Mechanisms of Successful Treatment**

*Chair:* Maureen Whittal  
*Discussant:* G. Terence Wilson

▷ VIOLENCE/AGGRESSION

**Contextual Factors Surrounding College Women's Use of Intimate Partner Violence**

*Chairs:* Nicole Kreiser, Cara Pugliese  
*Discussant:* John Richey

**Inward- and Outward-Directed Aggression and Violence in Veterans of the Iraq and Afghanistan Wars**

*Chairs:* Matthew Jakupcak, Rebecca Blais  
*Discussant:* Candice Monson

**Women's Experiences of Sexual Victimization and Postassault Outcomes: Implications for Cognitive Behavioral Interventions**

*Chair:* Christine Gidycz  
*Discussant:* Terri Messman-Moore

▷ YOUTH ANXIETY

**Beyond Attention Bias: Understanding the Role of Attentional Mechanisms in the Development and Treatment of Anxiety in Youth**

*Chairs:* Amanda Morrison, Richard Heimberg  
*Discussant:* Meredith Coles

**Innovative Treatments for Anxiety Disorders in Youth: Examining Predictors, Moderators, and Mediators of Treatment Outcome**

*Chairs:* Candice Chow, Courtney Weiner  
*Discussant:* Brian Chu

**Modeling the Shape and Sequence of Changes in the Treatment of Youth Anxiety: Moving Beyond Traditional Two-Wave Evaluations**

*Chairs:* Jonathan Comer, Kaitlin Gallo  
*Discussant:* Anne Marie Albano

**Reducing Child and Youth Anxiety Through Mindfulness and Acceptance-Based Treatment Components: Linking Research to Practice**

*Chairs:* Priscilla Chan, Donna Pincus  
*Discussant:* Lizabeth Roemer

**Who Gets Better in Individual CBT for Child Anxiety? Preliminary Findings From the Child Anxiety Treatment Study**

*Chairs:* Jennifer Silk, Greg Siegle  
*Discussant:* Philip Kendall

**See you in Toronto!**

**To receive the program book prior to the meeting, be sure to register by October 3.**



# Registration / Hotel

Preregister on-line at [www.abct.org](http://www.abct.org) or, to pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the pre-registration deadline of Friday, October 14, 2011. **Only those individuals who register by midnight, Monday, October 3, will be mailed the convention program book.** All other attendees will receive their program book on-site.

**To receive discounted member registration fees, members must renew for 2012 before completing their registration process.**

## *Preconvention Activities*

The preconvention activities will be held on Wednesday, November 9, and Thursday, November 10. All preconvention activities are designed to be intensive learning experiences. Preregister to ensure participation.

On-site registration for Wednesday and Thursday activities will be open Wednesday from 7:30 A.M. to 9:00 A.M. and Thursday from 7:30 A.M. to 1:00 P.M.

For sale on Wednesday will be the 2-day (Wed. and Thurs.) Clinical Intervention Training. For sale on Thursday will be the 1-day Clinical Intervention Training (Thurs.), the full-day Institutes, the 5-hour Institutes, the full-day AMASS, and the 4-hour AMASS.

To register, please choose one format:

## *Registering On-Line*

The quickest method is to register on-line at [www.abct.org](http://www.abct.org). Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members' discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew. To get member rates at this conference, your ABCT dues must be paid through October 31, 2012. The ABCT member year is November 1 – October 31.

For those registering on-site, you may renew membership at the ABCT membership booth located in the ABCT registration area.

For preregistration rates, please register **before** the deadline date of October 14. NO registrations will be accepted in any format from October 15 until November 10, when on-site will open in Toronto.

## *Registering by Fax*

You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will likely cause double payment. For pre-registration rates, please register BEFORE the deadline date of October 14. No registrations will be accepted in any format from October 15 until November 10, when on-site will open in Toronto.

## *Registering by Mail*

All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, New York, NY 10001. For pre-registration rates, forms must be postmarked by the deadline date: October 14. Forms postmarked starting October 15 will not be processed and will be mailed back to the sender. There will be no exceptions.

## *Confirmation*

ABCT will email confirmation shortly after you register. For on-line registration you will receive confirmation the next day. For fax and mail registration, please allow one week. If confirmation is not received, please email Tonya Childers at [tchilders@abct.org](mailto:tchilders@abct.org) detailing the date you registered and the fees you paid.

## *Hotels*

This year, the ABCT meeting will take place at two hotels:

**Sheraton Centre Toronto** (416-361-1000)

**Hilton Toronto** (416-869-3456)

Activities and sessions will occur across both venues. For example, registration will take place at the Sheraton, and all workshops will occur at the Hilton. Situated in the heart of downtown Toronto, the Sheraton and Hilton hotels are a 2-minute walk across the street from one another. The Hilton and Sheraton are also connected underground (about 5 minutes apart) by PATH, North America's largest continuous underground pedestrian walkway ([www.toronto.ca/path](http://www.toronto.ca/path)).

