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PRESIDENT'S COLUMN

Why I Support the American Psychological Foundation (APF), and Why You Should Too

Terence M. Keane, Ph.D.

In 1953, a group of pre-eminent psychologists started a not for profit foundation to support psychological studies worldwide. This was the beginning of the American Psychological Foundation (APF). Each year, APF provides small grants to graduate students, early career psychologists, and to those psychologists engaged in innovative work unlikely to garner support from the usual federal funding agencies. In addition, APF makes many awards recognizing outstanding students and early career psychologists; plus multiple lifetime achievement awards for our most accomplished scientists, academics, and scholars come from or through the APF. This is an amazing organization.

The range and scope of the work of APF is nothing short of remarkable. To understand the depth of the work, consider visiting the website: www.apa.org/apf

I should disclose that I am a member of the Board of Trustees of the APF and it is a role that I truly value given its mission and vision. I've also decided that this is one place where I not only wanted to dedicate some personal time, but also where I wanted to contribute philanthropically. As a senior member of the Psychology community, I deeply appreciate what this profession means to me and what it has given me over the course of my many decades of studying and practicing Psychology. APF is one place where I can express my appreciation while supporting young psychologists complete their dissertations, collect pilot data for a major grant submission, or conduct a clinical program that might serve as a demonstration project. In all cases, the APF helps the psychologists involved, the community, and the participants in any given project. APF does good things for many people with every grant it makes. The reach is astounding in many cases.

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While the areas of interest supported by APF are broad and defined, the models, methods, and measures to study these areas aren't at all specified. Intentionally, projects are drawn from the deep theoretical and methodological strengths that characterize our field. Thus, projects from clinical, counseling, developmental, experimental, cognitive, and the neurosciences are all solicited and funded in any given round of grant submissions. The areas of interest include topics of great current interest to our communities and to society broadly: a) Treating serious mental illness, b) Studying gifted children and adolescents, c) Preventing violence, d) Understanding prejudice, e) Connecting mental and physical health, f) Combating homophobia, g) Examining human reproductive behaviors, h) Exploring child psychology, and e) Using psychology to aid in disaster recovery. Yet, there are many other mechanisms established by philanthropically minded psychologists that address an even broader range of topics in Psychology. These are all delineated on the website. Do take some time to explore these opportunities.

Today, the APF is engaged in a capital campaign to raise funds that will permit the organization to fund more grants than ever from young people. We need help from all corners. We need your help. With a lean staff of five exceptionally talented people working for an outstanding Executive Director, Lisa Straus, and with the help of the APA for infrastructure, the APF is a lean organization that returns excellent yields on investments and operates with a very low level of overhead. This means that contributions go in large measure to the purposes intended by contributors.

At the annual SCP Board meeting in Toronto fellow Board member David Barlow and Executive Director Lisa Straus presented the APF mission, vision, and portfolio to the Board of SCP. The reception was excellent and the Board encouraged me to bring to our membership the opportunities that APF presents. With this Presidential Column, I am bringing to the attention of all the unique opportunity that APF presents to us to give back, to help the next generation, and to recognize the value of the work that our profession does for our community and for our country.

For me, APF represents great value. It is a trusted organization with more than sixty years of history doing good things for Psychology and for the people we serve. The range of grants it provides to young people touches upon the interests of almost all of us and these areas represent reasons why many of us became psychologists initially. APF also permits us to give back to the field, to make it ever stronger, and even more valuable to our society.

Let me provide an example of this. Mary Woody is a graduate student in clinical psychology at Binghamton University (SUNY) where she is studying depression with Brandon Gibb, Ph.D. one of the country's bright young investigators working to understand the nature of intergenerational transmission of mood disorders. With her recent grant from the APF, Mary will extend their collaboration to study high risk children and their families looking for a neurodevelopmental marker in brain circuitry. By studying these children from a genetic, psychophysiological, and behavioral perspective the goal is to shed new light on the frequent observation that depressive disorders runs in families. Approaching the problem from multiple levels of analysis was made possible by the APF funds. Importantly, this work will serve as a dissertation that promises to make a significant contribution to this literature by studying children prior to their first episode of depression.

So many of us in this field are blessed with interesting jobs, work, patients, and colleagues and are grateful for the chance to do the work we do and have the careers we've chosen. Now, as the APF is engaged in a Capital Campaign, isn't it time to ponder ways at this time of the year in which we can give back to the field? Doing so is easy: you can make a one-time contribution by going to the website, or you can send an email to foundation@apa.org. One of our senior development people will be back in contact with you to present the various options for making a philanthropic gift.

Many years ago I was celebrating the awarding of a grant on PTSD with a collaborator who was decades my senior. We drove to a fine restaurant in Boston's Back Bay for dinner. Immediately in front of us was another customer driving a car valued at over a hundred thousand dollars then! I was driving my trusty Toyota Camry and jokingly commented that maybe I couldn't afford eating at this nice a place. My friend and colleague turned immediately to me and said: "Terry, there's someone who doesn't really know what to do with their money." Over dinner, I learned what causes this person supported over the course of their lifetime and was deeply impressed. It was a lesson I vowed never to forget: those of us who do well have the responsibility to give back.

Please join me in supporting APF. There is never a better time than now for all of us to join together to make the world better, one psychology grant at a time.

THANK YOU!

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The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders

A Progress Report

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Abstract: Transdiagnostic approaches represent a significant shift in how we conceptualize the classification, etiology, treatment, and prevention of psychopathology. Amid increasing recognition that diagnosis-specific approaches are not achieving their intended public health impact, transdiagnostic interventions also offer a more parsimonious solution to the barriers associated with the dissemination and implementation of evidence-based psychological treatments. The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2011) is an emotion-focused, cognitive-behavioral intervention designed to target transdiagnostic temperamental features. The present article provides a progress report on the UP's efforts to increase the quality and availability of evidence-based psychological treatments and ultimately reduce the mental health treatment gap. The article summarizes the progress achieved since the concept of a unified treatment for emotional disorders was first introduced, as well as some more recent research that is currently in progress. Lastly, in acknowledgment that there is still a long way to go before effective treatment is readily available to all those in need, directions for future research are proposed.

Key words: unified protocol, transdiagnostic, emotional disorders, psychological treatments, dissemination, implementation

Introduction

Jacqueline Bullis

Transdiagnostic treatment approaches have gained impressive momentum in recent years. These interventions, which reflect a more parsimonious approach to treatment, may help facilitate the dissemination and implementation of evidence-based treatments in real-world clinical settings since proficiency in only one protocol would allow a practitioner to provide evidence-based treatment for a variety of clinical presentations (McHugh, Murray, & Barlow, 2009). When delivered in a group-based format, transdiagnostic treatments have pragmatic benefits, such as cost-effectiveness and scalability (e.g., the ability to deliver a transdiagnostic protocol to a diagnostically heterogeneous group of patients). Transdiagnostic interventions are also well suited to address comorbidity and other-specified disorders (i.e., clinically significant symptoms that do not meet diagnostic criteria for a specific diagnosis), both of which are highly prevalent in routine clinical practice (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; McLaughlin, Geissler, & Wan, 2003). Equally important, transdiagnostic protocols that directly target core mechanisms may improve therapeutic outcomes (Craske, 2012; McManus, Shafran, & Cooper, 2010).

As interest in transdiagnostic approaches increases, so does the number of transdiagnostic treatment protocols. There are now multiple transdiagnostic protocols for the treatment of anxiety and depressive disorders in existence, including cognitive-behavioral, mindfulness-based, and acceptance-based interventions (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015). Additionally, because the term transdiagnostic is used broadly to characterize interventions that are applicable to more than one diagnosis, it does not distinguish between different categories of transdiagnostic approaches. For example, some transdiagnostic interventions represent a distillation of evidence-based strategies commonly included in treatment protocols for a group of disorders, such as exposure for the treatment of

anxiety disorders, while others target the mechanistic processes responsible for the maintenance of symptoms across disorders (Sauer-Zavala et al., under review). Due to the multiplicity of transdiagnostic approaches and their relative recency, the particulars of existing protocols are easily confounded with one another.

