President’s Message

Michelle G. Craske, UCLA

I AM EXTREMELY HONORED and excited to be President of ABCT. I look forward to the coming year where we will be working on a number of important initiatives and of course celebrating our 50th anniversary at the Annual Convention. The Board of Directors has been working diligently on enacting the ABCT strategic plan from the September 2013 meeting. I will use the opportunity offered by this presidential column to provide updates on the strategic plan over the months to come. But here, I would like to introduce you to the main elements of the plan. ABCT is a multidisciplinary organization whose mission is to enhance health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through behavioral, cognitive, and other evidence-based principles. Our core values are science, quality, diversity, mentorship, and accountability. The strategic plan includes five primary strategic initiatives. These are (1) member community and value, with the goal of enhancing membership and membership satisfaction; (2) dissemination, through means such as clinical guidelines, resources that translate research into practice, and engaging health-care practitioners and directing them to evidence-based practices; (3) outreach, which includes building media relations and public education; (4) funding, or working to increase funding opportunities for CBT research; and (5) technology upgrades for membership and the ABCT infrastructure. Some of these initiatives...
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may be fueled by collaborations with like-minded organizations in order to drive favorable policy outcomes. Alongside these initiatives, changes have been happening in our association governance to ensure that roles are clearly delineated, and responsibilities are well understood and fulfilled, so that the mission and strategic initiatives of ABCT can be carried out in the most effective way possible. I am confident that our organization is on track and moving forward in a strategic direction.

My own mission as President is to maintain ABCT as a leader in the field and to support our goals and objectives. We must continue to foster awareness of cognitive and behavioral therapies to increase their acceptance and impact, augment funding for CBT research, and expand access to CBT through training, dissemination and implementation. I strongly believe that increased public and practitioner acceptance of and access to CBT goes hand in hand with continuing research efforts aimed at improving the outcomes from our therapeutic methods. This is essential because there is an upper limit on effectiveness on existing CBT, with clinically meaningful response rates hovering around 50% in the case of anxiety and depression as an example. I believe we can develop more effective cognitive and behavioral methods by advancing our understanding of the mechanisms underlying psychopathology and the mechanisms underlying therapeutic change—this information will inform more mechanistically targeted cognitive behavioral methods that offer more efficient and potent impact on more precise targets. I also believe that knowledge of the mechanisms that explain response to one particular therapeutic strategy relative to another will allow us to more effectively personalize specific cognitive and behavioral strategies to the needs of a given individual, which in turn will improve outcomes. I further believe that our understanding of underlying mechanisms will be advanced by greater integration between cognitive-behavioral science and neuroscience. Neuroscience provides complementary methods and models that can enhance the comprehensiveness of our understanding of mechanisms relevant to psychopathology and cognitive behavioral treatments. This is not to argue for a reductionist perspective by any means, but rather to appreciate the value of neural indices as another response modality to add to our existing array of behavioral, psychophysiological, cognitive and self-report response modalities. Moreover, I see added benefits from such integration in terms of increased funding opportunities, greater engagement of early-career investigators, and encouragement of neuroscientists and other basic scientists to direct more of their attention to our essential questions: What are the factors that contribute to psychopathology and how can they be best prevented or treated? Joint efforts will enable greater strides in the development of more effective cognitive and behavioral therapies.

This vision is included within the planning for the 50th anniversary, where we will be “Honoring the Past, Envisioning the Future.” The topics that will be central to the 2016 Convention in New York City (October 27–30) include (a) neuroscience and psychological treatment, (b) cognitive science and trans-treatment principles, (c) dissemination and implementation, and (d) technology and treatment. In addition to invited symposia involving worldwide leaders in these topics, submissions around these themes will be encouraged from the membership at large. It promises to be an amazing convention, with many new and exciting features and activities.

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RESEARCH-TRAINING LINKS

How to Not Train in Vain: Recommendations for Training Community Clinicians

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OVER RECENT YEARS, THE DISSEMINATION and implementation of cognitive-behavioral therapy (CBT) has garnered increasing attention from ABCT and its inter disciplinary membership. With the 2015 Annual Convention in Chicago receiving a record-breaking 2,300 submissions under the theme of “Improving Dissemination by Promoting Empirically Supported Principles of Psychopathology and Change,” it is clear that researchers and clinicians are increasingly viewing their work with a dissemination lens. Accordingly, the Dissemination and Implementation Science (DIS) Special Interest Group (SIG; Becker, Nakamura, Young, & Chorpita, 2009), which was established in 2008 by Drs. Brad Nakamura (SIG leader), Bruce Chorpita (SIG advisor), Kimberly Becker (Treasurer), and John Young (Communications Officer), has been growing substantially—with 266 current members and 3 active subcommittees (Training Workgroup, Assessment Workgroup, and Stakeholder Liaison Committee).

Recognizing the influx of research and clinical work involving the delivery of CBT within service settings, the topic of strategies for training community-based clinicians in CBT has become a frequent discussion point among DIS SIG Training Workgroup members. From these discussions, a common theme that emerged was members’ desire to have known about such strategies before conducting their own community-based trainings. Thus, utilizing the collective experiences and expertise of the DIS SIG Training Workgroup, we have compiled the following general recommendations, which we humbly offer to the ABCT community with the hope that
they will facilitate further advances in the dissemination of CBT.

**Conceptualize Training as Professional Development and Support**

Broadly speaking, our jobs as trainers are to assist others in the pursuit of their goals of improving the well-being and reducing the psychological distress of those seeking mental health services. Accordingly, training is not simply a matter of a trainer or expert teaching a clinician an abundance of new material, but rather involves trainers working in the service of clinicians to help them do their work better. That is, trainers have the opportunity to help clinicians avoid getting stuck, burned out, and discouraged, or “leveling off” in their professional growth. Although some of this training mission can be accomplished through teaching specific competencies, it also means understanding the broader context in which services are delivered and the challenges to implementation that clinicians face. By doing so, trainers can help to establish a culture of learning orientation, openness, enrichment, and a willingness to try new things in the pursuit of professional excellence.

**Meet Clinicians Where They Are in Terms of Their Current Needs and Strengths**

Traditionally, training in evidence-based treatments (EBTs) has followed a one-size-fits-all approach, with standardized workshops conducted by treatment developers being the norm. However, clinicians enter trainings at a variety of developmental stages in terms of EBT knowledge and attitudes, training background, level of motivation, and more (Chorpita & Daleiden, 2014). Thus, just as there is value in personalizing EBT delivery to address clients’ individual differences (e.g., cognitive capacity, behavioral patterns, treatment history, comorbidity; Lau, 2006; Stirman, Miller, Toder, & Calloway, 2013b), a parallel process of personalizing EBT training for clinicians may be similarly beneficial, especially because clinicians value trainings that are responsive to their needs (e.g., Beidas et al., 2013).

**Build Developmentally Sensitive, Flexible Training Models**

Prior to training, it is important to assess where each clinician is in her or his developmental pathway (Chorpita & Daleiden, 2014)—with the goal being to improve the fit between the training and the clinician’s current competencies and needs. For instance, if the EBT being introduced is a CBT model and the clinician already has extensive experience with CBT, an option could be offered for clinicians to skip or test out of content involving basic CBT principles. Training models should also be sensitive to common factors that may interfere with the standard training process. For example, as a backup plan, self-guided content could be made available for clinicians who miss a day of training, allowing for opportunities for them to follow up with questions. In addition, trainers should be aware of the training format that will likely optimize clinicians’ learning. For instance, Carpenter and colleagues (2012) found that real-time feedback better enhanced motivational interviewing skills in clinicians without a graduate degree, whereas supervision using tape review was more likely to improve motivational interviewing skills in graduate-level clinicians.

**Allow Clinicians to Contribute to the Design of the Training**

Training is an interactional process that, at best, incorporates the strengths of all parties involved (e.g., treatment developers, trainers, clinicians, supervisors, agencies). In addition to building developmentally sensitive and interference-resistant models, as described above, trainers should collaborate with clinicians to understand their current approaches to treatment and training goals and to develop a plan to use training resources to reach those goals. A modular training framework (see Chorpita, Daleiden, & Weisz, 2005), for instance, maximizes learning by allowing clinicians to choose training content that will enhance their developing skill set (Chorpita & Daleiden, 2014). Importantly, when utilizing a flexible training infrastructure such as a modular framework, training outcomes should be routinely tracked and monitored to ensure that training is progressing as expected (for instance, on a Therapist Portfolio as in Managing and Adapting Practice [MAP]; Southam-Gerow et al., 2014). Additionally, efforts should be made to identify and address any concerns that clinicians may have about the training. This process, similar to assessing barriers to treatment—an evidence-based engagement strategy that promotes treatment attendance (Becker et al., 2015)—is likely to foster clinician buy-in during the training process. The concept of incorporating clinician feedback into decisions about their training is also consistent with the broader principles of community-based participatory research, an emerging model that focuses on improving health care outcomes through bidirectional learning between researchers and local stakeholders (see Wallerstein & Duran, 2009, for an overview).