To reserve your room go to <http://www.abct.org/conv2011> and click HOTEL RESERVATIONS.

## 2011 ABCT Convention: Welcome to Toronto

Cynthia E. Crawford, *Chair, ABCT Local Arrangements Committee*

Martin M. Antony, *ABCT Local Arrangements Committee*

**A**BCT is going international this year! The conference was previously held in Toronto in 1999 and we are excited to welcome you back to our fantastic city. This article provides insider information about Toronto as well as practical suggestions to help you prepare for your trip, including details about the weather, metric conversion, Canadian currency, taxis and public transportation, customs/immigration matters, and getting to and from the airport.

The old town of “York” was established in 1793 and was incorporated about 40 years later as the city of “Toronto” (a Huron language word for “meeting place”). You may notice during your visit that the “York” name figures prominently in Toronto streets, hotels, and other businesses. Since its founding, Toronto has indeed become a meeting place for many people. It is ranked one of the most livable and multicultural urban centers in the world, and in 2011 Toronto was named by the London-based Global Financial Centre as one of the world’s top-10 financial centers.

With close to 3 million people in the city proper, and over 5 million in the greater Toronto area, Toronto is the largest city in Canada and the fifth largest city in North America. In fact, one third of Canada’s population is located within 100 miles of Toronto and about half of the population of the United States is within 1 day’s drive of Toronto. Toronto is well known for its ethnic and cultural diversity, great cuisine and shopping, outstanding entertainment, and low crime rate. Close to 150 languages and dialects are spoken here; in fact, fully half of Toronto’s population was born outside Toronto. There are three daily Toronto newspapers (*The Globe and Mail*, the *Toronto Star*, and the *Toronto Sun*), and a number of free weekly entertainment newspapers (NOW magazine is the largest).

For the first time since 1975, the 2011 ABCT meeting will take place at two hotels, the Sheraton (416-361-1000) and Hilton (416-869-3456). Activities and sessions will occur across both venues. For example, registration will take place at the Sheraton, and all workshops will occur at

the Hilton. Situated in the heart of downtown Toronto, the Sheraton and Hilton hotels are a 2-minute walk across the street from one another. The Hilton and Sheraton are also connected underground (about 5 minutes apart) by PATH, North America’s largest continuous underground pedestrian walkway ([www.toronto.ca/path](http://www.toronto.ca/path)). PATH connects over 1,000 stores and restaurants, six major hotels, and several entertainment centers. PATH is marked throughout by the multicolored PATH logo and PATH maps are available at the hotel concierge desks as well as the ABCT hospitality table. (Note: using PATH to travel between the convention hotels means no coat needed!). Both hotels have indoor/outdoor pools and excellent fitness centers available at no cost to guests. They are walking distance from countless cafes, restaurants, performing arts venues, art galleries, and shops.

With over 10,000 restaurants, you’ll find an abundance of dining options available to you in Toronto. From the assured sophistication of Nota Bene (416-977-6400, [www.notabenerestaurant.com](http://www.notabenerestaurant.com)) and Le Select Bistro (416-596-6405, [www.leselect.com](http://www.leselect.com)) to the eclectic eateries found along King and Queen Streets, rest assured that there are ample cuisine choices for every budget. Opportunities for great theater, film, and music are also plentiful. Did you know that Toronto is the third largest English-language theater center in the world, behind New York and London? When it comes to film, Torontonians have a strong reputation in “the industry” as eager film aficionados, which helps to explain the success of the Toronto International Film Festival and the recent opening of beautiful Bell Lightbox, a year-round international film complex, within walking distance of the convention. Music is another performance art that is plentiful in Toronto, and venues both large and small are located close to the conference hotels. If comedy is your thing, check out Second City ([www.secondcity.com](http://www.secondcity.com)) and Yùk Yùk’s ([www.yukyus.com](http://www.yukyus.com)) comedy clubs. For shopping, the Sheraton and Hilton are about a 5-minute walk from the 300-plus stores of Eaton Centre, located at the corner of Yonge and Queen Streets, just east of the

hotels, as well as lots of interesting shops along Queen Street, heading west from the convention. Listed below are some additional areas to check out for food, fashion, and entertainment. More detailed recommendations for restaurants and fun things to do will be available at the Local Arrangements hospitality table (described in more detail near the end of this article.)

### Interesting Neighborhoods

#### Bloor-Yorkville

Yorkville (5 to 10 minutes by cab) is a decidedly high-end shopping/small gallery/dining area that includes carefully restored Victorian residences, galleries, and shops in restored townhouses. Streets worth exploring include Cumberland Street, Bellair Street, Yorkville Avenue, and Scollard Street. Just around the corner on Bloor Street, between Avenue Road and Yonge Street, you’ll find luxury designer shops such as Prada, Gucci, and Chanel.