The conceptual framework and clinical utility of a treatment approach based on a shared etiology of emotional disorders was first presented by one of us (D.H.B) in a paper entitled "Toward a Unified Treatment for Emotional Disorders" (Barlow, Allen, & Choate, 2004). In the decade that has since passed, the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders has been published as a manualized protocol and translated into over six languages (Barlow, Ellard, et al., 2011; Barlow, Farchione, et al., 2011). However, research on transdiagnostic approaches is still a developing area; a search of PSYCInfo in August of 2015 revealed that 75% of articles with the term transdiagnostic in the title were published within the past five years and 98% were published within the past 10 years.

The purpose of this article is to provide an update on the Unified Protocol (UP), a transdiagnostic, shared mechanism treatment. We begin with an overview of the development of the UP and the intervention itself, followed by a summary of the empirical research that has been conducted to date. We then discuss some of our research efforts related to the UP that are currently underway, including preliminary results when available, to provide a preview of forthcoming developments. We conclude with some proposals for future directions in transdiagnostic research.

The Unified Protocol: 2004 – Present

Protocol Development

The concept of a unified treatment approach evolved from an amalgamation of empirical evidence from different research areas demonstrating that emotional disorders (i.e., anxiety, mood, somatic, obsessive, trauma, and related disorders) share more similarities than differences. First, the considerable comorbidity that exists among emotional disorders suggests the presence of shared features (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Kessler, Berglund, et al., 2005; Merikangas et al., 2003), as does evidence that a targeted treatment for one diagnosis also yields improvements for comorbid diagnoses (Craske et al., 2007; Moscovitch, Hofmann, Suvak, & In-Albon, 2005; Tsao, Mystkowski, Zucker, & Craske, 2005). Next, research from affective neuroscience has demonstrated that individuals with anxiety and depressive disorders display similar structural and functional abnormalities in areas of the brain associated with heightened negative affect, such as hyperactiviation of the insula and amygdala (Etkin & Wager, 2007; Holmes et al., 2012; Shin & Liberzon, 2010). Lastly, research utilizing structural equation and latent variable modeling has identified a hierarchal structure of emotional disorders where higher-order temperamental constructs (e.g., neuroticism, negative affect) account for significant variability in the onset, overlap, and maintenance of emotional disorders (Brown, 2007; Clark, 2005; Watson, 2005).

David H. Barlow

The integration of these research findings suggests a general biological vulnerability shared among emotional disorders, which we refer to as neuroticism (Barlow, Ellard, Sauer-Zavala, Bullis, & Carl, 2014). Neuroticism is a dimension of temperament that is characterized by the frequent experience of negative affect and a perceived inability to cope in response to stress. Individuals with emotional disorders not only experience heightened levels of negative affect, but they also find the experience of negative emotions more distressing and are less accepting of their emotional experiences than healthy individuals (Campbell-Sills, Barlow, Brown, & Hofmann, 2006a; Tull & Roemer, 2007). Consequently, they engage in efforts to suppress or avoid the emotional experience (Aldao & Nolen-Hoeksema, 2010; Ottenbreit & Dobson, 2004), which paradoxically results in the persistence of emotional distress and associated interference (Abramowitz, Tolin, & Street, 2001; Campbell-Sills, Barlow, Brown, & Hofmann, 2006b; Moore, Zoellner, & Mollenholt, 2008). It is the interpretation of emotions as unacceptable or intolerable and subsequent attempts to control the emotional experience that we view as the phenotypic expression of neuroticism and the core mechanism for the maintenance of emotional disorder

symptomatology (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014). Therefore, the treatment focus of the UP is conceptualized as neuroticism itself. A more detailed discussion of the conceptual background and development of the UP is available elsewhere (see Wilamowska et al., 2010).

Treatment Components

The UP is an emotion-focused, cognitive-behavioral intervention that was developed to target core temperamental characteristics underlying anxiety, depressive, and related disorders (e.g., somatic symptom disorders, dissociative disorders). The goal of the UP is to help patients cultivate a greater willingness to experience uncomfortable emotions and to reduce maladaptive emotion response tendencies.

There are eight modules in total and five core treatment modules (Modules 3-7). Perhaps due to its modular design, the UP is often incorrectly described as a therapeutic toolbox or as a distillation of existing evidence-based treatment strategies that can be flexibly implemented. It is important to clarify that the UP is a modular treatment to the extent that the treatment approach is divided into individual, self-contained modules that are connected to one another in content, but can also function independently (Chorpita, Daleiden, & Weisz, 2005). However, unlike other modular treatments that consist of a collection of empirically supported treatment elements and guidelines for how to select the appropriate elements for a given patient, the UP is an intervention driven by a theoretical conceptualization (see Protocol Development above).

The first module focuses on motivation enhancement and treatment goal setting to promote treatment engagement. Module 2 provides psychoeducation on the adaptive, functional role of emotions and explains how emotions alert us to important information. The skill of tracking emotional experiences is also introduced, which emphasizes how avoidance behaviors perpetuate emotional reactivity through negative reinforcement. Module 3, the first of the core modules, helps patients begin to develop a present-focused, nonjudgmental awareness of emotions and their reactions to their emotional experiences. Judgments about emotions are often associated with negative, evaluative interpretations of the experience (e.g., "I'm a horrible person for being jealous of my friend's promotion") and prevent us from viewing the emotional experience as informative and temporary. Next, Module 4 increases cognitive flexibility through the introduction of cognitive appraisal and reappraisal strategies. Patients learn that their automatic appraisals influence how they feel and that their feelings influence their future appraisals of situations, and moreover, that they can utilize reappraisal strategies to change the way they experience a negative emotion.

Module 5 addresses emotional avoidance by teaching patients how avoidance inhibits distress extinction and prevents them from developing a sense of self-efficacy regarding their ability to tolerate distressing emotions. Patients then identify their problematic emotion-driven behaviors and begin countering those behaviors by engaging in incompatible response tendencies. In Module 6, patients engage in interoceptive exposure exercises to increase both their awareness of how somatic sensations influence emotional experiences and their tolerance of these uncomfortable sensations. The final core module, Module 7, focuses on emotion exposures and allows patients to confront distressing emotional experiences while utilizing skills acquired throughout treatment. Specifically, patients learn to fully tolerate the emotional experience while implementing a new response, which facilitates the formation of new, more adaptive interpretations and appraisals. Finally, Module 8 reviews patients' progress throughout treatment and discusses specific strategies for relapse prevention.

Empirical Support

There is preliminary evidence to support the efficacy of the UP as a transdiagnostic intervention, namely an open clinical trial (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010) and a small randomized controlled trial (N = 37) comparing the UP to a delayed treatment condition (Farchione et al., 2012) for patients with a principal diagnosis of an anxiety disorder. These studies demonstrated that treatment with the UP significantly reduced both symptom severity and symptom interference across all anxiety and comorbid unipolar depressive disorders, with treatment gains maintained up to 18-months post-treatment (Bullis, Fortune, Farchione, & Barlow, 2014). In addition to reductions in symptomatology, the UP produced significant improvements in quality of life (Gallagher et al., 2013). In a preliminary exploration of the effectiveness in a group format, the UP resulted in moderate to strong effects on anxiety and depressive symptoms, functional impairment, and quality of life, and received strong acceptability and satisfaction ratings from patients (Bullis et al., 2015).

Ancillary analyses from the Farchione et al. (2012) study

have provided initial support that treatment with the UP produces changes in temperamental constructs, as well as evidence that the UP targets negative reactivity to emotional experiences. Specifically, treatment with the UP achieved moderate effect sizes for decreases in neuroticism/behavioral inhibition and increases in extraversion/behavioral activation that were associated with symptom improvement and largely stable through a 6-month follow-up period (Carl, Gallagher, Sauer-Zavala, Bentley, & Barlow, 2014). Treatment with the UP also produced significant changes in both the frequency of and reactivity to negative emotions from pre- to post-treatment (Sauer-Zavala et al., 2012). However, emotional reactivity emerged as the only significant predictor of symptom change, suggesting that the way individuals interpret and relate to their emotions is more closely linked to symptomatology than the frequency with which they experience negative emotions.