**Consider Differences Between Community Clinicians and Graduate Students/Postdocs**

Researchers leading trainings in EBTs should be aware of community-based clinicians’ day-to-day responsibilities and training goals as well as the practicalities of delivering EBTs in service settings. For example, as compared to clinicians in research contexts, it may be unrealistic to expect clinicians in service contexts to read training materials e-mailed on a weekend or to have time to conduct extensive preparation for treatment sessions. Relatedly, certain clinicians may not be interested in becoming an expert in CBT, but instead may be looking for tools to integrate into their practice. Preemptively identifying these types of cultural differences is likely to increase clinician engagement and to reduce misunderstandings during the training process.

**Utilize Active Training Strategies**

Although still relatively common within educational contexts, traditional passively delivered training methods, such as didactic lectures, have been shown to have limited effects on learners’ subsequent skill or behavior (Beidas & Kendall, 2010; Rakovshik & McManus, 2010). In contrast, active training strategies employ an interactive process of simulation and reflection that engages learners and builds upon their competencies (Joyner & Young, 2006). Active training strategies, such as modeling, allowing opportunities for practice, promoting confidence in one’s capacity to execute specific behaviors, and encouraging interactions among peers, have also been shown to facilitate learning, particularly when behaviors must be contextual rather than rote (Cross, Matthiew, Cerel, & Knox, 2007). Thus, for community-based clinicians who often see a wide variety of clients, active training strategies may be especially relevant and are likely to foster more successful learning outcomes (e.g., greater skill) than passive strategies such as discussion (Bearman et al., 2013).
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Model What Implementation Should Look Like

Modeling by trainers or via video recordings provides an avenue for clinicians to see what the treatment looks like in action. In addition to initiating active learning processes, modeling offers an exemplar of treatment delivery that is likely to help clinicians feel better prepared to use such practices with their own cases and to clarify misconceptions or confusion that may have developed during training—particularly if the content is new or different from other approaches in a clinician’s repertoire. Although the benefits of modeling have been studied relatively less compared with other active learning strategies such as behavioral rehearsals, modeling is featured in several successful community-based training protocols including, but not limited to, CBT for childhood anxiety (Beidas et al., 2012), cognitive therapy for depression (Stirman et al., 2012), and suicide prevention (Cross et al., 2011).

Plan for Behavioral Rehearsals

A robust literature indicates that behavioral rehearsals (often referred to interchangeably as role-plays), or simulations of specific situations in which learners practice behaviors that they are expected to carry out in a future role, are effective for enhancing interpersonal skills, competencies, knowledge, and attitudes (Cross et al., 2007). To successfully incorporate behavioral rehearsals into trainings, Joyner and Young (2006) recommend clearly stating the learning objectives and value of behavioral rehearsals, creating challenging practice cases, allowing adequate time (i.e., approximately one-third of training should be dedicated to behavioral rehearsals; Beidas, Cross, and Dorsey, 2014), involving all learners (i.e., everyone should have a chance to practice the role of clinician, client, and observer; Beidas et al., 2014), and debriefing and providing feedback about what did and did not go well after each practice opportunity. Based on the comfort level of the training group, behavioral rehearsals can also be adapted to be more or less demanding (e.g., by utilizing “hot seat” role-plays in which a volunteer practices in front of the room or group role-plays in which multiple clinicians enact each role; PracticeWise, 2015) to optimize participation and ease the minds of those who may approach behavioral rehearsals with reluctance.

Promote Peer Interaction and Collaboration

As the above suggests, each clinician enters training with her or his own therapeutic style and areas of expertise (Chorpita & Daleiden, 2014). Accordingly, although trainers may be experts in a given treatment protocol, the clinicians in the room are experts in working with the clinic’s targeted population, in understanding the needs of the clinic and their fellow clinicians, and in their own areas of study (e.g., their program of research or their experiences working with certain populations, in certain settings, with certain treatment approaches, and so forth). Thus, through collaboration among learners, clinicians can benefit from the knowledge afforded by their peers (e.g., by observing a multitude of ways for delivering a practice) and from the comfort and accountability inherent to peer interaction (e.g., Boyle & Hineline, 2002). Although peer collaboration is often accomplished through behavioral rehearsals (Beidas & Kendall, 2010), trainers can also consider small group discussions or activities (Boyle & Hineline, 2002), peer instruction (Crouch & Mazur, 2001), and peer evaluation (Eldredge, Bear, Wayne, & Perea, 2013), when possible, based on review of work samples—all of which have been shown to promote learning.

Remember That Training Is an Ongoing Process

A growing body of research suggests that while initial training may improve clinicians’ knowledge of a given treatment, training alone may not be sufficient for changing clinicians’ actual practice. Specifically, studies indicate that ongoing support is critical to influencing clinicians’ adoption of and competency in using new treatments (Beidas et al., 2012) and to promoting better client outcomes (Schoenwald, Sheidow, & Chapman, 2009). Although many terms have been used, sometimes interchangeably, to describe ongoing support after initial training, here we broadly refer to such support as supervision. It is important to note that “supervision,” which denotes support provided by a licensed superior within the existing service setting, typically differs from “consultation,” which denotes support provided to an independent professional by an outside expert who specializes in the delivery of a given EBT (Nadeem, Gleacher, & Beidas, 2013). Supervisors also differ from consultants in that supervisors are legally liable for the implementation of care whereas consultants are not. Accordingly, for those who are considering offering consultation, it is important to clarify with an organization where the legal responsibilities will fall.

Build Ongoing Support Into the Training Model

In considering how best to incorporate ongoing support for an EBT, attention should be paid to a number of factors. First, given that supervisors play an integral role in determining clinicians’ mastery of and experience with the treatment, we recommend assessing supervisors’ competencies and expertise with the treatment before and during the supervision process. This can be achieved through measuring adherence to a structured supervision protocol (as in Multisystemic Therapy; Schoenwald et al., 2009), observational coding of key skills in role-play situations (Nakamura et al., 2014), or assessing competency via evidence-based “supervisor guides” that feature common clinician goals and benchmarks (as in MAP; Chorpita & Daleiden, 2014). Second, supervision should include effective supervisory strategies, such as incorporating active learning techniques (see above) and reviewing actual practice (e.g., by watching session tapes; Dorsey et al., 2013). Third, trainers should take care not to neglect valued aspects of supervision, such as connectedness with the supervisor, authentic interactions around actual cases, and responsiveness to individual clinician needs (Beidas et al., 2013).

Consider Efficient Supervision Models

Although recent reviews on training in EBPs recommend training models that include multiple components and extensive resources (Beidas & Kendall, 2010; Rakovshik & McManus, 2010), time- and cost-effective models are key within community settings. Some models that have been recently developed with these goals in mind are train-the-trainer and peer coaching models. Train-the-trainer or pyramid models utilize “master” trainers to teach existing supervisors or skilled clinicians within the agency EBT content as well as effective teaching strategies, such as the active learning techniques discussed above. Those individuals are then responsible for training clinicians within their agency in the EBT, thereby allowing for many more clinicians to be trained in less time and with fewer resources and staff relative to that of traditional, developer-led workshops (Nakamura et al., 2014). Train-the-
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trainer models also provide a naturalistic solution for providing clinicians with ongoing support; however, it is important to remember that the agency personnel who serve as trainers will benefit from ongoing support as well. Alternatively, peer coaching models, used most frequently in education, use peer-to-peer networks to provide discussion and feedback of a program’s use (Lyon, Stirman, Kerns, & Bruns, 2011). One application of this model is the Triple P Positive Parenting Program, which guides agencies in creating supportive peer groups with rotating peer facilitators and feedback provided through case review of taped sessions (Sanders & Turner, 2005). Although evidence for the effectiveness of these models is preliminary, both train-the-trainer and peer coaching models have the advantage of using the existing workforce to provide ongoing support. Given that supportive social networks are critical to successful implementation (e.g., Glisson et al., 2008), such models have potential to improve sustainability of EBTs over time.

Consider Organizational Factors That May Affect Training

Training and eventual implementation occurs within the context of a service organization (Beidas & Kendall, 2010). That is, management decides which EBTs to adopt, supervisors determine the level of support to provide clinicians in the EBTs’ delivery, and clinicians govern the type and quality of services that clients receive—with the ultimate goal of improving the well-being and functioning of the organization’s client population. However, factors at any of these organizational levels can facilitate or hinder the implementation of an EBT within a service system. For instance, management may be unwilling to endorse trainings in EBTs that do not complement their existing treatment offerings or that necessitate additional resources (Herschell, Kogan, Celedonia, Gavin, & Stein, 2009). Relatively, supervisors may be unable to advise clinicians on the delivery of a treatment in which they have little knowledge or experience, and clinicians may be unable to attend trainings that require them to put their cases on hold, particularly if they are working at a fee-for-service clinic (Higa & Chorpita, 2008). Thus, maximizing the fit between training and an organization’s culture and climate is essential for successful dissemination and implementation.

Solicit Stakeholder Support and Advocacy

Regardless of how knowledgeable, engaging, encouraging, attractive, or funny trainers undoubtedly are, it is likely that not everyone who is enrolled in the training will actually want to be there. That said, any benefits or incentives for clinicians to participate should be stated clearly and early on in the training process (e.g., Becker et al., 2015). For example, clinicians may be more amenable to attend a training if it propels them toward one of their goals (e.g., the therapy procedures covered during training adds to their toolbox of skills) or solves a clinical problem (e.g., the treatment is indicated for some of their cases who are presently demonstrating stagnant progress; or the training provides materials or strategies that will facilitate the writing of treatment plans, case notes and other documentation; Stirman et al., 2013a).

