Cognitive Behavioral Therapy Tools for Clients With Limited Functional Literacy

Freddie A. Pastrana, Ana J. Bridges, Bianca T. Villalobos, Aubrey R. Dueweke, Juventino Hernandez Rodriguez, University of Arkansas

COGNITIVE BEHAVIORAL THERAPIES (CBT) are a family of interventions that explain mental health problems in clients as stemming from the interactions between thoughts, feelings, and behaviors. These include treatments that focus primarily on thoughts (cognitive therapies) and actions (behavior therapies). Behavior therapy, in particular, focuses on how rewards influence the likelihood of behavior being repeated. CBT is perhaps the most well-researched intervention in mental health service delivery (Hoffmann, Asnaani, Vonk, Sawyer, & Fang, 2012), having amassed an impressive amount of evidence supporting its efficacy at treating a wide variety of disorders, beginning from its roots in the treatment of depression (Beck, 1970; Ellis, 1962) and extending to the treatment of substance use disorders (Dutra et al., 2008), psychotic disorders (Gould, Mueser, Bolton, Mays, & Goff, 2001), antisocial behavior (Gibbon et al., 2010), and internalizing symptoms (Ismail, Winkley, & Rabe-Hesketh, 2004).

CBTs are collaborative and empirically based, and make use of client data in order to assist people in making quick and clinically meaningful change. Homework assignments and symptom tracking play a crucial role in the beneficial outcomes of CBT for clients (Kazantzis, Deane, & Ronan, 2000; Proudfoot &
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Lower English literacy levels are associated with greater likelihood of having a physical, mental, or other health condition that keeps the person from being able to participate fully in work, and is associated with greater health care expenses (Kirsch et al., 2002; Lincoln, Arford, Doran, Guyer, & Hopper, 2015). Furthermore, lack of literacy is stigmatizing, impedes a client’s ability to fully participate in treatment decision-making, and may limit access to needed evidence-based treatment (Lincoln et al., 2015). Limited literacy is associated with living in poverty and difficulties with finding adequate employment (Kirsch et al., 2002), all of which can contribute to or exacerbate mental health difficulties (Lincoln et al., 2006). Limited literacy also indeed appears to impact therapists’ willingness to utilize CBT or its components with clients (Lincoln et al., 2015).

Cognitive behavior therapists are increasingly recognizing the role that limited literacy plays in treatment. For instance, Kuhajda, Thorn, Gaskins, Day, and Cabbll (2011) described the modification of a CBT protocol for treating chronic pain in a low-literacy rural population by simplifying language, reducing the number of concepts discussed in each therapy session, incorporating more visual aids, and increasing in-session interactive practices and activities. Also, Kneebone (2016) described modifying CBT to accommodate acquired communication deficits in victims of stroke, including using more behavioral versus cognitive strategies, recording exercises completed in session so that clients can refresh their memories of materials covered in session between sessions, and involving caregivers or significant others in treatment. Though some studies have begun focusing on literacy as a potential barrier to health care, clinicians are still lacking a general consensus of how to manage challenges associated with service provision for clients with limited literacy. Unfortunately, there is little empirical data regarding clinicians’ experiences working with clients evincing literacy problems.

A Snapshot of the Problem

In our own clinical work, we have experienced the challenges of working with clients with limited functional literacy. The authors of this paper have provided or supervised clinical service provision at two integrated primary care clinics in northwest Arkansas. These clinics are part of a federally qualified health center (FQHC) providing services to medically underserved community patients. A recent study by Bridges et al. (2015) reported that the demographic makeup for patients across these clinics was approximately 50% Hispanic, 60% female, 40% uninsured, and 50% children or adolescents. In these clinics, over 10% of our adult clients struggled with basic reading and were unable to complete symptom checklists or read psychoeducational handouts without assistance. Our clinical experiences have suggested that limited client literacy can be a barrier to successful implementation of and compliance with CBT.

To complement our own informal observations, we recruited CBT clinicians to complete a brief online survey, approved by our institutional IRB. The survey asked what clinicians are doing to assess client literacy, adapt CBT for limited literacy populations, and evaluate outcomes of CBT with clients evidencing limited functional literacy. Participating clinicians were recruited via an e-mail solicitation distributed through three professional organization listserves: Association for Behavioral and Cognitive Therapies (ABCT), American Psychological Association (APA) Division 38 (Society for Health Psychology), and APA Division 45 (Society for the Psychological Study of Culture, Ethnicity and Race). To be eligible to participate in the survey, clinicians had to currently (a) devote a minimum of 20 hours per week to clinical service provision; (b) ascribe primarily to a cognitive-behavioral treatment approach; and (c) provide therapeutic services to adult clients (i.e., at least half of the cases seen by the participant had to be adults).

Participating were 75 clinicians (Mage = 37.7 years; 72.9% female; 82.4% White), of which 78.4% had doctoral degrees and 21.6% had master’s degrees. Of these clinicians, 67.6% were licensed as mental health professionals, with an estimated 30% working under a licensed mental health provider. Clinicians reported averaging 9.8 years (range = 1–37) as practitioners in mental health professions (83.8% in clinical psychology) across various settings (27% in medical centers; 20.3% in Veterans Affairs Medical Centers; 14.9% in private practice). One-third of respondents (31%) reported providing therapeutic services to a moderate to large percentage of clients with limited literacy (26–75%). Similarly, 36.3% of respondents indicated regularly assessing the literacy levels of their clients. More clinicians in Veterans Affairs Medical Centers (80%), psychiatric hospitals

Nicholas, 2010). Increasingly, clinicians are being urged to track client symptoms early and often so as to better ensure the quality of services (Lambert et al., 2003). Data obtained through various methods, including symptom tracking, mood ratings, logging responses to behavioral experiments, and so forth, lie at the heart of effective CBT interventions. However, the quality of the data collected may be compromised and the ability to obtain data for activities occurring outside of session can be difficult when working with clients with limited literacy. Alternatively, clinicians often must rely on client self-report during sessions, but this is also problematic because retrospective recall is notoriously inaccurate (Proudfoot & Nicholas, 2010). In response to these challenges, we describe literacy rates in the U.S., the impact that a client’s literacy level might have on the provision of and adherence to CBT treatments, and briefly review the results of a survey of CBT practitioners regarding their own clinical work with limited literacy clients. We then describe the development of a set of psychoeducational and monitoring CBT tools for clinicians, modified for use with clients evincing limited literacy, which we have found to be helpful with this underserved population.

Functional Literacy: Prevalence and Mental Health Outcomes

Functional literacy comprises both skill (reading and writing) and application (understanding and applying what is read) components (UNESCO Education Sector, 2004). According to a 2002 report by the U.S. Department of Education (Kirsch, Jungeblut, Jenkins, & Kolstad, 2002), 21–23% of U.S. adults demonstrate English literacy skills in the “lowest level of prose, document, and quantitative proficiencies” (p. xvi). Recently, the National Center for Educational Statistics reported that 18% of adults in the U.S. who completed the Program for the International Assessment of Adult Competencies (PIACC) Household Studies experienced problems at the lowest level of literacy (Rampey et al., 2016). Older adults and immigrants make up a disproportionate number of this low-level English literacy group, and most of the individuals in this lowest performing group have less than a high school education. These and other studies suggest ethnic and racial minorities, including Hispanics, are more likely to be in this lowest literacy group compared to White adults.

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(50%), and other medical centers (42%) reported having a sizeable portion of their clients struggle with literacy compared to clinicians who worked in other settings (e.g., university counseling, independent practice).

When asked about strategies used to assess literacy, 36.5% of clinicians surveyed noted they do not typically use formal assessment to evaluate clients’ literacy level; instead, informal approaches (e.g., behavioral observations, asking clients to read out loud) are commonly used. The majority of respondents (80.6%) reported believing that limited literacy decreases the effectiveness of CBT, and 85.4% believed that limited literacy decreases clients’ ability to complete CBT homework. Most were less likely to provide a psychoeducational handout or monitoring sheet to clients with limited literacy compared to clients with adequate literacy levels. Almost half of respondents (47.6%) indicated that they would provide these materials for clients with limited literacy if they were simple and easy-to-understand or included visuals. However, almost a quarter of clinicians (23.8%) reported a lower likelihood of providing a monitoring sheet, noting that they would not want to embarrass or shame their clients who cannot read or write. One clinician noted, “there are not enough resources . . . for my patients with limited literacy. If I had the time to adapt and create simple photos with pictures to capture their self-ratings of feelings, thoughts, and situations, our sessions would have more of an impact.” This informal survey of CBT clinicians highlights the extent to which limited literacy patients are underserved by traditional approaches to client data gathering. Therefore, the remainder of this article describes methods to adapt CBT tools for clients with limited functional literacy.

Guidelines for Creating CBT Tools for Clients With Limited Functional Literacy

The Centers for Disease Control and Prevention (CDC, 2009) drafted a guide for creating health information materials for people with limited reading ability. We used these guidelines to develop a set of templates for CBT tools. According to the CDC, health educational and information sheets should be developed with the following considerations in mind. First, clinicians should identify the audience and key health problems or areas they want to target. For instance, in the primary care clinics where we practice, patients tend to be adults of Hispanic ethnicity, only half of whom use English as their primary language, and the most frequent reasons for behavioral health referrals are depression and anxiety (Bridges et al., 2015). Therefore, it was important to us to create materials in both Spanish and English that would target depression and anxiety disorders in adults.

Second, clinicians should determine the key messages they wish to convey to clients about these health problems or areas. These messages should be pilot-tested to ensure they are received appropriately, are culturally congruent, and are not offensive. Relatedly, knowing ahead of time what the best method is for delivering the health information (print materials, audio or video recordings) and how these materials will be distributed (via postal mail, in person, via brochures, or on the Internet, for instance) can help streamline the process of developing CBT materials for low-literacy clients. In our case, we felt that print materials that could be given to patients during their behavioral health visit by the therapist would be most effective, given many of our patients may not have Internet access in the home (Perrin & Duggan, 2015).

Third, the CDC (2009) recommends psychoeducational materials should convey messages that are clear, relevant, and appropriate to the client. In order to do so, they recommend the following: (a) give the most important information first; (b) limit the number of main ideas or points to just three or four per document, skipping details when possible; (c) tell the client what they need to do or what action steps should be taken (using active voice, and stating what should be done rather than what should not be done); (d) explain why this action is important; and (e) use short words or phrases, avoid acronyms and jargon, and write in a conversational tone that is respectful.

Fourth, the CDC (2009) recommends print material should be attractive and easy to understand. This is helped by selecting large font sizes (between 12 and 14 points), fonts with serifs (which give individual letters more distinctiveness), avoiding use of all capital letters, and being judicious in the use of bold, underline, and italic type. The materials should have plenty of white space, present an entire message or idea on a single page (rather than break up a message across multiple pages), and use bullet

Figure 1. Psychoeducational handout and symptom monitoring sample templates for use with clients evincing limited functional literacy.
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points or text boxes for emphasis and ease of reading.

Fifth, health information materials for clients with limited literacy should employ the use of visual aids, including pictures or clip art. According to the CDC (2009), the choice of which types of visual aids to use depends on the purpose of the health information, with photographs best for showing “real life” events or “how-tos,” and cartoons or simple drawings best for highlighting key points that may be detailed in text. In all cases, visuals should have sharp resolution and be high in contrast. Visual aids such as clip art or photographs should include a brief caption and present only one idea or message. In the case of developing materials for clients with no literacy, visual aids can sometimes replace entire sections of text.

Sixth, once a first draft of the materials is completed, clinicians should test this draft for cultural sensitivity, appropriateness, and readability. This can be done informally, such as by asking a few clients to provide feedback on the materials, or more formally, such as through focus groups. The readability statistics of a document can be easily determined through functions within word processing programs, special software, or even through free readability calculators housed on websites such as Online-Utility.org (Tests Document Readability, n.d.).

