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Contents

President's Message

Another Look Inside the Boardroom: Dissemination, Dissemination, Dissemination

Frank Andrasik, *University of Memphis*

Most realtors claim the three most important features in selling a home are *location, location, location*. Throughout this year, ABCT's Board has been addressing a number of important topics (see earlier columns), but, to borrow a real estate phrase, the three most important topics settled upon are *dissemination*, *dissemination*, and *dissemination*. Progress is being made on all goals earlier identified (continue web development, enhance the value and usefulness of our listserve, increase our endowment to cover a year of operating expenses, strengthen and enhance our member base, and help grow our next generation of leaders), but our biggest push is dissemination.

I wish you could join us for the many Board calls where this topic has been (and is continuing to be) debated. Our discussions are guided by the collective experience of our own Board, coordinator, and committee members; the exemplary work being conducted in the United Kingdom; and the scholarly papers written by our members (such as the recent article by McHugh & Barlow, 2010).

A continuing topic is how to best focus our efforts. Here we keep returning to education and training—the activities that represent our strengths, what we should be doing, what we have been doing, and what can fit within our budget. Our discussions have been wide rang-

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INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
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Submissions must be accompanied by a Copyright Transfer Form (a form is printed on p. 24 of the January 2008 issue of *tBT*, or contact the ABCT central office): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Submissions via e-mail are preferred and should be sent to the editor at **drewa@albany.edu**. Please include the phrase ***tBT submission*** in the subject line of your e-mail. Include the first author's e-mail address on the cover page of the manuscript attachment. By conventional mail, please send manuscripts to:

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ing. Should we focus on "competency training" and "sustainability" as they relate to the offerings at our annual meeting? (e.g., institutes, workshops, master clinician sessions)? Do we need to establish outcome and feedback mechanisms for these training endeavors? Should we arrange follow-on training (e.g., establish supervision groups)? Should we offer training programs at times other than the annual meeting? Could we be using our website more effectively, such as by making available a greater array of training material (e.g., videostreams, podcasts, PowerPoints, tips of the week, focused reading lists, lectures from our members for courses they teach), as well as our other outlets (Facebook, listserve, our journals)? The answer here, of course, is yes, and we are moving forward on these fronts. In addition, we continue to debate where best to focus our initial efforts: Consumers at large? Professionals within our ranks? Professionals outside our ranks? County and state associations? Governmental agencies? Third-party payers? The list is endless.

We always come back to the need to impact the training students receive in their doctoral programs. Kevin Arnold, who has served admirably as our Chair on the Committee on Specialization in Behavioral and Cognitive Therapies Within Various Professions, and various members over the years (Art Nezu, Keith Dobson, Art Freeman, Sharon Morgillo Freeman, Joann Wright, Stefan Hofmann, Chris Nezu, Tom Dowd, George Ronan, among others) recently advocated for ABCT to convene a summit for this purpose. The Board is in full agreement and planning for this summit is now under way. I want to thank Kevin and his various committee members over the years for helping us get to this point. Finally, I am pleased to announce that our President-Elect, Bob Klepac, has agreed to chair our Task Force on Dissemination, with George Ronan serving as co-chair. Their task is to keep the ball rolling. Once their committee is assembled, they will begin work on developing questions/topics to be addressed, identifying leaders of like-minded societies (or stakeholders, if you will) with whom to coordinate our efforts, and securing the location and date for this summit. The hoped-for outcome is development and subsequent promotion of a model curriculum that identifies core competencies for training in CBT at the doctoral level.

Yes, this is a most ambitious goal, but it is a goal we can and must achieve for our dissemination efforts to move forward. Look to future issues of *tBT* for progress updates.

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Clinical Forum

Should Insomnia Be a Primary Focus for Treatment ?

Michael L. Perlis, *University of Pennsylvania*, and Donn Posner, *Brown University*

In the early 1980s, as the sleep medicine movement was just gathering momentum, there was perhaps no rallying cry as popular as "insomnia is a symptom, not a disorder." Presumably, this position was adopted for one of two reasons. First, and perhaps foremost, because it was genuinely believed that the polysomnographic (PSG) study of sleep was destined to reveal all the underlying pathologies that give rise to the "symptoms" of not only insomnia but fatigue and sleepiness as well. Second, to the extent that insomnia was to be considered "just a symptom" of medical and/or psychiatric disease, it was believed that the treatment of the parent disorders would result in the resolution of the insomnia.

After more than three decades of sleep research and sleep medicine, it is interesting to find that "all things old are new again": Insomnia is once again considered, within the sleep medicine and behavioral sleep medicine communities, a distinct nosological entity. This change perspective, however, has yet to influence the general standard of practice. This, in large measure, likely owes to the fact that findings within behavioral sleep medicine have yet become common knowledge in the larger psychology community. Accordingly, this brief review serves to (a) highlight the findings that undergird the claim that insomnia, when chronic, tends to be unremitting, disabling, costly, pervasive, and pernicious; and (b) provide the justification for the perspective that insomnia should be a primary focus for treatment.

Insomnia Is Unremitting

There are very few studies on the natural history of insomnia (Hohagen et al., 1994; LeBlanc, Merette, Savard, & Morin, 2007; Mendelson, 1995; Morin et al., 2009; Young, 2005). In general, these studies find that chronic insomnia does not spontaneously resolve (LeBlanc et al., 2007; Mendelson; Young) and the presenting form of insomnia (i.e., initial, middle, or late) tends to be unstable or variable over time. With respect to spontaneous remission, Mendelson reported that subjects who reported difficulty sleeping at their initial assessment (average chronicity of 10 years) continued to report insomnia at two follow-up intervals (70% at 40 months and 88% 64 months).

Insomnia Is Disabling

To date, there are a number of investigations that suggest that individuals with chronic insomnia, as opposed to no or occasional insomnia, have more difficulty with intellectual, social, and/or vocational functioning.

With respect to intellectual functioning, there are numerous studies (e.g., Carey, Moul, Pilkonis, Germain, & Buysse, 2005; Roth & Roehrs, 2003; Shochat, Umphress, Israel, & Ancoli-Israel, 1999) documenting that patients with chronic insomnia report impaired cognitive performance. In fact, this type of daytime complaint constitutes one of the defining attributes of insomnia as it is delineated in the *International Classification of Sleep Disorders* (American Academy of Sleep Medicine, 2005).

With respect to social functioning, patients with chronic insomnia reliably report decreased interest in, facility with, and satisfaction from interpersonal relationships and social interactions. For example, in patients being seen in a primary care practice, chronic insomnia is associated with decreased ability to handle minor irritations, decreased ability to enjoy family/social life, and poorer interpersonal relationships with spouses (Shochat et al., 1999).

With respect to vocational performance, several studies have found that sleep disturbance and/or chronic insomnia is associated with less job satisfaction, lower performance scores, less productivity, and higher rates of absenteeism (Johnson & Spinweber, 1983; Kupperman, Lubeck, & Mazonson, 1995). A more recent study by Leger et al. (2002) found that those with insomnia had, compared to good sleepers, more absenteeism (31% vs. 19%), made more errors at work in the previous month (15% vs. 6%), and reported poor work efficiency in the past month (18% vs. 8%; Leger et al., 2002).

Insomnia Is Costly

In the United States alone, the direct and indirect costs attributable to insomnia exceed $100 billion annually (Fullerton, 2006). Direct costs, including physician visits, prescriptions, and procedures, equal or exceed $13 billion per annum (Walsh & Engelhardt, 1999). These costs are, in part, related to the increased tendency of patients with insomnia to use health care resources and to the costs of pharmacotherapy (Leger et al., 2002). Indirect costs associated with motor vehicle and workplace accidents, reduced productivity, and absenteeism are thought to account for the majority of the economic consequences of insomnia, with cost estimates between $77 and $92 billion per annum. Recent work by Ozminkowski, Wang, and Walsh (2007) suggests that the individual cost per annum, as compared to patients without insomnia, is increased by $1,253 in younger adults and $1,143 in older adults (Ozminkowski et al., 2007).

Insomnia Is Pervasive

As stated in the NIH State of the Science Statement on Manifestations and Management of Chronic Insomnia in Adults (2005), "Chronic insomnia is known to be common. . . . Population-based studies suggest that about 30 percent of the general population complains of sleep disruption, while approximately 10 percent has associated symptoms of daytime functional impairment consistent with the diagnosis of insomnia."

Insomnia Is Pernicious

While it may seem an overstatement to say "insomnia is pernicious," there are a variety of studies suggesting that chronic insomnia is a significant risk factor for both new onset and recurrent medical and psychiatric illness.