Additionally, research indicates that clinicians are likely to be more supportive of a treatment and its associated training if it is well received by their colleagues (Nelson & Steele, 2008). For this reason, local champions may be an invaluable resource to trainers and organizations alike. A local champion is an individual within the organization who is willing to advocate for the treatment and to generate support from other members of the organization (Greenhalgh et al., 2004). Although the literature on local champions within mental health services settings is presently sparse, the increasing prevalence of local champions within service systems (e.g., for integrated dual disorders treatment, Gotham, 2006; for individual and group CBT, County of Los Angeles Department of Mental Health, 2014; and for MAP, PracticeWise, 2015) as well as the success of champion roles within other fields (e.g., community-based heart health promotion, O’Loughlin et al., 1998) suggests their promise for facilitating EBT implementation within service organizations.

Relatedly, because of their status and responsibilities within service organizations, supervisors have the ability to promote clinicians’ adherence to and competence with a given treatment, as mentioned above, and to advance the goals and objectives of the trainers (e.g., Dorsey et al., 2013). Accordingly, it is important to solicit supervisors’ buy-in as early as possible. One way to encourage supervisor support is to hold a separate training for supervisors prior to the training for clinicians and/or to invite supervisors to lend their expertise and insight both when planning for and during the actual clinician training (Stirman et al., 2010). Inviting supervisors to collaborate with trainers will not only ensure that supervisors are knowledgeable about the treatment, but will also allow supervisors to express confidence when advising clinicians on treatment implementation and assist with addressing barriers to EBT implementation.

Maximize Contextual Fit

Training within the context of a service organization requires consideration of its many moving parts. From financial expenses to staff workload and availability to resources and supports, these various organizational factors must somehow fit together to make the training and implementation of a given treatment a worthwhile endeavor. While there may not be a way to strike a perfect balance, training methods that attempt to optimize value, utility, and feasibility can be more readily accepted into service systems. For example, to reduce the financial and opportunity costs associated with comprehensive training experiences, the content from initial and/or booster trainings can be adapted and incorporated into monthly staff meetings. Alternatively, trainers and organizations can consider Internet-based training approaches to increase clinicians’ knowledge about the treatment (e.g., by offering supplemental, online training materials), to ease planning (e.g., clinicians can access training materials when it is convenient for them and on multiple occasions), and to reduce training costs (Fairburn & Cooper, 2011).

On a related note, trainers should also be conscious of the organization’s climate and structure training and their recommendations for treatment implementation accordingly. As an example, it may be unrealistic to expect clinicians at a paper-based clinic to utilize an electronic measurement feedback system after every treatment session, but it may be reasonable to offer a paper-based alternative for monitoring and tracking progress—an option that is likely to be better received by clinicians and that achieves the same goal.

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week out and those represented in the treatment literature (Garland, Bickman, & Chorpita, 2010). Indeed, research indicates that individuals seen in service settings present with more comorbidity, have more psychosocial and life stressors, are more financially disadvantaged, and are more ethnically diverse than individuals seen in research clinics (e.g., Baker, Ericzén, Hurlburt, Brookman-Frazee, Jenkins, & Hough, 2010; Southam-Gerow, Weisz, & Kendall, 2003). Given such discrepancies, trainings that anticipate the characteristics of the intended clientele (e.g., Chorpita & Daleiden, 2009) and that consider how distinct client features may impact the implementation and effects of the treatment (e.g., Huey & Polo, 2008) can facilitate clinicians’ application of the treatment protocol.

**Select Materials That Are Applicable to the Intended Consumers**

To ease clinicians’ ability to use the protocol with their clients following training, client handouts or worksheets, as well as any case examples discussed or role-played during training, should be pertinent to the service system’s client population (Hersen, Drabick, & Vivian, 2012). For example, trainers may want to consider offering handouts or worksheets in the languages spoken by the intended clientele (e.g., Chorpita & Weisz, 2012) to remove the risk of treatment principles getting “lost in translation” and to reduce the work required by clinicians to implement the intervention. In addition, trainers should use case examples that resemble the clients served by the service system (Stirman et al., 2012). As an example, when training clinicians on how to implement a rewards system, trainers may choose to incorporate suggestions of no- or low-cost rewards, such as going to the park or watching 30 minutes of TV, if the families who are typically referred to that agency or clinic cannot afford more expensive rewards (Kendall & Beidas, 2007). Advance consideration of the intended consumers of the treatment is likely to appease clinicians’ concerns about the appropriateness of the intervention for their clients and to increase their likelihood of implementing the intervention as intended (Southam-Gerow et al., 2012).

**Provide Strategies for Applying the Intervention With Complex Clients**

Regardless of trainers’ attempts to prepare clinicians to deliver the intervention with their subsequent cases, our experiences have taught us that treatment interference in the form of complex clients is almost guaranteed (e.g., Chorpita, Korathu-Larson, Knowles, & Guan, 2014). To help clinicians proceed with the treatment protocol (when appropriate) in the face of unexpected complications, trainers may want to survey clinicians to get a sense of difficult clinical situations that they have previously encountered and prepare to incorporate pertinent strategies for addressing such situations into their discussions and role-plays (as opposed to handling inquiries about implementation with complex cases with on-the-spot improvisation). Another option is for trainers to engage in a collective role-play wherein clinicians take turns acting as a complicated client and the trainer and other clinicians in the group work together to identify and practice clinician responses that manage the treatment interference while staying true to the principles of the intervention. By demonstrating the intervention’s ability to treat even the most complex cases and soliciting the collective wisdom of the group, clinicians will likely feel encouraged about the applicability of the intervention and more confident in utilizing appropriate portions of the treatment protocol if and when challenges arise. Through this exercise, they can also receive corrective feedback if a strategy they suggest in response to a challenging situation is inconsistent with the new treatment they are learning.

**Think About Treatment Fidelity Early and Often**

Treatment fidelity, or the extent to which an intervention is delivered as intended, is an important consideration in successful implementation. In addition to increasing the likelihood that study outcomes can be attributed to the intervention as opposed to its delivery (Schoenwald et al., 2011), treatment fidelity—especially clinicians’ adherence to and competence with delivering the treatment protocol—is a primary indicator of the effectiveness of training (McLeod, Southam-Gerow, Tully, Rodriguez, & Smith, 2013). Early and frequent treatment fidelity measurement and monitoring can provide important information as to whether additional training or consultation is needed (Beidas et al., 2012), lend insight into whether implementation should be more flexible, more stringent, or continue with the current pattern of delivery (Beidas, Koerner, Weinhardt, & Kendall, 2011), and increase the chances of improving client outcomes (Beidas & Kendall, 2010).

**Consider Alternative Fidelity Instruments**

Within research contexts, fidelity measurement and monitoring has typically involved observational coding of the clinical strategies employed in a given treatment session (Hogue et al., 1996). However, this approach to fidelity measurement is labor-intensive and may present considerable challenges in service systems (Garland et al., 2010). Fortunately, researchers have recently started to identify a number of suitable alternatives, including interviews (e.g., Consultation Record; Ward et al., 2013), clinician report (Session Report Form; Kelley et al., 2010; Therapy Process Checklist; Weersing et al., 2002), clinician report (e.g., Multisystemic Therapy care-giver-report of therapist adherence; Henggeler et al., 2009), and clinical and administrative records (e.g., CBT worksheets and session documentation; Stirman et al., 2015b). As each of these alternative fidelity measurement approaches has distinct advantages and disadvantages in terms of their objectivity, capacity to provide detailed information, training and resources required, and contextual fit, researchers should consult with stakeholders from the service system to determine which approach will best serve their joint needs.

**Be Specific About When and What Adaptations Are Appropriate**

Although the literature on treatment adaptations is still in its infancy, preliminary research indicates that adaptations to the treatment protocol are the norm rather than the exception (Palinkas et al., 2013; Park, Chorpita, Regan, & Weisz, 2014). Clinicians may receive training in an EBT without ever intending to fully adopt it, and may instead plan to “add to their toolkit.” Thus, it is important that clinicians understand which procedures are “core” to the treatment model and that the timing, intensity, and type of adaptations that are consistent with the protocol be clearly articulated during training. For example, while one treatment protocol may allow for “cosmetic” adaptations (e.g., having a client squeeze a ball of Play-Doh instead of simply clenching his hand into a fist when covering a progressive muscle relaxation skill), another may allow for content adaptations (e.g., omitting a worksheet that evaluates a client’s readiness to change if that client is extremely motivated
and engaged in therapy), and another may allow for sequencing adaptations (e.g., skipping a therapy practice related to the development of a rewards program if the family already has one in place). Relatedly, one protocol may prescribe adaptations when engagement is perceived to be low (e.g., Becker et al., 2015) while another may encourage adaptations in the face of stagnant or worsening treatment progress (e.g., Bickman, Kelley, Breda, Andrade, & Riemer, 2011). Similarly, protocol adaptations may pertain to culture (Huey & Polo, 2008), age (Palinkas et al., 2013), comorbidity (Orimoto, Mueller, Hayashi, & Nakamura, 2014), emergent life events (Chorpita et al., 2014), and several other factors (e.g., Stirman et al., 2013b); therefore, providing guidance for adapting the treatment protocol can not only improve client outcomes (e.g., Weisz et al., 2012), but also decrease the risk of clinicians making fidelity-inconsistent adaptations (e.g., Stirman et al., 2015a).