#### Queen Street West

The Queen Street West area (begins about a 5-minute walk west from the hotels) is a stylish shopping district with a kinetic energy located along Queen Street between University and Spadina Avenues. If you are so inclined, travel a bit further West along Queen to the more trendy and alternative “West Queen West” area, which begins just west of Spadina Avenue and continues past Bathurst Street for a mile or so. If you prefer, you can hop on the streetcar for this short ride along Queen Street. Purveyors of food, furniture, and fashion have opened storefronts at a rapid pace, and this area is becoming more interesting by the week. Many excellent galleries have relocated to the West Queen West area, between Shaw and Gladstone Streets. Ossington Avenue (in “West Queen West”) is the newest “hip” dining area—reservations essential! Also, a 5-minute cab ride north from Queen Street (along Ossington Avenue) brings you to the Little Italy part of College Street, another good dining area.

#### Chinatown

Five minutes by cab, located in the Dundas St. and Spadina Ave. area, Toronto’s Chinatown is one of the biggest in North America. Right next to Chinatown, between College and Dundas, is Kensington Market, one of Toronto’s oldest and best-known outdoor markets, with its open-air stalls, hip restaurants, and cafés.

## *Church-Wellesley*

Also about 5 minutes by cab, Church-Wellesley is a large and bustling LGBT community situated around Church and Wellesley Streets. Also, check out [www.seetorontonow.com/Visitor/Gay-Community/The-Gay-Village.aspx](http://www.seetorontonow.com/Visitor/Gay-Community/The-Gay-Village.aspx) for information on dining, nightlife, and shopping that extends beyond the village. A few blocks South, you'll find The Esplanade. Also known as "Old Toronto," this area contains an interesting mix of old and new architecture as well as graciously restored old buildings (e.g., the Flatiron Building located at Church and Front Streets). Try the French Canadian cuisine at Le Papillon (416-367-0303, [www.lepapillonfront.com](http://www.lepapillonfront.com)). The vibrant and historic St. Lawrence Market (Saturday morning) and the Hockey Hall of Fame are located in the Esplanade district. Just east of the Esplanade is the Distillery District (about 10 minutes by cab from the convention; [www.thedistillerydistrict.com](http://www.thedistillerydistrict.com)), which is both a destination and a growing, vibrant community neighborhood located at Mill Street between Parliament and Cherry Streets. Established in 1832, the brick-and-cobblestone building was once the largest distillery in the British Empire. It now houses a complex of unpretentious galleries, boutiques, and restaurants with hardly a chain store in sight.

## *Greektown*

A bit farther afield is Greektown (also known as The Danforth), about 15 minutes by cab from the Sheraton and Hilton hotels. Located on Danforth Avenue between Chester and Jones Avenues, this is the place to go for authentic Greek cuisine.

## *Toronto Islands*

A very different neighborhood, Toronto Islands offers over 600 acres of parkland, accessible by ferry only. Adult fare is \$6.50 (Canadian) for a return trip. For ferry schedule information, call 416-392-8193 or ask the hotel concierge. The ferry docks are located at the foot of Bay Street. If you do get to the islands, check out the lovely Rectory Café (416-203-2152, [www.therectorycafe.com](http://www.therectorycafe.com)) near the Ward's island dock.

## **Downtown Toronto Attractions**

### *Museums and Galleries*

Several of the city's art institutions have undergone substantial renovations. Close to the hotel you'll find the Art Gallery of Ontario or AGO ([www.ago.net](http://www.ago.net)), 317 Dundas Street West, a couple of blocks north of Queen Street West (416-969-

6600). A recent new design by Toronto-born architect Frank Gehry includes extensive use of Canadian Douglas Fir throughout. The AGO contains a new contemporary floor and an outstanding collection by sculptor Thomas Moore, as well as a Canadian Wing.

Before or after visiting the AGO, walk a minute or two south (toward the lake) on McCaul Street to see the new Ontario College of Art and Design University ([www.ocad.ca](http://www.ocad.ca)) building. This is one of the most interesting buildings in the city—much of it is suspended in the air on giant sticks. A bit further uptown is the Royal Ontario Museum (ROM), located at 100 Queen's Park, just south of Bloor Street, 416-586-8000 ([www.rom.on.ca](http://www.rom.on.ca)). Here you'll find valuable collections of Chinese and Nubian art as well as archeological and scientific treasures. A few blocks west from ROM is the Bata Shoe Museum, 416-979-7799, a beautiful small building containing approximately 13,000 shoes dating back thousands of years ([www.batashoemuseum.ca](http://www.batashoemuseum.ca)). If you are a hockey fan, the Hockey Hall of Fame and Museum located at Yonge and Front Streets, 416-360-7765, is not to be missed ([www.hhof.com](http://www.hhof.com)).

### *Entertainment District*

The premier theater district in Toronto, located primarily on King Street starting west of Simcoe Street, also includes TIFF Bell Lightbox, 350 King Street West, 416-599-8433 ([www.tiffbelllightbox](http://www.tiffbelllightbox)), a new year-round home for Toronto International Film Festival that includes a three-story public atrium, five public cinemas, and two galleries, three learning studios, and both casual and high-end dining.