With respect to medical disease, the data suggesting that insomnia confers risk are preliminary. Only a few epidemiologic studies have been conducted and even fewer studies have assessed the association prospectively. This said, the existing data suggest that patients with insomnia are more likely to suffer from pain conditions and gastrointestinal distress (Kupperman et al., 1995) and that untreated insomnia puts sufferers at risk for hypertension (Phillips & Mannino, 2007; Suka, Yoshida, & Sugimori, 2003) and heart disease (Phillips & Mannino; Schwartz et al., 1999). It has also been suggested that insomnia may be a risk factor for the development of diabetes. Experimental data in good sleeper subjects

has shown that sleep loss is associated with reduced insulin sensitivity (Mander, Colecchia, Spiegel, & Van Cauter, 2001). Observational data in patients with Type II diabetes have shown that poor sleep quality is associated with poor glycemic regulation (Ryden, Knutson, Mander, & Van Cauter, 2002). Finally, there are data indicating that insomnia and/or short sleep duration are associated with increased all-cause mortality (Dew et al., 2003; Kripke, Simons, Garfinkel, & Hammond, 1979). Whether these associations are causal remains to be determined, as does what factors related to insomnia in specific confer and moderate/mediate risk.

With respect to psychiatric disease, there is a preponderance of data to suggest that insomnia confers increased risk for new onset and recurrent illness, and that this is particularly true for depression/major depressive disorder (MDD; Pigeon & Perlis, 2007). There are now at least 14 longitudinal studies showing that subjects with chronic insomnia are between 2 and 6 times more likely to have a new onset or recurrent episodes of depression (within 6 months to 3 years) as compared to subjects without chronic insomnia (Breslau, Roth, Rosenthal, & Andreski, 1996; Chang, Ford, Mead, Cooper-Patrick, & Klag, 1997; Dryman & Eaton, 1991; Ford & Kamerow, 1989; Hohagen, Rink, Kappler, & Schramm, 1993; Kennedy, Kelman, & Thomas, 1991; Livingston, Blizard, & Mann, 1993; Livingston, Watkin, Milne, Manela, & Katona, 2000; Mallon, Broman, & Hetta, 2000; Paffenbarger, Lee, & Leung, 1994; Perlis et al., 2006; Roberts, Shema, Kaplan, & Strawbridge, 2000; Vollrath, Wicki, & Angst, 1989; Weissman, Greenwald, Nino-Murcia, & Dement, 1997).

In addition to the risk for new onset and recurrent illness, there are two studies that suggest that insomnia is associated with the clinical course of MDD. In the first study (Perlis, Buysse, Giles, Tu, & Kupfer, 1997), subjects with recurrent MDD were assessed to determine whether insomnia severity increases prior to recurrence of MDD (i.e., whether insomnia exists as a prodromal or precipitating factor for MDD). The time series data from this study showed that the nonrecurrent group exhibited an elevated but stable level of insomnia while the recurrent group exhibited an increased level of sleep disturbance that began 5 weeks prior to, and was of highest severity at, the week of recurrence.

In the second study (Pigeon et al., 2008), the association of insomnia to treatment response was assessed in a large interventional study of late-life depression. Subjects were assessed for their clinical status at baseline, 3, 6, and 12 months to determine whether insomnia at baseline and 3 months (classified as no insomnia, insomnia, and persistent insomnia) was associated with clinical improvement and/or the occurrence of remission at 6 and 12 months. The groups were found to be significantly different in terms of the percentage of subjects who remained ill at 6 months according to two measures of depression (remission and less than 50% improvement). Overall, patients with persistent insomnia were 2 to 4 times less likely to achieve remission or an improvement of 50% or more in depressive symptoms as compared with patients with no insomnia.

Taken together, these data suggest that insomnia may serve as a predisposing, precipitating, and/or perpetuating factor for depression. That said, as with medical disorders, it remains to be shown that these associations are causal, and it remains to be determined what factors related to insomnia confer and mediate risk. For additional information on the association between insomnia and depression, the reader is referred to Perlis, Smith, and Orff (2002) and Pigeon and Perlis (2007).

CBT-I Is Efficacious and Effective

Since the 1930s, more than 200 trials have been conducted on either single interventions for insomnia (stimulus control, progressive muscle relaxation, and sleep restriction) or multicomponent interventions that may be characterized as CBT-I. This extensive literature has been quantitatively summarized using meta-analytic statistics on at least three occasions (Irwin, Cole, & Nicassio, 2006; Morin, Culbert, & Schwartz, 1994; Murtagh & Greenwood, 1995) and there is at least one comparative meta-analysis that evaluates the relative efficacy of CBT-I as compared to benzodiazepine receptor agonists (BZRAs; Smith et al., 2002). The data from these literatures suggest, consistent with the conclusions of the NIH State of the Science Conference (2005), that (a) CBT-I is highly efficacious (approximately 50% reduction in sleep continuity disturbance during treatment), (b) BZRAs and CBT-I produce comparable outcomes in the short-term; and (c) CBT-I appears to have more durable effects when active treatment is discontinued.

Beyond the issue of efficacy is the issue of effectiveness. That is, are the clinical outcomes observed in clinical trials comparable

to investigations of treatment outcome in (a) patients with insomnia comorbid with other medical and/or psychiatric illnesses (e.g., Currie, Wilson, Pontefract, & deLaplante, 2000; Edinger et al., 2009; Edinger, Wohlgemuth, Krystal, & Rice, 2005; Jungquist et al., 2010; Lichstein, Wilson, & Johnson, 2000; Savard, Simard, Ivers, & Morin, 2005) and/or (b) studies of patients who are treated in clinical care settings (e.g., Perlis et al., 2000; Perlis, Sharpe, Smith, Greenblatt, & Giles, 2001). To date, more than 20 studies have examined patients who suffer such comorbidities as cancer, chronic pain, depression, and PTSD. The data from these studies not only show CBT-I to be effective, the clinical outcomes are, by and large, comparable to those found with patients with primary insomnia. In some cases, the effects are actually larger (e.g., Jungquist et al., 2010; Savard et al., 2005). As noted above, there also have been a variety of clinical case series studies. The effect sizes for these studies also appear comparable to those obtained in randomized clinical trials. Finally, there is emerging evidence that the effects of CBT-I extend beyond insomnia to the comorbid conditions (the current findings are with depression, Manber et al., 2008; and chronic pain, Jungquist et al., 2010).

Concluding Remarks

Why treat insomnia? At present, the answer is simply because insomnia can be effectively treated with CBT-I and treatment can be expected to reduce insomnia-related distress and suffering in the tens of millions of patients who live with this disorder. This, along with the growing evidence that the effects of CBT-I extend beyond insomnia and may serve to promote better quality of life and health in general and diminish the severity of comorbid illness in specific, suggests that it is time for CBT-I to become widely disseminated and implemented among clinicians already familiar with other forms of CBT.

In closing, and on a personal note, we hope that this brief summary serves to pique the interest of the ABCT membership and that some of you will join us in the effort to (a) disseminate and implement CBT-I at the national level and (b) forge the next generation of cognitive and behavioral treatments for not only insomnia but the entire compendium of sleep disorders.

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Research Forum

How Well Are We Doing at Reporting Participant Characteristics in Our Research?

Jesse M. Crosby, Jessica M. Gundy, Andrew B. Armstrong, Emily W. Nye, Adam Boman, Casey R. Nelson, and Michael P. Twohig, *Utah State University*

The American Psychological Association (APA) maintains that the integrity and validity of research findings is partially supported by reporting adequate sample demographic characteristics and methodological procedures (APA Publications and Communications Board Working Group on Journal Article Reporting Standards, 2008). Evaluating how carefully participant characteristics such as race/ethnicity are reported provides a source of information about the efficacy or effectiveness of clinical interventions for mental health issues within diverse populations (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). This position signifies the advancement in evidence-based practice that integrates the best available research with clinical expertise (APA Presidential Task Force on Evidence-Based Practice, 2006). Additionally, understanding the generalizability of research data associated with participant characteristics is essential for drawing meaningful conclusions from any psychological research.

Despite the wide recognition that adequate representation of diverse samples is fundamental to treating mental health problems, a recent study examining NIMH-funded clinical trials published between 1995 and 2004 reported no significant progress observed in the reporting of race/ethnicity information over the past 10 years across leading journals in the field (Mak, Law, Alvidrez, & Perez-Stable, 2007). Additionally, there is evidence suggesting that behaviorally oriented journals tend to report participant characteristics even less frequently in comparison to more mainstream psychology journals (Sass, Twohig, & Davies, 2004).

Traditional behavioral viewpoints have historically paid less attention to participant characteristics and cultural diversity while focusing more on identifying processes that underlie behavior change as they relate to changes in the environment (Bolling, 2002). This stance limits the likelihood of certain behavioral interventions being identified as evidence-based practice and overlooks how diversity is understood within behavioral research. Sass et al. (2004) evaluated the frequency and percentage of studies that reported age, sex, and race/ethnicity of participants from 1995 to 2000 in three peer-reviewed journals (*Journal of Applied Behavior Analysis* [*JABA*], *Behavior Therapy* [*BT*], and *Journal of Consulting and Clinical Psychology* [*JCCP*]). Result indicated that *JCCP* and *BT* reported age and sex frequently (>95%), while *JABA* reported these variables fairly consistently (>85%). Participant race/ethnicity was reported significantly less in studies in *BT* (42%) and *JABA* (4%) when compared to *JCCP* (62%).

To apply and implement evidence-based practice within diverse populations and produce generalizable results from any psychological research, it is imperative that the support comes from representative samples. While some have attempted to motivate the behavioral research community to improve their reporting of participant characteristics and increase their recognition of diversity issues (e.g., Carter & Forsyth, 2007; Iwamasa, Sorocco, & Koonce, 2002), this has not been adequately reflected in the literature, and the reporting practices in recent research have yet to be reviewed.