With these guidelines in mind, we developed a set of templates for three types of CBT tools: psychoeducational information sheets, behavior tracking sheets, and symptom rating sheets. The generic templates we used for these types of CBT tools are in Figure 1. Our template for psychoeducational handouts included two pages of pictures with captions. All pictures we used are publicly available, royalty-free clip art. The sheet page provides information about the symptoms associated with a particular mental disorder (such as major depressive disorder) or problem in living (such as managing stress). The second sheet includes information about causes of the disorder or problem and evidence-based treatment approaches to managing that problem or disorder. For instance, Figure 2 depicts the psychoeducational materials we created to address substance use disorders. The pictures represent a few of the most common symptoms of a substance use disorder, including tolerance, withdrawal, cravings, use in risky situations, time spent obtaining, using, or recovering from the effects of substance use, and social or psychological problems as a result of use. The causes of drug use are depicted by pictures and captions, which illustrate the role of genetics, life stress, and peer pressure or social norms. The treatment approach includes information about psychotherapy, medications, and support groups. Importantly, these psychoeducational sheets are meant to be used by the clinician in session first, with the clinician providing verbal details about the disorder, its symptoms, and the evidence-based treatment options that can be discussed with the client, allowing the client to ask questions, provide input, and otherwise respond to the material. The sheet can then be given to the client to take home, where it can serve as a cue or reminder of the detailed conversation that took place in session.

Tracking behaviors that are targets of change in CBT is critical to evaluating whether treatment is working. As such, we have included a template for tracking behaviors of interest that can be easily used by clients with limited literacy. Sometimes, we want clients to track the behavior that is the target of change (such as the number of alcoholic drinks they had in a day). Figure 1 depicts a sample template for tracking the severity or amount of problems and symptoms that are the target of change. At other times, we would like the client to track engagement in intervention behaviors, such as finding time to engage in behavioral activation for depression or taking medications as prescribed. The last sheet depicts a sample template that includes the target behavior, an estimated time of day in which the behavior is either scheduled for or occurring, and the day of the week. The specifics will vary by client; thus, the templates we have created are only suggested guidelines but can be fully customized by clinicians after crafting individualized treatment plans with clients. An example template for tracking generalized anxiety disorder is shown in Figure 2. In this particular case, the client’s treatment plan included (a) engaging in regular physical activity; (b) making time for daily relaxation (something the patient and therapist had practiced in session); and (c) setting aside time to worry.

We have placed our templates on a website (comp.uark.edu/~abridges/resources.html) so that others can freely utilize them. The templates we created are only suggested starting points for how to customize CBT tools for clients with limited literacy.

![Figure 2](image-url)
EVIDENCE-BASED RESOURCES
TO HELP CLIENTS THRIVE

DON’T FEED THE MONKEY MIND
HOW TO STOP THE CYCLE OF ANXIETY, FEAR & WORRY
JENNIFER SHANNON, LMFT
Illustrations by BOYD SHANNON
Foreword by MICHAEL A. TOMPKINS, PhD.


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The pictures, captions, and behaviors can all be fully customized. They are equally useful for working with adults and younger children, as well as potentially useful for working with people of diverse cultures who speak different languages. In our own practice, we have found that going over the materials with our patients during session and providing these sorts of materials, largely pictorial and lacking much text, resulted in increased patient self-efficacy and compliance to complete needed homework assignments and tracking sheets.

Discussion

Despite the strong evidence that cognitive behavioral interventions are highly efficacious in treating a variety of mental and behavioral health concerns (Hofmann et al., 2012), they frequently rely on written materials and between-session assignments that can serve as impediments for clients with limited literacy (Lincoln et al., 2015). In our clinical practice, we have increasingly worked to adapt CBT materials for this underserved population. Our survey of CBT clinicians also found approximately one-third of respondents have a significant caseload of adult clients with limited literacy. Clinicians working in medical centers, psychiatric hospitals, and Veterans Affairs Medical Centers were more likely to report having clients who struggle with literacy compared to those working in other settings, such as private practice or community health centers. This is consistent with data showing associations between limited literacy, poverty, and ill health (Kirsch et al., 2002) and suggests clinicians in these settings should be particularly attentive to literacy issues with their patients.

The bulk of clinicians in our survey reported believing limited literacy decreases the effectiveness of CBT for adult clients, and reported they would be less likely to provide psychoeducational handouts or tracking sheets and worksheets to clients who struggle with literacy. This is consistent with Lincoln and colleagues’ (2015) assertion that limited literacy can reduce treatment effectiveness in this already underserved population.

So how do clinicians manage treatment with limited literacy patients? First, it is clear from our survey that clinicians are attuned to these issues and make efforts to modify CBT to accommodate their clients. Clinicians whose caseloads included a sizeable portion of clients with limited literacy noted they adapt CBT “much of the time.” Qualitative data indicated clinicians mostly adapt CBT by changing the language they use and ensuring language is simpler and culturally appropriate. Clinicians also commonly incorporated visual aids into treatment, including using videos, pictures, and drawings to illustrate concepts. In our own clinical practice, we found the use of images for psychoeducational handouts and tracking sheets to be especially helpful. However, because of the limited text in our adapted materials, we recognize their use requires extended time in session to explain what each picture means to the client. The adapted materials serve more as visual reminders or cues to memory, rather than as sole teaching devices. Use of comprehensive instructional video or audio recordings could help reduce time burden on clinicians, but requires clients to have access to electronic devices outside of session.

Scholarly interest in the intersection of functional literacy and cognitive-behavior therapy is increasing, and ripe for future research and for clinical toolkits. For instance, we do not know how clients with limited literacy perceive CBT in its traditional or adapted forms. It would be helpful in future studies to collect data from clients regarding literacy and what materials or adaptations they would find most helpful. The materials we developed only address a limited number of concerns that we see frequently in our own practice setting, and may not fit well with other types of cognitive behavioral therapies. Further, patients’ functional literacy appears to have significant implications for broader health outcomes and medical treatment adherence (Miller, 2016). As such, it might be beneficial for clinicians to collaborate with other health care professionals to continue discussing and exploring strategies to improve treatment provision and adherence for patients evincing limited functional literacy. It would be helpful to build an expanded library of resources for clinicians, perhaps encouraging others to share materials they have found or developed would be useful, especially if these resources were in one central location. Finally, the lack of a rapid and reliable measure of clinical literacy is a barrier to treatment adaptation and suggests that efforts to develop such a measure for mental health, much like the Short Assessment of Health Literacy (SAHL; Lee, Stucky, Lee, Roziere, & Bender, 2010), would encourage clinicians to adopt a standardized practice of assessing literacy in clients.

Conclusion

CBT clinicians are likely to have a sizeable portion of clients who struggle with literacy. The effectiveness of CBT may be reduced because of limited literacy. Our own clinical work suggests more attention should be paid to this underserved population and to creating CBT materials that can be readily utilized with clients who struggle with literacy. We hope others will join us in sharing resources and adaptations that have been effective with other clinicians so access to this family of evidence-based treatments is not limited to just those who can read and comprehend well.

References


Acceptance and Commitment Therapy for PTSD and Trauma: An Empirical Review

Ron C. Bean,* Clarissa W. Ong,* Jason Lee, Michael P. Twoordig, Utah State University

THE ESTIMATED LIFETIME prevalence of posttraumatic stress disorder (PTSD) is 8.3% (Kilpatrick et al., 2013). Effect sizes for PTSD treatments are large for cognitive processing therapy, exposure therapy, and eye movement desensitization and processing (g = 1.63, 1.08, and 1.01, respectively; Watts et al., 2013). Cognitive behavioral therapy (CBT) approaches outperformed pharmacotherapies and are among the most effective treatments for PTSD (Watts et al.). In addition, Watts et al. reported no differences among cognitive-behavioral approaches that emphasized cognitive restructuring, exposure, or a combination of the two, suggesting that individuals have multiple options when seeking treatment for trauma symptoms. However, CBT for PTSD is not a cure-all, with a recent meta-analysis showing pre-

treatment to posttreatment response rates of 59% (63% to follow-up) and high dropout rates (up to 54%; Loerinc et al., 2015). Therefore, there is a need for additional treatment options.

A potential alternative for trauma and PTSD is Acceptance and Commitment Therapy (ACT), which has been increasingly studied due to demonstrated efficacy for a number of treatment concerns (Hayes, Pistorello, & Levin, 2012). The goal of ACT is to increase psychological flexibility, the ability to flexibly engage in valued behaviors in the presence of difficult internal experiences. As such, ACT promotes a stance of acceptance—the willingness to experience thoughts, feelings, and sensations as they are, without efforts to change or control them—as opposed to experiential avoidance, which encompasses attempts to alter and/or escape unpleasant internal experiences, which result in lower functioning. Acceptance is an active choice

* These authors contributed equally on this manuscript.
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<td>Lang et al. (2016)</td>
<td>Veterans (M age = 34.2)</td>
<td>160</td>
<td>BSI-18 GSI ACT (Avg.)</td>
<td>73.3</td>
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<td>BSI-18 GSI PCT (Avg.)</td>
<td>74</td>
<td>66.8</td>
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<td>SDS - ACT (Avg.)</td>
<td>6.7</td>
<td>4.9</td>
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<td>SDS - PCT (Avg.)</td>
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<td>5.3</td>
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<td>AUDIT - PCT (Avg.)</td>
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<td>Jansen &amp; Morris (2016)</td>
<td>Adults, Aged 21-27 (M age = 23.7)</td>
<td>3</td>
<td>AAQ-II (Avg.)</td>
<td>44</td>
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<td></td>
<td></td>
<td>BAI (Avg.)</td>
<td>28</td>
<td>8</td>
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<td>58</td>
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<td>PCL-C (Avg.)</td>
<td>51</td>
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<td>Woidneck, Morrison, &amp; Twohig (2014)</td>
<td>Adolescents, Aged 12-17 (M age = 14.6)</td>
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<td>Self-Monitoring</td>
<td>27</td>
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<td>CAPS-CA (Avg.)</td>
<td>60</td>
<td>23</td>
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<td>23</td>
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<td>54</td>
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<td>ComQol-S (Avg.)</td>
<td>66</td>
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<td>TEI-SF (Avg.)</td>
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<td></td>
<td>AFQ-Y (Avg.)</td>
<td>31</td>
<td>12</td>
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<tr>
<td>Boals &amp; Murrell (2016)</td>
<td>Adults, Aged 22-52 (M age = 35.7)</td>
<td>63</td>
<td>CES ACT+TAU (Avg.)</td>
<td>28</td>
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<td>TAU Only (Avg.)</td>
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<td></td>
<td>TAU Only (Avg.)</td>
<td>25.4</td>
<td>22.6</td>
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Note. SCL-90-R=Symptom Checklist-90-R; BDI=Beck Depression Inventory; AAQ=Acceptance and Action Questionnaire; ATQ-F=Automatic Thoughts Questionnaire-Frequency; ATQ-B=Automatic Thoughts Questionnaire-Believability; PCL-C=Posttraumatic Checklist–Civilian Version; BDI-II=Beck Depression Inventory-II; BAI=Beck Anxiety Inventory; AAQ-II=Acceptance and Action Questionnaire-II; WBSI=White Bear Suppression Inventory; TSC-40=Trauma Symptom Checklist-40; VLQ=Valued Living Questionnaire; BSI-18 GSI= Brief Symptoms Inventory–18 Global Severity Index; SDS=Sheehan Disability Scale; AUDIT=Alcohol Use Disorders Identification Test; IES-R=Impact of Event Scale–Revised; CAPS-CA=Clinician Administered PTSD Scale for Children and Adolescents; CPSS=Children’s PTSD Symptom Scale; ComQol-O=Comprehensive Quality of Life Scale–Objective; ComQol-S=Comprehensive Quality of Life Scale–Subjective; TEI-SF=Treatment Evaluation Inventory–Short Form; AFQ-Y=Avoidance and Fusion Questionnaire for Youth; CES=Centrality of Events Scale; PCL-S=PTSD Symptom Checklist.
undertaken by an individual to embrace inner experiences while they are occurring.