Conclusion

The recommendations provided here reflect strategies that the DIS SIG Training Workgroup has found to be effective in their trainings with community mental health clinicians. By sharing these ideas with the ABCT community, we hope to start conversations with other members who are encountering and thinking about these issues and to help community-based trainings become a more central part of the ABCT dialogue over time. As the ABCT Annual Convention heads to New York, San Diego, and beyond, we look forward to the advances in effectiveness research that are to come, the research-practice partnerships that are to be developed, and the training success stories that we hope will be shared.

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Nadeem, E., Gleacher, A., & Beidas, R. S. (2013). Consultation as an implementation strategy for evidence-based practices across multiple contexts: Unpacking the
Three Steps:

1. Review of education and training;
2. Submission of a practice sample; and
3. Collegial, in-vivo examination. Please note that a consulting service to support the application process is an available option and is free of charge for all candidates.

Specific requirements and online application: http://www.abpp.org/i4a/pages/index.cfm?pageID=3299

Early Entry Application: Start Early! Application fee is discounted from $125 to $25 for graduate students, interns, and residents: http://www.abpp.org/i4a/pages/index.cfm?pageID=3299

Senior Option: With 15 years of postdoctoral experience in cognitive and behavioral psychology there is flexibility in the requirement for a practice sample: http://www.abpp.org/i4a/pages/index.cfm?pageID=3299

When are Exams Conducted? Exams are conducted in different places, but are typically done at the APA (Denver 1st week in August 2016) and ABCT (New York last week in October 2016) annual conferences. This year exams can also be conducted at the ABPP conference in Chicago in early May 2016. Other exams can be arranged in other locations on a case-by-case basis.


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TECHNOLOGY UPDATE

Clinicians’ Attitudes and Experiences Regarding Telemental Health Services

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REMOTE CLINICAL SERVICES, or the delivery of services by telephone, videoconference, or the Internet, are emerging modes of communication in the behavioral health community. Professionals may utilize remote methods to offer psychological assessment, psychotherapy, support, case management, and life coaching to patients. Clinicians also train and supervise other mental health professionals using remote methods. Remote clinical services include: (a) telephone-based delivery, such as calls and texts; (b) video web-based services such as videoconferencing; (c) nonvideo web-based delivery including chat rooms, free-standing websites, and email; and (d) dedicated Internet connections that connect individuals directly and exclusively to clinicians. Evidence suggests that remote clinical services increase client access to specialized care, reduce costs, and increase convenience (Nelson, Bui, & Velasquez, 2011). Remote services have been shown to be effective across many populations and settings (Hilty et al., 2013). Notably, patients tend to report comparable treatment satisfaction and ratings of therapeutic alliance relative to face-to-face services (Jenkins-Guarnieri, Pruitt, Luxton, & Johnson, 2015).

Despite preliminary evidence of effectiveness, and enhanced capabilities of current technologies, prior research suggests low rates of utilization of remote technologies to deliver behavioral health services (Mora, Nevid, & Chaplin, 2008; Wells, Mitchell, Finkelhor, & Becker-Blease, 2007). For example, Wells and colleagues (2007) found that only 2% of the 2,098 mental health professionals surveyed reported using the Internet to provide therapy. This survey, however, did not assess whether mental health professionals used remote therapy tools as adjuncts to in-person treatment (e.g., telephone sessions in addition to face-to-face sessions). Negative clinician attitudes towards remote treatment may be one barrier to adoption of such services (Mora et al., 2008; Perle et...
Multiple Sclerosis

Pearl B. Werfel / Ron E. Franco Durán / Linda J. Trettin

Multiple Sclerosis

Advances in Psychotherapy—Evidence-Based Practice, Vol. 36
US $29.80
(Series standing order price US $24.80)
ISBN 978-0-88937-409-6

Comprehensive, practical, concise, and up-to-date guidance on the most effective medical, psychological, and neuropsychological diagnostic methods and interventions with multiple sclerosis (MS)

This innovative book will help both mental health and medical professionals empower patients or clients to live well with multiple sclerosis (MS). It is a practical, evidence-based, culturally relevant guide to the most effective current medical, psychological, and neuropsychological diagnostic methods and interventions. The book describes a biopsychosocial, multidisciplinary, and integrative approach to treatment and provides information on psychological, mind-body, and complementary interventions for symptom management and to increase quality of life. Both seasoned practitioners and students will find this volume useful in helping clients cope with this complex, unpredictable, and chronic neurological disorder.

“Multiple sclerosis and its sometimes subtle symptoms present unique challenges to carers and mental health providers. This book provides an excellent guided tour into its symptoms and long term course of multiple sclerosis, as well as medical background relating to diagnosis and treatment. It will help any mental health professional provide better care for those with MS.”

John Schafer, MD, FAAN, Director, Mercy MS Center, Sacramento, CA, Medical Director, MS Achievement Center, Citrus Heights, CA
The popularity of technological tools is increasing rapidly; reports indicate that the percentage of American adults who owned a smartphone increased from 31% in 2011 to 57% in 2013 (Kakihara, 2014). Similarly, 71.7% of American households reported accessing the Internet in 2011 (File, 2013). In 2013, this percentage increased to 74.4% (File & Ryan, 2014). Significant changes in both attitudes and actual use may have occurred in response to the rapid development of remote technologies and the growth in access to cell phones, computers, and other remote platforms over the past decade. To our knowledge, no study has examined in detail the particular ways in which clinicians currently use remote treatment services, including which specific issues are treated and in which settings, and the differential use of these services as stand-alone versus adjunctive treatments.

We administered an online survey to a national convenience sample of behavioral health professionals to address three aims: (a) provide a comparison between clinicians who have versus have not used remote treatment services of the perceived challenges and benefits of these services; (b) conduct a survey of clinicians’ understanding of the legal status of using remote telemental health services; and (c) assess how these various technologies are being used (e.g., only within states in which clinicians are licensed versus in states in which clinicians are not licensed; by billing through insurance or fully out-of-pocket), and the type of settings in which they are most commonly employed.

Method

Participants

After obtaining Institutional Review Board approval, participants were recruited through professional listservs and mailing lists associated with state, national, and international behavioral health provider organizations. The listservs included the following: Association for Behavioral and Cognitive Therapies (ABCT), Society for a Science of Clinical Psychology (SSCP), Academy of Cognitive Therapy, Counselor Education Listserv (CESNET), and Association for Contextual Behavioral Science (ACBS). Advertisements were posted on the listservs inviting interested professionals to participate, and provided a link to the online survey. Participants who completed the survey were given the opportunity to enter a drawing to win a $10 Amazon gift card (1 in 10 chance). The contact information was delinked from participants’ survey responses to ensure confidentiality.

Participants were self-identified practicing behavioral health clinicians. Eligibility required (a) being 18 years of age or older, (b) an education level of active graduate student or beyond, and (c) fluency in English.

Procedure

After clicking on the link embedded in the invitation email, participants were presented with a screen of instructions regarding the voluntary and confidential nature of their participation, anonymity, the time commitment (approximately 15 minutes), and information about the drawing. By clicking to the next screen, participants provided consent for enrollment. It was not possible to quantify how many individuals were reached through the email invitation, so response rate is unknown. All procedures were performed in compliance with relevant laws and institutional guidelines, and the research was approved by the Drexel Institutional Review Board. The procedures followed were in accordance with the Helsinki Declaration of 1975, as revised in 2000.

Survey

The survey consisted of basic demographic items including primary clinical orientation, and questions regarding the use of remote technologies for clinical services. Remote treatment was defined to include technologies such as telephone, email, videoconferencing, instant messaging, and free-standing websites. Depending on initial response regarding experience with technology for delivery of services, participants received follow-up questions regarding their previous history (frequency and specifics of use) with technology in this context, and perceived challenges and benefits of remote treatment within clinical settings. The generation of the survey items was informed by previous research. Specific questions included: “What do you view as some of the benefits of providing clinical services remotely?” “What do you believe are challenges of providing clinical services remotely?” and “What do you think is the current legal status of providing services on the Internet?” Participants were asked to select all that apply. All items were multiple choice.
Results

Results are primarily descriptive in nature. In comparing the two clinician groups, chi-square tests for independence were conducted for relevant items.

Participants (n = 213) were primarily female (66.7%) with an average age of 40.2 years (SD = 11.6). The majority resided in the United States (86.9%) and were currently employed full-time (62.9%). Respondents’ highest degree obtained was a Ph.D. (42.7%); a master’s degree (M.S./M.A./M.S.W.) (39%); a B.A./B.S. (6.1%); a Psy.D. (5.6%); or an M.D. (4.2%). Participants reported an average of 8.62 (SD = 9.47) years of clinical practice. Twenty-three percent of the sample identified as students, trainees, or predoctoral interns. The majority of participants identified as having a behavioral or cognitive-behavioral orientation (85.4%). The most common primary settings of practice included private practice (25.4%), veterans affairs medical centers (VA; 14.1%), other medical centers (12.2%), and university-based training clinic (8.9%).