Broadway-style shows play in venues located both in the "official" Entertainment District and on Yonge Street: check out [www.Toronto-theatre.com](http://www.Toronto-theatre.com) for information on shows and venues playing during your stay. Venues include the Princess of Wales, Canon, Royal Alexandra, and Elgin Theatres, and for major concert venues, Roy Thomson Hall and Massey Hall. A bit further South is the CN Tower, 301 Front Street West, 416-868-6937 ([www.cntower.ca](http://www.cntower.ca)). The views from its observation decks are breathtaking (but beware, wait times to enter the Tower can be significant).

### *Professional Sports*

Toronto is home to five professional sports teams, including the NHL's Toronto Maple Leafs and the NBA's Toronto Raptors, both of whom play at the Air

Canada Centre ([www.theaircanadacentre.com](http://www.theaircanadacentre.com)); the Canadian Football League's Toronto Argonauts and baseball's American League East Toronto Blue Jays, both playing out of the Rogers Centre, ([www.rogerscentre.com](http://www.rogerscentre.com)), and the Toronto FC soccer team ([www.torontofc.ca](http://www.torontofc.ca)).

## **Getting to Toronto and Your Hotel**

### *How to Get to and From the Airport*

The major airport is Pearson International Airport (YYZ), located about 25 miles or 40 kilometers from the conference hotels, or 30 to 40 minutes by car.

*Airline Limousine Service.* Offers flat rates to and from the airport. Tel: 416-678-7077. Cost (at time of printing) is \$53.00 including taxes, about the same price as a taxi ride from Pearson International Airport to the Downtown Sheraton/Hilton hotels.

In addition to taxis, you may also get to the hotel with Airport Express (905-564-3232 or 1-800-387-6787), which offers regularly scheduled service from Pearson airport to the conference hotels. You can purchase tickets online: [www.torontoairportexpress.com](http://www.torontoairportexpress.com).

For those interested in renting a car, you'll find the car rental counters on Level 1 of the parking garages adjacent to both Terminals 1 and 3 (there is no Terminal 2).

**Avis** (1-800-879-2847): Terminal 1, 905-676-1032/33; Terminal 3, 905-676-1034/35

**Budget** (1-800-268-8900): Terminal 1, 905-676-1500; Terminal 3, 905-676-0522

**Dollar/Thrifty** (1-800-THRIFTY): Terminal 1, 905-673-8811 ext. 6256; Terminal 3, 905-673-8811, ext. 6251

**National/Alamo** (1-800-CAR-RENT or 1-800-GO-ALAMO); Terminal 1 and 3, 905-676-2647

If you fly Porter Airlines to Toronto ([www.flyporter.com](http://www.flyporter.com)) you will arrive at the Toronto City Centre (island) Airport, also known as Billy Bishop Toronto City Airport (Code YTZ), located minutes from the heart of downtown. There is usually a good supply of taxis, and it will cost about \$10.00 to travel to the convention hotels. Porter Airlines flies between Toronto and a small number of U.S. cities, including New York, Chicago, and Boston. Air Canada ([www.aircanada.com](http://www.aircanada.com)) also has limited flights between Toronto and Montreal via the island airport.



## Entering Canada

The ABCT website includes important information on entering Canada, so please check [www.abct.org/Conv2011](http://www.abct.org/Conv2011). Everyone from every country arriving in Canada by air, land, and sea must have a passport or equivalent travel document (e.g., a NEXUS card, a U.S. Passport, etc.). A standard driver's license or birth certificate will not be sufficient.

You may be asked for proof that you are attending a meeting or convention and it may be useful to have a copy of your meeting agenda or proof of registration on hand. Every 30 days, returning U.S. citizens are allowed to bring back \$800 (retail value) in merchandise duty-free, provided they have been out of the U.S. for 48 hours. See [www.cbp.gov](http://www.cbp.gov) for further information. Children 15 years of age and under are now required to show proof of citizenship.

## Getting Around Toronto

### City Taxi Service

Taxis within the city operate on a meter system. You can usually hail a taxi from any street corner. Some good local taxi companies include Beck Taxi (416-751-5555), CO-OP Taxi (416-504-2667), and Diamond Taxi (416-366-6868). The base rate is \$4.25 and the following website will provide a cost estimate for your trip. <http://www.worldtaximeter.com/toronto>

### Toronto Transit Commission or TTC (Buses, Streetcars, and Subways)

The TTC adult fare is \$3.00 cash (use exact change when using bus or streetcar—drivers do not make change) or you may buy tokens at any subway station in quantities of 5 or 10 for \$12.50 or \$25.00, respectively (discounted tickets are available for seniors and children). A 1-day pass can be purchased for \$10.00. It is important to obtain a transfer wherever you first get on the TTC as this transfer will allow you to move from one vehicle (e.g., bus, subway, and streetcar) to another. If you do not have a transfer ticket you will likely need to pay again when you transfer from, for example, bus to subway.

### Sightseeing Tours

*Toronto Tours.* Call toll free, 1-888-811-9247, check out the website, [www.toronto-tours.net](http://www.toronto-tours.net), or check with the hotel concierge.