As noted earlier, the UP was designed to be applicable to disorders characterized by non-acceptance and avoidance of emotional experiences. Although the majority of existing empirical support for the UP is limited to patients with a principal diagnosis of an anxiety disorder, there is early support derived from clinical replication series and case studies for the efficacy of the UP for other diagnoses, including patients with bipolar disorder and comorbid anxiety (Ellard, Deckersbach, Sylvia, Nierenberg, & Barlow, 2012), borderline personality disorder (Sauer-Zavala, Bentley, & Wilner, 2015), and principal depression (Boswell, Anderson, & Barlow, 2014). There is also support from a randomized placebo controlled trial for the treatment of individuals with comorbid anxiety and alcohol use disorders, where the UP was the only treatment condition that produced significant decreases in heavy drinking, outperforming both an antidepressant and the combined treatment condition (Ciraulo et al., 2013).

Research in Progress

Although the efficacy of transdiagnostic interventions for the treatment of anxiety and depressive disorders is now supported by two meta-analyses (Newby et al., 2015; Reinholt & Krogh, 2014), a number of important empirical questions remain. As Norton and Paulus recently wrote: "Moving forward, the question may not be whether transdiagnostic and unified therapies work, but rather how they work, what mechanisms are at play, how do we integrate them into our systems of healthcare and personalize care for individuals, and for whom are they most effective?" (2015, p. 10). Our current research efforts are focused on answering precisely those questions, as well as a number of complementary ones. The examples discussed below, although not exhaustive in nature, represent a selection of some of the more recent research related to the UP that is currently underway.

Our Current Clinical Trial

To date, only one clinical trial has compared a transdiagnostic approach to well-established single-disorder protocols (SDPs) (Norton & Barrera, 2012). Findings from this trial demonstrated equivalent reductions in self-reported measures of anxiety and depression in sample of 46 treatment initiators with social anxiety disorder, generalized anxiety disorder, or panic disorder, but analyses of clinician-rated measures were inconclusive. Consequently, despite a consensus that transdiagnostic approaches may significantly improve the adoption and availability of evidence-based psychological treatments (EBPTs), further evaluation of how transdiagnostic treatments compare to "gold standard" psychological treatments is necessary.

Our research team is now approaching completion of a large equivalence randomized trial (N = 250) to determine whether the efficacy of the UP differs significantly from that of existing empirically supported SDPs for patients with a principal diagnosis of generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, or social anxiety disorder. Patients were randomized to either treatment with the UP, the SDP indicated for their principal diagnosis, or a waitlist control condition. The acute treatment phase of the trial has been completed and we will continue to collect 6- and 12-month follow-up data through early 2016. This trial will allow us to evaluate the relative efficacy of the UP compared to well-established SDPs on symptom reduction, comorbidity, and overall functioning at both acute outcome and over a one-year follow-up period. Moreover, we will be able to assess the relative effects of each treatment on temperament and the extent to which changes in temperamental variables mediate outcome.

Mechanisms of Change

If we are to optimize the efficiency and effectiveness of psychological treatments, we must understand the mechanisms through which change occurs (Kazdin, 2007). Although there is preliminary support from our earlier clinical trial that treatment with the UP produces changes in temperament (Carl et al., 2014) and changes in negative reactivity to emotional

experiences (Sauer-Zavala et al., 2012), further research is necessary to more explicitly identify the mechanism through which these changes occur. One proposed mechanism of change in the UP is that the development of present-focused, nonjudgmental emotional awareness facilitates distress extinction and consequently the associated emotional reactivity and avoidance. We recently evaluated this hypothesis in small sample of patients with heterogeneous anxiety disorders utilizing an alternating treatment design; patients alternated between using mindfulness- and avoidance-based strategies to cope with distress experienced during emotion exposures over the course of six weeks (Brake, Sauer-Zavala, Boswell, Gallagher, Farchione, & Barlow, under review). Although the use of mindfulness-based strategies was associated with higher overall distress, distress levels declined throughout the course of treatment, whereas avoidance-based strategies were associated with more static distress levels, suggesting that a larger dose of treatment may be necessary to achieve a therapeutic effect for mindfulness-based strategies. Our current clinical trial will allow us to further explore treatment mechanisms in a much larger sample.

Long-Term Outcome

To our knowledge, there are currently only two studies published on the efficacy of therapist-delivered transdiagnostic treatments beyond a 6-month follow-up assessment (Bullis et al., 2014; Garcia, 2004). An important future direction for transdiagnostic interventions will be to evaluate the long-term maintenance of treatment gains, particularly in comparison to SDPs. Our current equivalence trial evaluates patients at 6- and 12-months posttreatment, which will allow us to not only determine whether the UP is equivalent to SDPs at acute outcome, but also whether the maintenance of treatment gains are equivalent at one-year posttreatment. However, existing studies of long-term cognitive-behavioral therapy (CBT) outcomes for anxiety disorders suggest that a meaningful number of patients who achieve remission will experience symptom reoccurrence during the first two years post-treatment (Scholten et al., 2013). By targeting core temperamental vulnerabilities, it is possible that the UP will result in superior long-term outcomes over an extended follow-up period. To examine this hypothesis, we are currently recruiting patients who were treated with either the UP or an SDP in our equivalence trial for a long-term follow-up study. This adjunctive study assesses the maintenance of treatment gains for an additional two years (i.e., three-years posttreatment) and will provide valuable insight into the durability of treatment effects.

Treatment Augmentation

Although the contribution of emotion regulation to development and maintenance of emotional disorders is well established (e.g., Aldao, Nolen-Hoeksema, & Schweizer, 2010), the majority of research has focused on negative emotions. However, recent research suggests that dysregulation of positive emotions occurs across emotional disorders and that deficits in positivity affectivity may be an important transdiagnostic treatment target (Carl, Soskin, Kerns, & Barlow, 2013). In line with these findings, we have developed a novel augmentation intervention targeting disturbances in positive emotion regulation and conducted a preliminary evaluation of the intervention's feasibility and utility (Carl, 2015). The intervention, which was evaluated in patients with heterogeneous anxiety disorders who completed a course of CBT during our current equivalence trial, was delivered over the course of four sessions and significantly improved positive emotion regulation skills for 55% of the sample. Gains in these skills were also associated with moderate to large effects on anxiety and depression symptomatology, positive and negative affectivity, functional impairment, and quality of life. Further empirical support and more controlled evaluations of this intervention are necessary, but it is an important initial step increasing the efficacy of transdiagnostic treatments and maximizing their impact on quality of life and overall well-being.

Personalization

The National Institute of Mental Health recently called for greater personalization of treatment outcome research as one of the four objectives in their strategic plan to translate scientific opportunity to public health impact (Insel, 2009). Although the UP was designed as a modular treatment, existing studies have only evaluated the efficacy of the UP when it is delivered in entirety (i.e., all eight modules) and in sequential order. As an initial step toward maximizing the efficiency of the UP and establishing guidelines for treatment personalization, we recently explored the sensitivity (i.e., whether module delivery produces change on the associated treatment skill) and specificity (i.e., whether changes that occur during module delivery are limited to the associated treatment skill) of four UP treatment modules in a small sample of patients with heterogeneous emotional disorders, all patients received the same dose of treatment (i.e., four sessions). Results found that the four modules

evaluated (psychoeducation and tracking of emotional experiences, emotion awareness training, cognitive flexibility, and emotion avoidance) demonstrated sensitivity, while specificity was only supported for emotion awareness training and cognitive reappraisal (Sauer-Zavala, Cassiello-Robbins, Conklin, Bullis, Thompson-Hollands, & Kennedy, under review). These findings, which suggest that individual modules of the UP exert a therapeutic effect even when delivered in isolation, provide preliminary empirical support for the modularity of the UP. Future studies will evaluate whether personalization of the UP optimizes the efficacy and efficiency of the intervention.

Novel Applications

Although the bulk of existing empirical support for the UP is for the treatment of anxiety and comorbid unipolar depressive disorders, the UP was developed to address other disorders characterized by negative reactions to and avoidance of emotional experiences. Therefore, systematic evaluation of the UP within emotional disorders other than anxiety disorders is a priority for our research team.