The current study updates and extends the Sass et al. (2004) research by evaluating the current state of participant characteristic reporting practices. Empirical studies from 2004 to 2008 were reviewed, and the findings are compared to the data from 1995 to 2000. To allow for comparisons with a journal that places a strong emphasis on issues of diversity, in addition to *JABA*, *BT*, and *JCCP*, the study included the peer-reviewed journal *Cultural Diversity and Ethnic Minority Psychology* (*CDEMP*). As in the previous study, participant characteristics of age, sex, and race/ethnicity were included; however, additional sample characteristics were also reviewed, including marital status, language, citizenship, sexual orientation, education, income, socioeconomic status, rural/urban, and religion. The results of this evaluation will shed light on the practice of reporting participant characteristics across a variety of journals to evaluate the applicability of psychological research to diverse populations.

Method

Studies published in *JABA*, *JCCP*, *BT*, and *CDEMP* from 2004 to 2008, inclusive, were reviewed. Two levels of inclusion criteria were developed to facilitate comparison with the Sass et al. (2004) study and then to extend the review to include broader coverage of study type. To facilitate direct comparison between the current study and the Sass et al. research, articles were included for review if they used an experimental design to evaluate research with human participants. To extend the review, any article that reported original research with human participants was included in the study and coded for participant characteristic reporting. The total number of articles included for the direct comparison was 570 (*JABA* = 265, *JCCP* = 230, *BT* = 75). The total number of articles that met criteria for the extended review and then included for coding was 1,031 (*JABA* = 298, *JCCP* = 463, *BT* = 112, *CDEMP* = 158). For the extended review, it seemed prudent to review all studies with human participants, not just experimental ones, because they all impact the knowledge base that informs the field of psychology.

Articles were reviewed by three undergraduate research assistants. A 2-hour training session was held to explain the inclusion criteria and operational definitions of the variables of interest. Several practice articles were coded as a group to address any problems and establish consistent coding procedures, and then articles were coded independently until near complete agreement was achieved on at least two articles. Together, the undergraduate assistants reviewed every issue of *JABA*, *BT*, *JCCP*, and *CDEMP* from 2004 to 2008, reading the title, abstract, and methods section of each published article to identify articles for coding. Articles that met the inclusion criteria were coded on a worksheet and entered in a spreadsheet. A graduate student independently reviewed 5% of the coded articles to evaluate interrater reliability. This was calculated by dividing the total number of agreements by the total number of ratings for each article that was coded. Interrater reliability for this review was .96.

Results and Discussion

Table 1 displays rates of reporting from 1995 to 2000, taken from Sass et al. (2004), and our current study for 2004 to 2008. To

remain consistent across reviews, 2004 to 2008 studies included in Table 1 were selected using the same inclusion criteria as in the 1995 to 2000 review (i.e., only experimental studies with human participants). The most notable finding was the increase in the levels of reporting of race/ethnicity by *JCCP* and *BT* (22% and 18%, respectively) compared to the 1995 to 2000 review. *JABA* did increase reporting for race/ethnicity by 7% from 4% to 11%, but this is still a relatively low number considering the importance of addressing issues of diversity. *JABA*, *JCCP*, and *BT* reported sex and age characteristics slightly less in the current review than in the 1995 to 2000 review.

Table 2 provides percentages for all the variables examined in the 2004 to 2008 review; inclusion criteria for this table were expanded to include all studies with human subjects. Across all categories, *JABA* reported the least demographic information; only sex (71.1%), age (84.9%), and education (28.2%) were reported at levels higher than 10%. Not surprisingly, *CDEMP*, a journal that focuses on diversity issues, tended to report sample characteristics with more frequency and specificity compared with the other journals. However, *JCCP* reported language proficiency, education, income, and socioeconomic status at levels comparable to *CDEMP*. Marital status was actually reported more frequently in *JCCP* (41.0%) and *BT* (33.9%) than in *CDEMP* (18.9%). It appears that socioeconomic status is underreported—only 13.9% of articles in CDEMP included this information.

Table 1. Percentages of Reported Participant Characteristics Across Reviews

	JABA		*JCCP*		*BT*	
	1995–2000	2004–2008	1995–2000	2004–2008	1995–2000	2004–2008
Variable	(*n*=259)	(*n*=265)	(*n*=182)	(*n*=230)	(*n*=65)	(*n*=75)
Age	88	84	98	91	95	93
Sex	86	72	98	97	97	95
Race/ Ethnicity	4	11	62	84	46	64

Note. *JABA* = *Journal of Applied Behavior Analysis*; *JCCP* = *Journal of Consulting and Clinical Psychology*; *BT* = *Behavior Therapy*.

Table 2. Percentage of Articles That Reported Participant Characteristics

Variable	*JABA* (*n* = 298)	*JCCP* (*n* = 463)	*BT* (*n* = 112)	*CDEMP* (*n* = 158)
Age	84.9	91.1	91.1	89.9
Sex	71.1	96.5	94.6	98.7
Race / Ethnicity	10.1	86.6	68.8	99.4
Marital Status	3.0	41.0	33.9	18.4
Language	0.7	1.9	0.9	1.9
Language Proficiency	1.0	10.8	4.5	11.4
Citizenship	0.3	1.5	1.8	29.1
Sexual Orientation	0.0	3.7	2.7	10.1
Education	28.2	56.4	38.4	59.5
Income	3.4	26.8	17.0	29.1
Socioeconomic Status	0.7	10.4	3.6	13.9
Rural/Urban	1.3	3.9	0.9	9.5
Religion	0.0	2.2	0.0	8.9

Note. *JABA* = *Journal of Applied Behavior Analysis; JCCP* = *Journal of Consulting and Clinical Psychology; BT* = *Behavior Therapy; CDEMP* = *Cultural Diversity and Ethnic Minority Psychology*.

Submission guidelines of each journal were reviewed to examine which specific participant variables were requested (Association for Behavioral and Cognitive Therapies, 2010; APA, 2010a, 2010b; Society for the Experimental Analysis of Behavior, 2010). *CDEMP* requests that, at a minimum, authors report age, gender, ethnicity, and socioeconomic status. *JCCP* requests age, gender, and ethnicity. No recommendations regarding demographic variables were included in the submission guidelines of the behaviorally oriented journals *BT* and *JABA*. Inclusion of specific variables in publication guidelines may be needed and may encourage researchers to recruit more diverse and representative samples for their studies.

It has been suggested that clear and consistent definitions are important to understanding, interpreting, and applying research results (Ford & Kelly, 2005). Therefore, the reviewers were instructed to look at race and ethnicity as separate variables to see if this might be an emerging trend in reporting participant characteristics. Ultimately, the two variables were combined in the review because the terms were used interchangeably in the articles that were reviewed, and it was not clear if the articles were referring to race or ethnicity as a biological or social/political construct. This finding was not surprising as the definition of these constructs is a contemporary issue, but it does suggest that further definition may be useful in the publication guidelines.

Recent reporting standards from the APA call for the inclusion of "major demographic characteristics as well as important topic-specific characteristics" in every report of new data collection, regardless of research design (APA, 2008, p. 842). Although "major demographic characteristics" are not defined in the APA standards, we recommend that the collection and reporting of age, sex, and race/ethnicity data be considered fundamental. These demographic variables are easy to track and are being reported by most major psychology journals. After age, sex, and race/ethnicity, the most commonly reported characteristics in the journals we reviewed were education, marital status, income, socioeconomic status, and language proficiency. In clinical contexts, reporting these and other participant characteristics increases the likelihood of inclusion in meta-analyses and considera-

tion for empirically validated status. In that "evidence-based practice cannot be rightfully applied and implemented in routine care settings with diverse populations if the evidence is not based on representative samples" (Mak et al., 2007, p. 502), recruiting and reporting on diverse samples enhance a study's external validity by helping to clarify the applicability of treatments for various groups (Sue, 1999). Even if such variables are not "topic-specific," their inclusion provides readers with important contextual information to aid in the interpretation of findings. The reporting of these variables is also important in research that is not clinically focused. The integrity, validity, and generalizability of all outcome work is, at least partially, dependent on the sample used in the investigation (APA, 2008).

This paper is intended as a review of progress as the field has recognized the importance of accounting for participant diversity in psychological research. We hope that this review serves as a reminder to collect this information and include it in published manuscripts. We also suggest that editors and reviewers ask for this information on manuscripts where it has not been included.

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Student Forum

Getting Ahead of the Curve as a Graduate Student and Beyond

Adam S. Weissman, *Harvard Medical School*

Graduate school is a pivotal time of personal and professional growth, knowledge acquisition, and opportunity. Many opportunities are created for us by our supervisors and graduate programs; others we carve out for ourselves. This article provides some recommendations and keys for success for current graduate students. Start cultivating your professional network and identity, and make your mark as an emerging clinical scientist!