Experiential avoidance has been suggested as a key factor in the development and maintenance of PTSD, as well as a potential barrier to improved psychological functioning (Bluett et al., 2014; Hayes et al., 2013). This is because experiential avoidance reduces behavioral flexibility in the face of distressing stimuli. For example, an individual with military trauma and high levels of experiential avoidance may choose to keep away from situations that contain trauma cues, such as celebratory events where loud noises are present, even when being at those situations may be important or meaningful to them.

Other ACT processes are pertinent to PTSD as well. Cognitive defusion aims to alter the way individuals interact with thoughts or the function of thoughts. Specifically, defusion weakens the literality of thoughts and instead encourages seeing thoughts for what they are, in lieu of what they say they are. For instance, a trauma survivor may be plagued by the thought, “Everything was my fault.” Taken literally, the thought can occasion self-blame, additional self-critical thoughts, and self-punishing actions. However, if taken to be a thought that shows up in one’s mind, the individual may instead be able to make valued choices in the presence of a once-powerful thought. Distressing thoughts about the future or the past (e.g., flashbacks) can result in loss of contact with the present moment, such that the individual fails to live life as it is occurring. Yet, by experiencing the world as events occur, the individual’s behavior can become more flexible, sensitive to direct contingencies, and consistent with values (Hayes et al., 2011).

Self-as-context is another ACT process that entails viewing oneself as a context for internal experiences; as such, it involves perspective taking. Rather than holding on to a self-narrative tightly (e.g., “I am a bad person”), the self-as-context perspective encourages contact with an “observer self” who notices these self-stories and can flexibly respond to them. Clarifying values—things that are important to the individual—can help the individual maintain focus in the face of life challenges. In other words, values are what make difficult experiences worth having. Values are also used to evaluate the effectiveness of behavior; behaviors that bring one closer to values are effective, whereas those that bring one further away from values are ineffective. Committed action is the behavioral instantiation of one’s values. These processes do not function independently, but rather collectively to describe the overarching goal of psychological flexibility that defines the ACT model.

The Acceptance and Action Questionnaire (AAQ; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) is a measure of psychological inflexibility and experiential avoidance. Currently, the second version of the AAQ, the AAQ-II is more commonly used, and scores between 24 and 28 on the AAQ-II have been associated with clinically significant distress (Bond et al., 2011). Higher scores on the AAQ have been associated with reexperiencing, avoidance/numbing, and hyperarousal, the three PTSD symptom clusters (Meyer, Morisette, Kimbrel, Kruse, & Gulliver, 2013). Higher scores on the AAQ-II were also associated with more severe PTSD symptomatology, controlling for avoidance symptoms and negative emotionality (Meyer et al., 2013). While there is some support for this model of PTSD, the effects
of ACT on PTSD have not been recently reviewed.

The objective of this review was to summarize data on the effectiveness of ACT interventions on PTSD and trauma symptoms. Specifically, this paper reviews treatment studies using ACT in cases of PTSD and trauma, discusses clinical implications of these data, and highlights future research directions.

**Method**

A literature search on PsycINFO and MEDLINE/PubMed using three combinations of search terms was conducted: (1) "ACT" AND "trauma," (2) "AAQ" AND "PTSD," and (3) "ACT" AND "PTSD." To be included, articles had to be published in English between 1990 and 2016. Prior to 1990, research on ACT was limited to the treatment of depression and Follette first used ACT in the treatment of trauma in 1990 (McLean & Follette, 2016). Articles were reviewed for relevance and those that did not report on the treatment of trauma using ACT were excluded. Studies reporting on individuals with a diagnosis of PTSD or with clinically significant trauma symptoms were included. In total, three case studies, one case series, one single-subject design, and two randomized trials were included in this review.

**Empirical Support**

**Case Studies**

Three case studies applying ACT to trauma have been published. ACT was used with a 19-year-old female diagnosed with substance abuse and PTSD resulting from a history of sexual abuse (Batten & Hayes, 2005). ACT was chosen because a transdiagnostic treatment specifically focused on the reduction of experiential avoidance might be expected to simultaneously affect PTSD and substance abuse, which are disorders commonly associated with significant levels of experiential avoidance that can be comorbid. In other words, ACT targeted the function of the client’s behavior—avoidance of unpleasant internal experiences—through increasing psychological flexibility rather than the disparate behaviors themselves. The client’s AAQ score fell from 36 at intake to 27 at termination. Additionally, her scores on measures of general psychopathology and believability of thoughts decreased at termination (see Table 1). Batten and Hayes reported that the client’s self-report scores on the measures were below cutoffs for clinically significant distress after 12 months of therapy, and that these gains were maintained until treatment termination. In addition, the client reported abstinence of substances from the 7th month until the end of therapy (see Table 1).

A second case study involved a 43-year-old female who was diagnosed with PTSD after experiencing verbal and physical abuse (Twohig, 2009). The client reported experiencing flashbacks, intrusive recollections, and dreams of the abuse. She did not respond to previous CBT interventions that focused on cognitive challenging and exposure scripts. Prior to beginning the 21-week trial of ACT, she scored 33 on the AAQ and 67 on the Posttraumatic Checklist – Civilian Version (PCL-C; Ruggiero, Ben, Scotti, & Rabalais, 2003). By the end of the trial, her score was 8 on the AAQ and 28 on the PCL-C. The mean upper quartile scores of experiential avoidance on the AAQ was 42 for clinical samples and 38 for nonclinical samples (Hayes et al., 2004). Clinical range for the PCL-C is indicated by scores of 44 and above, which suggests that the client’s trauma severity was no longer in the clinical range. The client’s depression and anxiety scores also declined (see Table 1).

In the third case study, Burrows (2013) conducted a case study with an 18-year-old female who experienced sexual assault. She developed self-deprecating thoughts and a high level of anxiety at the prospect of going out in public, due to avoidance of flashback-inducing stimuli. The therapist conceptualized the client’s struggles as stemming from maladaptive ways of avoiding uncomfortable inner experiences (e.g., thought suppression, withdrawing from social relationships). Thus, ACT was the indicated treatment. By the end of the 18-session ACT trial, the client’s AAQ-II score had fallen from 36 to 26. AAQ-II scores in the range of 24 to 28 are considered clinical (Bond et al. 2011). Measures of thought suppression and trauma symptoms also declined, while her scores on the Valued Living Questionnaire rose (see Table 1).

**Case Series**

Jansen and Morris (2016) conducted a 12-week ACT study with three participants who met criteria for schizophrenia and PTSD. Mean AAQ-II score dropped by an average of 23 by the end of the therapy. Improvements were also reported at post-treatment in other self-report measures of PTSD, anxiety, and depression symptoms (see Table 1). This study provides additional evidence that in vivo ACT treatment programs can result in improvements across a variety of measures and can be effective for those with comorbid conditions.

**Single-Subject Designs**

Seven adolescents with a variety of trauma experiences participated in a 10-week course of ACT tested in two multiple baseline designs (Woidneck, Morrison, & Twohig, 2014). There was a decrease in self-reported and observer-rated PTSD symptomatology, as well as psychological inflexibility. Additionally, objective and subjective quality-of-life scores increased (see Table 1). In this study, the three participants that were considered treatment dropouts experienced considerable sexual abuse histories and exhibited complex symptomatology, suggesting a possible need to modify or augment the treatment protocol to target interfering behaviors. One set of participants also lived in residential care and were concurrently receiving individual, family, and group therapy while participating in this study, though trauma was not targeted in the other types of therapy.

**Randomized Controlled Trials**

A treatment comparison study examined 160 individuals with current diagnoses of PTSD, anxiety, depression, and postconcussive symptoms (Lang et al., 2016). These individuals were randomly assigned to either the ACT or present-centered therapy (PCT) condition. Twelve 1-hour sessions of individual therapy were conducted for each participant in each group. Scores on measures of well-being, functioning, and alcohol use all decreased (see Table 1). Improvements were observed for both groups and the only significant difference between groups was that ACT was associated with more improvement in insomnia at posttreatment. This study, like others working with veterans, experienced a high rate of attrition. Another consideration with regard to this study was that 82% of the sample was diagnosed with PTSD, thus results may not generalize to individuals with only traumatic experiences.

Boals and Murrell (2016) conducted a clinical trial that included 63 participants with elevated PTSD symptoms. Their active intervention consisted of four 1-hour ACT sessions that emphasized self-as-context to target event centrality, or the degree to which the traumatic event is incorporated into the individual’s identity, in addition to treatment as usual at a com-
munity outreach center. The control group only received treatment as usual. Results indicated a significant effect of treatment condition from pre- to posttreatment on event centrality, PTSD symptoms, and depression. In addition, Boals and Murrell found that event centrality significantly mediated the link between study condition and PTSD symptoms, suggesting that the ACT intervention worked in a theoretically consistent way (see Table 1). It is important to note that control participants who wanted to switch to the treatment condition were allowed to do so at the pretreatment assessment; thus, this was a semirandomized trial.

Discussion

The objective of the present review was to summarize existing data on the application of ACT to trauma and PTSD. This area of research is in its nascence and preliminary evidence suggests that ACT is potentially an effective intervention, though the dearth of large-scale trials with well-defined PTSD symptoms tempers recommending dissemination of ACT for PTSD. More information on moderating factors of treatment response or mediational pathways through which psychological flexibility and quality of life improved would enable more informed clinical decision making and individualization of treatment approaches.

Because ACT adopts a transdiagnostic stance on psychopathology and has demonstrated its efficacy across a range of conditions (A-Tjak et al., 2015), one might assume that ACT will be effective for treating PTSD. However, clinical trials demonstrating the effectiveness of ACT across varying trauma presentations and client variables are still needed to better understand the best ways to apply ACT in the context of PTSD. Examining the acceptability and feasibility of ACT in non-research settings may reveal practical advantages to presenting ACT as a treatment option for PTSD.

References


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When are Exams Conducted? Exams are conducted in different places, but are usually done at the APA (Washington, DC, 1st week in August 2017) and ABCT (San Diego, 3rd week in November 2017) annual conferences. This year exams can also be conducted at the ABPP conference in San Diego in early May 2017. Other exams can be arranged in other locations on a case-by-case basis.

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Correspondence to Ron C. Bean, Utah State University, 2810 Old Main Hill, Logan, UT 84322-2810; roncbean@gmail.com
Mixed Methods Research Offers a More Powerful Gold Standard for Evaluating Psychological Treatments

Frank M. Dattilio, University of Pennsylvania and Harvard Medical School
David J.A. Edwards, Rhodes University and University of Cape Town
Stanley B. Messer, Rutgers University–New Brunswick
Daniel B. Fishman, Rutgers University–New Brunswick

THE RANDOMIZED CONTROLLED TRIAL (RCT) has been regularly referred to as the gold-standard methodology in research evaluating the efficacy of psychotherapies and providing evidence for what works in real-world clinical settings (Baker, McFall, & Shoham, 2009). This is an ambiguous metaphor. After all, the gold standard failed as a basis for the world economy and was eventually abandoned in 1971. Several commentators, in pointing out the limitations of the conclusions that can be derived from RCTs, have used the counter metaphor of “fool’s gold” (e.g., Edwards, 2007). In our recently published book (Fishman, Messer, Edwards, & Dattilio, 2017), we contend that if we are to retain the “gold standard” metaphor, it needs to be expanded. We argue that important limitations of and problems caused by relying on RCTs as the main source of evidence can be addressed by using a mixed methods approach. More specifically, we advocate incorporating qualitative methods into outcome studies that include a close examination of single cases that were part of the clinical trial.

RCTs employ elaborate logical designs to achieve experimental controls. They focus on specific variables and controls, quantitative measures of them; require fidelity to therapy manuals; and rely on extensive statistical analysis of the results. All of these factors contribute to building confidence in general laws about what treatments work and for which problems. On this basis, some have argued that clinicians should only deliver treatments that follow manuals used in research trials where efficacy has been demonstrated through one or more RCTs (e.g., Baker et al., 2009). However, this attitude has maintained a divide between researchers and practitioners in clinical psychology (Barlow, 1981; Dattilio, 2002; Jones, 1993; Silverman, 2001).