A large majority (n = 153; 71.8%) of the sample endorsed a history of providing remote treatment. Table 1 presents data about how clinicians reported using various technological tools for adjunctive versus independent clinical services. Telephone (72.5%) was the most commonly used tool for treatment adjunctive to in-person care, whereas videoconferencing (44.4%) was the most common tool for independent use. Table 1 also displays the frequency of use of technological tools among clinicians who endorsed having used remote treatment services.

Clinicians reported using remote treatment services to treat patients with many different presenting concerns and diagnoses. The most common disorders were depression (81.2%) and generalized anxiety disorder (60.2%), followed by personality disorders (47.4%), posttraumatic stress disorder (41.4%), and panic (41.3%). Eating disorders were reported as less commonly treated using remote treatment services (8.3–10.5%), and few clinicians reported treating psychotic disorders using remote technologies (3.8–9.0%).

A significant minority (36.8%) of clinicians reported providing remote services to patients in a state, province, territory in which they were not licensed. Among clinicians who endorsed using these services for treatment, 15.8% indicated that they bill through insurance, while 84.2% indicated that they do not bill third-party payers for remotely delivered services.

Chi-square tests for independence examined differences in clinicians’ understanding of the legal status of remote treatment services and perceived benefits and challenges of using them between clinicians with versus without a history of using remote treatment services. Tables 2 and 3 present the number of clinicians who endorsed certain responses regarding legal issues and benefits and challenges, respectively. In response to the question, “What do you think is the current legal status of providing services on the Internet?” a chi-square test for independence indicated a significant association between history of providing remote treatment services and endorsement of the response “I’m not sure,” such that a higher proportion of clinicians without a history of providing remote treatment services endorsed uncertainty about legal status (55.0%). Notably, 24.2% of clinicians who endorsed using...
remote treatment services also indicated uncertainty about legal status. Table 3 summarizes responses to the question, “What do you view as some of the benefits of providing clinical services remotely?” in which participants were asked to select all that apply. Both clinicians with and without a history of using the services endorsed the following as benefits: providing services for patients who are too far away; convenience for the client; and provision of specialized services to patients who would not otherwise have access. A chi-square test for independence indicated a significant association between history of providing remote treatment services and endorsement of the response, “providing services to clients who are too far away,” such that a higher proportion of clinicians with a history of providing remote treatment services endorsed this item as a benefit (90% versus 70.6%). Analyses also indicated a significant association between history of providing remote treatment services and endorsement of the response “convenient for therapist” (48.7% versus 13.3%). Significantly more clinicians with a history of providing remote treatment services endorsed this item as a challenge (47.1% versus 33.3%).

### Discussion

The purpose of the present study was to assess clinicians’ use of telemental health services. We also aimed to examine and compare the perceived challenges and benefits, and perceived legal status, of using remote treatment services between clinicians with and without a history of using remote behavioral health services. Results indicated that the large majority of our sample (71.8%) endorsed using telemental health services, a usage rate that is much larger than what has been found by previous research groups (Wells et al., 2007). Clinicians reported use of remote treatment services across various settings, with private practice listed as the most common (25.4%). Respondents endorsed using a variety of technological tools to provide therapy independently and as adjuncts to in-person treatment. Notably, almost half of those who endorsed using remote treatment services reported using videoconferencing as independent means of providing therapy, and 20.9% reported using the telephone for that purpose. Many clinicians also endorsed use of telephone, e-mail, and videoconferencing as an adjunctive to in-person treatment. The clinicians in our sample reported utilizing telemental health services in the treatment of a wide variety of conditions, the most common being depression and generalized anxiety disorder.

Our findings regarding the high endorsement of use of remote treatment services are promising in light of a growing body of research that indicates that remotely delivered behavioral health interventions are effective across many populations and in many settings (Aboujaoude, Salame, & Naim, 2015; Hilty et al., 2013). The findings suggest that telemental health services are not only being accepted but also disseminated at higher rates than previously reported. All participants in our sample, regardless of their history of providing remote treatment services, acknowledged benefits and challenges of telemental health treatment. Our findings indicate that clinicians without a history of using remote treatment services endorsed cost-effectiveness and convenience for the therapist as benefits significantly more than clinicians with a history of using services. Clinicians with a history of using remote treatment acknowledged technological difficulties and challenges in responding to crisis situations as perceived obstacles to using these services significantly more than clinicians without such a history. It may be that those without a history of using the services overestimate the cost-effectiveness of these services and convenience for the therapist and underes-

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**Table 1. Type and Frequency of Technological Tool Use among Those Who Endorse History of Remote Treatment Services**

<table>
<thead>
<tr>
<th>Type of use (n = 153)</th>
<th>Frequency of use (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjunctive (to in-person treatment)</td>
<td>Never</td>
</tr>
<tr>
<td>Telephone</td>
<td>72.5%</td>
</tr>
<tr>
<td>Email</td>
<td>56.2%</td>
</tr>
<tr>
<td>Videoconferencing</td>
<td></td>
</tr>
<tr>
<td>Skype</td>
<td>39.2%</td>
</tr>
<tr>
<td>FaceTime</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Text messaging</td>
<td>28.1%</td>
</tr>
</tbody>
</table>

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**Note:** Type and Frequency of Technological Tool Use among Those Who Endorse History of Remote Treatment Services.
The APA recommends that clinicians refer to and comply with specific state laws and regulations. The Telepsychology Task Force acknowledges the need for a mechanism to regulate interjurisdictional practice on a national and international level and suggests the possibility of developing a “telepsychology credential” or “e-passport” that may facilitate delivery and regulation of telepsychological services in the future.

There are two important implications that can be drawn from this study. First, as use of telemental health treatment increases, we must address issues cited by clinicians using these services. Specifically, future work is needed to ascertain the type and frequency of technological difficulties experienced by clinicians in order to develop appropriate solutions. Guidelines must also be developed to address concerns about responding to a crisis situation during remote treatment. Second, the field must continue to grapple with the complex legal issues surrounding remote treatment services in order to reach resolution regarding interstate and international practice, and disseminate this information widely.

There are several limitations associated with this survey. Our sample was self-selected through e-mail announcements. Although a large majority of clinicians in the sample endorsed using remote treatment services, this may be partially due to our method of advertisement (i.e., through technology). Previous research assessing prevalence of use of remote clinical services recruited respondents through mailed surveys (Mora et al., 2008; Wells et al., 2007). Additionally, previous studies did not ask participants explicitly about their use of remote clinical services as adjunctive treatment. Respondents to surveys in prior research may have interpreted questions to refer only to stand-alone treatment with remote services. Our use of e-mail as a recruitment method and our inclusion of questions asking about adjunctive and stand-alone use of remote services may partially account for the high rates of endorsement among our respondents. Clinicians with a history of using these services may have been more interested in answering survey questions on the topic. Relatedly, the clinicians in our sample who do not report using remote services appear to utilize technology regularly enough to respond to our advertisement; as such, they may have had more accepting attitudes towards technology. Participants in our sample were contacted primarily through cognitive-behavioral professional listservs. Accordingly, the majority (85.4%) of our sample endorsed a cognitive-behavioral orientation. Our results may not generalize to a more theoretically diverse population of clinicians, especially in light of findings that clinicians with a cognitive-behavioral orientation are more likely to have positive attitudes about remote treatment than clinicians from other theoretical perspectives (Mora et al., 2008; Perle et al., 2013; Wangberg et al., 2007). Because of the sample’s relatively low percentage of clinicians without a history of using these services, future research should examine further perceived barriers to adoption of these services specifically.
### Table 3. Perceived Benefits and Challenges of Remote Services

<table>
<thead>
<tr>
<th></th>
<th>With History (n = 153)</th>
<th>Without History (n = 60)</th>
<th>χ²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing services to clients who are too far away</td>
<td>70.6%</td>
<td>90.0%</td>
<td>8.92</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Convenient for client</td>
<td>66.0%</td>
<td>76.7%</td>
<td>2.29</td>
<td>0.09</td>
</tr>
<tr>
<td>Convenient for therapist</td>
<td>34.0%</td>
<td>48.3%</td>
<td>3.76</td>
<td>0.04</td>
</tr>
<tr>
<td>Real-time monitoring and intervention</td>
<td>52.9%</td>
<td>41.7%</td>
<td>2.19</td>
<td>0.09</td>
</tr>
<tr>
<td>Provision of specialized services to clients who would not otherwise have access</td>
<td>62.1%</td>
<td>75.0%</td>
<td>3.19</td>
<td>0.05</td>
</tr>
<tr>
<td>Cost-effectiveness</td>
<td>36.6%</td>
<td>55.0%</td>
<td>6.00</td>
<td>0.01</td>
</tr>
<tr>
<td>No benefits</td>
<td>0.0%</td>
<td>0.0%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited personal connection</td>
<td>46.4%</td>
<td>38.3%</td>
<td>1.14</td>
<td>0.18</td>
</tr>
<tr>
<td>Technological difficulties</td>
<td>48.7%</td>
<td>13.3%</td>
<td>23.83</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Too costly</td>
<td>6.5%</td>
<td>5.0%</td>
<td>0.18</td>
<td>0.38</td>
</tr>
<tr>
<td>Uncertainty about legal issues</td>
<td>47.7%</td>
<td>56.7%</td>
<td>1.38</td>
<td>0.15</td>
</tr>
<tr>
<td>Concerns about privacy</td>
<td>35.3%</td>
<td>45.0%</td>
<td>1.72</td>
<td>0.12</td>
</tr>
<tr>
<td>Challenges in responding to crisis situation</td>
<td>47.1%</td>
<td>33.3%</td>
<td>3.31</td>
<td>0.05</td>
</tr>
<tr>
<td>Other:</td>
<td>0.0%</td>
<td>38.3%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Scheduling is too difficult</td>
<td>1.3%</td>
<td>3.3%</td>
<td>1.14</td>
<td>0.29</td>
</tr>
<tr>
<td>Setting is not preferred</td>
<td>0.0%</td>
<td>10.0%</td>
<td>23.83</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Logistics (distributing materials)</td>
<td>3.3%</td>
<td>0.0%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

among populations without experience using them.