Taking Opportunities: Embracing Challenges and Prioritizing Your Agenda

Like academia, graduate school is a balancing act: An integration of multitasking, self-care, and stress-management skills are essential to a balanced and successful graduate school experience. Many interesting and exciting research/writing projects and clinical training opportunities will be shared and/or promoted by your academic advisors, clinic/research directors, and graduate programs. As a result, one of the most important keys to graduate student success is learning to pace yourself and prioritize your agenda, without letting those potentially important and career-shaping opportunities slip by. A number of experiences, including specialized clinical training, grant and award applications, and targeted research/writing projects—albeit time-consuming and anxiety-provoking the first time around—may be well worth the investment. Consulting a trusted mentor about which projects and experiences may be most helpful to your future goals may help minimize your anxiety and improve your overall efficiency as a graduate student.

In general, opportunities tend to inspire and build upon opportunities. For me, the practice of co-authoring a book chapter with my advisor as a 3rd-year graduate student was instrumental in developing my

confidence as an academic writer, and has been indispensable in future writing projects, including book editing, grant writing, and manuscript preparation. Equally important to embracing/prioritizing new challenges, however, is your ability to resist the temptation to compare your progress and productivity to fellow students and colleagues. It is helpful to keep in mind that there are many ways to achieve success as a clinical psychologist. Identifying what you are passionate about, staying true to yourself, your values, and your long-term goals, pacing yourself, and finding the path that works best for you are just some of the ingredients for success.

Opportunities to Take

- co-author peer-reviewed articles and book chapters;
- write a peer review;
- write an article for an ABCT SIG newsletter or website;
- present your research at graduate school colloquia;
- teach a class in an area you hope to pursue;
- diversify your clinical portfolio en route to becoming a skilled, well-rounded clinician;
- apply for grants and awards to build your CV and fund your research.

You've gotta be in it to win it!

Making Opportunities: A Little Exposure Therapy Never Hurts

We all know that new ventures can be intimidating and may require lots of time and initiative first time around. However, sometimes the best way to grow, both personally and professionally, is to be proactive and take risks. One of the most rewarding and effective ways to disseminate your research and make a name for yourself as a graduate student is to present in front of colleagues at graduate school colloquia and professional conferences. Presenting is a great way to get some exposure, while undergoing a little exposure therapy of your own. For example, chairing your own symposium in which you present your master's or dissertation research is a great way to forge collaborations with new friends and colleagues and overcome your own performance anxiety in the process. My advice to every graduate student is to practice presenting your research at professional conferences in the form of a talk or symposium, even if it seems daunting at first; and if you are feeling particularly bold, coordinate a panel based on your own area of interest. Get your name out there, and more importantly, get some practice feeling comfortable in front of a crowd. Regardless of where your career is headed, you will most likely be speaking in front of colleagues the rest of your life!

Opportunities to Make

- attend/volunteer at professional conferences;
- present your research at professional conferences in the form of a talk or symposium;
- chair your own panel/symposium.
- join one or two smaller professional groups (e.g., ABCT SIGs);
- run for student leadership positions.
- reach out to professors whose work interests you;
- "pay it forward" by mentoring junior colleagues and graduate students.

Networking 101

Networking is one of those intangibles you don't learn in the classroom or by working in a research lab. However, it may be equally important (if not more so) than your productivity as a graduate student. There are plenty of smart, well-qualified students with good clinical experience and a publication or two under their belt. But, what sets them apart? Using your people skills in the professional arena and cultivating your collegial network by volunteering, attending, and presenting at professional conferences is an integral part of "getting ahead of the curve." Forging your own collaborations and getting involved in projects requiring multiple collaborators within or across institutions (e.g., symposia, papers, books, correspondence as a SIG student representative) are great ways to build lasting professional relationships and give colleagues a sample of what it is like to work with you. Not only will you find yourself emailing and sharing ideas with some of your favorite researchers, but over time, your name (and contributions) will gradually become recognizable to many more, and new collaborations/opportunities may come your way. Making these important connections and forging strong, lasting, collaborative relationships may especially come in handy when applying for internship, postdoctoral, and faculty positions down the road. At the very least, you will find yourself in a larger circle of friends and colleagues at professional conferences, and in the "virtual world" of academia.

Schmoozing

Don't be afraid to schmooze; it's an important skill in any field—and clinical psychology is no exception. But remember, there is an important distinction between pestering a busy professor about your interest in his/her work following a conference symposium versus meeting someone in a more relaxed, social context—perhaps at the ABCT SIG student poster exposition and cocktail party, or if you can bear the sight of your own academic advisor "breaking it down" on the dance floor, maybe even at the ABCT dance party! Believe it or not, professors and postdocs do have lives outside of academia and may be lots of fun to get to know on a more personal level if you can catch them in the right atmosphere.

Closing Thoughts

In summary, if you are willing to put yourself out there, think outside the box, take chances, and show a genuine interest in learning from and getting to know your fellow colleagues—graduate students and beyond—the academic world will become a friendlier and more fulfilling place to be. So, go ahead, dust off that power tie or your favorite pair of shoes, attend/volunteer at ABCT or WCBCT, join and become active in one or two smaller professional groups, run for student leadership positions, present your research and coordinate panels, and embrace new and exciting opportunities/challenges as they come your way. Most importantly, be yourself and don't forget to bring your unique personality!

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Letter to Editor

Yes, I Have an Allegiance . . . to the Research Evidence

Bruce E. Wampold, *University of Wisconsin–Madison*

Science is not simply the production of research evidence. The results of studies must be synthesized and valid inferences drawn. Who is privileged to decide what is valid or not? It is the community of scientists, constrained and guided by the canons of research methodology, that is entrusted with the precious responsibility of deciding what constitutes knowledge in our field. The entire scientific enterprise is constructed on this premise.

Research evidence, of course, must be evaluated on its merits. As someone who has produced research evidence that supports conclusions that sometimes differs from the received view, I expect, given the nature of the scientific enterprise, that this evidence will be scrutinized intensely. A scientist must be prepared to have every research operation examined—the exposure of mistakes is intrinsic to the progress toward understanding.

Before 1997, I trained my students to use cognitive and behavioral treatments for some disorders because I believed that was consonant with the research evidence. However, as my students challenged me to provide them the studies that supported that conjecture, I became concerned because many of the conclusions that were being drawn in the literature did not seem to be supported by sound research evidence. As a scientist, this greatly disturbed me. As a psychologist and an advocate for the best treatment for patients, I feared that unjustifiably privileging some treatments restricted the array of effective treatments that were available to patients. As any good scientist would do, I sought out the truth by examining the research evidence and conducting further research into these issues.

In 1994, Lambert and Bergin (1994) reviewed the research evidence on the effectiveness of psychotherapy and made the following observation:

> There is a strong trend toward no difference between techniques in amount of change produced, which is counterbalanced by indications that, under some circumstances, cognitive and behavioral methods are superior even though they do not generally differ in efficacy between themselves. An examination of selected exemplary studies allows us to further explore this matter. Research carried out with the intent of contrasting two or more *bona fide* treatments show surprisingly small differences between the outcomes for patients who undergo a treatment that is fully intended to be therapeutic. (p. 158; emphasis added)

To test Lambert and Bergin's conjecture, my students and I conducted a meta-analysis of all trials that directly compared two bona fide psychological treatments (Wampold, Mondin, Moody, Stich, et al., 1997). We found that there was insufficient evidence to conclude that any bona fide treatment for any disorder was more efficacious than any other. Of course, this was a controversial conclusion and, as expected, there was plenty of criticism of this meta-analysis (Crits-Christoph, 1997; Howard, Krause, Saunders, & Kopta, 1997). Not only did I welcome these comments, I used them to guide my program of research to address the purported threats to validity raised. The resulting research provided evidence that further corroborated the conclusions that bona fide psychological treatments for particular disorders are equally effective (Benish, Imel, & Wampold, 2008; Imel, Wampold, Miller, & Fleming, 2008; Miller, Wampold, & Varhely, 2008; Wampold, Mondin, Moody, & Ahn, 1997).

The present perseverance on the dodo-bird conclusion, which seems to have irritated some, was initiated by Siev, Huppert, and Chambless' (2009) article, "The Dodo Bird, Treatment Technique, and Disseminating Empirically Supported Treatments." Much of this article involved criticisms of my and my colleagues' work. Again, I welcome these critiques because this is how science sifts and winnows evidence. Because we disagreed with many of the conclusions that Siev et al. (2009) reached, my colleagues and I responded (Wampold, Imel, & Miller, 2009). In a recent issue of *the Behavior Therapist*, three letters to the editor were published that were again critical of my and my colleagues' work (Barlow, 2010; Hofmann & Lohr, 2010; Siev, Huppert, & Chambless, 2010). As you might expect, I disagree with many of the conclusions reached in these letters. However, the process is a viable one—let the arguments be made cogently and scientifically.