Moreover, the serious limitations of this approach, offered in the name of science, and its damaging impact on clinical practice have attracted considerable commentary from psychotherapy researchers over the past two decades (Barber, 2009; Dattilio, Piery & Davis, 2014; Hollon, 2006; Messer, 2004; Wampold, Imel, & Miller, 2009; Westen, Novotny & Thompson-Brenner, 2004). A large number of limiting factors of RCTs have been identified, including those that can be addressed specifically through a mixed methods approach.

For example, because of the difference in the controlled, experimental setting of RCTs and the naturalistic setting of practice, RCT studies have not been viewed by practitioners as attuned to their thinking and clinical experience (Barlow, 1981; Dattilio, 2002; Jones, 1993; Silverman, 2001). Specifically, treatment protocols in research trials may be artificially constrained to accommodate the requirements of research designs, such as artificially shortening the treatment time (Dattilio, Edwards, & Fishman, 2010) or limiting the responsiveness of clinicians that is a normal part of their clinical behavior and indeed essential for ethical practice (Stiles, 2009). Moreover, practitioners in naturalistic practice may have more complex cases and fewer resources available, such as ongoing supervision, than in research trials (Schoenwald & Hoagwood, 2001). Consequently, treatments delivered in RCTs may differ from those offered in routine clinical practice. In response to this apparent “lack of fit” between RCTs and naturalistic practice, systematic case studies of clients within RCTs capture the important clinical contexts of the RCT treatment, not apparent from the RCT research design per se, so that the full contexts of RCT cases can be compared with those of practice in naturalistic settings. Such a comparison of these contexts can help to answer the question of whether the case studies associated with RCT manuals are effectively transportable to naturalistic contexts of practice. Such a comparison is enhanced by also conducting systematic case studies of routine practice and comparing and contrasting them with the case studies drawn from an RCT.

In addition, the requirement of quantification leads to a reliance on established metrics that don’t fully and accurately capture the experiences of participants available in case studies and can result in bias with respect to the conclusions that are drawn (Blanton & Jaccard, 2006; Kazdin, 2003; Levitt, Pomerville, & Surace, 2016). Because the focus of RCTs is on the efficacy of treatments, they typically provide limited information about the mechanisms through which treatments work, the type of information which case studies can substantially augment. Findings are largely limited to the conclusion that a treatment works the same as or better than placebo or than another treatment. While such conclusions are, of course, important, they are very broad and sweeping and do not do justice to the complexities involved in individual participants’ responses to treatment. There are wide individual differences with respect to how clients respond to different treatments or even aspects of a single treatment. Factors such as client characterological features, the therapeutic alliance, the credibility of the therapy in the eyes of the client, the client’s motivation and expectations, the client’s life context with respect to social support and competing demands, the therapist’s theoretical allegiance, and the therapist’s skill can all affect the nature of participants’ engagement with the therapy process (Barber, 2009; Fishman et al., 2017; Wampold et al., 2009). In short, the internal validity of the findings is compromised by the fact that there is little or no evaluation of the role of a large number of factors—indeed of the techniques outlined in the therapy manual employed—that impact the course of treatment and whether it will be effective in particular cases, and all this is the very type of information that systematic case studies can provide.
Practitioners are responsible for keeping informed about research findings so that they can deliver interventions considered to be best practice in light of current knowledge. At the same time, they are strongly influenced by their clinical experience of how different clients respond. Indeed, studies suggest that most clinicians tend to rely largely on clinical experience and give limited attention to the research literature (Mussell et al., 2000; Stewart & Chambless, 2007). In this context, it is important to note that in a recent issue of *the Behavior Therapist*, Babeva and Dawson (2017) discuss the nature of effectiveness in continuing education in the health professions and conclude from the empirical research on medical education that “problem-based learning, an interactive approach requiring students to synthesize and critically apply knowledge in solving real-world clinical problems, predicts clinical competency and is also associated with high levels of self-reported satisfaction” (p. 8). Systematic case studies provide a crucial vehicle for such problem-based learning.

Research on the accuracy of clinical decisions (mostly about diagnosis and prognosis) guided by statistical information and normative data, as compared with pure clinical judgment, has shown that, although the former have a somewhat higher level of accuracy, in some studies clinical judgment is superior (Ágísíðóttir et al., 2006). It is unfortunate that these two sources of knowledge have often been seen as pitted against each other, rather than complementary (Messer, 2016).

Fortunately, the American Psychological Association’s Task Force on Evidence-Based Practice in Psychology (EBPP) concluded that clinicians need to base decisions about treatment on a synthesis of their clinical experience and clinical judgment together with evidence from research that would include but not be limited to RCTs (Goodheart, 2005). Thus, qualitative studies, including narrative case studies, are considered appropriate sources of evidence that can contribute to making clinical decisions.

This was not a radical position but was in line with the view of evidence-based practice in medicine (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) and psychology. Over three decades ago, Kiesler (1981) argued that the development of interventions in psychotherapy calls for a multidimensional research enterprise requiring various talents and approaches. Different research methods (e.g., multivariate and experimental studies, group comparisons, outcome designs, therapy process models, case-based studies, and qualitative research methods) each offer a unique type of evidence that can be drawn on to contribute to the scientific development and evaluation of useful treatments. The availability of a wider set of information and the synthesis of perspectives and conclusions from qualitative and quantitative methods offer a more balanced view of what has been discovered in a project.

Twenty years after Kiesler’s statement, in the United Kingdom, Salkovskis (2002) articulated this approach more sharply with the concept of “empirically grounded clinical interventions,” which, he argues, are established when the evidence from different types of studies is carefully evaluated and integrated. This integrative research perspective is more widely recognized in the U.K. with the result that clinical psychologists there have a greater respect for the research literature than those in the U.S. (Cooper & Graham, 2009).

A mixed methods research strategy goes beyond the view that data from multiple studies employing different sources and methods need to be drawn on in clinical decision-making. It advocates the use of a range of research methods within a single study (Hanson, Creswell, Clark, Petska, & Creswell, 2005). This would mean, for example, conducting an RCT with all that this involves in terms of controlling for extraneous variables, quantification, and statistical analysis, together with studying the same clients within the same study. Reporting a series of largely qualitative case studies would bring into focus the wider range of factors that impacted the treatment than can be measured in the formal quantitative study. The results would not be presented in independent reports, with one describing the RCT and another describing the case studies and/or other qualitative analyses. Both would be incorporated into a single research report, which would draw conclusions on the basis of both kinds of findings. In this spirit, Dattilio et al. (2010, p. 433) proposed that “reporting a small set of representative SCs [systematic case studies] should become a mandatory part of the scientific reporting of studies evaluating psychological treatments through RCTs.”

The comprehensive information on individual cases that is often gathered in well-conducted RCTs constitutes a rich source of untapped scientific data. On occasion, these are employed in the writing of case studies for publication. Several of the case studies published in the journal *Clinical Case Studies*, for example, have been taken from clinical trials. Such studies may provide valuable instantiations of the kinds of processes that unfold when a treatment works (Messer, 2011), or of the kinds of obstacles encountered that impact negatively on outcome (Rizvi, 2011). However, the publication of case studies from clinical trials so far has been a largely haphazard process. Barlow and Knock (2009) have argued that “the time is now right to put more emphasis on idiographic strategies that can be integrated in a healthy way into existing normothetic research approaches” (p. 20). Requiring that systematic case studies from therapy trials be integrated into reporting and the drawing of conclusions would be a way of making this a reality.

A more refined strategy, proposed by Fishman (2011), is to select two cases from a trial, one where treatment was effective and one where it was not, and publish these together (for examples, see Burckell & McMain, 2011). In all these publications, however, the case reports are independent of the report of the RCT. For the first time, as far as we know, combined reports of an RCT and those of case studies are examined together in single book chapters (Fishman et al., 2017), although the RCTs themselves were also published previously and independently. These, therefore, are unique examples of mixed methods reporting.

**Case Studies Within a Mixed Methods Approach**

Creswell, Fetters, and Ivankova (2004) pointed out that case studies are particularly appropriate for inclusion as the qualitative perspective in mixed methods research evaluating health service interventions like psychotherapy. Bromley (1986) aptly argued that case study research constitutes the “bedrock of scientific investigation,” and the details of clinical practice are invariably derived from a synthesis of clinical principles derived, at least informally, from case observations, rather than from the findings of multivariate research (Edwards, 1996). This is because case studies in which the individual is “the unit of the interest and the unit of analysis” (Eells, 2007, p. 35) allow for an examination of multiple complex processes as they interact across time within the same individual. When evaluating the treatment of different individuals within the same RCT condition, comparative case studies, as in the example of the Fishman (2011) strategy.
described earlier, are particularly valuable in that they permit the formal examination of individual differences in response to the same treatment approach. They also provide information of relevance to therapists with respect to their need to be responsive to client differences, such as a client’s stage of readiness for a particular treatment intervention.

In the final phase of the research process, case studies have another important value to science, which is the communication of findings. Well-written case studies offer a unique means of communicating clinical knowledge because reading them can directly engage the interest of busy clinicians and inform practice in a way that is not achieved by other methods of research publication (Stewart & Chambless, 2007).

Methodological Standards for Systematic Case Studies

Case studies were discredited during the latter half of the 20th century on the ground that there was inadequate quality control in so far as authors could easily select and distort the narratives to suit their own theoretical or ideological agendas. This outlook underestimated the value of case studies to clinical practice and overestimated their limitations. In the context of the growing appreciation of the value of qualitative research, and with the articulation of principles and methods to ensure the greater trustworthiness of conclusions drawn, case studies are once again taking their rightful place as a foundational form of clinical research (Fishman et al., 2017).

Case studies in which a qualitative narrative account of the assessment and therapy process is a central feature are termed “pragmatic case studies” (Fishman, 2005), or “systematic case studies” (SCSs; McLeod, 2010). Criteria for quality assurance in such studies have been extensively described (Dattilio, 2006a, 2006b; Edwards, Dattilio, & Bromley, 2004; Fishman, 2005; Kazdin, 2003).

Drawing on Peterson’s (1991) disciplined inquiry model, Fishman (2005) argued for a five-stage process of assessment, case formulation, treatment, ongoing monitoring leading to possible revision of the treatment, and concluding evaluation. In the assessment phase, information is systematically gathered about the case using clinical interviews, self-report measures and, where available, collateral information from significant others. This provides the basis for a case formulation within whatever treatment model the clinician is using and for which there is an existing body of basic and applied research. The formulation incorporates several clinical hypotheses that are used as a basis for a treatment plan. Once the treatment is initiated it becomes a test of the formulation and of the clinical hypotheses it incorporates. A limited response to treatment captured by monitoring can lead to a revision of the formulation and a change of treatment approach, a course correction that can be documented in the case narrative. Finally, a systematic evaluation of the process and outcome of the case is conducted to understand both the case itself and its relevance for generalizations about other, similar cases.

Fishman recommends that self-report scales be used to monitor specific symptoms that are related to the presenting problem, and that these are administered not only during assessment but on a regular basis until the end of treatment and at follow-up. The quantitative results of these can be presented in graphical form as part of the case study and linked to the processes described in the narrative. Systematic case studies are, therefore, mixed methods studies in that conclusions are based on a synthesis of both qualitative and quantitative data. When possible, all sessions should be recorded and the transcripts used as the basis for constructing the case narrative. This will necessarily be selective and the material included will be relevant to the central themes that emerge from the clinician’s qualitative understanding of the salient factors in the case either as the case proceeds or in retrospect. The session transcripts provide a basis for quality assurance that the selection and thematic interpretation of the therapy process has not been biased.