**References**


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The Affordable Access Gap: CBT’s Hidden Dissemination Problem

Donna M. McNally, Private Practice, Cambridge, MA

Richard J. McNally, Harvard University

THIS YEAR MARKS THE 50TH ANNIVERSARY of the founding of the Association for Behavioral and Cognitive Therapies (ABCT), and there is much to celebrate. Behavior therapy has come a long way since the 1960s when the embattled pioneers of our field struggled against the hegemony of psychoanalytic psychotherapy (e.g., Wolpe, 1958; Wolpe & Rachman, 1960). Gone are the days when directly desensitizing phobic fears or extinguishing maladaptive behavior while reinforcing alternative responses would get one criticized for fostering symptom substitution (for a review, see Tryon, 2008). Gone are the days when traditional clinicians begrudgingly conceded that behavior therapy worked, but only for simple problems.

Behavior therapy and cognitive-behavior therapy (CBT) are fast becoming the gold standard of clinical care in the treatment of many mental health problems. Publishing companies have issued excellent treatment manuals written by eminent clinical researchers that provide step-by-step guidance on how to conduct evidence-based interventions for many syndromes. It has become increasingly evident that one of our biggest challenges is how best to disseminate CBT and other evidence-based treatments to mental health practitioners in America and beyond (McHugh & Barlow, 2010). Unless practitioners acquire the skills to deliver these treatments, all the work of applied clinical science will be in vain. There are three aspects to the dissemination challenge: one well known, another reasonably familiar, and the third one largely unnoticed. We focus mainly on the third one.

Training Clinicians in CBT

Ensuring that mental health professionals acquire the skills to deliver evidence-based treatments is surely the most obvious aspect to the problem. Training young therapists in clinical psychology, social work, psychiatry, and psychiatric nursing is the first channel for disseminating information and skills to new members of these professions. Training workshops, webinars, and other evidence-based continuing education channels are the obvious routes for those already practicing. ABCT has long been in the forefront here, sponsoring training institutes and workshops at the annual conference.

Identifying Genuine CBT Practitioners in the Community

In today’s challenging climate of managed care, evidence-based treatment has become the gold standard recognized by both third-party payers and savvy behavioral health consumers. CBT has become a desirable buzzword for branding one’s services in online directories. Hence, clinicians describe their approach as “CBT” when many may actually be delivering an eclectic brew of treatments. Such marketing practices need not be deceptive; some clinicians may genuinely but mistakenly believe that they are conducting CBT. Accordingly, these advertising practices may lead us to underestimate the dissemination problem.

The Affordable Access Gap

The least noticed aspect of the dissemination problem concerns the limited access to affordable evidence-based treatment. The problem of dissemination is ultimately one of ensuring that clients receive the standard of care they need, and if trained CBT specialists do not accept insurance, efficacious treatment can become unfeasible for all but the most affluent.

Indeed, mental health professionals appear increasingly reluctant to accept insurance. For example, Bishop et al. (2014) found that the percentage of psychiatrists accepting private noncapitated insurance had declined by 17% from 2005 to 2010. Moreover, psychiatrists are much less likely to accept such insurance than are other medical specialists (55.3% versus 88.7%). President Obama signed the Affordable Care Act of 2010, establishing parity of insurance coverage between mental and physical disorders. However, the Act does not compel clinicians to accept third-party reimbursement, and multiple factors discourage them from doing so. In striking contrast to the United States, evidence-based mental health treatment is both mandated and affordable via the National Health Service in England (Clark et al., 2009).

One of us (DMM) is a licensed independent clinical social worker (LCSW) and a licensed alcohol/drug professional (LADC1) practicing privately in Cambridge, Massachusetts, and trained in CBT. In addition to her work as a private practitioner, she has extensive experience working and consulting within Employee Assistance Programs (EAPs), including one at a major teaching hospital affiliated with a Boston-area medical school. One of the primary goals of an EAP is to identify problems affecting employees and to facilitate appropriate referrals by matching clients to providers offering efficacious treatments. The EAP’s overarching aim is to promote optimal functioning, thereby maximizing employee productivity as well as restoring the employee’s work-life balance.

Accomplishing this aim not only requires accurate and timely clinical assessment and intervention but, most important, matching clients to clinicians trained to provide evidence-based treatment. However, identifying such providers, even within the greater Boston area, has been surprisingly challenging due to multiple barriers that impede this process.

Affordable access to outpatient CBT treatment is limited as many clinicians have opted out of third-party insurance networks. The motivations for opting out are many. Substandard reimbursement rates, time-consuming billing efforts, and exasperating bureaucratic challenges created by third-party payers make it difficult for clinicians in smaller practices to engage in the “paper chase” involved in receiving payment.

The affordable access gap occurs in large, clinic-based programs as well as in smaller group and solo practices. Some of the finest evidence-based programs can be prohibitively expensive because they are not third-party reimbursable. Even when specialized CBT programs do accept insurance for the provision of evidence-based treatment, long waiting lists are common, often as long as 3 to 4 months. Hence, the shortfall between those needing treatment and the number of available practitioners is striking.
(Kazdin & Blase, 2011) seems especially serious for CBT.

What Can Be Done?

The problem as we see it is systemic. Trained CBT professionals are offering a relatively scarce resource in a climate of high demand. Accordingly, clinicians certainly cannot be blamed for seeking to maximize their income and reduce the multiple burdens and financial risks associated with accepting third-party payer contracts. Economics 101 teaches us that quality services in relatively short supply in a market of high demand will command a high price. It is unsurprising that clinicians avoid the hassle of accepting insurance.

We see a possible solution to the affordable access gap. Competition among providers offering affordable access to CBT may provide an opportunity for change. By training practitioners via workshops and institutes, ABCT serves competition and thereby clients. If the supply of well-trained clinicians increases, those willing to accept insurance will gain a competitive edge over their equally well-trained counterparts who do not accept insurance. When supply increases, those who choose to opt out of insurance networks may find their offices empty.

However, training alone does not ensure access to affordable care. Indeed, the third-party bureaucratic paper chase can be a daunting obstacle for individual practitioners. Accordingly, larger systems of care, whether nonprofit hospitals, clinics, or group practices, have the resources to overcome the challenges of dealing with insurance reimbursement. These larger systems of care may be instrumental in providing a solution. Perhaps by increasing awareness of the mechanisms maintaining these problems, we can take steps to close the affordable access gap that ultimately undermines our dissemination efforts.

References


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Spotlight on a Mentor: Dr. Donald Baucom

Helen Z. MacDonald, Emmanuel College

ABCT’s Spotlight on a Mentor program aims to highlight the diversity of excellent research mentors within the organization’s membership ranks. Our goal is to spotlight both promising and accomplished mentors across all levels of academic rank, area of specialization, and type of institution. We are excited to present ABCT’s inaugural spotlighted mentor: Dr. Donald Baucom.

Dr. Baucom is the Richard Simpson Distinguished Professor of Psychology at the University of North Carolina at Chapel Hill. Since receiving his doctorate in clinical psychology in 1976, he has been actively involved in the development and empirical evaluation of the theoretical, basic research, and treatment interventions employed in cognitive-behavioral couple therapy (CBCT). This work has included focusing on interventions for relationally distressed couples, enhancing the relationships of happy couples, developing interventions for couples who have experienced infidelity, and employing couple-based interventions for couples in which one partner has psychopathology or a health problem. In addition to his research in the couple’s area, he has co-authored two widely used books on CBCT. He holds an endowed chair at UNC for his research contributions to the field. He also has been an active clinician in private practice with couples for more than 40 years. Consistent with his active engagement in both an academic and applied world, an important part of his professional role is disseminating empirically based couple interventions to clinicians who are practicing in a variety of settings. Thus, he frequently conducts workshops for professionals in the United States and other countries around the world.

One of the most rewarding and enjoyable aspects of Dr. Baucom’s professional life is working with and mentoring students at various levels of training. He has received a university-wide award from UNC for lifetime excellence in mentoring. The doctoral students in his clinical program have honored him as the outstanding clinical supervisor in the program for his supervision in the couple therapy clinic he directs. He also has received university-wide and departmental awards for excellence in undergraduate teaching at UNC.