Although I welcome the give and take with regard to aspects of the evidence, Barlow's comments took a very different course. *It is one thing to examine research evidence and disagree; it is quite something else to declare a particular researcher untrustworthy*: "I don't trust any meta-analysis conducted by anyone with an agenda, and this includes . . . Bruce Wampold, and neither should anyone else" (Barlow, 2010, p. 15). Exactly what is it that leads David Barlow to state that my research is not to be trusted? He claims I have an *agenda* to promote long-term psychotherapy based on my "personal experience with and strong allegiance to individual long-term psychotherapy" (p. 15). Yes, I have personal experience with therapy (although the dose was not greater than many manualized evidence-based treatments), which I am quite willing to discuss, but the inference here is that my work is biased as a result—this is pure foolishness, and more importantly, antiscientific. I would never have thought that receiving therapy would disqualify my research from scientific consideration, or that perhaps it best not to talk about it. (I had thought we were working against the stigma associated with mental health treatment.)

What evidence is there that my research is untrustworthy? Ironically, of all methods, meta-analysis is the most transparent—anyone can have access to the same corpus of studies and reanalyze the data, correcting any purported biases. No one has ever reanalyzed any of my meta-analyses and shown systematic errors favoring one conclusion—indeed, I take pains to use explicit and objective criteria and to use blind coders for that reason. Some have criticized various methods, and some have suggested that research operations have led to bias (e.g., Ehlers et al., 2010), but the bases of the research methods we have used can be defended (e.g., Wampold et al., in press); this is part of the scientific process and I will enter into that process willingly, anticipating that the process will further the goals of science. Ironically, Barlow cites the same sort of bias in Gene Glass' work. Yet, despite several attempts to prove that Glass' work was

flawed (e.g., Andrews & Harvey, 1981; Landman & Dawes, 1982), his and Smith's meta-analyses (Smith & Glass, 1977; Smith, Glass, & Miller, 1980) have stood the test of time. Robyn Dawes, an esteemed scientist, with J. Landman, declared as the title of their reanalysis of Smith and Glass' work: "Psychotherapy Outcome: Smith and Glass' Conclusions Stand Up Under Scrutiny" (Landman & Dawes, 1982). Being compared to Gene Glass is an honor.

Let me make a few more points. First, my conclusions are supported by the work of many others, going back to Smith and Glass (1977) and including many others (Grissom, 1996; Luborsky, Singer, & Luborsky, 1975; Powers, Halpern, Ferenschak, Gillihan, & Foa, in press; Shapiro & Shapiro, 1982a, 1982b; Spielmans, Pasek, & McFall, 2007). Second, Barlow claims that meta-analyses are flawed because they contain outdated research, even though Wampold et al. (1997) found no effects for date of publication. Where are the "thousands of positive clinical trials demonstrating superiority of psychological treatments carefully tailored to presenting psychopathology compared to some good alternatives" (Barlow, p. 15) that have appeared since the advent of evidence-based treatments that demonstrate that one bona fide treatment is superior to another? Third, I have never said that any clinician should provide the same treatment regardless of the disorder—indeed, I have said, quite clearly, that the treatment needs to be tailored to many aspects of the patient, including problem, complaint, or disorder, but also including attitudes and values, history, culture, resources, context, and so forth (Wampold, 2001, 2007). Fourth, Barlow defers to "independent and impartial groups" (p. 15). Who do you think makes up these groups? Let's be frank—there are more people who have agendas than Gene Glass and Bruce Wampold. Rather than debating agendas, let's examine closely the research evidence.

My allegiance is foremost to the research evidence. You may not agree with my conclusions—and you may not like them—but I am willing to debate, within the rules of science, any issue about the evidence. If you don't like my conclusions, prove me wrong, but please refrain from saying that, because of my personal experience, I am not to be trusted.

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Obituary

In Memoriam: John R. Z. Abela, Ph.D.

Benjamin Hankin, *University of Denver*, Brandon Gibb, *SUNY-Binghamton*

John R. Z. Abela, Professor of Psychology at Rutgers University, died in his home in Manhattan from sudden cardiac arrest on June 18, 2010. John was a scholar and a gentleman. His passing is a tragic loss not only for his friends and family, but for the field of depression research as a whole. John was only 39 years old when he died. Only 2 weeks earlier, he celebrated his birthday with friends and colleagues at the World Congress of Behavioral and Cognitive Therapies in Boston. Indeed, at a symposium he co-chaired regarding psychosocial vulnerabilities to depression in youth, the entire audience sang Happy Birthday to celebrate. Despite this young age, John had already made a significant impact on the field of depression research, particularly in the area of cognitive vulnerabilities to depression among youth.

John attended Brown University and received his Bachelor of Arts in 1993. From there, he matriculated from the University of Pennsylvania with his master's and doctorate in 1995 and 1999, respectively. He completed his clinical internship at McLean Hospital/Massachusetts General Hospital. He joined the ranks of academic clinical psychology at McGill University in 1999. In 2008 he moved to Rutgers University. John made a significant impact on knowledge in depression and clinical science and published over 70 empirical articles. He also published many chapters and co-edited two books.

Numerous organizations recognized the impact of John's research. He received the 2003 President's New Researcher Award from ABCT as well as early career/young investigator awards from the National Alliance for Research on Schizophrenia and Depression and the Canadian Psychological Association.

John's research focused on several areas regarding the role of cognitive vulnerability to depression in youth. First, he investigated the ages at which cognitive vulnerabilities most strongly serve as risk factors for depression in children. In this vein, he developed the "weakest link" theory that various cognitive vulnerabilities should not be considered in isolation, but rather that a child may be as vulnerable to depression as his or her most negative domain of negative cognition. With this work, he showed that children as young as 6 years old may exhibit cognitive styles that confer risk for later depression. Translating this work into practice, John went around the world teaching others CBT techniques from the Penn Prevention Project with Martin Seligman, Jane Gillham, and others, to reduce depression risk. Last, John was most recently interested and investigated cultural influences on depression risk.

John was an avid traveler. He loved China and was focused on understanding potential reasons underlying the increase in rates of depression occurring in recent years. John applied cognitive models of depression and integrated them with a cross-cultural model to understand the universality and cultural specificity of risks to depression among Chinese youth.

John was engaged in and completing four large-scale, longitudinal research projects at the time of his death. The first is a two-site, multiwave longitudinal study of approximately 350 adolescents who have been followed from an initial assessment, when ages 11 to 14, for 6 years to ages 17 to 21. The purpose was to examine the emergence of sex differences in depression during the transition from early to middle adolescence as well as the surge in depression rates during the transition from middle to late adolescence. The second is a 3-year, multiwave longitudinal study of 750 3rd, 6th, and 9th graders across two sites, examining genetic, cognitive, and interpersonal vulnerabilities to depression throughout childhood and adolescence. The third is a 3-year multiwave longitudinal study of 900 10th graders in both urban and rural China, examining the relationship between cultural beliefs, cognitive vulnerability factors, interpersonal protective factors, stress, and depressive symptoms/episodes. The last is a 1-year multiwave longitudinal study of 1,000 2nd and 3rd graders in Changsha, China, and Milan, Italy, examining consolidation, emergence, and stabilization of cognitive vulnerability to depression in childhood.

In addition to his tireless research efforts, John devoted his considerable energies and talents as a dedicated mentor and teacher. He was an outstanding teacher and won several awards while at McGill. His current and former graduate and undergraduate students provided exceptional comments, all of which highlight his enthusiasm and perspicacity. His students also relished how he encouraged their ideas and gently supported them to refine and polish their work. Finally, John's students all loved him dearly on a personal level, and they speak of a mutual respect between student and teacher.

Finally, John's death represents a significant loss to his family and friends. John loved life and shared his enthusiasm with those around him. He had amazing wit and a mischievous sense of humor. He was a dedicated patron of the New York theaters. Indeed, John chose to live in Manhattan so that he could more easily attend all the musicals he loved so much. John frequently told those around him how much they meant to him. Those of us who knew and loved John also knew how very much he appreciated having us in his life. John was happy and enthusiastic, and he died doing what he most loved—analyzing data and writing a new manuscript. John is survived by his partner Hubert, his dog Adler, his mother, sister, brother, stepsister, and stepbrother, as well as his truly appreciative students, colleagues, and friends.

The John R. Z. Abela Memorial Fund

Friends and colleagues of Dr. Abela have created a John Abela Memorial Fund. Beginning in 2011, the ABCT Awards and Recognition Committee will accept submissions for the John Abela Student Dissertation Award. You will see details of the award in the 2011 Call for Award Nominations, located on p. 147 of this issue of *tBT*, or in the Awards & Recognition section of our website at www.abct.org). If you would like to contribute to the fund, please make your checks payable to ABCT and mention the John Abela Memorial Fund in the memo section of your check. Mail to ABCT, 305 Seventh Avenue, New York, NY 10001.

Statistics and Research Methodology at ABCT: AMASS and Beyond

Scott N. Compton, *Duke University*, and David C. Atkins, *University of Washington*

Twenty years ago, hierarchical regression and analysis of covariance were the established statistical methods commonly found in clinical psychology research studies. At present, these methods have largely given way to hierarchical linear models (HLM) and structural equation models (SEM), which are used in many—if not most—research studies. This should not be surprising; for in the same way that clinical methods evolve and change with the accumulation of new knowledge, a similar process occurs within statistics and research methodology. However, postgraduate training in statistics and research methods pales in comparison to the postgraduate clinical training opportunities available to clinical researchers.