Recommendations: Towards a Credible Gold Standard for Psychotherapy Outcome Research Using a Mixed Methods Paradigm

A number of the criticisms of RCTs can be addressed by including in an RCT protocol systematic case studies drawn from the experimental condition of the RCT, by providing insight into dimensions of the response to treatments that are missing in a typical RCT report. The number of real-world factors that impact on participants’ response is so large that even where researchers include measures of critical variables (such as the therapeutic alliance, or the credibility of the treatment), information about other important factors will simply not be available. The same is true for factors that impact on the enormous variability across participants in response to treatment. Qualitative studies, and case studies in particular, can bring these factors sharply into focus and provide a basis for guidelines for clinicians in how to deal with them in practice.

We therefore recommend that reporting a small set of representative systematic case studies becomes a mandatory part of the scientific reporting of studies evaluating psychological treatments through RCTs. This would balance the reporting of group comparisons and effect sizes, and would allow a focus on the process of treatment and the factors that affect its delivery in specific cases and context. Given that electronic publication need not have the same space limitations as print publication, the full case studies might be included in a separate online Appendix to the journal in which RCTs are reported. However, the conclusions of the article should be based on combining the perspectives and insights gained from both methods, and selected material from the systematic case studies should be incorporated into the main article.

In the context of the above, we propose that in addition to the RCT and case studies, a comprehensive mixed methods strategy should also include a third evaluative component in which questions are asked about the process and implementation of the research plan (Teddlie & Tashakkirre, 2009). For example, in multisite studies, conflicts between the researchers and the managers of the research site (hospital or clinic) may lead to steps that compromise the research protocol. There may be similar conflicts between researchers and clinicians who feel that an inappropriately rigid protocol has been imposed on a clinical situation. At some sites, there may be practical problems such as limited availability of therapy rooms or an environment that is noisy. These types of factors are likely to affect the data collected, but remain hidden in the report of quantitative results where the impact on scores is simply ignored, or statistical procedures are employed for dealing with “missing data.”

Finally, we believe that for practitioners who are asked to follow treatment protocols in ways that are at odds with their need for situational, clinical responsiveness and even with their professional judgment, the kind of mixed-method study described here can be a most important useful resource and reference point.
References


The ABCT Spotlight on a Mentor program aims to recognize excellence in mentorship by profiling a selection of exceptional mentors within the membership of ABCT. We are pleased to present an interview with our most recent spotlighted mentor, Dr. Scott Coffey.

Scott F. Coffey, Ph.D., received his Bachelor of Science degree from Arizona State University and his Ph.D. in Clinical Psychology from the University of Mississippi. He completed his internship at the Medical University of South Carolina (MUSC) followed by a Postdoctoral Research Fellowship, sponsored by the National Institute on Drug Abuse, focused on the co-occurrence of addiction and posttraumatic stress disorder (PTSD). He is Professor and Director of the Division of Psychology in the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center and is the Vice Chair for Research. His research interests, funded by the National Institutes of Health and the Substance Abuse and Mental Health Services Administration, include mechanisms that initiate or maintain substance use disorders, PTSD, the co-occurrence of PTSD and substance abuse, psychotherapy treatment development, and impulsivity.

Within the Mississippi Psychology Training Consortium, Dr. Coffey has formally mentored 6 postdoctoral research fellows and 11 psychology residents (the term for “psychology interns” at this site) and has informally mentored numerous psychology residents and psychology graduate students. Dr. Coffey, along with Dr. Julie Schumacher, leads a 12-session grant-writing seminar directed at psychology residents within the Mississippi Consortium. Through this activity, Dr. Coffey has an opportunity to provide focused, limited mentoring on the process of successful grant writing. For his research mentoring efforts, he was awarded the Faculty Research Mentor Award from the Mississippi Consortium in 2011–2012, 2013–2014, and 2015–2016. He was also honored with the 2009–2010 Faculty Clinical Mentor Award from the Mississippi Consortium and was named Teacher of the Year in the Residency Training Program in Psychiatry at the University at Buffalo.

Dr. Coffey received nominations from seven former trainees for the Spotlight on a Mentor award. The nomination letters praised Dr. Coffey for his exemplary clinical and research mentorship. Specifically, Dr. Elizabeth Nosen wrote: “Dr. Coffey is an amazingly dedicated, considerate and caring mentor. He clearly prides himself on meeting students where they are and providing very honest and constructive feedback to help students take whatever next step they desire. He also has a keen sense of what kind of guidance would be useful to students, whether that be clinical advice related to handling difficult cases and collegial relationships or provision of in-depth coaching and walk-throughs related to filling gaps in one’s CV and navigating job markets, post-doc interviews, salary negotiations and NIH grantmanship. Dr. Coffey wants everyone he mentors to succeed and he is willing to go above and beyond to make this happen.”

Another former trainee, Dr. Rita E. Dykstra, spoke about Dr. Coffey’s clinical mentorship: “I was fortunate to have him as my clinical mentor on internship, and I can honestly say that I left a better clinician because of his feedback and teaching. He helped me learn to be kind and compassionate during treatment while still encouraging clients to do the ‘hard work’ necessary for a successful treatment outcome. It’s rare to find someone who is equally committed to their research and to serving clients, and Scott was a fantastic mentor in this regard. Scott is truly the embodiment of what it means to be a scientist-practitioner.”

Dr. Dykstra went on to state, “When Scott gives you advice, it’s not based on his personal beliefs, it’s based on what he thinks is best for the person in that particular situation and on years as a successful clinical psychologist and researcher. In the years since I completed internship, Scott is still one of my go-to people when I need professional advice. I place a high value on his opinions and professional judgments and have the utmost trust in the advice he gives.”

Dr. Erin Berenz described her mentorship relationship with Dr. Coffey this way: “Dr. Coffey is committed both to high-quality research and clinical training, which is a rare combination. I feel so privileged to have had the opportunity to train with him on internship, and to be able to continue working with him today. Given the strength of our relationship, which is largely based in Dr. Coffey’s generosity in...
mentoring and fostering my professional development, Dr. Coffey and I have continued to collaborate on manuscripts, conference presentations, and NIH grant applications. I would not be the professional I am today without having him as a role model.”

Finally, several of Dr. Coffey’s former trainees credited Dr. Coffey with future professional achievements. For example, Dr. Kathryn A. Roecklein wrote, “I attribute to him much of my ability to obtain a tenure track [faculty position] at the prestigious University of Pittsburgh in the Clinical Psychology program, and independent NIMH funding for my work. He was immensely helpful when it came to negotiating when I had an offer in hand.”

Similarly, Dr. Andrew K. Littlefield described the role that Dr. Coffey’s mentorship played in his professional trajectory: “There are multiple times each week that I ask myself, ‘What would Scott Coffey do?’ I ask this not only in terms of how he might reach critical clinical and/or research decisions, but also how he would tactfully approach and manage interpersonal exchanges with his mentees. Scott certainly highlighted that mentorship IS a process and a continual one at that. I think overall Scott ‘taught’ mentorship by example. For instance, he provided mentorship on all stages of a novel prospective data collection that I was able to complete during my internship year. This project was invaluable to my research career, and I have little doubt that having this research experience directly contributed to me getting an offer to be an assistant professor following my internship year. This exemplification of generosity has impacted my own behavior.”

Dr. Coffey responded to questions from ABCT’s Academic Training and Education Standards Committee about his experience and goals as a mentor, as well as his mentorship philosophy and mentorship practices.

**For how long have you engaged in the type of mentoring that you engage in now?**

Since coming to the University of Mississippi Medical Center and joining the Mississippi Consortium in 2004, I have sought to have a close relationship with one to two psychology residents each year and my postdoctoral fellow. Although I am available and frequently meet privately with all 11 residents, particularly when the residents are negotiating faculty position offers or have grant-related questions, I tend to focus my time and efforts on the psychology resident assigned to me as a research preceptor, my postdoctoral fellow, and, on occasion, one additional resident.

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

Relatively early in my career, I realized that 10 to 20 years after I publish my last article, I will no longer be cited in peer-reviewed papers unless I happen to publish a seminal work. Given the definition of the term “seminal work” and the specificity of my research area, I recognized it was unlikely that I was going to publish a seminal work. I continued to believe that my research was, and is, important, but I now recognize that it is a building block that is part of a much larger project. It is my hope that my research will play a part in helping alleviate human suffering and it might affect the trajectory of the field, but it is far from lasting. However, effectively mentoring junior colleagues and trainees has the potential to have a much more enduring impact on the field and the lives of the mentees. So, the type of mentor I aspire to be is one that will have a lasting impact on behavioral psychology through the impact the mentor has had on his mentees.

**What are your strengths as a mentor?**

I believe my most important strength is a willingness to spend time and to listen to the needs of a person seeking my help. It is my goal that the individual in front of me will receive my undivided attention, and, I believe, this is an important first step in mentoring. I enjoy meeting with young academics, and I have experience in two important and related issues they will face: how to negotiate an academic position, how to develop a fundable program of research, and how these issues are interwoven. For example, it is important that trainees don’t apply for faculty positions at locations that are unable to support their program of research and I find this important point is sometimes overlooked in the anxiety-driven search for a first academic job.

As a clinical mentor, it is my hope that one of my strengths is that my mentee recognizes how important I think effective cognitive behavioral therapy is in alleviating human suffering and why I think it is important to help alleviate human suffering. Perhaps another strength I have as a mentor is simply the fact that while I greatly enjoy research and providing clinical care to patients, the most enjoyable aspect of my job is mentoring young academics. It is my hope that this love for mentoring comes across in my interactions with my mentees.

**Whom do you perceive to be your most influential mentors? Describe the main lessons that you have learned from your mentors.**

I have had numerous wonderful mentors throughout my career and if I did not have their wise counsel, I would not have the satisfying career that I have enjoyed to date. However, two mentors stand out because they helped me a great deal during a period of career transition: Bonnie Dansky, Ph.D., and Kathleen Brady, M.D., Ph.D. Although I was interested in research coming into graduate school, I did not pursue a research track when I first entered graduate school. However, over time, I became more and more interested in research and was fortunate enough to match at an internship with ample research opportunities: the Charleston Consortium. The research preceptor assigned to me was Bonnie Dansky and I was her first preceptee. She was a young Assistant Professor, only a couple of years older than I was. Although I learned many things from Bonnie, such as how to be a generous mentor, how to assess the strengths and weaknesses of a preceptee, how to focus on the needs of the preceptee, how to help a trainee network professionally, etc., the most important lesson I learned was how to have an appropriate relationship with a mentee. Bonnie and I were approximately the same age and had many overlapping interests outside of work and it would have been very easy for us to become friends. It was very clear to me from the beginning of our relationship that this was not going to happen during internship. Bonnie established excellent boundaries that allowed us to be friendly with one another without becoming friends. Since we were not friends, it was very easy for her to give me the feedback I needed when I needed it and for the relationship to focus on my professional needs; the relationship did not need to be balanced. I believe this aspect is central to a healthy mentoring relationship and I had this style modeled very well for me early in my career. As my role changed at MUSC and other mentors replaced her, she and I became close friends and remain friends to this day.
My other mentor during this transition phase was Kathleen Brady. Kathleen was one of my mentors while I completed my National Institute on Drug Abuse-funded postdoctoral research fellowship at MUSC. From Kathleen, I learned how to be an unselfish mentor. For example, during the 1990s, impulsivity was all the rage in the addictions literature. While I was familiar with the literature, I was focused on my primary research interest investigating the relationship between PTSD and substance use craving. During a meeting with Kathleen in which we were discussing impulsivity, she offered to send me to the laboratory of the late Charles Schuster, Ph.D., former director of the National Institute on Drug Abuse. His group was very involved in studying impulsivity in addicted individuals, so I quickly took her up on her generous offer. This opportunity led to my first grant, an institutional grant from MUSC, and a publication that has turned out to be my most frequently cited peer-reviewed publication. It also served as pilot data for a NIMH-funded R21 focused on impulsivity and emotion dysregulation in borderline personality disorder with and without substance use disorders. These experiences have enabled me to mentor students, such as Andrew Littlefield, Ph.D., on impulsivity-focused projects that, I believe, have furthered their careers. This whole line of research and mentoring in the area of impulsivity is the ever-growing, outward-moving impact of a single generous act, much like a small pebble dropped in a body of water. It is my hope that over the course of my career I will continue to drop small pebbles in water.