As Dr. Baucom’s former student, Dr. Steffany Fredman, wrote, “Don is brilliant, but one of his unique strengths as a mentor is that he lets his students be smart, too. His manifest enthusiasm for research, teaching, and clinical work is infectious, and as a student, one had the feeling of being a junior colleague who had her or his own wisdom to share and that could be appreciated even though we lacked Don’s depth of knowledge and experience. By modeling a spirit of curiosity and respect for others’ opinions, Don had a profound influence on getting us to take risks in how we thought about things in the research lab, classroom, and clinical settings.” Dr. Fredman further describes Dr. Baucom’s mentorship qualities: “Don taught me that the process of mentorship is about motivating the student/mentee to join up with the mentor through encouragement and aligning of shared interests and common goals, rather than by invoking a power differential to compel the other individual to follow along. Through shaping and positive reinforcement, a good mentor helps students to challenge themselves to do things they might not have known they were capable of and, in so doing, to enjoy the process and sense of mastery that results from these experiences.”

Dr. Baucom responded to questions from ABCT’s Academic Training and Education Standards Committee about his history as a mentor, his mentorship philosophy, and his effective mentorship practices.

How long have you been a member of ABCT?

I joined ABCT 40 years ago as a graduate student, and it has been my major professional home since that time. It was an exciting experience to join the organization when behavior therapy was young and still defining itself. None of the faculty from my graduate program were members of ABCT, but I decided this is where I belonged and started coming to conferences knowing absolutely no one. Obviously, much has changed since then, but ABCT has continued to be my academic home.

What type of mentor do you aspire to be? Do you have a mentorship philosophy?

Reportedly, Michelangelo once stated, “In every block of marble I see a statue as plain as though it stood before me, shaped and perfect in attitude and action. I have only to hew away the rough walls that imprison the lovely apparition to reveal it to the other eyes as mine see it.” This phenomenon, known as the Michelangelo effect, embodies what I believe is the essence of mentoring: while always being genuine, I believe mentoring means seeing the potential in others that they might not even see in themselves and helping them to become the best versions of themselves that they can be—often, this means going well beyond what they thought was possible. Mentoring is about creating optimal long-term relationships, believing in your mentees, and helping them grow into who they want to be, not who you want them to be, including all the struggles and missteps that are so common along the way. For me, this means that I genuinely have to care for and be concerned about the people I am in a mentoring relationship with, be available to them, and commit to putting in the effort to help them grow.

While it is important that both people have a clear understanding of their relative roles, a mentoring relationship (like all others) works best if it is reciprocal. So I try to be open and learn from people I mentor, showing them that they have much to offer, that they can help me continue to grow and learn, and that within the context of our respective experiences and areas of expertise, we are on a common journey of growth and development. And I expect to have fun while doing all of this. Professional life requires a great deal of energy to do it well, and if I am not enjoying myself and having fun with the other person, it will not work long term. So it means working out the intricacies of a long-term mentoring relationship, respecting each other, and enjoying interacting around the various tasks before us. I am fortunate that my area of research and clinical focus—long-term relationships—helps to remind me of these issues on a daily basis and, hopefully, focuses me to maintain my own mentoring relationships in the real world.
What practices do you engage in that foster your mentorship style?

I have written many times that in order for a relationship to work well across time, it needs to be responsive to (a) the needs of both individuals, (b) the relationship, and (c) how the two people interact with the environment. This remains true for a mentoring relationship. First, I need to be responsive both to my own needs and those of the other person. On a broad level, I need good self-care, which sounds trite but is important after decades in this profession; so I exercise regularly, eat well, try to sleep well, and enjoy myself in personal pursuits. Within the mentoring relationship, I need to conduct myself so that I give a great deal without feeling like a martyr, experiencing that the other person appreciates my efforts and gives in return in appropriate ways. I also need to be responsive to the person I am mentoring, so I check in almost every time we meet to find out how the other person is doing in general, not just addressing our current encounter. I need to know broadly how my mentee is feeling, progressing on various tasks, and so forth so that I can focus and adapt our current interaction accordingly. Second, on a relationship level, I need to be mindful and monitor if our interactions are effective, as well as having our current focus clearly in my mind, so that we both agree on expectations for our current endeavors, have a work plan, and monitor whether we are moving forward as expected. I also engage regularly in long-term planning with the other person, so that we can see and strive toward long-term goals, adapting as new opportunities arise and as the other person continues to grow and change. Third, we both need to be responsive to the environment in which we are operating. Often I ask much of the other person and convey the message that the mentee can ask much of me. Generally this works well, but the risk is exhausting ourselves, particularly if we are not attentive to other demands in our professional and personal environments that impact both of us. So we discuss these broader contextual factors on an ongoing basis.

Whereas the above pattern describes my frequent interactions with current students, I also have been blessed to continue my relationships with many former students. Some of these ongoing relationships involve frequent interactions around collaborative research or clinical training, whereas others are more infrequent yet still quite important. This might involve catching up once a year at conferences and continuing to encourage and affirm the mentee’s development. Or I might get a message asking for a quick Skype call for input on career choices or difficulties in some area of a mentee’s professional lives. The basic message is I am here if and when I can be of assistance in times of difficulty or to celebrate successes.

I believe the above process needs to occur within a developmental perspective based on the student’s ongoing growth and change. Over time, a student takes on greater leadership in our joint endeavors and hopefully develops a sense of self-efficacy in doing so. Also I make strong efforts to provide opportunities for students that go beyond the walls of the university. The students in my lab and I have made many trips to visit colleagues and peers in other countries and have had major senior investigators visit with us. Not only do these opportunities expand their experiences, but also it is important that students develop relationships with other scholars in addition to me. I actively encourage my students to build meaningful collaborative relationships with other scholars, and most of them do so. In many cases, we collaborate on research or other activities together across universities and countries. In addition, it is crucial that students learn that they can be successful when they are working independently from me, so I encourage collaborations with other investigators without my involvement when appropriate. In addition to research collaborations, I also present many clinical training workshops in other countries. Students often accompany me and help lead the workshops, providing training to other professionals in interventions we have developed in our lab. I ensure that these activities and opportunities are individualized to a student’s own career goals. Thus, being committed to nurturing a student’s professional and personal growth is not just a statement of philosophy for me; it is a way of behaving and interacting long term that is lived out every day in a multitude of ways.

What do you tend to look for in potential mentees?

Every year, a large number of applicants are very bright and are likely to succeed in a doctoral program in clinical psychology, so this is an important requirement but does not differentiate among the many qualified applicants. Thus, I look for quality human beings to work with long term. I look for people who have true passion for our field and research on intimate relationships, and who are psychologically minded and insightful. These qualities are important because they are hard to teach, and understanding human relationships in depth will shape their research questions in our domain of investigation, their clinical work, and their own interactions. I can teach students about the literature and help them learn about therapeutic interventions, how to be successful in the classroom, and how to supervise and train others. Those are skills I can help them develop. I want to do that with someone who is committed to doing this long term, is willing to do the hard work and put in the hours to be successful, and has fun while doing it. I want to work with people who have strong values, because they will conduct themselves honorably both as individuals and in interactions with others, and they will represent the field well. I want to work with students who are open to learning from me and others, and students who will push me, stretch me to learn in new ways, and take me into new domains. I interact with my doctoral students more than anyone else in academia, so I need to learn from them and continue to grow through our collaborative efforts. That is why after decades I feel as passionate about my work as when I began; it is because of the outstanding people I work with and the new domains we explore together. I look for students who want to go on that journey.

What advice would you give to others starting out as mentors?

Find something you are passionate about, work hard at it, and treat people well. If you do that, people will want to work with you, will learn from you, and will teach you as well. You have to be responsive to the demands of the situation, but be yourself in all of the settings in which you operate. There should be a constant essence of you that comes across in research meetings, clinical supervision, classroom activities, etc. While being appropriately professional, be open, have fun, and enjoy the people you are with. If you do, you will be a good model, and you will create an environment in which people will trust you, learn from you, and confide in you in ways that are appropriate. It will sustain you over many years and decades in our profession. Above all, enjoy the ride; it is awesome!

If you are interested in learning more about Dr. Baucom’s work, other exceptional ABCT mentors, or to add your mentorship profile to the ABCT Mentorship Directory, please visit www.abct.org/mentorship/
Nominate the Next Candidates for ABCT Office

I nominate the following individuals:


__________________________


__________________________

NAME (printed)

SIGNATURE (required)

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, 2016, 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 form to: Christopher Martell, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 (fax: 212-647-1865)

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.

NOTE: To be nominated for President-Elect of ABCT, it is recommended that a candidate has served on the ABCT Board of Directors in some capacity; served as a coordinator; served as a committee chair or SIG chair; served on the Finance Committee; or have made other significant contributions to the Association as determined by the Leadership and Elections Committee. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle.

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. Each representative serves as a liaison to one of the branches of the association. The representative position up for 2016 election will serve as the liaison to Academic and Professional Issues Coordinator and Committees.