For more than two decades, ABCT has attempted to meet the ever-widening gap by offering a series of workshops during its annual conference that focus on topics related to statistics and research methodology. These workshops, known as the Advanced Methodology and Statistics Seminars (AMASS), are presented by nationally renowned statisticians, clinical trialists, and research methodologists. Topics covered in past AMASS workshops include longitudinal data analysis, meta-analysis, clinical significance, causal modeling, taxometrics, and clinical trial design and monitoring, and past presenters have included Ken Howard, Phil Lavori, Don Hedeker, Tom Ten Have, Danny Almirall, Satish Iyengar, and many other ABCT members with quantitative backgrounds.

AMASS workshops offer ABCT attendees an opportunity to review core statistical techniques as well as to obtain an introduction to newer, cutting-edge statistical and research methodologies and, as can be seen from the list above, often from the people who are leading the vanguard in that area.

The primary motivation for applied researchers to stay on top of advances made in statistics and research methodology is that as our field matures, we are asking increasingly complex questions about human behavior that require more sophisticated research designs and statistical techniques. Fortunately, theoretical statisticians, biostatisticians, and epidemiologists continue to make significant progress in their respective fields. For example, biostatisticians are actively engaged in research on mediation that departs radically from the classic Baron and Kenny (1986) approach to mediation (e.g., see work by Ten Have and colleagues; Ten Have et al., 2007), and Bayesian statistical methods allow models that would not be feasible through other approaches (e.g., see Gelman & Hill, 2007). Although methods should never drive research questions, a sound knowledge of cutting-edge design and statistics can provide more appropriate analyses of research questions, as well as open up research possibilities by expanding the types of questions that can be asked. Pragmatically, a well-grounded training in statistical and research methods will lead to improved research designs, the appropriate use and interpretation of statistical models, and, perhaps most important, more rapid advances in our field.

Despite the importance of this information and the excellence of past presenters, attendance at AMASS workshops has been highly variable. Possible reasons for this variability include (a) competition with more clinically oriented workshops/presentations offered at the same time and (b) AMASS offerings that are not meeting the broader needs of the ABCT membership.

Given that organizers of the AMASS series have some control over the latter reason, we recently completed a web-based survey to identify statistical and methodological topics that have the most appeal among those ABCT members who completed the survey. Here we present findings from this survey, address a frequent misunderstanding about AMASS sessions, and introduce the creation of a new Special Interest Group (SIG) devoted to Clinical Research Methods and Statistics.

The AMASS survey was advertised via email to ABCT members and completed by 106 members in March 2010. Respondents were asked to indicate their level of interest in a variety of topics in statistics and research methodology. Although the overall response rate is low relative to the total membership of ABCT, AMASS sessions clearly have a more focused audience within ABCT compared to general clinical offerings, and the data provide a preliminary view toward the needs and interests of ABCT members around statistics and methodology. Survey topics were generated to cover a broad range of areas, including (a) introduction to advanced statistics/methods, (b) review of core statistical topics, and (c) introduction to newer, cutting-edge statistics and research methods. In addition, respondents were asked about whether they had attended an AMASS workshop in the past and their current professional status. Finally, respondents could provide open-ended comments or concerns about past and future AMASS workshops. (Our sincere thanks to Scott Baldwin and Bob Gallop for help constructing the survey and to Jackie Holmes for constructing the survey itself.)

Of the 106 ABCT members who completed the survey, 64% had never attended an AMASS workshop in the past (a somewhat surprising finding), 59% identified themselves as a psychologist/professor, 27% as a graduate student, 13% as a postdoctoral fellow, and 1% as other. The results from this survey are presented in Figure 1. Each topic was rated on a 4-point scale (1 = *not at all interested* to 4 = *very interested*). As Figure 1 shows, respondents expressed the most interest for workshops focused on HLM for continuous and nonnormal outcomes, power analyses, longitudinal mediation, missing data, and SEM approaches (including basic methods and more advanced topics like growth mixture models). From our perspective as applied methodologists and teachers, this list comprises topics that researchers will commonly face in their data analyses and grant writing, which is precisely what AMASS sessions would hope to target.

The results from this survey informed this year's AMASS offerings. AMASS 2010 will offer two 4-hour workshops: Applied Longitudinal Data Analysis With HLM (Presenter: Dave Atkins, Ph.D.), and Applied Structural Equation Modeling (Presenter: James Henson, Ph.D.). A change for this year's AMASS offerings is that both sessions will be offered on the Thursday (preconference day) of the conference. See the conference schedule for further details.

One frequently asked question by ABCT members about AMASS workshops is whether continuing education credits

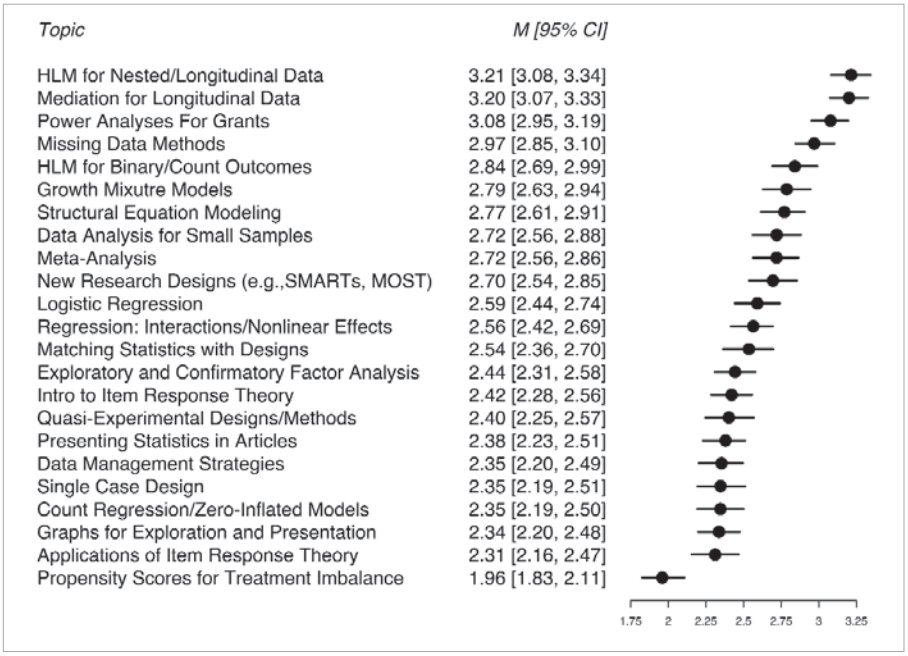

Figure 1. Results of the AMASS Survey

(CEUs) are given to those who attend an AMASS workshop. The answer to this question is unequivocally yes. We hope that clarifying this misunderstanding will encourage more people to attend this year's informative workshops, as well as others in the future.

Finally, we would like to take this opportunity to announce a new SIG that is likely to be of interest to those who attend AMASS workshops and to ABCT members who are quantitatively inclined. The new SIG, "Clinical Research Methods and Statistics," aims to provide a resource and forum for clinical researchers to promote discussions on clinical methodology broadly defined, including topics within statistics, research design, and quantitative measurement. Like other SIGs within ABCT, the Clinical Research Methods and Statistics SIG will promote discussion between its members via listserve, newsletter, and sponsoring sessions at ABCT's annual conference. Our inaugural meeting of the SIG will be at this year's conference, where many of the foundational decisions for the SIG will be made. Please come and get involved in this new start-up. Individuals who might be interested in joining should contact Dave Atkins (datkins@u.washington.edu) or Scott Compton (scompton@duke.edu).

We are fortunate to be part of an organization that values and is committed to facilitating the translation of new statistical methods and research designs into current clinical and applied research practices. We hope that you too will take advantage of the opportunities offered by the AMASS series. We have exciting lineups for ABCT 2010 in San Francisco, as well as for the following year, 2011, in Toronto.

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At ABCT

The ABCT Convention Workshop Proposal Submission Process: Frequently Asked Questions

Jillian C. Shipherd, *VA Boston Healthcare System, National Center for PTSD,* and *Boston University*

As the current chair of the Workshop Committee, I receive a lot of questions about the process of getting a workshop accepted into the convention. The workshop submission deadline is earlier and the review process is different from other conference submissions.

What is a workshop?

A workshop is a 3-hour presentation, typically presenting an overview of a treatment. Conference attendees must purchase tickets to attend workshops.

How do I propose a workshop?

To propose a workshop, send a 250-word abstract and CVs of all presenters to jillian.shipherd@va.gov. There is a template for the abstract. To view the format for submitting a proposal, go to ABCT's convention website at www.abct.org/conv2010. Click on "How to . . ." and then click FAQ → Worshops. The deadline for submissions is February 1, 2011.

How quickly are decisions made?

We try to send out acceptance and rejection emails by early March, prior to the regular conference submission deadline.

How competitive is the selection process?

We receive 50 to 80 proposals each year. We are able to accommodate about 20 workshops.

How are workshops evaluated?

Our primary goal is to select workshops that will be of interest to ABCT conference attendees. We use data from the past sev-

eral years on attendance numbers at all workshops to guide these decisions. If we are considering repeating a workshop, we also look at participants' evaluations of workshops, selecting those that were highly rated in the past. We also take into account how well the submissions fit the conference theme. And of course, consistent with ABCT values, treatment approaches must have empirical support.