What advice would you give to other professionals in your field who are starting out as mentors?

If a faculty member is just beginning to mentor others, such as students and fellows, it may be that this individual is relatively junior. For these individuals, the best advice I can provide is to maintain clear boundaries in the mentor-mentee relationship. Maintaining clear boundaries in mentor-mentee relationships can be challenging early in an academic’s career because the mentor might have more in common with the mentee than he or she has with other faculty members. However, it can be difficult to simultaneously manage the dual relationship of mentor and friend, so my advice is to avoid the dual relationship.

Spotlight on a Mentor interviews are presented by ABCT’s Academic Training and Education Standards Committee with editing by Helen Z. MacDonald. If you are interested in learning more about Dr. Coffey’s work as a mentor, to learn about other exceptional ABCT mentors, or to add your mentorship profile to the ABCT Mentorship Directory, please visit www.abct.org/mentorship/.

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NEWS

Featured Award Recipient: Outstanding Contribution by an Individual for Education/Training

Katherine J. W. Baucom, Chair, Awards & Recognition Committee

This month we are pleased to feature Christine Maguth Nezu, Ph.D., ABPP, recipient of the 2016 Outstanding Contribution by an Individual for Education/Training Award. This award recognizes ABCT members who have provided significant contributions to the education and training of behavior therapists.

Dr. Maguth Nezu is a Professor of Psychology and Professor of Medicine at Drexel University. She has maintained a licensed practice for nearly 30 years (Nezu Psychological Associates, of which she is Clinical Director of Training) and is board certified in Clinical as well as Behavioral and Cognitive Psychology. Over the course of nearly 30 years, she has provided training in behavior therapy to hundreds of doctoral students, practicum externs, psychology interns, and postdoctoral supervisees. As co-developer and master trainer of Contemporary Problem-Solving Therapy (PST), Dr. Maguth Nezu has provided 24 training workshops at ABCT and the WCBCT, as well as scores of other national and international workshops on PST. She has trained nearly 1,000 VA and DoD professionals in the nationwide roll-out of Moving Forward, a PST-based intervention she co-developed to enhance resilience and reduce emotional distress.

In addition to this long list of contributions, Dr. Maguth Nezu has made substantial contributions through her participation on and leadership of the American Board of Professional Psychology (ABPP). She was pivotal in the designation of Behavioral and Cognitive Psychology as a specialty, and represented the specialty as a member of the Board of Trustees of the ABPP for 10 years. She is a past president of ABPP and the recipient of the 2014 Russell Bent Award for Distinguished Contributions to ABPP.

Although this award recognizes professional accomplishments, at the Awards Ceremony in New York we learned that Dr. Maguth Nezu’s training in the principles of behavior therapy permeates all aspects of her life. Her children and grandchildren sent the following note that was read at the ceremony: “Your 3 children and 4 grandkids want to send their love and admiration on this special occasion. We can’t imagine a more appropriate honor for our mom given how you were able to teach and train us to solve problems, live passionately, and try our best. Although we cannot be physically present in NYC today, we are there in spirit and incredibly proud of you for getting this award. We know dad (Dr. Art Nezu) feels the same way! Much congrats, mommers!—From Frank, Ali, & Linda and the 4 grandkids.”

Given the extent of her direct or indirect impact on the training of countless ABCT members in cognitive and behavioral therapy, the Awards Committee agreed with her nominators that “it [was] time for ABCT to recognize her with this distinguished award.”
Addictive Behaviors Special Interest Group Early Career Achievement Award: Jennifer Merrill

Ellen L. Leavens, Oklahoma State University

The Association for Behavioral and Cognitive Therapies Addictive Behaviors Special Interest Group recognizes members who have made a substantial impact in the field of addictive behaviors. At the 2016 ABCT Convention, we honored Dr. Jennifer Merrill, who was nominated and selected for the Early Career Achievement Award. This award is presented biannually to a member who has made substantial early career contributions to the field of addictive behaviors. Jennifer Merrill received her Ph.D. from the University at Buffalo in 2012. She is currently an Assistant Professor (Research) at the Center for Alcohol and Addiction Studies in the Department of Behavioral and Social Sciences at Brown University. In their enthusiastic recommendations, Jennifer Merrill’s mentors describe her as “highly productive” and note “the depth of her work in multiple areas defines an impressive trajectory as an early career scientist.” Only 4.5 years post-Ph.D., she has over 40 peer-reviewed publications with numerous others under review.

Dr. Merrill has primarily focused on investigating the etiology and consequences of alcohol misuse among young adults, with a particular interest in the subjective evaluation of alcohol-related consequences. During her graduate training, she earned an NIH F31 from NIAAA. In her dissertation, she showed that when upperclassmen perceive their recent consequences as particularly negative, they engage in downward shifts in drinking in the short term (Merrill et al., 2013). She later replicated and extended this study in a larger sample of underclassmen, followed over 2 years (Barnett, Merrill et al., 2015). She has documented that subjective evaluations mediate the relationship between two other antecedent variables (perceived consequence norms and prior experience with consequences) and alcohol use (Merrill et al., 2013). Recently, she documented both between- and within-person predictors of consequence evaluations (Merrill et al., 2016). Passionate about this line of research, Dr. Merrill has secured a K01 award from NIAAA to support implementation of an ecological momentum assessment study to examine whether evaluations of consequences in real-time are associated with later drinking. Her work in this area highlights the etiological importance of how students personally experience alcohol consequences and is likely to inform interventions for young adult drinkers.

Dr. Merrill has also been adding to a growing body of literature on pregaming among college students. Specifically, she examined risk factors and reasons for pregaming (Read, Merrill, & Bytschkow, 2010), and helped to develop a measure on motivations to pregame (Bachrach, Merrill, Bytschkow & Read, 2012). She later adapted the Timeline Follow-back interview to assess links between pregaming behaviors and associated alcohol-related consequences in a fine-grained manner. She used multilevel modeling to demonstrate that pregaming put students at greater risk for consequences at the event-level (Merrill et al., 2013). Most recently, she examined descriptive pregaming norms as a predictor of pregaming, and theory-based moderators of this association (Merrill et al., 2016).

In addition, she has a growing interest in mobile-health interventions for alcohol misuse, and recently completed a pilot study to deliver accurate descriptive and injunctive norms information to college student drinkers, via text messaging, in hopes of impacting their drinking attitudes and behaviors. She has current interests in qualitative methods, ecological momentary assessment, advanced data analysis, and intervention development.

References


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The Cruel Postdoctoral Tutelage of Dr. Mei

Jonathan Hoffman, Neurobehavioral Institute

Dean McKay, Fordham University

“OCD treatment is a dish best served a la carte”  
—Old CBT Proverb

My advisor, Dr. Bill, had scheduled a sendoff meeting with me after graduation. I’d finally earned the “comma Ph.D.” after my name. Like dragon images branded on the forearms of Shaolin temple grads, this sacred lettering would forever be in my signature.

I swaggered into Bill’s office like an ABPP in Behavioral and Cognitive Psychology. After all, I was about to begin two years of postdoctoral residency specializing in obsessive-compulsive disorder (OCD) with the fabled Dr. Mei. Dr. Mei was Bill’s mentor, and had been a highly sought after supervisor for ages. I had obtained this coveted but enigmatic posting—no applicant had been accepted in recent memory—only thanks to the philosophical backing of Dr. Bill in her recommendation letter.

To prepare for this “beyond the match” APPIC-approved training program, I had immersed myself in the latest manualized interventions for OCD. Endless hours of role-playing as both therapist and patient while leaping back and forth between chairs in my living room had helped me learn each exact step in my manuals by heart. My “manuels’ kata” was flawless.

I told Dr. Bill all about my prowess. Then she said, “Kiddo, I can see you’re feeling pretty good. I don’t want to be a Dr. Debbie Downer, but there’s a historical case example that I need to tell you.” She stopped to play her dizi, a long bamboo flute. “Ah, tenure,” I thought.

The parable commenced, “Once upon a time at the very first ABCT annual conference, in around the year one-double-knot-time at the very first ABCT annual conference, in around the year one-double-knot—

three . . .”2 (Of course it wasn’t known as ABCT back then.)

And continued, “. . . coming from opposite directions toward a salon to hear a panel called ‘The Great Wall of China as a Metaphor for Denial,’ a talented young postdoc and an infinitely powerful Fellow named Dr. Mei crossed paths. Dr. Mei, in an almost unfathomable display of generosity, gave the postdoc the slightest of nods. The nod was not returned.”

Bill mused, “Now was it the intention of the resident to insult Dr. Mei? Or did he just fail to see the generous social gesture? That remains unknown. What is known were the consequences.” The resident had soon realized his grievous affront and tried to console Dr. Mei, only to find him “in . . . consolable.”

< Pause for effect > “So began the massacre of the postdoc’s record of supervised hours toward licensure.” < Flute solo > “And so the legend of Dr. Mei’s Five-PowerPoint-Exploding-Reputation technique began.”3

Bill had wrapped up our meeting saying, “one of the things I’ve always liked about you, Kiddo, is < flute interlude >, you appear wise beyond your years. So, allow me to impart a word to the wise: Whatever—WHAT-EVER—Dr. Mei says, reinforce it. If you flash, even for an instant, any prepackaged therapeutic verbiage, or if you throw him any Third Wave CBT sas, he will snap your treatment plans like they were twigs, and that will be the narrative of you. Now remember, no post-truth explanations, or referencing your adulting workshops, at least for the first year or so . . . Adios.”

Ah, so the point of the parable had emerged: Dr. Bill was concerned that my clinical acumen that were so intellectually rigorous that the “manualized CBT styles” I had practiced were useless. I was “as helpless as a worm fighting an eagle,” Dr. Mei observed.

But as soon as I had totally capitulated to his overwhelming therapizing dominance, Dr. Mei’s stern countenance softened. He gently inquired, “Is it your wish to understand the mysteries of evidence-supported OCD interventions for diverse clinical presentations?” “Yes,” I whimpered, not so was old school. She always wanted me to think of metaphors for action in response to patients’ interests and readiness for change in any given moment. Honestly, who had time for that with so much research to consume? Anyway, I had no doubt that manualized OCD interventions were the future.

Not long afterwards, I tackled the 100 steep and overgrown rock-hewn steps to the OCD treatment center. Dr. Bill had warned me, saying, “Ugh, just recalling those stairs makes my back ache, and not only that, so many new patients struggle to get up them due to the asymmetry and the need to count.” When I reached the top, Dr. Mei was waiting in an executive-style office chair blocking the entrance, compulsively flicking at his long white beard (“There’s probably an excellent manualized app for that,” I thought). I walked toward my new master clinician and put the backpack carrying my arsenal of manuals down. Then I greeted him saying, “I am unworthy to be your student.” After observing me closely, Mei sighed deeply and said, “Bill is your advisor, is she not? “Yes,” I answered. “She’s informed me you’re not entirely un schooled in OCD treatments. What clinical training do you possess?”

“I am proficient in the exquisite art of manualized exposure-based interventions for OCD,” I answered proudly, with just a soupcon of arrogance. In response, Mei unleashed a torrent of invectives about my shortcomings as a clinician. Giving him the benefit of the doubt, I wondered if this was coprolalia or if it was a guilt-induced symptom from his “massacre” of the ill-fated postdoc, a.k.a. Dr. Jackson. (Of course, thanks to Dr. Bill, I knew it was best not to share my opinions with my new supervisor.)

Once he was finished swearing at me, Mei calmly asked, “Do you consider yourself my equal as a practitioner-scientist?” I indicated I did not (and said, again just to myself, “It’s scientist-practitioner, you dolt”), to which he replied, “Let’s see how you good you really are.” Whirling his fighting staff around at incredible speed, he attacked me with a series of rapid-fire challenges to my clinical acumen that were so intellectually rigorous that the “manualized CBT” I had practiced were useless. I was “as helpless as a worm fighting an eagle,” Dr. Mei observed.