Eating disorders. Recent research has begun to emphasize the role of emotion dysregulation in the development and maintenance of these diagnoses (Lavender et al., 2015). For example, individuals with eating psychopathology demonstrate higher intensity and less acceptance of their emotions (Svaldi, Griepenstroh, Tuschen-Caffier, & Ehring, 2012). Eating disorders are also frequently comorbid with other emotional disorders (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004), suggesting that the UP may be both an efficacious and efficient treatment for these patients. We recently adapted the UP for use in a group format for patients with severe eating disorders, and it is currently in use at two residential and five non-residential treatment centers, with plans for implementation at an additional nine treatment centers within the next six months. We are collecting data on treatment outcomes for eating-related symptomology, as well as anxiety, depression, distress aversion, and emotional avoidance. Preliminary findings suggest that compared to a pre-implementation sample of patients, the UP is associated with greater symptom reductions across a variety of outcomes. A complementary aim of this initiative is to collect data on training outcomes and clinician attitudes toward EBPTs to inform future implementation efforts.

Suicidality. Patients at high risk of suicide are typically hospitalized for a short period of time in an acute care setting, and thus interventions designed to reduce suicidality must be parsimonious and time-limited. Individuals who engage in more avoidant-based coping are at an elevated risk of suicide, suggesting that interventions that focus on decreasing emotional avoidance, such as the UP, may be particularly efficacious (Cukrowicz, Ekblad, Cheavens, Rosenthal, & Lynch, 2008). We recently began evaluating the feasibility, acceptability, and preliminary efficacy of an abbreviated version of the UP in an acute stabilization unit with patients who either recently attempted suicide or are experiencing severe suicidal ideation. Patients are randomized to receive either treatment as usual (TAU) or to five sessions of the UP targeting suicidal ideation and behaviors. Although data collection is ongoing, preliminary results suggest that the UP is very well received among patients and also produces large effect sizes for the reduction of anxiety, depression, hopelessness, and suicidality when compared to TAU. Follow-up assessments, which are being conducted at one- and six-months after discharge, will provide data on maintenance of treatment gains, as well as whether the intervention reduces future suicide attempts.

Dissemination and Implementation

Despite the development of many evidence-based psychological treatments (EBPTs), fewer than 40% of individuals suffering from a mental illness receive treatment in a given year (Wang et al., 2005). The lack of therapists trained to deliver EBPTs remains one of the primary barriers to the availability of effective care (McHugh & Barlow, 2010). Transdiagnostic approaches like the UP, which are designed to target a range of clinical presentations, may prove more efficient and cost-effective for the dissemination and implementation of EBPTs (Farchione & Bullis, 2014; McHugh, Murray, & Barlow, 2009). As such, it is essential to not only evaluate the efficacy of the UP, but also its effectiveness when delivered in routine care settings. We are currently evaluating the feasibility, acceptability, and tolerability of the UP among patients with diverse medical and psychiatric comorbidity within a hospital setting. In tandem, we are assessing stakeholders' response to the implementation of the UP to determine their satisfaction and perceptions of the UP's fit within a generalist setting, which will provide valuable information as to the UP's readiness for broader implementation within routine care settings.

The disparity between the number of people in of need of mental health care and the availability of effective treatment is even greater in low- and middle-income countries (Kohn, Saxena, Levav, & Saraceno,

2004). Accordingly, researchers are beginning to evaluate the efficacy of interventions that can address a range of clinical presentations in these settings (e.g., Murray et al., 2014). We have recently partnered with the Colombian Innovation Agency to evaluate the effectiveness of a culturally adapted version of the UP for victims of the Columbian armed conflict, many of whom were affected by displacement, torture, kidnapping, and sexual assault. This partnership will provide valuable data on the feasibility of implementing a transdiagnostic, shared mechanism intervention in trauma-exposed and low-resource countries.

Assessment

Despite the recent interest in transdiagnostic approaches to the conceptualization and treatment of psychopathology, our current diagnostic system, DSM-5, continues to reflect a categorical approach to assessment. Given an accumulation of evidence suggesting that categorical classification is likely imposing artificial boundaries on constructs that are inherently continuous in nature (e.g., Brown, 2007; Brown, Chorpita, & Barlow, 1998), we have proposed a dimensional approach based on the shared features of emotional disorders as an alternative (Brown & Barlow, 2009). Instead of assigning DSM diagnoses, a profile is generated that reflects a patient's standardized scores across a variety of constructs, such neuroticism, behavioral activation/positive affect, mood, and avoidance behaviors. An initial empirical evaluation in a large sample of adults with anxiety and depressive disorders demonstrated that a dimensional profile approach accounted for variance above and beyond DSM diagnoses in the prediction of both self-reported and clinician-assessed outcomes (Rosellini & Brown, 2014). The Multidimensional Emotional Disorder Inventory (MEDI; Rosellini, 2013) is a recently developed self-report measure designed to assess transdiagnostic vulnerabilities consistent with a dimensional approach. Although it is currently under validation, the MEDI is representative of a transdiagnostic assessment approach that is well suited for treatment planning and outcome monitoring for shared mechanism treatments like the UP (Rosellini, Boettcher, Brown, & Barlow, in press).

Prevention

It has been proposed that neuroticism may play a significant role in the prevention of adverse physical and mental health outcomes if interventions were able to successfully intervene upon this temperamental risk factor (Lahey, 2009). The UP was designed to target neuroticism and thus may be an efficacious preventive intervention for young adults at-risk for developing emotional disorders. We recently developed such an intervention through the distillation of the core

The **Society of Clinical Psychology** is planning a poster award competition for Student Posters accepted through Division 12 for the 2016 APA Convention in Denver, CO.

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For questions: contact Sharon Berry, PhD, ABPP at Sharon.berry@childrensmn.org

UP treatment components into a single, two-hour workshop. We are currently delivering the workshop to an indicated sample of university freshmen and collecting pilot data to determine the initial feasibility and acceptability of the intervention, as well as skill acquisition. Preliminary results from workshops conducted to date are promising, with participants who received the workshop reporting significantly lower levels of depression at a three-month follow-up after controlling for baseline scores than participants in the assessment-only condition. Future research will examine utilize larger samples and extended follow-up assessments to determine whether the intervention is efficacious for prevention of emotional disorder symptomatology.

The Unified Protocol Institute

We recently launched the Unified Protocol Institute to promote the dissemination of evidence-based care. The Unified Protocol Institute regularly hosts training workshops at the Center for Anxiety and Related Disorders at Boston University, and our certified trainers travel around the world to provide workshops and specialized trainings. In addition, we offer a program implementation package for treatment centers seeking to implement a site-wide roll out of the UP. For those who may be interested in more extensive training, we offer a therapist training program consisting of individual supervision in the delivery of the UP. We also offer the option to become a certified UP trainer, which upon successful completion allows therapists to administer the UP, train other clinicians within their institution, and to provide clinical supervision in the UP.

An important initiative of the UP Institute is assess the effect of workshops on clinicians' knowledge and use of the UP, and to use these data to inform future training efforts. In line with this initiative, we are collecting data on knowledge acquisition of workshop content, implementation of UP following workshop attendance (e.g., how often clinicians use the UP in their routine practice, how closely do they follow the protocol), and possible moderators of training outcomes (e.g., theoretical orientation, degree). Empirical evaluations of community therapists' declarative knowledge following a one-day CBT workshop are discouraging, with more than 75% of therapists scoring 50% on a measure of knowledge acquisition (Scott, Klech, Lewis, & Simons, 2015). It is possible that the UP, a parsimonious intervention based on a unified theory of emotional disorders, will result in enhanced knowledge acquisition.

Final Remarks

Research suggests that approximately 50% of individuals in the United States will suffer from a psychological disorder at some point in their lifetime, and yet the majority will not receive treatment (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Kessler, Demler, et al., 2005). Of the minority who do receive some form of treatment, even fewer receive care that is consistent with evidence-based treatment recommendations (Wang, Berglund, & Kessler, 2000). It is disappointing that this epidemic is driven not by lack of efficacious treatments, but rather by a lack of access to effective treatment. By eliminating the need to train therapists to administer a different manualized protocol for each diagnosis, transdiagnostic approaches have the potential to greatly improve the quality, availability, and efficiency of evidence-based care. Indeed, a primary motivation for the development of the UP was to reduce a key barrier to the dissemination and implementation of effective psychological treatments through the reduction of the number of diagnosis-specific protocols.