## Practical Information to Help Plan Your Trip

The Toronto telephone area codes are 416 and 647. Some telephone numbers in the Greater Toronto Area (including the airport) have a 905 area code.

### Canadian Money

All prices quoted in this article are in Canadian Dollars. The best places in Toronto to obtain Canadian money are at any bank or ATM in the city. At the time this article was written, the U.S. dollar was trading at close to par to the Canadian dollar. You may check the exchange rate closer to the time of your trip at: [www.xe.com/ucc](http://www.xe.com/ucc). Most stores will accept U.S. currency, but generally, the exchange rate is not as favorable as the banks. Note that the denominations and names for Canadian currency are more or less the same as for American currency (e.g., pennies, nickels, dimes, quarters, dollars), with two exceptions. Our 1-dollar coin has come to be known as a Loonie (it has a picture of a loon on it) and our 2-dollar coin is often called a Toonie. When making purchases in Ontario, you may see a 13% Harmonized Sales Tax (HST) on your receipts. While books are partially exempt, the HST applies to almost every purchase and service. Tipping in restaurants is typically 15 to 20% of the total bill before tax.

### Toronto Climate

Although there are no guarantees (!), the mean November temperature in Toronto is a high of approximately 46° Fahrenheit (7.8° Celsius) and a low of about 35° Fahrenheit (1.8° Celsius).

Speaking of temperature measurement, Canada has been using the metric system for over 35 years. Here are a few conversions that will help you.

30 miles = 50 kilometers  
50° Fahrenheit = 10° Celsius  
39° Fahrenheit = 4° Celsius  
32° Fahrenheit = 0° Celsius

### Jogging in Toronto

Jogging is a popular activity in Toronto and among ABCT attendees. Runs are planned for Friday and Saturday mornings, both guided by local runners. The runs will convene in the early morning on both days. Information on the routes, landmarks, and tips for jogging in the city will be available at our hospitality table near the main ABCT registration area at the Sheraton Centre.

## Dine With a Local

The Local Arrangements Committee is organizing opportunities for groups of ABCT attendees to have dinner with a Torontonian at a favorite local restaurant. More details and sign-up sheets for this event will be available at our hospitality table.

## Your 2011 Local Arrangements Committee

Looking for a good restaurant? Wondering about photocopying or shoe repair options? The 2011 Local Arrangements Committee is looking forward to making your stay in Toronto as enjoyable as possible. To this end, we will be setting up a hospitality table near the ABCT registration area at the Sheraton Hotel, where we will assist you with any questions you may have—from helping you to find a certain meeting room in the hotel to recommending a favorite French restaurant. The committee is in the midst of preparing a restaurant list, an all-important list of options for breakfast/coffee and lunch nearby the hotels, and a service guide, all of which will all be available to you at the hospitality table. We aim to complement the first-rate service offered by the hotels' concierge desks. We will have maps of the city, free weekly newspapers, tourist guides and other helpful information. Local events being organized include runs and opportunities to dine with "locals" at their favorite restaurants. The hospitality table will be open on Thursday, November 10; Friday, November 11; and Saturday, November 12. Please drop by and say hello!

### Additional Relevant Internet Resources

[www.seetorontonow.com](http://www.seetorontonow.com)  
[www.fodors.com/world/northamerica/canada/ontario/toronto/](http://www.fodors.com/world/northamerica/canada/ontario/toronto/)  
[www.nowtoronto.com](http://www.nowtoronto.com) (Toronto's largest alternative arts and entertainment newspaper)  
[www.north.ca/](http://www.north.ca/)

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### 2011 LOCAL ARRANGEMENTS COMMITTEE

Cynthia E. Crawford (Chair),  
Rixi Abrahamsohn, Martin Antony,  
Amy Brown-Bowers, Stephanie Cassin,  
Susan Chudzik, Eilenna Denisoff, Elissa  
Golden, Joelle LeMoult, Danielle  
MacDonald, Randi McCabe, Candice  
Monson, Alex Naber, Karen Rowa, Alex  
Vasilovsky, Andrea Woznica, Sandra Yuen

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## Book Review

### Smith, P., Perrin, S., Yule, W., & Clark, D. M. (2010) *Post Traumatic Stress Disorder: Cognitive Therapy With Children and Young People*

New York: Routledge

Reviewed by Jorden A. Cummings, *University of Saskatchewan*

**P**ost Traumatic Stress Disorder: Cognitive Therapy With Children and Young People describes a cognitive-behavioral approach to child and youth PTSD. This book was developed from materials used as a therapist guide in an initial randomized-control trial of the treatment (Smith et al., 2007). The therapy presented in this guide is based upon Ehlers and Clark's (2000) cognitive model of PTSD, adapted for use with children and adolescents aged 7 to 16. The authors recommend that this model be implemented over approximately 10 to 12 sessions of 90 minutes' duration. Although the authors indicate the model can be adapted for multiple traumas, the focus of this treatment guide is on single-trauma incidents, including accidents, medical trauma, and violent assaults by strangers.