But as soon as I had totally capitulated to his overwhelming therapizing dominance, Dr. Mei’s stern countenance softened. He gently inquired, “Is it your wish to understand the mysteries of evidence-supported OCD interventions for diverse clinical presentations?” “Yes,” I whimpered, not so
much out of meekness but because he had me in an excruciatingly painful Chicken Wing Wrist Lock.

So began my postdoctoral training under the cruel tutelage of Dr. Mei.

**Day 1**

I was told to design three recommendations for each OCD case discussed in the morning staffing, but to refrain from mentioning them. Although I didn’t get the point, I dutifully obeyed.

**Day 5**

What a week! I’d done nothing but stay quiet, and do the required readings—which were manga written entirely in Japanese. And I don’t speak Japanese! I had also been told I would be examined on their plot elements but never was. I was beyond confused; and jealous. I saw on Snapchat that my peers at the other OCD training programs were already filling in the blanks on hierarchy worksheets.

**Day 8**

When would my real training in how to treat OCD begin? Where were the manuals? I hoped that the first week of my program would turn out to be some traditional hazing we’d all get a big laugh from later. Still, recalling the importance of being sensitive to different CBT cultures, I persevered. I was told to binge watch the entire “Drunken Master” martial arts film series. What this had to do with treating OCD I couldn’t imagine. I thought nothing could’ve been more frustrating than having been a teaching assistant for Stat. 101, but this was.

**Day 22**

It had been one bizarre task after another since my first day as a postdoc, and still, no sign of an OCD manual. And yet . . . the patients in the clinic seemed to be progressing. My assignment on this shift was to conduct a literature review of Marvel’s Avengers, highlighting the various metahumans’ personality deficits and illustrating them with quotes from “Ant-Man while acting like I was the Professor from the X-Men.” What a juggling act! I was also assigned to read an unintelligible tBT “Lighter Side” series called “CBTers Assemble.”

**Day 47**

This was a new low. Dr. Mei said, “Kiddo, no matter what a patient verbalizes, respond with a joke.” An adolescent in our program said, “I had the thought that unless I knocked on wood in three series of eight perfectly timed taps someone in my family would get sick.” I responded, “How ‘thoughtful’ of you.” As the day progressed, my jokes improved, albeit slightly. An older gentleman whose OCD interfered with his marriage complained that his wife would not go to the gym with him, to which I quickly replied, “Well you know, some relationships just don’t work out.” Nonetheless, I was determined to see my training program through, if only to prove to Drs. Bill and Mei that I was worthy indeed.

**Day 60**

Each day I thought, “It can’t get any worse.” But Dr. Mei gave me his most bizarre instruction yet: to wax and then unwax his car, a gleaming Datsun 240Z. I could not experientially tolerate him one second longer. Yet, staying professional, I clenched my teeth and said, “Dr. Mei . . . I came here for training in OCD treatment, but I haven’t learned . . . a . . . single . . . thing . . . in . . . two . . . months!”

His immediate reaction was to assault me with vignettes of highly complex and refractory OCD cases. But this time, my responses were instinctive and uncannily on-point—I was using OCD treatment-relevant concepts and strategies at a level of clinical acumen that I had never experienced. Thought-action fusion. Boom! Inflated sense of responsibility. Boom! Overvalued ideation; Intolerance of uncertainty; The “just right” error. Boom! Boom! Boom! But I didn’t plan any of these concepts, they were just there. I also somehow knew how to contextualize my clinical protocols in the proper theory. At will, I was utilizing Inhibitory Learning Theory, even Neural Network Models, as conceptual frameworks for exposure-based therapy.

But how had I learned all of this? Even stranger: I wasn’t relying on what I had memorized in the OCD treatment manuals, not at all! I was flexibly and dynamically utilizing principles and neuroscience-based mechanisms of action, adapting to what each patient was doing in the moment rather than imposing any a priori structure. As our sapping ended, Dr. Mei simply bowed and stated, “You have been set free from the manual, grasshopper.” I was taken aback by the insect reference, but it was still a high compliment, and as I had not received any the past two months, I was grateful.

Then I had an epiphany; OCD treatment could not live by manual alone. As Bruce Lee, the founder of Jeet Kune Do, the art of fighting without a fixed methodology, said:

“Don’t get set into one form, adapt it and build your own, and let it grow, be like water. Empty your mind, be formless, shapeless—like water. Now you put water in a cup, it becomes the cup; you put water into a bottle it becomes the bottle; you put it in a teapot it becomes the teapot. Now water can flow or it can crash. Be water, my friend.”

To me, in the blink of an eye, Dr. Mei had metamorphosed from being a detested mentor to an honored mentor. I realized what he and his unorthodox “teaching way” had accomplished; he’d transformed me from a clinical mechanic into a clinical-scientist-warrior. I finally understood that Dr. Bill had been trying to save me from myself. Manuals Schmanuals! What a lucky postdoc resident I was! I, Dr. Beatrix Kiddo, told Dr. Mei I was ready to be like water in conducting OCD treatment.

Beaming with satisfaction, he said, “Call me Pai.” Then he put a pebble in his hand and asked me to try and snatch it before he could close his fingers. I failed. He said my training would be concluded when I could do this, inherently linking it to mastery of skills not a set time. Then he said, “okay, if you can’t grab the pebble, see what happens when you pull my finger.”

That infantile comment from Dr. Mei summed up the essence of OCD treatment. It is “never a straight line. It’s a forest. And like a forest it’s easy to lose your way.” I now understood that weird “Old CBT proverb.” This treatment, at its highest level, must be constantly renewed and reimagined in the instant of its application, “a la carte.” Its complexities cannot be learned from the pages of a manual any more than the nuances of Kung Fu. “Beyond the manual” OCD treatment can be deadly serious, opaque, frustrating, take the therapist and patient down many blind alleys, and even be quite silly, especially the exposure exercises—but for all you Kiddos out there like me, that’s the process you’ll need to master to truly learn the art of practicing this clinical science.

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4This is how the character Hattori Hanzo, an incomparable swordsman, described “revenge” in *Kill Bill*. FYI, in history there was a famous ninja with this name.
Welcome, New Members!

**Associate**
- Ofer Bar Nahum
- Gail Glass-Malley
- Donald K. Vardell
- Jennifer Winkelmann

**Full Members**
- Tahirah Abdullah
- Woo-Young Ahn
- Nadjet Aknouche
- Kenneth Alexander
- Jessica Allen
- Suman Ambwani
- Brenda Aranda
- Ashley Arens
- Nanci Argueta
- Nancy Arikan
- Agusta Arnardottir
- Amy Bach
- Larry Baer
- Eugene Baker
- Tanya Bannister
- Abigail Batchelder
- Tom Beckers
- Michele Bedard-Gilligan
- Patricia Behnke
- Belinda Bellet
- Andrea Bergman
- Shadi Beshai
- Sarah Best
- Jennifer Betkowski
- Fernanda Bianchi
- Mathieu Bilodeau
- Janie Black
- Melissa Blanock
- A. Maya Borgueta
- Andrea Brandon
- Christiana Bratiosi
- Brittany Brothers
- Melissa Brotman
- Anat Brunstein Klomek
- Berglind Brynjolfsdottir
- Jennifer Burbidge
- Kimberly Busi
- Karina Campos
- Susan Caplan
- Kristen Carpenter
- Gabrielle Carson
- Hilary Cartwright
- Corinne Cather
- Kelly Champion
- Tulsi Das Chel-Lapilla
- Kristin Christodulu
- Michelle Chung

**ABCT**

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<td>Annie Ginty</td>
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WELCOME, NEW MEMBERS

Erin Rivelis
Courtney Rodrigue
Deborah Rosenberg
Kate Rosenblatt
David Rosenstein
Jeffery Roskelley
Luba Royburd
Amy Rubin
Lesia Ruglass
Meredith Rumble
Paul Salkovskis
Matthew Sanders
Douglas Scambler
Amanda Scanlon
Jack Schapiro
Charles Schrier
Brandon Scott
Kay Segal
Rhonda Seiman
Shannon Self-Brown
James Seltzer
Mavis Seow
Kelly Serafini
Lacey Seymour
Daniel Shapiro
Jack Sherratt
Benedikt Sigurdsson
Stacy Simon
Erica Simon
Jo Ann Sirey
Nicole Siritine Marshall
Amer Smajlic
Deborah Smyth
Mary Solanto
T. (Soma)

Somusundaram
Sue Sonshine
Erin Sparapani
Anthony Speier
Elizabeth Spencer
Elana Spira
Clint Stankiewicz
Georgia Stathopoulou
Selden Stern
Regan Stewart
Randi Streisand
Stefanie Sugar
Aimee Sullivan
Beth Surbeck
Nicole Swain
Vandana Syali
Deborah Szanto
Christina Theodore-Okolta
Kerrie Thompson
Margret Thorarinsdottir
Katherine Thorpe
Hrund Thrandardottir
Heedie Tinker
Timothy To
Meghan Tomb
Tea Trillingsgaard
Beth Troutman
Julia Turovsky
Alanna Updegraff
Nehal Vadhvan
Nady Van Broeck
Saskia Van der Oord
Carmelo Vazquez
James Vermilyea
Peter Vik
Denise Walker
Kathryn Walker
Megan Wallace
Marion Wallace
Kate Walsh
Kristen Walter
Carl Weems
Jessica Weiss
Christopher Wenner
Patricia Wightman
Daniel Williams
Jayne Williams
Kenneth Wilson
Cami Winkelspecht
Til Wykes
Paula Yanes-Lukin
Fatih Yavuz
Elizabeth Yeater
Michael Zarabi
Sigal Zilcha-Mano
Heidi Zinzow

New Professional

Leah Adams
Rizwan Ahmad
Dana Anderson
Robin Aupperle
Kimberly Avalone
Shelley Avny
Margaret Bockrath
Michael Boroughs
Yegeyot Botanov
Laura Boucher
Abby Braden
Kelsey Bradshaw
Christine Brady
Amber Brandes
Douglas Brodman
A. Meltem Budak
Teresa Burrell
Matteo Capriotti
Leonardo Caraballo
Ruby Charak
Taylor Chesney
Carla Chugani
Molly Cox
Sarah Craig
Julia Craner
Elin Eadie
Tara Emrani
Sherry Fawcett
Hope Forbes
Nicole Fowler
Pablo Gagliesi
Yuliana Gallegos
Rodriguez
Kristine Gerwell
Karen Ghelani Ghelani
Loren Gianina
Deborah Golden
Arlene Gordon-Hollingsworth
Andrea Gottlieb
Kelly Grailing
Brittany Hall
Anna Harrison
Jennifer Herring
Catherine Herrington
Regina Hiraoka
Olha Hoxha
Margaret Hunt
Brian Kaufman
Stephanie Keller
Bin-Na Kim
Abigail Lambert
Jan Leonardi
Svetlana Levak
Cheri Levinson
Ari Lowell
Alexandria Luxon
Ana Carolina Macchio
Alyssa Mandel
Doron Marbe
Joseph Meyer
Meredith Meyer
Nida Mirza
Tina Montreuil
Stuart Murray
Andrada Neacsu
Hong Nguyen
Anthony Onyemenem
Michele Parkhill
Sheena Potzrecht
Kristina Reigstad
Meg Reuland
Jennifer Rodgers
Vivian Rodriguez
Archilla
Johana Rosas
Lilly Rousseva-Stoyanova
Sarah Savoy
Julia Schirm
Doni Silverstein
Elizabeth Smyth
Lauren Steffel
Suzanne Straebler
Elin Taylor
Kristel Thomassin
Mary Tooan
Jay Tramadina
Letitia Travalgini
Aaron Trinh
Julia Vahlson
Jorge Valderrama
Jared Van
Johanna Vignusdottir
Duyen Vo
D. Catherine Walker
Terrance Walker
Emma Warnock-Parkes
Kerry Wells
Miriam Wollesen
Caroline Wright
Ali Yurasek
Imad Zaheer
Deborah Zlotnik