The trickiest part in putting together a program of workshops is creating balance among various topics. We strive to cover a wide variety of therapy approaches, psychological disorders, and age groups. We often get multiple strong submissions for very similar workshops, particularly for anxiety disorder treatments and couples treatments, but we can only select one or two. Popular previous workshops are often repeated, but we like to offer new workshops as well.

Finally, we work with the rest of the Program Committee to balance possible workshops with offerings for institutes and the master clinician series. With so many fascinating potential topics, the Program Committee makes every effort to create a program that will offer something for everyone. We work together through meetings at the annual convention, conference calls, and lengthy e-mail discussions to develop an enticing program.

Are there particular topics that you are looking for?

Many states require continuing education units in ethics to maintain licensure, so we try to offer a workshop that will fulfill those requirements. We also look for workshops on newly developed treatments and approaches with culturally diverse populations. If you have an idea for a workshop, send in a proposal.

What experience level should I propose?

There are 3 levels of audience familiarity with the content. Please specify in your submission what level audience member you are seeking to attract (see options below):

Basic—casual familiarity with topic area e.g., treated one case

Intermediate—working knowledge of topic area e.g., treated a few cases

Advanced—known locally for expert knowledge e.g., regularly carrying several of these cases

Do you ever invite presenters for workshops?

Yes. In the Program Committee meeting at the convention, we begin to develop a list of topics that we would like to see presented at the following conference. If we do not have an appropriate proposal, we extend invitations to possible presenters.

How do I submit a proposal for a master clinician series or an institute?

You don't. Master clinician series (a 2-hour format limited to 40 participants) and institutes (a 5-hour format) are by invitation only. Workshops serve as the "gateway" to these other formats. The most successful workshops (large enrollments and high evaluations) are invited to present in these formats. If you would like to be considered for other formats (institute or master clinician) you can specify this in your email with your workshop submission.

Are workshop proposal reviewers blind to the presenters?

No. We want to know who the presenters will be. Our most popular workshops are often presented by well-known scholars.

Are workshop presenters paid?

Up to two presenters can receive free conference registration. We do not reimburse travel expenses, provide accommodations, or honoraria.

Where can I go for more information?

Feel free to contact me via email at jillian.shipherd@va.gov with any additional questions or snail mail at: Jillian Shipherd, National Center for PTSD, Women's Health Sciences Division (116B-3), VA Boston Healthcare System,150 South Huntington Ave. Boston, MA 02130

Classified

Classified ads in tBT are only $4.00 per line. Send your copy to sschwartz@abct to receive a free price estimate.

THE TRAUMA AND ANXIETY RECOVERY PROGRAM, EMORY UNIVERSITY SCHOOL OF MEDICINE, PSYCHIATRY, seeks a postdoctoral fellow to serve as the study therapist on an NIMH grant investigating exposure therapy in the ER following trauma. Evening and weekend shifts are required. Requirements: PhD in Clinical Psychology, experience in research, exposure therapy and PTSD desired. Send CV, letter of interest, and four letters of recommendation to Barbara O. Rothbaum, PhD, 1256 Briarcliff Road, Atlanta, GA 30322

Call for

WORKSHOP SUBMISSIONS

46th Annual Convention | November 10–13, 2010
Toronto

Please send a 250-word abstract and a CV for each presenter to:

Jillian C. Shipherd, Ph.D.
National Center for PTSD, 116B-3
150 S. Huntington Avenue
Jamaica Plain, MA 02130-4817
email: Jillian.Shipherd@va.gov

For information on the workshop selection process, please see the Frequently Asked Questions section of the ABCT Convention page.

DEADLINE for submissions: February 1, 2011

Convention 2010

Getting Ready for San Francisco! The City by the Bay

Kate A. Kaplan, Jennifer C. Kanady, Adriane M. Soehner, Allison G. Harvey,
ABCT, Local Arrangements Committee

We're getting excited about our ABCT conference coming to San Francisco, November 18-21. Don't forget to book your flights, hotel, and register, as this is going to be an amazing conference. Do make sure the Saturday-night party is in your calendar. Music starts at 9:00 P.M. Below we hope to whet your appetite and stir you into action and planning mode for the conference of a lifetime!

San Francisco, the City by the Bay, is incredible. Particularly in November, it is world famous for its picturesque views, extraordinary cuisine, and diverse cultures. In addition to the iconic Golden Gate Bridge, Alcatraz, Lombard Street, Pier 39, and Coit Tower, San Francisco is also home to many different neighborhoods that boast unique personalities and represent the diverse population that makes up this great city. Some of the most popular neighborhoods include North Beach, San Francisco's Little Italy, best known for its checkered-tablecloth *ristorantes*, *caffes*, and delicatessens; the Mission District, home to the hipsters, with unique coffee shops, dive bars, galleries, and some of the best murals in the city; the Marina District, with an incredible night life and singles scene; the Haight, the place to go for those one-of-a-kind vintage finds; and Union Square, where the conference is located and one of San Francisco's most popular retail and cultural sites. The excitement and commotion of the city is nicely balanced with recreational parks and calming yoga studios dispersed throughout the districts.

San Francisco is home to some of the best restaurants in the country and is the center of West Coast culinary cuisine. The cuisine in San Francisco has undoubtedly been influenced by the cultural diversity of the city and San Francisco offers virtually every type of food a diner could desire. The city is littered with neighborhood restaurants and there is always a new restaurant to try. At last count, the city was home to more than 4,300 restaurants, 1 restaurant for every 179 residents. San Francisco restaurants have some of the most celebrated chefs and the wine selection is world-renowned. San Francisco is uniquely situated in the heart of one of the most important wine regions in the country, with Napa and Sonoma Valley only a little over an hour away.

The City by the Bay also has some of the most breathtaking views: the afternoon sun hitting the Golden Gate like handfuls of diamonds; the Bay Bridge at night with its lights reflecting in the water; the skyline with the Embarcadero buildings like books on a shelf; St. Ignatius, sitting on the hill, watching over the neighborhood. Carry a camera because picture opportunities present themselves frequently!

The best way to see the Golden Gate Bridge is to walk—or better yet, bike—across it. Renting bicycles is easy around the Fisherman's Wharf/Pier 39 area (e.g., Blazing Saddles; 2715 Hyde St., $32+/day) and, from there, it's a pleasant 8-mile ride past Fort Mason and Crissy Field, over the bridge, and into Sausalito. The bridge has a protected bicycle lane separate from foot and car traffic to ensure safety. Have lunch at Fish (350 Harbor Drive; 415-331-3474) in picturesque Sausalito and take the ferry or bike the 8-mile return back to the Pier. If your sightseeing itinerary takes you by Ghirardelli Square for a tour and chocolate tasting, spend a bit of time having an afternoon tea service at Crown & Crumpet (415-771-4252) next door—the decor, scones, and variety of fresh teas are the perfect way to rest weary feet after a day of walking around.

Golden Gate Park is a great place to explore if you have littler ones in tow. The newly opened California Academy of Sciences (415-379-8000) boasts a four-story rainforest, a living roof, an albino alligator, and plenty of attractions to keep children entertained. Tucked within Golden Gate Park can also be found a carousel, live bison, windmills, and the iconic "Hippie Hill," where locals still form large drum circles on any given afternoon. If you have a car, end your park day with a meal at the Beach Chalet (415-386-8439), where the western edge of the park meets the pounding surf of Ocean Beach.

The museum scene in San Francisco is wonderful, and many are located within walking distance from the conference. San Francisco's Museum of Modern Art has a great permanent collection and rotating exhibits that are sure to please modern art enthusiasts. Visit the exceptional Asian Art Museum (415-581-3500), which houses a wide variety of art from all over eastern and central Asia. And for something a bit different, try the Cartoon Art Museum (415-227-8666) to peruse their rotating collections of comics, graphic novels, and pop art.

San Francisco has a variety of exceptional restaurants that are sure to leave even the most gourmand of palates satisfied (reservations recommended). Around Union Square and the Financial District, try Perbacco (415-955-0663) for amazing pastas or Canteen (415-928-8870) for fresh California cuisine. Other exceptional restaurants in the area include Quince (415-775-8500), Café Claude (415-392-3505), and Gitane (415-788-6686). For great vegetarian fare, head to Greens (415-771-6222) at the Fort Mason Center. And for cheaper fare, try Pagolac (415-776-3234) for Vietnamese or Shalimar (415-928-0333) for Indian cuisine. A bit farther afield but easily accessible with public transit, Restaurant Delfina (415-552-4055) and the more wallet-friendly Pizzeria Delfina next door (415-437-6800) offer exceptional Italian cuisine in the heart of the vibrant Mission District.

Union Square, adjacent to our conference, has all the major stores and brands found in any metropolitan U.S. city, and the Westfield Shopping Center on Market St. contains many of them. For a day of more local San Francisco shopping, head to Hayes Valley (Hayes St. between Webster and Franklin Sts.) for small boutiques, local designers, and charming gift stores. Have a casual lunch or a glass of wine in the shaded backyard patio at Arlequin Café (415-626-1211) and don't miss the Bay Area's hidden gem, Blue Bottle Coffee (315 Linden St.), for a caffeinated treat.