The authors begin by providing an overview of PTSD in children and youth, including a description of symptoms and important diagnostic considerations, such as the context of the client's age. Ehlers and Clark's (2000) cognitive model of PTSD is presented, modified to be appropriate for children and youth. This model focuses on understanding how a sense of threat is maintained for children and youth with PTSD via individual differences in trauma memory representations, appraisals of the trauma experience, and unhelpful cognitive and behavioral avoidance strategies. Clinicians who have experience with cognitive-behavioral models will likely feel comfortable with this model and treatment approach.

Smith and colleagues (2010) provide thorough and detailed information regarding the assessment of PTSD symptoms with children and adolescents. Not only do the authors suggest several helpful assessment tools, they also provide the reader with detailed recommendations regarding the assessment process with traumatized children and their families, as well as a discussion of potential hurdles to the assessment process

and how to adjust assessment strategies to account for these challenges.

The treatment portion of the model is not outlined in a session-by-session format, but rather provides general information regarding the intervention strategies derived from Ehlers and Clark's (2000) model and the suggested order of these strategies. These treatment targets include helping the child create a coherent narrative of the trauma, restructure misappraisals of the trauma and trauma reactions, target avoidance, and recruit caregivers as cotherapists. Separate chapters are also provided specifically discussing intervention strategies for children and youth, respectively, including psychoeducation and cognitive restructuring, for example. The authors also provide chapters focused on real-world barriers to treatment and common comorbidities associated with child and youth PTSD.

*Post Traumatic Stress Disorder: Cognitive Therapy With Children and Young People* has several notable strengths. The authors' aim, as described in the introduction, is to be accessible, practical, and clinically relevant. The book is written in a straightforward and clear manner that makes it accessible for both clinicians new to PTSD-related interventions and experienced therapists. Throughout the book, summary boxes are provided to review and reiterate important components and considerations. Furthermore, the authors provide many case examples throughout this book that illustrate the cognitive-behavioral model, case conceptualization and treatment, and how to adjust treatment to deal with hurdles or individual client presentations. In addition, several longer case examples are provided to illustrate treatment from initial presentation and assessment through treatment and termination. In the Appendices, the authors provide helpful measures, handouts, and worksheets for use during assessment and treatment.

The authors indicate that clinicians with some prior CBT experience will benefit

most from this guide, and that regular supervision would be helpful in implementing this treatment model; I agree with this position. Clinicians (or trainees) unfamiliar with cognitive-behavioral therapies might find that Smith et al. (2010) do not provide enough detail or session-by-session information to implement this model without supervision.

As mentioned, this guide focuses primarily on single traumas, including accidents, medical trauma, or violent assault by strangers. Although the authors describe modifications for working with children who have experienced multiple traumas, the authors do not provide much detail on how to do this. Nor is information provided on how to modify this treatment for other forms of trauma such as child sexual abuse; it is unclear if the authors would consider this model appropriate for such traumas.

This book would be an excellent resource for use with clinical trainees being introduced to cognitive-behavioral therapy for child and youth PTSD, in conjunction with supervision from more experienced clinicians. It would also serve as a helpful introduction to cognitive-behavioral therapy for CBT therapists looking to extend their practice to child and youth PTSD. The case examples, summary boxes, and appendices would be particularly useful in this regard. For more experienced trauma clinicians, or for clinicians who primarily see multiple-trauma clients, this resource might not be a necessary purchase.

## References

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- Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & Clark, D. M. (2007). Cognitive-behavioral therapy for PTSD in children and adolescents: A preliminary randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1051-1061.

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## Want to Be Involved? Here Are Some Suggestions

David Teisler, *ABCT Director of Communications*

*For those interested in research issues, consider . . .*

**Committee on Research Facilitation**, which monitors issues of interest to researchers, including available grants. Contact Michael Twohig, Chair.

**Serving as a reviewer for *Behavior Therapy***, ABCT's flagship journal and one of the most important arbiters of research in CBT. Contact the Editor, Tom Ollendick.

*For those interested in clinical issues, consider . . .*

**Clinical Directory and Referral Issues Committee**, which reviews the Find-a-Therapist directory, providing guidance on fact sheets, and suggesting new specialties for inclusion in the directory. Contact the Chair, Catharine P. MacLaren.

**Serving as a reviewer for *Cognitive and Behavioral Practice***, ABCT's practice journal featuring case conferences, and real-world applications of research findings to clinical settings. Contact Editor Maureen Whittal.

**The Academic Training Committee** maintains the syllabi on ABCT's website. You can contribute your own, or if you want to help the group maintain this great service, contact the Chair, Kristalyn Salters-Pedneault.

*For other training issues, consider . . .*

**The Medical Educator Directory**, headed by Barbara Kamholz, is an interesting new ABCT service organizing CBT educators as potential resources to those involved in training physicians and allied health providers.

*How about communications?*

There's the **List Serve Committee**, which monitors the traffic and develops protocols; it's headed by Carl Indovina.