Postbacalaureate

Kala Allen
Murat Artiran
Isabel Apy
Samantha Auty
Margaret Baer
Kirstin Baker
Maha Balouch
Katherine Benjamin
Emilie Bertschinger
Kavita Bhandari
Katherine Bogen
Simone Budzyn
Moira Butler
Camila Caballero
Emilia Cardenas
Sofia Cardenas
Cintly Celis-de Hoyos
Kathryn Coniglio
Kristina Conroy
Abigail Cooper
Samantha Cootner
Katherine Corteselli
Rebecca Crochiere
Katherine Cottner
Katharine Criteselli
Kelly Dorn
Karla Dowdy
Savannah King
Kianna King
Alexander Kinzler
Alexandra Klein
Madison Knox
Maya Krek
Elizabeth Lagbas
Lauren Laifer
Robbert Langwerden
Adina Lieberman
Frances Loeb
James Madole
Gerald Martin
Colleen Maxwell
Ciara McAfee
Allyson McHugh
Katherine Melz
Hannah Milhorn
Hannah Miller
Rose Miller
Mirinda Morency
Valerie Everett
Margaret Farney
Julia Felicione
Michelle Ferris
Natalie Finn
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Anna Fouser
Aubrey Francavilla
Aaron Frazier
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Natz-a-ru Gonzalez
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Kathryn Harris
Kirstie Herb
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Mira Hoffman
Jordan Hoffmeister
Kelyn Holmes
Birgitte Holvand
Jessica Hruschak
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Franklin Huntington
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Jeremy Karp
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Yehsong Kim
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Hannah Milhorn
Hannah Miller
Rose Miller
Mirinda Morency

the Behavior Therapist

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Allison Flett
Christina DiSanzo
Laura Distel
Louise Dixon
Sara Dobosh
Michael Dolsen
Jim Doorley
Morgan Dorr
Halina Dour
Taylor Dovała
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Deborah Duke
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Tamará Grent
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Gabriella Grimaldo
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Cortney Janicki
Iman Jarad
Megan Jeffreys
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August Jenkins
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Olga Kucherrina
Anastasia Kudinova
Stephanie Kuhlman
Andrea Kulish
Amy Kupper
Bryan Kutner
Leigh Kwansky
Rebecca La Prade
Jamie Lacey
Ryan Lackner
Brittany Lance
Natalie Lankford
Leann Lapp
Caitlin Larsen
Madeline Larson
164 the Behavior Therapist
Welcome, New Members

April • 2017

Denise Lau
MarLe Lauber
Rebecca Lauzier
Elaine Lavin
Jeffrey Lawrence
Nicholas Lazzareschi
Thien-An Le
Trang Le
Yana Lechtman
Annie Ledoux
Jasper Lee
Angela Lee
Erica Lee
Daniel Lee
Jin Lee
Alena Lee
Alison Legrand
Jennifer Lehmann
Austin Lemke
Ariella Lenten-Brym
Karena Leo
Erin Leonard
Ruscelle Leone
Francesca Lewis-Hatheway
Qian Li
Corey Lieneman
Stacy Lin
Tanya Line
Lance Linke
Arielle Linsky
Alexandra Lipinski
Levi Lipovenko
Rachel Lippin-Foster
Leah Litwin
Nicholas Livingstone
Louiza Livschitz
Maxine London
Alexandra Long
Devon LoParo
Patricio López Salazar
Jennifer Lorenzo
Noah Lorincz-Comi
Rachel Luba
Lauren Lucente
Rachel Luckman
Kelsey Ludwig
Kelsey Luk
Ryan Lundell-Creagh
James Lyng
Maddison Lynn
Laura Machlin
Natalia Macynikola
Kelsey Magee
Ioan Malu
Alyssa Mall
Molly Maloney
Kathleen Maloney
Joclyn Malys
Adam Mandel
Faigy Mandelbaum
Atina Manvelian
Igor Marchetti
Russell Marks
Elizabeth Marks
Lauren Martel
Kimberly Martin
Nicole Massa Calderon
Babette Mathai
Brandon Matsumiya
Caitlyn Maye
Christina Mayfield
Caroline Mazzer
Laura McArdell
Shannon McCarrick
Julie McCarthy
Michael McClay
Katherine McCurry
Kellie McFarlane
Shaam McGhie
Anastasia McClade
Andrew McGrath
Kate McGrath
Caitlin McIlwee
Allison Mckinnon
Tierney McMahon
Jennifer McMahon
Elizabeth McRae
Elleni Mehari
Kritzia Merced
Kristina Metz
Allison Meyer
Kelly Meyerling
Whitney Mhoon-Mock
Brett Miller
Elizabeth Miller
Natalie Miller
Llewellyn Mills
Summer Millwood
Marissa Miroglotta
Erin Mistretta
Neha Mistry
Jenny Mitchell
Lauren Mize
Anthony Molloy
Hylton Molzof
Allison Momany
Lyndsey Moran
Aisa Moreno Megui
Alyssa Morgan
Daniel Moriarity
Elizabeth Moroney
Sarah Morris
Jessica Morse
Hannah Morton
Danielle Moskow
Cameron Mosley
Sara Moss
Michael Mularkey
Rachel Munnn
Kristina Murani
Lexa Murphy
Meghan Murray
Sara Muscat
Zoe Mushkat
Michelle Myers
Laura Nagy
Khadeja Najjar
Claire Nakajima
Monica Nanda
Jessica Nardi
Samuel NAYman
Ronnit Nazarian
Allyson Negreja
Erin Neill
Nicole Nelson
Brady Nelson
Khlaudia Nephotou
Andrea Newman
Leora Newman
Lauren Ng
Bao-Tran Nguyen
Victoria Nicosia
Marie-Christine Nizzi
Lucy Nonas-Barnes
Sarah Nowalis
Stephen Nitt
Karey O’Hara
John O’Hara
Robert Ogle
Sunyoung Oh
Kimberly Oleary
Olenka Olesnycky
Lisa Olinger
Kathryn Oost
Sikandar Ortega
Brenda Osorio
Hannah Ottmar
Melina Omanessian
Victoria Owen
Sarah Owens
Nico Pagan
Jessica Palmer-Bacon
Santiago Papini
Anna Papova
Alexandra Pappas
Michaela Paraskeva
Siama
Meera Parbhakar
Juhyun Park
Suzanne Parker
Delana Parker
Sarah Parrish
Carly Parsons
Brandon Patallo
Anushika Patel
Jennifer Patten
Kaitlyn Patterson
Briana Paulo
Rena Pazienza
Bethany Pecora-Sanefski
MacKenzie Peltier
Ellie Peskosky
Madeline Peters
Deena Peyser
Randy Phelps
David Phillips
Steven Pilato
Daniel Pineau
Jennifer Piscitello
Maribel Plasencia
Kasia Plessy
Lillian Polanco
Ilana Pomerantz
Gabriella Ponzini
Gina Poole LaPosta
Colleen Popores
Will Porta
Andrew Porter
Amberly Portero
Sriramya Potluri
Allison Powell
Andrea Pratt
Jennifer Prentice
Nikki Press
Jun Qi
Serene Qiu
Dakari Quimby
Victoria Quinones
Alyssa Raggio
Kanthi Raja
Pamela Rakhshan
Allura Ralston
Amrita Ramakrishnan
Kaitlyn Ramian
Jennifer Ramirez
Sofia Ramirez
Devon Rand-Giovannetti
Alora Rando
Osiris Rankin
James Rankin
Natalia Rappa
Zach Rawlings
Lauren Reeves
Kimberly Reinstein
Frances Rekrut
Alejandra Reyna
Brooke Reynolds
Catherine Rice
Malaya Richard
Jenae Richardson
Julia Richmond
Natalie Richton
Nicole Ricketts
Lara Rifkin
Laura Rindlaub
Marina Ritchie
Clair Robbins
Ciara Roberts
Lauren Rodriguez
Craig Rodriguez-Seijas
Mary Rogers
Andrew Rogers
Brooke Rogers
Anna Rogic
Rosalyn Rohling
LG Rollins
Brenton Roman
Julie Rones
Benjamin Rooney
Andres Roque
Anna Ros
Chelsey Rosen
Tamura Rosen
Naomi Rosenbach
Zach Rosenberg
Eve Rosenfeld
Allen Rosenthal
Karlie Roshong
Cari Rosoff
Jaclyn Ross
Karen Rothman
Melanie Roys
Lauren Rozmus
Boaz Safer
Alison Sagon
Devora Samet
Courtney Santucci
Naama Sarig
Melissa Saucedo
Danielle Sauro
Pamela Scalise
Gabriella Scalzo
Kayla Scamaldò
Lauren Schafer
Jamie Schaffer
Christina Scharmer
Jennifer Schild
David Schillinger
Andi Schmidt
Taylor Schnaper
Mallory Schneider
Nicole Schultz
Amihai Schwab
Kay Schwader
Rosanna Scott
Matthew Scult
Kimberly Selgrad
Antonia Seligowski
Katelyn Selver
When was the last time you took a look at your membership data?

April is election month. By now you should have received your username and password. This is an excellent time to look at your membership directory information. Do we have all of your data correct? Is critical information missing? Did you know that ABCT’s leadership looks to see how our members spend their time doing research, practice, and teaching and makes some decisions based on these data?

Do we have your licensure information and board updates? If not, send copies of this documentation to Sue Bezares, Membership Services Association, sbezares@abct.org
Implementing LGB-affirmative CBT: A Transdiagnostic Minority Stress Treatment Approach

John Pachankis, Ph.D., Associate Professor at the Yale School of Public Health and Director of the ESTEEM Research Group in New York City

- 11:00 A.M.–12:30 P.M. Eastern | 10:00 A.M.–11:00 A.M. Central | 9:00 a.m.–10:30 A.M. Mountain | 8:00 A.M. – 9:30 A.M. Pacific
- $30 for members | $45 for nonmembers

Sexual orientation disparities in mental health and related psychosocial outcomes are one of the most robust population disparities in psychiatric epidemiology, likely driven by LGB people's disproportionate exposure to stigma-related stress. This presentation will review the first evidence-based treatment package to reduce depression, anxiety, and related health conditions by reducing the processes through which stigma-related stress impairs the mental health of this population. Attendees will learn to utilize LGB-affirmative therapeutic principles and techniques to adapt standard cognitive-behavioral approaches to specifically address the stigma-related stress faced by LGB people across development. Preliminary efficacy data from a recent RCT will be presented suggesting that this LGB-affirmative treatment package, called ESTEEM, can reduce sexual minority men's depression, alcohol abuse, sexual compulsivity, and HIV risk behavior.

Register at www.abct.org
ABCT 50th Anniversary Album • PLAY IT FORWARD

Jon Abramowitz, Ph.D. • Jon Comer, Ph.D. • Aaron Fisher, Ph.D. •
Elizabeth Hall, Ed.D., Ph.D. • Steve Hayes, Ph.D. • Jon Hershfield,
MFT • David Juncos, Psy.D. • Reed Kendall • Sam Kramer, MA •
Adam LaMotte, M.A. • Jaimie Lunsford, B.S. • Steve Mazza, M.A. •
Tony Puliafico, Ph.D. • Jose Soler-Baillo, M.A. • Dennis Tirch, Ph.D.
• Tim Verduin, Ph.D. • Jerome Yoman, Ph.D., ABPP

To celebrate the 50th anniversary of ABCT, Play It Forward has released a compilation album featuring 14 songs written and performed by ABCT members. Proceeds go to the ABCT student research grant and travel award funds.

Those who donate at least $10 will receive a CD in the mail in addition to the digital download.

Now available for download

All donations go to ABCT

MINIMUM DONATION: $5.00

https://www.playitforward.com/projects/14