The Mission District of San Francisco is a wonderful place to spend an afternoon. For shopping with a slightly edgier vibe, try Valencia St. (between 16th and 21st streets)

for paper goods, curio shops, local artwork, and clothing stores. Don't miss the murals in and around the Mission District—Balmy Alley and Clarion Alley are two exceptional thoroughfares with vibrant murals on every garage—and you won't want to forget your camera as you stroll past the artwork. For a cheap and delicious lunch, try a burrito at any one of numerous Mexican restaurants in and around the area (El Farolito has numerous locations in the Mission district; this author enjoys their super grilled chicken burritos).

Getting to and Around San Francisco

The San Francisco International Airport (SFO) is highly accessible from most U.S., Canadian, or international cities, with direct flights available from many locations. The airport houses three terminals (1, 3, and International), with domestic flights arriving at Terminals 1 and 3. A free tram, the AirTrain, runs between the terminals, parking garages, a rental car center and public transportation.

SFO is 13 miles south of San Francisco city center and 14 miles from the conference site. There are several convenient and comfortable ways of travelling to and from the airport. From SFO, one can take the BART rapid train service directly into San Francisco. BART is easily accessed from any terminal by riding the AirTrain to the Garage G/BART Station stop. The BART trip from the airport to the city takes 15 to 30 minutes (depending on your destination) and costs about $8. To get to the conference, one can take BART to the Powell St. station, which is approximately 8 minutes walking distance from the Hilton San Francisco Union Square.

Taxis are available at the arrivals/baggage claim level of all terminals. They depart from designated zones located at the roadway center islands. Depending on traffic, the taxi ride from the airport to the city takes about 20 to 40 minutes and typically costs between $30 and $45. Up to five people can ride for the price of one.

Other transportation options for SFO that require reservations include: vans and shared-ride vans, limousines, rental cars and charter bus operators.

Transportation in San Francisco is rather effortless, as BART and MUNI are easily accessible, inexpensive, and will take you just about anywhere you need to be. Walking and biking are also common and the weather in November is perfect for being outdoors. Fall in San Francisco is arguably the best time of year for weather. Rainfall is rare, the fog has cleared; November days are warm and sunny and November nights are mild and cloud-free.

We look forward to welcoming you to the Bay Area! Don't forget to make it back to the party on Saturday night. It's one not to be missed!

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Correspondence to Allison G. Harvey, Ph.D., The Golden Bear Sleep and Mood Research Clinic, Department of Psychology, UC-Berkeley 94720; aharvey@berkeley.edu

Nominations for ABCT Officers: Get Into Choosing the Leaders

Raymond DiGiuseppe, *St. John's University*, *Chair, Leadership and Elections Committee*

We are quickly approaching the period for nominations for ABCT's elected leadership positions. Any professional organization is only as strong as its members' participation. This association belongs to all of us and the selection of leaders is among the most important task that members can accomplish. Please take ownership of your association and take part in the leadership selection process. Make this the year you take steps to guide your professional home and make a contribution by running for office or taking an active role in selecting the leaders. If you ask members who have previously served in an ABCT office, you will find that many share similar reasons for participating in the leadership: They wanted to make a difference, and they did. So could you or someone you know. In addition to the inherent satisfaction achieved from contributing to ABCT, you have the opportunity to develop new friendships while reconnecting with old ones.

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. Those members who receive the most nominations will appear on the ballot. In April, full and new professional members in good standing vote for the candidates of their choice to serve for 3 years. The President-Elect serves in that function from 2011 to 2012, then as President from 2012 to 2013, and then as Past President from 2013 to 2014. Each representative serves as a liaison to one of the branches of the association. The position of Representative-at-Large serves as the liaison to the Membership Issues Coordinator. This representative will review, develop, and maintain activities that service and support the members of ABCT. All full members in good standing are eligible to be nominated, and there is no limit to the number of members you can nominate for either position. A very thorough description of each position can be found in ABCT's bylaws, which you can access at www.abct.org/docs/Home/byLaws.pdf.

Electioneering starts to occur at the annual convention. So if you are interested in running for office, or you have a candidate in mind, it is important that you go to the annual convention and start making your case to the electorate.

Nominating a candidate is very easy. Nomination ballots will be posted on our web page, printed in *the Behavior Therapist* (in this issue and in the Winter and January issues), and will be available at the convention.

How to Nominate: Three Ways

- ➔ Mail the form to the ABCT office (address below)
- ➔ Fill out the nomination form by hand and fax it to the office at 212-647-1865
- ➔ Fill out the nomination form by hand and then scan the form as a PDF file and email the PDF as an attachment to our committee: membership@abct.org.

The nomination form with your original signature is required, regardless of how you get it to us.

Good governance requires participation of the membership in the elections. ABCT is a membership organization that runs democratically. We need your participation to continue to thrive as an organization. Thank you.

NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals for the positions indicated:

PRESIDENT-ELECT (2011–2012)

_____

_____

REPRESENTATIVE-AT-LARGE (2011–2014)

_____

_____

NAME (printed)

_____

SIGNATURE (required)

_____

2011 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2011, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send this nomination form to Raymond DiGiuseppe, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.

Convention 2010

RRT *San Francisco*

Research Round Tables

Program Chair John Otis Announces ABCT Research Round Table Discussion Groups

Have you ever wanted to consult with a leader in your field on a grant idea, dissertation topic, research methodology, or paper? In an effort to facilitate communication among ABCT members interested in research, this year ABCT will be featuring a special new event, Research Round Table (RRT) discussions. The RRT is not a lecture or presentation; it is an opportunity for you to talk face to face with leaders in your area of research and to receive feedback and suggestions on your research ideas. The RRT will also be an opportunity to hear what others are doing and learn about cutting-edge research.

Based on the results of the Survey Monkey survey conducted among ABCT members, a number of research areas were identified that members were interested in focusing on during the RRT discussions. Some suggestions include research discussions on Acceptance and Commitment Therapy, PTSD, adult and child anxiety, parenting, obesity, health psychology, substance abuse, effectiveness research, older adults, and couples, to name just a few categories. The RRT is open to anyone who wants to attend, but seating will be limited so it suggested that you arrive a few minutes early. We will have experts and leaders in many fields ready to offer their help and suggestions.

Check the ABCT addendum for the specific topics that will be covered during the RRT meetings and for time and place.

Some of the most useful Convention experiences occur in the hallways.

Things to Do Now, Things to Do Soon (Pertaining to the Annual Convention)

- ***Renew*** your membership for 2011
- ***Register*** by October 15 for the great pre-registration rates
- ***Determine*** your Convention activities by using the online Itinerary Planner. You can Search by keyword or presenter. You can Browse by day and time.
- ***Learn*** from all the generations of the behavioral and cognitive therapies: from the founders to the third wave.
- ***Network*** at SIG meetings and social hours. Remember that just about everyone you will be seeing at the San Francisco Hilton will be attending the Convention. ABCT is using every inch of meeting space, so feel free to chat with other attendees – on the elevator, on the Starbucks line, or at the Lobby Bar. Some of the most useful Convention experiences occur in the hallways. Dance the night away at the Saturday evening party. A fabulous d.j. will be providing music, you and your friends provide the action.

17th Annual Awards & Recognition

Call *for* Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shelley Robbins of Holy Family University, is pleased to announce the 2011 awards program. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category.

Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Outstanding Contribution by an Individual for Clinical Activities

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, and Jacqueline Persons. Complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Clinician, 305 Seventh Ave., New York, NY 10001.

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include the Clinical Psychology Program at SUNY Binghamton, The May Institute, the Program in Combined Clinical and School Psychology at Hofstra University, and the Doctoral Program in Clinical Psychology at SUNY Albany. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

Student Dissertation Awards:

- **Virginia A. Roswell Student Dissertation Award ($1,000)**
- **Leonard Krasner Student Dissertation Award ($1,000)**
- **John R. Z. Abela Student Dissertation Award ($500)**

Each award will be given to one student based on his/her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor may complete the nomination. Self-nominations are also accepted. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holyfamily.edu. Please include an e-mail address for both the student and the dissertation advisor. Also, mail a hard copy of your submission to ABCT, Student Dissertation Awards, 305 Seventh Ave., NY, NY 10001.

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Jon Kabat-Zinn, Nora Volkow, John Allen, Anne Fletcher, Jack Gorman, Art Dykstra, Michael Davis, and Paul Ekman. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Albert Ellis, Leonard Krasner, Steven C. Hayes, David H. Barlow, and G. Alan Marlatt. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

NOMINATIONS FOR THE FOLLOWING AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

Outstanding Service to ABCT

Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to srobbins@holyfamily.edu. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

Questions? Contact: Shelley Robbins, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: srobbins@holyfamily.edu

Nominate on line: www.abct.org
Deadline for all nominations:
Monday, March 1, 2011

the Behavior Therapist
Association for Behavioral and Cognitive Therapies
305 Seventh Avenue, 16th floor
New York, NY 10001-6008
212-647-1890 | www.abct.org
ADDRESS SERVICE REQUESTED