There's the **ABCT website**, headed by Web Editor Mitch Prinstein. One needn't be technical: they're not looking for web

masters, per se, but someone who's interested in making sure the web has information of import to our own members, other professionals, as well as the general public.

Daniel Hoffman guides the **Social Media Network Committee** that looks to increase traffic on Facebook and will soon be expanding to other social networking sites. For more information, contact Daniel.

An interesting group is the **Public Education and Media Dissemination Committee**. One needn't be able to say it 5 times fast to join. This committee is looking at Wikipedia and making sure entries reflect CBT accurately and providing relevant linking URLs; they are developing 5-minute video explanations of disorders and treatment approaches; and they work on adding to our definition of symptoms and modalities. Susan White heads this multi-pronged approach.

*For continuing education issues . . .*

To help decide what is offered at upcoming ABCT Conventions, start with the 2012 meeting and Program Chair Jeffrey Goodie. The November 2012 Convention will take place at the Gaylord National, outside of Washington, DC. Feel free to let Dr. Goodie know which topics or speakers you most want to hear. The submission deadline is March 1 and each year the number of submissions grow. Full members interested in joining the **Program Committee** and reviewing general sessions should contact Dr. Goodie in the fall. Be sure to provide your c.v. and information on your specialty areas. Be forewarned that a fairly short turnaround time is allowed for reviews.

Want to present a continuing education event? February 1 is the deadline for abstract submissions for workshops, institutes, and master clinician seminars. Check the ABCT website for submission requirements. The **CE Committee**, chaired by Muniya Khanna, is investigating various dissemination formats. Everything from online CE for *C&BP* to webinars to workshops on the road to online access to con-

vention materials are being considered. Let her know if the Association should sponsor or cosponsor a CE event in your area.

And don't forget *the Behavior Therapist*, where Editor Kate Gunthert continues a storied tradition of presenting cutting-edge research along with great how-to articles on getting into grad school, making the most of a convention, starting a practice, talking to the media and more.

ABCT can be seen as an association, a network, a professional home, or an extended family. We are as strong and productive as our members' commitment. For a fuller overview of ABCT activities, take a moment to browse the Association's governance listing, which can be found on the ABCT website under ABOUT ABCT. These are members who are shaping the Association and the field. Here are a few opportunities to join them.

*Correspondence to* David Teisler, ABCT,  
305 Seventh Ave., New York, NY 10001;  
teisler@abct.org

### **Committee on Research Facilitation**

Michael Twohig: michael.twohig@usu.edu

### **Behavior Therapy**

Tom Ollendick: tho@vt.edu

### **Clinical Directory and Referral Issues Committee**

Catharine P. MacLaren:  
maclarenc@aol.com

### **Cognitive and Behavioral Practice**

Maureen Whittal: whittal@ubc.ca

### **Academic Training Committee**

Kristalyn Salters-Pedneault:  
saltersk@easternct.edu

### **Medical Educator Directory**

Barbara Kamholz:  
barbara.kamholz2@va.gov

### **List Serve Committee**

Carl Indovina: cindovina@comcast.net

### **Website**

Mitch Prinstein: mitch.prinstein@unc.edu

### **Social Media Network Committee**

Dan Hoffman: psydlh@gmail.com

### **Public Education and Media Dissemination**

Susan White: sww@vt.edu

### **Program Committee**

Jeffrey Goodie: jgoodie@gmail.com

### **CE Committee**

Muniya Khanna:  
muniya@mail.med.upenn.edu

### **the Behavior Therapist**

Kate Gunthert: gunthert@american.edu

At ABCT

## Members Based in University Settings: We Need Your Help

Mary Jane Eimer, *Executive Director*

Lisa Yarde, *Membership Services Manager*

Are you receiving our broadcast emails or able to access our list-serve? We are experiencing technical difficulties and need your help. If at all possible, please check with your IT department to insure that broadcast emails from ABCT or our list-serve are not viewed as spam.

ABCT does not sell your email address for commercial purposes. We only send you notices of new issues of our journals, *Behavior Therapy* or *Cognitive and Behavioral Practice*, approaching deadlines for dues renewals or convention registration, or calls for action such as award nominees, candidates for office, or to call your attention to new services.

We know it's frustrating. It is frustrating to us too. Our broadcast emails come from an internal server that spam filters can check it has the same IP address. Our list-serve is handled from a separate company. We are looking into alternate options but it takes time to do the research, try the demos, and check the references. Then we have to present the information to the Finance Committee and ultimately the Board determines our technological priorities. But we continue to work on the problem. Any help you can give us is greatly appreciated. We know one of the basics of good membership service is clear, concise, and timely communication. Thank you.

...

**Correspondence to** Lisa Yarde,  
Membership Services Manager, ABCT,  
305 Seventh Ave., New York, NY 10001;  
lyarde@abct.org

## Call for Candidates

### Editor of BEHAVIOR THERAPY

*Candidates are sought for Editor-Elect of Behavior Therapy, volumes 45 – 48.*

The official term for the Editor is January 1, 2014, to December 31, 2017, but the Editor-Elect should be prepared to begin handling manuscripts at least 1 year prior.