Since the publication of our initial proposal for a unified treatment approach in 2004, research on transdiagnostic interventions has proliferated, resulting in the development of numerous transdiagnostic protocols, particularly for the treatment of anxiety disorders. If the publication trends observed within recent years continue, research in this area will continue to grow exponentially. However, the impact of transdiagnostic treatments on the mental health treatment gap will continue to be minimal if these treatments are not readily available to those in need. Therefore, it is imperative that future research prioritizes the identification of mechanisms of action of existing efficacious treatments so that we can augment their efficiency and effectiveness. Similarly, we must explore more creative ways to increase the demand and availability for effective treatments, including direct-to-consumer marketing (Santucci, McHugh, & Barlow, 2012) and greater utilization of technology (Jones et al., 2015). It is our hope that the current article, which reports on the evolution of the UP from treatment development to research currently in progress, will encourage others engaged in transdiagnostic research to consider which questions are most important to answer with regard to moving us closer to our collective goal of alleviating suffering and promoting well-being.

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Material to be submitted should conform to the format described in the sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries and submissions may be made to editor Jonathan S. Comer at: **jocomer@fiu.edu**.

Articles published in *The Clinical Psychologist* represent the views of the authors and not those of the Society of Clinical Psychology or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

Jonathan S. Comer, Ph.D. - Editor

Guidelines for Identifying Empirically Supported Treatments

Practical Recommendations for Clinical Researchers and Reviewers

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Recently, the Society of Clinical Psychology (SCP) updated its criteria for empirically supported treatments (ESTs). Whereas the original criteria (Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1993) identified a psychological treatment as "well-established" when it was supported by at least two independently conducted, well-designed studies or a large series of well-designed and carefully controlled single case design experiments, and "probably efficacious" when it was supported by at least one well-designed study or a small series of single case design experiments, the new criteria (Tolin, McKay, Forman, Klonsky, & Thombs, in press) take advantage of the dramatic increase in published clinical trials over the past two decades, requiring the presence of systematic reviews of existing studies.

Based on the entire body of published research as synthesized in systematic reviews, treatments will now be assigned a recommendation level, derived from a modified version of the widely-used Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system (Atkins et al., 2004; Guyatt et al., 2008). The level of recommendation for a given psychological treatment may be Weak, Strong, or Very Strong. A Very Strong recommendation is made when there is high-quality evidence that the treatment produces a clinically meaningful effect on symptoms of the disorder being treated, as well as a clinically meaningful effect on functional outcomes, with significant improvement noted at immediate post-treatment and at a follow-up interval of not less than three months after treatment discontinuation, with relatively little risk of harm and reasonable resource use, and there is at least one well-conducted study that has demonstrated effectiveness of that treatment in non-research settings (e.g., settings that provide routine clinical care such as community mental health centers, inpatient or outpatient treatment facilities, health maintenance organizations, or private practices). A Strong recommendation requires the presence of moderate- to high-quality evidence that the treatment produces a clinically meaningful effect on symptoms of the disorder being treated, or on functional outcomes, again, with a clear positive balance in consideration of benefits versus possible harms and resource use. Evidence of external effectiveness of generalizability is not required for this level of recommendation. Weak recommendations are made when there is only low- or very low-quality evidence that the treatment produces a clinically meaningful effect on symptoms of the disorder being treated and/or functional outcomes, or when the evidence suggests that the effects of the treatment may not be clinically meaningful (though they may be statistically significant). When a given treatment does not merit one of the above recommendations, the Task Force will report on the reason(s) that the treatment was not recommended.

David F. Tolin

The aim of the present article is to guide researchers on how to produce and synthesize data in order

to obtain a recommendation for a psychological treatment according to the new EST criteria. We will work backwards through the process, beginning with the final step: the systematic review.

Developing systematic reviews that can be used to make EST recommendations

Systematic reviews will be evaluated by a Task Force, selected for breadth and depth of knowledge in psychological treatment and systematic reviews and absence of conflict of interest, operating under the SCP Committee on Science and Practice. The deliberations and findings of this Task Force will aim to be open and transparent at all times. The Task Force will evaluate published reviews as well as unpublished reviews which can be submitted by anyone, though it will not conduct its own reviews (that process will eventually be part of the American Psychological Association's Treatment Guidelines development process) (Hollon et al., 2014).

The Task Force will first evaluate the quality of a systematic review using an adaptation of the AMSTAR checklist (Shea, Bouter, et al., 2007; Shea, Grimshaw, et al., 2007; Shea et al., 2009). The aim of this checklist is to determine the degree to which a review's conclusions can be considered a reliable basis for clinical decision-making. The checklist is not used to generate a total score; accordingly, there is no cutoff at which a review is considered reliable; rather, the items on the checklist will be used to inform the group's decision of when a systematic review is of sufficient quality and reported sufficiently well. The checklist items give specific guidance for authors of systematic reviews. Specifically:

1. Use an 'a priori' design. Before the conduct of the review, define the research question and establish the study inclusion criteria. Ideally, systematic reviews will be registered with the PROSPERO international prospective register of systematic reviews.
2. Use duplicate study selection and data extraction. Have at least two independent data extractors, and develop a consensus procedure for disagreements.
3. Perform a comprehensive literature search. Search at least two electronic sources (e.g., MedLine, PsycInfo). In the report, describe the databases searched, as well as the publication years included in the search. List the search key words and/or MESH terms. Supplement the electronic search by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found.

Evan M. Forman

4. State how you addressed publication status in study inclusion. For a comprehensive search, attempt to find unpublished reports as well as published ones. A search for unpublished reports could include searching Dissertation Abstracts International, posting requests for unpublished studies on relevant listservs, or other strategies. State whether or not any reports were excluded based on their publication status, language, or other factors.
5. Provide a list of included and excluded studies. A list of included and excluded studies should be provided. Many journals are unlikely to publish a list of studies that were not included; however, a list of excluded studies could be offered as online supplemental material or should at least be available upon request.
6. Describe the characteristics of the included studies. Create a table or other format in which you provide information about the participants, interventions, comparator and outcomes of each included intervention trial. Include sample information such as age, race, sex, relevant socioeconomic data, diagnosis, illness duration, illness severity, comorbidity, and concurrent treatments.
7. Assess the scientific quality of the included studies. Assessment and documentation of the quality of the reports is often overlooked in meta-analyses. In the next section, we will describe methods for evaluating risk of bias across relevant domains of clinical trial designs.

E. David Klonsky

8. Consider the scientific quality of the included studies when formulating conclusions. When conducting your analysis and developing conclusions, incorporate the methodological quality of the studies. When making recommendations, include an explicit statement about how the quality of the studies informs (for better or for worse) those recommendations.
9. Use appropriate methods to combine the findings of studies. When creating pooled results, use tests to ensure that it is appropriate to combine the studies. When significant heterogeneity among the studies is found, use a random effects model and/or make a logical argument about whether it is clinically appropriate to combine studies.
10. Assess the likelihood of publication bias. Include a combination of graphical aids (e.g., funnel plot, other available tests) and/or statistical tests (e.g., Egger regression test).
11. State conflict of interest. This applies to the meta-analysis author as well as the authors of the included studies. For the meta-analysis author, acknowledge any sources of support or other potential conflicts of interest. For the included studies, indicate the degree to which conflicts of interest may constitute a risk of bias.
12. Calculate effect size estimates for both symptoms of the disorder and functional outcomes. A Very Strong recommendation is reserved for those treatments with a documented beneficial effect on both symptoms and functional outcomes.
13. Calculate effect size estimates at both post-treatment and at follow-up. For a Very Strong recommendation, clinically meaningful improvement must be documented not only at immediate post-treatment, but also at an interval of not less than three months after treatment discontinuation.
14. Identify studies that demonstrate effectiveness of the treatment in non-research settings. This study need not meet full inclusion criteria for the systematic review. However, in addition to the effect size estimates needed for the systematic review, A Very Strong recommendation also looks for at least one well-conducted study that suggests effectiveness of the treatment in settings that provide routine clinical care such as community mental health centers, inpatient or outpatient treatment facilities, health maintenance organizations, or private practices, not just in academic institutions.