A thorough description of each position can be found in ABCT’s bylaws: www.abct.org/docs/Home/byLaws.pdf.
below: **Outstanding Training Program**, co-directors of Charleston Consortium Psychology Training Program Daniel Smith (left) and Dean Kilpatrick (right)

David A. F. Haaga, **Outstanding Service to ABCT**

Benedict Carey, **Distinguished Friend to Behavior Therapy**

far left: Anne Marie Albano, **Outstanding Clinician**

right: David M. Clark receiving **Career/Lifetime Achievement** from President Jonathan Abramowitz
ABCT AWARDS & RECOGNITION 2015

ABCT Awards Chair: Katherine Baucom

above, clockwise, left to right:
Danielle E. MacDonald, Virginia A. Roswell Student Dissertation; Lauren E. Szkodny, Leonard Krasner Student Dissertation; Timothy Ritzert, Graduate Student Research Grant; Amy Kranzler, Student Travel

above, left to right: Spotlighted Mentors Scott F. Coffey (left) and Donald Baucom (right); President Jonathan Abramowitz with the President's New Researcher Rinad S. Beidas

Elsie Ramos First Author Student Poster Award Winners (left to right): Erica Meyers, Julia Carbonella, Andrew McClintock
The ABCT Convention is designed for scientists, practitioners, students, and scholars who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions, Targeted and Special Programming, and Ticketed Events.

ABCT uses the Cadmium Scorecard system for the submission of general session events. The step-by-step instructions are easily accessed from the Abstract Submission Portal, and the ABCT home page. Attendees are limited to speaking (e.g., presenter, panelist, discussant) during no more than FOUR events. As you prepare your submission, please keep in mind:

• **Presentation type:** Please see the two right-hand columns on this page for descriptions of the various presentation types.

• **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The chair may present a paper, but the discussant may not. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.

• **Title:** Be succinct.

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

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

• **Key Words:** Please read carefully through the pull-down menu of already defined keywords and use one of the already existing keywords, if appropriate. For example, the keyword “military” is already on the list and should be used rather than adding the word “Army.” Do not list behavior therapy, cognitive therapy, or cognitive behavior therapy.

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

**Overall:** Ask a colleague to proof your abstract for inconsistencies or typos.
General Sessions
There are between 150 and 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. These events are all submitted through the ABCT submission system. The deadline for these submissions is 11:59 PM, Tuesday, March 1, 2016. General session types include:

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

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

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

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

Targeted and Special Programming
Targeted and special programming events are also included with the registration fee. These events are designed to address a range of scientific, clinical, and professional development topics. They also provide unique opportunities for networking.

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

Mini Workshops
Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long.

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

Research and Professional Development
Provides opportunities for attendees to learn from experts about the development of a range of research and professional skills, such as grant writing, reviewing manuscripts, and professional practice.

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

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

Special Interest Group (SIG) Meetings
More than 39 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

Ticketed Events
Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment. See p. 30 for more information.

Clinical Intervention Training
One- and two-day events emphasizing the “how-to” of clinical interventions. The extended length allows for exceptional interaction.

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

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

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

Advanced Methodology and Statistics Seminars
Designed to enhance researchers’ abilities, they are 4 hours long and limited to 40 attendees.
Institutes
Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than FOUR presenters.

Lauren Weinstock, Institute Committee Chair
institutes@abct.org

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

Sarah Kertz, Master Clinician Seminar Committee Chair
masterclinicianseminars@abct.org

Workshops and Mini Workshops*
Workshops cover concerns of the practitioner/educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than FOUR presenters.

Mini Workshops* address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than FOUR presenters.

When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

*Mini Workshops are included in the general session

Barbara Kamholz, Workshop Committee Chair
workshops@abct.org

Deadline for Submission: February 1, 2016
ABCT is celebrating its 50th Anniversary! Indeed, there is much to celebrate. Founded in 1966 by 10 maverick behaviorists who opposed the dominant psychoanalytic model of the time, our organization now boasts over 5,200 members worldwide and continues to be at the forefront of scientific psychology and empirically supported treatment. Simultaneously, our organization faces significant questions and challenges for the future ahead. For example, we grapple with issues such as the dissemination of interventions on a global scale and integration of the growing neuroscientific perspective with behavioral research and treatment.

We are doing things a little differently for the 50th Annual Convention. The theme of the convention, “Honoring the Past, Envisioning the Future,” is intended to showcase research and clinical work that aligns with one of four broad, crosscutting topics central to the recent history and future of ABCT: (a) dissemination and implementation; (b) technology and treatment; (c) neuroscience and psychological treatment; and (d) cognitive science and transdiagnostic principles. In addition, we welcome submissions in traditionally underrepresented areas or disciplines. Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, Mini-Workshops, and Posters. Healthy, critical debate of the future of behavioral and cognitive research and therapy is strongly encouraged, both within and across presentations.

In complementary fashion, the convention will feature a set of invited panels on these four crosscutting topics (dissemination and implementation, technology and treatment, neuroscience and psychological treatment, and cognitive science and transdiagnostic principles). The luminary panel speakers will highlight recent scientific advances and envision the future of behavioral and cognitive therapies in each of these domains. All ABCT members are strongly encouraged to attend.

This coming year, be on the lookout for our videos spotlighting the past presidents of ABCT and invited panel speakers as we gear up for the 50th Anniversary Convention. In addition, we hope that you will participate in a number of celebratory activities over the coming year, the products of which will be displayed on the ABCT website and listserv and at the convention. Stay tuned for details.

Information about the convention and the process of submitting abstracts will be on ABCT’s website, www.abct.org, after January 1, 2016. The online submission portal will open on February 1, 2016. The deadline for submission is March 1, 2016.
The ABCT Awards and Recognition Committee, chaired by Katherine J. W. Baucom, Ph.D., of the University of Utah, is pleased to announce the 2016 awards program. Nominations are requested in all categories listed below. **Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below.** Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

### 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. Past recipients of this award include David H. Barlow, G. Alan Marlatt, Antonette M. Zeiss, Alan E. Kazdin, Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, and David M. Clark. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee’s curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include “Career/Lifetime Achievement” in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

### Outstanding Contribution by an Individual for Education/Training

Awarded to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Past recipients of this award include Gerald Davison, Leo Reyna, Harold Leitenberg, Marvin Goldfried, Philip Kendall, and Patricia Resick. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee’s curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include “Outstanding Educator/Trainer” in your subject heading. Also, mail a hard copy of your submission to ABCT, Educator/Trainer, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

### Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Previous recipients of this award are Richard Heimberg, G. Terence Wilson, Richard J. McNally, Mitchell J. Prinstein, and Bethany Teachman. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee’s curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include “Outstanding Mentor” in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Mentor, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

### 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 The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, Vikram Patel, and Benedict Carey. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee’s curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include “Distinguished Friend to BT” in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016
Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT’s mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano’s core commitments. This award includes a cash prize to support travel to the ABCT Annual Meeting and to sponsor participation in a clinical treatment workshop.

Eligibility requirements are as follows: 1) Candidates must be active members of ABCT, 2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care.

Applicants should submit: Nominating Cover Letter, CV, Personal Statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to Awards.ABCT@gmail.com. Include candidate’s last name and “Albano Award” in the subject line. Also, mail a hard copy of your submission to ABCT, Anne Marie Albano Early Career Award, 305 Seventh Ave., New York, NY 10001.

This award is made possible by a generous donation to ABCT. A family who benefitted from CBT and knows of Dr. Albano’s work expressed wanting to see others benefit from CBT and CBT-trained therapists.

**Nomination Deadline:** March 1, 2016

Student Dissertation Awards

- Virginia A. Roswell Student Dissertation Award
- Leonard Krasner Student Dissertation Award
- John R. Z. Abela Student Dissertation Award

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award 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. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2015. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents. Self-nominations are accepted or a student’s dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the nomination materials (including letter of recommendation) as one pdf document to awards.abct@gmail.com. Include candidate’s last name and “Student Dissertation Award” in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

Nominations for the following award are solicited from members of the ABCT governance:

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include “Outstanding Service” in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016
Learning doesn’t need to stop at the Convention! ABCT is proud to provide online webinars for psychologists and other mental health professionals. Our webinars can be attended live or viewed online at your convenience. The webinar series offers opportunities to learn about evidence-based treatments and latest research from the convenience of your home/office.

Abramowitz | Exposure for OCD
Albano | CBT for Adolescent Anxiety
Barnett | Ethics in Behavioral Telehealth
Brown | CBT for Child Trauma
Fisher | Ethics
Harvey | CBT for Insomnia (CBT-I)
Hayes | ACT for Anxiety
Herbert | ACT
McCraday | Substance Abuse
McNeil | Parent-Child Interaction Therapy
Miller | DBT With Adolescents
Persons | Overcoming Treatment Failure
Resick | CPT for PTSD
Roemer | Acceptance-Based BT for GAD
Segal | Mindfulness in Clinical Practice
Shafran | OCD/Perfection
Shear | Complicated Grief and Its Treatment
Sudak | Supervision
Tirch | Compassion-Focused Therapy
Gallagher | ADHD/Executive Functioning
Keane | Military Psychology

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

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master’s level therapists do not qualify and are not listed in this directory.

2. “Teaching” may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.

3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

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

To Submit Your Name for Inclusion in the Medical Educator Directory

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

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this listing serve strictly in a volunteer capacity.

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