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

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Communications, will provide you with more details at the appropriate time. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

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

**Letters of intent MUST BE RECEIVED BY October 1, 2011. Vision letters will be required by October 15, 2011.** The Editor will be selected at ABCT's Board of Directors meeting in November.

*Call for*

## Continuing Education Sessions

**46th Annual Convention | November 15–18, 2012**

**National Harbor, MD**

### Workshops

Workshops cover concerns of the practitioner / educator / researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday.

Jillian Shipherd, *Workshop Committee Chair*

**[workshops@abct.org](mailto:workshops@abct.org)**

### Institutes

Institutes, designed for clinical practitioners, are 5 hours or 8 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.

Risa Weisberg, *Institute Committee Chair*

**[institutes@abct.org](mailto:institutes@abct.org)**

### Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday.

L. Kevin Chapman, *Master Clinician Seminar Committee Chair*

**[masterclinicianseminars@abct.org](mailto:masterclinicianseminars@abct.org)**

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the continuing education session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at **[www.abct.org](http://www.abct.org)**.

**Submission deadline: February 1, 2012**



### **Lifetime Achievement**

- **Antonette M. Zeiss, Ph.D.**, *Department of Veterans Affairs, Office of Mental Health Services, Veterans Health Administration*

### **Outstanding Contribution by an Individual for Clinical Activities**

- **Judith S. Beck, Ph.D.**, *Beck Institute for Cognitive Therapy and Research*

### **Outstanding Training Program**

- **Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology**  
*Sabine Wilhelm, Ph.D., Director, Cognitive Behavioral Therapy Program, and Steven A. Safren, Ph.D., Director, Behavioral Medicine Program*

### **Distinguished Friend to Behavior Therapy**

- **The Honorable Erik K. Shinseki**,  
*Secretary, Department of Veterans Affairs*

### **Outstanding Service to ABCT**

- **George F. Ronan, Ph.D.**, *Central Michigan University*

### **Virginia Roswell Dissertation**

- **Katherine J. W. Baucom, M.A.**, *University of California*

### **Leonard Krasner Student Dissertation**

- **Christian Webb, M.A.**, *University of Pennsylvania*

### **John R. Z. Abela Dissertation**

- **Katie C. Hart, M.A.**, *SUNY-Buffalo*

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#### **Awards and Recognition Committee**

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*Andy Berger, Alina Bonci, Barry Edelstein, John Guthman, David A. F. Haaga, Dana Holohan, Robert Hynes, Carl Lejuez, Wilson McDermut, Lily McNair, Jan Mohlman, Todd Moore, Simon Rego, Shireen Rizvi, Denis Sukhodolsky, Mark Terjesen, Cindy Turk, Elizabeth Wack*





## Self-Help Seal of Merit

*Association for Behavioral  
and Cognitive Therapies*

### ***About ABCT's Self-Help Books of Merit***

The Association for Behavioral and Cognitive Therapies embraces the vision of “applying science to the prevention and treatment of behavioral and emotional problems.” To that end, ABCT has added the Self-Help Book of Merit to its annual awards program. The number of self-help books and resources available for mental health problems can be overwhelming. As part of our commitment to educating the public about scientific approaches to the treatment of psychological problems, ABCT recognizes published self-help books that are consistent with cognitive-behavioral therapy principles and that incorporate scientifically tested strategies for overcoming these difficulties.

### ***To earn the ABCT Self-Help Book Seal of Merit, a book must meet the following criteria:***

- employ cognitive and/or behavioral principles
- discuss cognitive and/or behavioral principles or theories explicitly in text
- have documented empirical support that lends support for the methods presented
- include no suggestions or methods that are contraindicated by scientific evidence
- present treatment methods that have consistent evidence for their effectiveness (books describing methods without a consistent track record of empirical support, or mixed evidence, would not be eligible)
- be consistent with best practices

The self-help books appearing on the ABCT website are solely intended to give the reader an overview of how a behavior therapist or cognitive behavior therapist might approach a particular problem or treatment. *In no way is the ABCT listing of self-help books exhaustive.* There are a good many excellent self-help books on a variety of disorders that do not appear on our website. Books appearing on our website or having been recognized as an ABCT Self-Help Book of Merit should be viewed as resources for members of the general public to learn more about disorders and approaches that CBT-trained therapists might use; thus, our self-help book web page is also a link on our Find-a-Therapist page, wherein we make clear to the treatment-seeking public that no book should be viewed as an endorsement, nor should the reader view the material in the books as a substitute for care from a professional, and that the Association is not responsible for treatment outcomes from books listed on our website or from treatment from a professional contacted via the ABCT Find-a-Therapist directory

### ***Publishers and authors, you can submit a book for consideration of the Self-Help Seal of Merit directly online:***

 <http://www.abct.org>

[Professionals, Educators, & Students](#) ↗

[Self-Help Books](#) ↗

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