Developing clinical trials that can be used for systematic reviews

Dean McKay

A systematic review is only as strong as the individual studies on which it is based. Therefore, it is important that clinical trial researchers produce high-quality studies that provide robust evidence for synthesis in meta-analyses. As noted above, it is incumbent on the authors of systematic reviews to evaluate the methodological quality of each of the included studies. The new SCP criteria (Tolin et al., in press) include an adaptation of the Cochrane Risk of Bias Tool (Higgins et al., 2011) for evaluating the quality of clinical trials. The items give specific guidance for authors of treatment outcome studies. Specifically:

1. Use an adequate sequence for allocating participants to treatments. There should be a random component in the sequence generation process such as referring to a random number table, using a computer random number generator, or coin toss. There should be no non-random factors involved with assignment to groups.
2. Conceal allocation adequately. If clinical staff have knowledge about the groups to which the next patients recruited will be allocated, there is potential that this may influence who is recruited and when they are recruited, even if group assignments were initially made via randomization. Central allocation or sequentially numbered envelopes are both ways of concealing the allocation sequence, though central allocation, out of the hands of the research team, is the strongest method.
3. Keep study personnel and outcome assessors blind to treatment condition to the extent possible. In any clinical trial of psychological interventions, it is usually necessary to have some study personnel (e.g., clinicians, study coordinators) unblinded. However, at a minimum, outcome assessors should be unaware of participants' allocation, and measures should be used to assess whether the blind was broken.
4. When applicable, keep participants blind to

Brett Thombs

treatment condition. We recognize that in studies of psychological treatments, it is usually not possible to keep participants unaware of their treatment condition. In a study of treatment versus wait list, for example, participants are certainly aware of whether or not they are being treated. However, there may be some cases in which at least partial blinding is possible. Certain computerized treatments, for example, may permit randomization to conditions that are topographically similar, thus making it harder for participants to know whether they are receiving the active treatment (e.g., Amir, Beard, Burns, & Bomyea, 2009). In other cases, it might be appropriate to keep participants unaware of the study hypotheses, so that participants receiving two different treatments might not know which one is the target of the study. We recognize that this is a difficult aspect of psychological treatment research, and recommend that investigators consider different ways to prevent participants' knowledge of their treatment assignment from introducing systematic bias.

5. Use adequate strategies for handling incomplete outcome data. In an ideal clinical trial, there would be no missing outcome data. However, in reality, clinical trial results often have missing data due to attrition, skipped questions or questionnaires, equipment failure, and other factors. Primary trial outcomes should be evaluated on an intent to treat basis, which will typically involve the use of statistical imputation methods to take all of the available data into account. Clinical trials must be adequately powered to allow for such analyses; in many cases this will require substantially larger sample sizes than those that have been used in previously published trials. Completer analyses are not appropriate when there is missing data, and strategies such as last observation carried forward may yield misleading results.
6. Avoid selective outcome reporting. Before the study begins, identify the primary and secondary outcomes in a publicly-available study protocol or on a site such as www.clinicaltrials.gov. Ideally, a single primary outcome will be specified. In exceptional situations when more than one primary outcome is specified, appropriate statistical methods to account for multiple hypothesis tests must be described. The final paper should report on all outcomes specified in the pre-trial protocol with primary and secondary distinctions intact. In unanticipated situations, such as if data for the primary outcome cannot be obtained consistently, then changes in primary and secondary variables must be described.
7. Assess and document treatment fidelity. It is important to insure that the treatment was implemented as intended. Select therapists that have adequate qualifications and training to provide the study treatment. Use a publicly-available treatment manual so that others can replicate your findings. Monitor adherence to the treatment protocol in an ongoing fashion, using corrective measures such as additional training as needed.
8. Reviewing the adapted AMSTAR checklist for evaluating systematic reviews, clinical trial authors should also consider providing information that will feed into reviews that could generate a positive treatment recommendation. Specifically:
9. Describe the sample adequately. Provide information about your participants such as age, race, sex, relevant socioeconomic data, diagnosis, illness duration, illness severity, comorbidity, and concurrent and/or prior treatments.
10. Publish your results, whether or not your hypothesis was supported. Publication bias is a significant concern when reviewing the scientific literature, and it is important that the results of all clinical trials are disseminated. In the field of pharmaceutical research it is well documented that trials favorable to a sponsored product are more likely to be published than are trials not favorable to the sponsored product (Lexchin, Bero, Djulbegovic, & Clark, 2003; Lundh, Sismondo, Lexchin, Busuioc, & Bero, 2012). It is quite likely that the same phenomenon occurs in psychological treatment research as well. Registration of clinical trials (e.g., at www.clinicaltrials.gov) is increasingly emphasized to address this problem.
11. State conflict of interest. Acknowledge any sources of support or other potential conflicts of interest for the study.
12. Assess both symptoms of the disorder and

functional outcomes. The exclusive focus on symptom reduction risks ignoring other potentially important clinical outcomes, such as functional impairment (Dobson & Beshai, 2013). Although symptom reduction and improvements in functioning are significantly correlated, there can be a mismatch after treatment (see Vatne & Bjorkly, 2008, for review). Thus, it is possible that a treatment is highly effective at reducing specific target symptoms, and yet the patient fails to achieve desired clinical outcomes such as improved social or occupational functioning. We recommend that all clinical trials include at least one measure of work attendance or performance, school attendance or performance, social engagement, family functioning, or other functional measures.

13. Include follow-up assessments. Continue to assess study participants for at least three months after treatment discontinuation. In many cases, longer follow-up periods are desirable, such as in research involving addictive behaviors.
14. Conduct effectiveness research in addition to efficacy research. Effectiveness research focuses primarily on the generalizability of the treatment to more clinically representative situations. Criteria that could be considered include more diagnostically complex patients, effectiveness with non-randomized patients, effectiveness when used by non-academic practitioners, utility in open-ended, flexible practice, and outcomes in settings such as community mental health centers, inpatient or outpatient treatment facilities, health maintenance organizations, or private practices, not just in academic institutions.

Summary

As the quantity and quality of research on psychological treatments has increased, so too has the possibility and necessity of raising the bar for determining that a treatment is empirically supported. The new, more ambitious, criteria are described in detail elsewhere (Tolin et al., in press). The aim of the present article was to translate those criteria into tangible recommendations for investigators who wish to produce research that can be evaluated for EST recommendation.

The recommendation itself will be based on a transparent process using adapted AMSTAR criteria. Authors of systematic reviews, which can be submitted to the Task Force for review, should consider these criteria carefully. Specific recommendations include the use of 'a priori' designs, using duplicate study selection and data extraction, performing a comprehensive literature search and stating how publication status was addressed in study inclusion, providing a list of included and excluded studies, describing the characteristics of the included studies, assessing the scientific quality of the included studies and considering that quality when formulating conclusions, using appropriate methods to combine the findings of studies, assessing the likelihood of publication bias, stating conflict of interest, calculating effect size estimates for symptoms of the disorder and functional outcomes at both post-treatment and at follow-up, and identifying studies that demonstrate effectiveness of the treatment in non-research settings.

Similarly, clinical trial investigators can structure their research to more effectively and efficiently inform the systematic reviews. Meta-analysis authors are advised to evaluate clinical trials according to an adapted Cochrane Risk of Bias Tool. Clinical researchers are advised to consider the items on which the studies will be evaluated, including using an adequate sequence for allocating participants to treatments, concealing allocation adequately, keeping study personnel and outcome assessors (and participants, when appropriate and possible) blind to treatment condition, using adequate strategies for handling incomplete outcome data, avoiding selective outcome reporting, assessing treatment fidelity, providing adequate sample descriptions, publishing all trial results regardless of the outcome, stating conflict of interest, assessing symptoms of the disorder and functional outcomes at both post-treatment and at follow-up, and conducting both effectiveness and efficacy research.

We are the first to acknowledge that these recommendations set a very high bar for the quality of clinical trial reporting as well as the production of systematic literature reviews. However, we believe that the field has matured to the point where reaching these goals is quite possible. Furthermore, these recommendations are consistent with recommended procedures for developing guidelines for health care interventions, generally. Inevitably, some studies that were considered ESTs under the old criteria will not merit a recommendation under the new criteria, or there simply may not be enough research on a given treatment to conduct a systematic review at all. However, our hope is that like the previous criteria, the new criteria will stimulate a new generation of clinical research that provides clear evidence of the effects of psychological treatments, and that the dissemination of those findings will benefit consumers, practitioners, and policymakers. Ψ

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Confidentiality and Disclosure Dilemmas in Psychotherapy with Adolescents

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Psychologists who provide mental health services to adolescents and their families must navigate complex ethical challenges with respect to confidentiality and disclosure decision-making. Therapy with adolescents may touch on a myriad of high-risk and health-compromising behaviors, such as alcohol and drug use, antisocial and potentially illegal behaviors, and sexual exploration. There may be situations in which the therapist believes that an adolescent is engaging in behaviors that raise the potential for harm, but are unsure as to what types of behaviors might warrant disclosure to adults, such as parents/guardians. In addition, clinicians may feel bound by promises of confidentiality or worry that the alliance between therapist and client will be harmed through disclosure. How do mental health clinicians develop confidentiality policies that serve to protect minors from serious harm, fulfill professional and legal responsibilities, and preserve the therapeutic relationship with the adolescent and parents/guardians?

Developing and communicating ethically responsible confidentiality and disclosure policies at the outset of the professional relationship may be one of the most effective ways of minimizing the possibility of future confusion, harm, and misunderstanding about the professional responsibilities of psychologists and the nature of the therapeutic relationship. Not surprisingly, adolescents entering therapy may be concerned that information discussed in session will be shared with others, such as parents, teachers, or even law enforcement officials. Like many adults, adolescents may also be confused about professional and legal confidentiality rules, including to whom psychologists may (or, in some cases, obligated) to disclose information.

Pitfalls of Promising Absolute Confidentiality

The trusting relationship developed between clinician and client is a critical tool in generating meaningful mental health improvement. Clinicians, in an attempt to encourage feelings of comfort and to establish a positive therapeutic alliance with an adolescent (who may be ambivalent or even hostile about seeing a therapist) may be tempted to promise absolute confidentiality (sometimes referred to as a "secrecy pact") to the adolescent. These promises, however, conflict with professional standards and state laws that may require therapist disclosure, such as in cases of reported child abuse, and may lead to irreparable damage of the therapeutic relationship if there's a situation in which the therapist determines that disclosure is ethically warranted.

Maintaining confidentiality reflects respect for the client's rights to and expectations of privacy, while disclosure of confidential information in certain circumstances may fulfill the clinician's obligation and duty to prevent harm. The moral principle of integrity calls for psychologists to be truthful in their work, including their ethical commitments and responsibility. Promising to maintain confidentiality in all circumstances in an attempt to build rapport and facilitate the provision of perhaps much-needed psychological services may, at first glance, appear to be in the service of the client, but doing so compromises the integrity of the therapist (and profession) by making promises that may not be able to be kept.

Moreover, although clinicians might assume that disclosures will always harm a therapeutic relationship or that minors prefer absolute confidentiality, research suggests that adolescents may, in fact, expect adults in positions of authority (including psychologists and researchers) to act to prevent harm, such as in situations of physical or sexual abuse or suicidal ideation (Fisher et al., 1996; O'Sullivan & Fisher, 1997).

Determining When to Disclose

Practicing psychologists are aware that confidentiality and disclosure decisions are informed by a number of sources, including the APA Ethics Code, institutional rules, state laws and federal regulations relevant to mandatory disclosures. For example, all 50 states have laws and regulations regarding child abuse and many states include duty to warn laws that require therapists to inform outside parties when a client may be a danger to themselves or others. When treating adolescents, however, how do mental health clinicians determine the extent to which certain risk behaviors, such as non-suicidal self-injury (e.g., superficial cutting), drug and alcohol use, and sexual risk behaviors1, may be seen as developmentally appropriate experimentation

or otherwise carry a low possibility of harm versus ones that may pose serious risk to the adolescent or others, warranting disclosure to parents/guardians or other adults?

Several researchers have conducted informative survey studies with mental health professionals assessing under which circumstances they might consider breaking confidentiality with adolescent clients. For example, Rae and colleagues have conducted some interesting surveys of pediatric psychologists (2002) and school psychologists (2009) assessing their likelihood to break confidentiality in response to a number of hypothetical adolescent risk behaviors that carry the possibility of harm, such as smoking, alcohol use, drug use, sexual activity, self-harm and antisocial behaviors. Results indicated that the intensity/magnitude and frequency/duration of the behavior were important determinants in the decision to break confidentiality. Surprisingly, there was a good deal of variation among professionals in terms of disclosure recommendations. In addition to intensity and frequency of the adolescent risk behavior, confidentiality recommendations also varied based upon the gender of both the professional responding to the survey and that of the hypothetical client, as well as the age of the client (respondents were more likely to recommend breaking confidentiality with younger hypothetical clients). These results are certainly revealing, but questions remain as to the actual behaviors of pediatric psychologists and mental health professionals who are confronted with these dilemmas on a regular basis.

Confidentiality and Disclosure Considerations2:

Below are some considerations with respect to confidentiality and disclosure policies and procedures that may be helpful:

During the informed consent process, engage in a frank discussion with both the adolescent and parents/guardians about their expectations regarding confidentiality, and the clinician's confidentiality policies and professional responsibilities, including the legal limitations of confidentiality in therapy settings and the types of information that would communicated to parents/guardians (and the types that would not). Although it's impossible to anticipate exactly what a client may disclose in future sessions, it may be helpful to provide general guidelines of what types of disclosures are legally required and/or otherwise may warrant notification to parents/guardians or other authorities.

It might prove helpful to discuss whether parents/guardians expect to receive regular feedback about therapeutic progress. Ideally and if appropriate, adolescents should be informed of these meetings, there should be agreement at the outset of the general nature of information that will be communicated, and clinicians should clarify their primary professional role (namely, by not becoming a therapist to a parent/guardian) (Koocher, 2008).

Rather than a one-time speech delivered in the initial session, adolescents and their families may benefit from discussions about and reminders of confidentiality and other policies throughout the therapeutic process. These discussions can also serve as opportunities for adolescent client and parents/guardians to learn more about the therapy process, the roles and responsibilities of the clinician, and continue to discuss expectations of each party.

When appropriate, therapists who plan to disclose confidential material should consider informing and discussing the reasons for disclosure with the adolescent client (Prout, DeMartino & Prout, 1999). If appropriate, encouraging the adolescent to lead or be a part of direct discussions with parents/guardians may also serve to empower adolescent client and facilitate open communication with family members.

Conclusion:

Confidentiality policies and disclosure decisions always require careful ethical analysis by clinicians. Disclosure dilemmas related to treatment with adolescents and their families may raise unique ethical concerns and seemingly competing moral principles. Therapists may understandably experience tension when confronted by difficult disclosure decisions that require consideration of both professional/legal obligations and the adolescent's expectation to privacy (as well as the potential impact to the therapeutic relationship that may be associated with disclosure). Therapist promises of absolute confidentiality, while intended perhaps to help clients and/or facilitate positive therapeutic change, may in actuality endanger the safety and well being of clients, threaten the integrity of the professional work, and place the psychologist at increased professional liability risk.

Notes

1 Psychologists should also be aware of laws and regulations in some states that protect professionals from being compelled to disclose certain information about a minor (such as records related to sexual health or substance use) to parents or others if they feel that the release of such information may negatively affect or harm the minor.

2 See Fisher (2014) for helpful disclosure-related decision-making considerations.

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Time Out:

Embedded in a broad paradigm

Arthur Staats, Ph.D.

The article in The Clinical Psychologist dealt deeply with time-out, what it is and how to employ it. The article also elaborates the time-out research that has grown and the knowledge that has been gained thereby. That enables definition of the procedure and the related use of positive parenting procedures that are also necessary. Importantly, the article indicates that time-out is related to applied behavior analysis treatment of other types of problem behaviors. The Clinical Psychologist article also indicates weak criticisms have been launched against time-out, derived from non-evidence based conceptions, showing how such conceptions can steer our field in wrong directions. Clinical psychology needs to continue to develop in rooting out such conceptions and in constructing good ones.

I would like to make two points in this consideration. One is that considering time-out as a particular technology opens such problems as those described. Actually, I introduced and disseminated time-out as an evidence-based procedure in 1962 as a part of a broad series of studies of child development. Time-out development emerged in work extending a number of years with my daughter Jennifer, and later my son Peter on a variety of behaviors. Their study began almost at birth and included their first learning of language, on through such repertoires such as learning reading; sensory-motor repertoires from eye-hand coordinations to tennis; and emotional repertoires such as parental love. Peter (and other young children) can be seen on YouTube (see Arthur Staats) beginning to learn to read and count at age three (I have several years of audio recordings of Jennifer learning to read). The author's original token reinforcer (token economy) system, used widely for research and application, is shown in 1966. The great central point is that human behavior, normal and abnormal, is learned. Treating time-out as a singular technology takes away being anchored in an extensive paradigm, and doing that contributes to the widespread use of non-evidence-based interpretations.

Secondly, The Clinical Psychologist article in showing how non-evidence produced conceptions lead to errant interpretations of time-out thus illustrates a general problem. Clinical psychology needs to work on its underlying conceptions, not just its evidence-based technologies and practices. Both research and practitioner clinicians need a conception of human behavior and human nature—humanness. Having a set of separate technologies is not enough, for clinicians face a variety of problems for which no technology or practice has been worked out, where it is necessary to use one's broad conception in constructing a solution. Clinicians need a unified conception of child development, of personality, and of abnormal psychology as well as well as analyses of behavior disorders, along with derived technologies (such as time-out) (interestingly, Freud's psychoanalysis aimed for that breadth, but without the necessary basic foundation in evidence). The present author's psychological behaviorism, in an over- sixty-year program of development, provides an evidence-based conception of that kind (see Staats, 2012).

The Clinical Psychologist article shows the needs, and helps open the door to fulfillment.

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ON BECOMING A FELLOW OF THE SOCIETY OF CLINICAL PSYCHOLOGY

The Society of Clinical Psychology, APA Division 12, welcomes within its membership psychologists who are interested in and who identify with the field of clinical psychology---its practice, research, service, and/or missions. Besides being an esteemed member of Division 12, there are within our Society those who should be considered to be nominated and elected to fellow status. Many such members have not taken steps to apply for fellow status. Sometimes this is due to extreme modesty in evaluating one's own achievements, intimidation by the thought of the application process and being reviewed by peers, modesty in asking others for endorsement, or simply time constraints. Yet becoming a fellow of Division 12 holds many rewards and benefits well worth applying and focusing on successful election to fellow status.

There are two categories of fellow status: initial fellows and current fellows. Initial fellows are those who have not yet been elected to fellow status in any APA division and need to apply for this in the division. Endorsements by three fellows is required. Current fellows are those who, having been fellowed by another division, can state how their work and experiences also qualify them to become fellows of Division 12. All members who are not yet Division 12 fellows nor fellows of any other division need to consider applying for fellow status in Division 12. All who are Division 12 fellows are encouraged to give a helping hand to deserving potential fellows who might otherwise be overlooked: Nominate others who should be recognized for their outstanding and unusual clinical research, practice, or services.

What are the benefits and rewards of becoming a fellow of the Society of Clinical Psychology? The deserved recognition, appreciation, and greater visibility of one's research, practices, and service by one's peers are highly important to most of us. Research can certainly be disseminated without being a fellow, but having one's work seen in the light of becoming a fellow within the Society of Clinical Psychology burns a far brighter and visible light on one's accomplishments and achievements. Often the more modest members within our Society feel overlooked and even isolated by the lack of colleagues recognizing and appreciating one's work and nominating him or her for fellow status.

The networking and cross-research connections may be much increased when members become fellows. Collegiality is usually increased as fellows more identify with the field and their contributions to clinical psychology. Greater opportunities to share what one has done in clinical psychology usually come with fellow status. Often more opportunities to enter divisional offices come after one is fellowed. Fellows are often more sought for mentors of peers and early career psychologists, as well as in teaching and advisor capacities. Fellows have often been cited and referenced before being fellowed but may find even more of such citations and references after their fellow status has been achieved.

Sometimes our members overlook Division 12 sectional interest groups, such as sections on children, women's issues, ethnic minority issues, and research. Special achievement within these groups may well merit fellow nomination and election. Further, opportunities for intra- and interdivisional interests may foster new opportunities and challenges for research, practice, and publication. Our Society has more abundant and untapped talents and skills than we have sufficiently appreciated and that need to be acknowledged.

The greater collegiality and sense of appreciation by peers in adding deserving fellows to the Division enhances division cohesiveness and solidarity and contributes to the strength of the field of clinical psychology itself. Look in the mirror and at your colleagues and nominate the worthy for fellows!

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Kaitlin P. Gallo, Ph.D. - Editor

Section VI: Clinical Psychology of Ethnic Minorities

Submitted by Frederick T. L. Leong, Ph.D.

Section VI offered exciting contributions to clinical science and clinical practice during this year's APA convention and in our activities since the convention ended. Our four Section VI programs were thought-provoking, substantive and well-attended by students and professionals across career stages and types of institutions represented.

APA 2015-Division 12, Section VI programming:

Challenges and Success Strategies for Ethnic Minorities in Clinical Psychology. Cheng, Z. H, Kim, J. H. J., Cole-Lewis, Y, Buchanan, N. T., Breland-Noble, A. M, Rodriguez, M. M. D., Leong, F. T. L., Bernal, G., Boyce, C. A. Division 12, Section VI has a long tradition of offering research-driven sessions that are also compelling venues for mentoring and supporting ethnic minority psychologists. There was standing room only for this year's symposium put together by our section's student representatives and senior leadership, which focused on time-tested and empirically-based strategies for success across all phases of one's career. Talks included: 1) Strategies for not only being successful, but also maintaining one's authenticity during graduate school; 2) Dr. NiCole T. Buchanan reviewed challenges and resilience strategies of ethnic minority psychologists when transitioning from graduate students to professionals in the field; 3) Dr. Melanie Domenech Rodríguez reviewed strategies for mentoring ethnic minorities and navigating challenges as senior faculty of color; 4) Dr. Guillermo Bernal presented his top 10 strategies, pitfalls, and warnings for faculty of color; and 5) Dr. Fred Leong provided a summary of his recent work on managing an academic career and departmental politics by applying adaptability portfolio theory to the research and publication process. It was an amazing event that easily could have filled another hour and still not be enough time for the timely information being shared!

Navigating your Training as a Woman of Color: A Conversation Hour and Safe Space (co-sponsored by Div 35 and Div 12, Section 8). Kim, J. H. J., Butler, A. M., Robinson, C., Boyce, C. A., Cheng, Z. H., Cole-Lewis, Y., Breland-Noble, A. M., & Joseph, J. A. Our Division 12, Section VI student representatives collaborated with Division 35 student representatives and several senior members of our section to host our annual discussion hour titled "Navigating your Training as a Woman of Color: A Conversation Hour and Safe Space." The focus of this discussion hour is to share successes and challenges faced by women of color training to be psychologists and for early career, mid-career, and senior professionals to share strategies, advice, and mentoring. Participants shared experiences, coping strategies, and fostered a community of support for participants. This is the third year we have hosted this discussion hour, and it continues to grow larger every year with over 25 women participating during this year's convention. We plan to continue this program and our support of ethnic minority women in the field at the 2016 convention.

Intersectionality: How race/ethnicity intersects with other important identities to uniquely impact clinical practice, research, and policy. NiCole T. Buchanan, Wendi S. Williams, & Ivy Ho. In an effort to increase collaborative discussion and programming, our section collaborated on a discussion hour focused on intersectionality theory and its impact on clinical science, practice and policy. This proposal represented a new era of active collaboration between Div 12, Section 6 [Clinical Psychology of Ethnic Minorities], sections of Div 35, AWP, Div 45 [Society for the Psychological Study of Ethnic Minority Issues], Div 9 [Society for the Psychological Study of Social Issues] and the Association of Women in Psychology. The goal of the discussion was to bring together a wide panel of experts addressing intersections of multiple identities (e.g., race, LGBTQ, gender, social class) to discuss commonalities and distinct considerations for each across practice, research and policy. It was a successful discussion hour that was not only well-attended, but also provided a venue for sharing timely research by our members, such as the recent work of Khanh T. Dinh, Michelle D . Holmberg, Ivy K. Ho, and Michelle C. Haynes, which found that harboring prejudicial beliefs, particularly racist and sexist beliefs, is associated with negative psychological and physical health outcomes. We hope to use this discussion as the basis of a future submission for an APA collaborative proposal across the social justice divisions and Division 12, Section 6.

Giving an exceptional job talk and academic interview: Planning from day 1 of graduate school and beyond. NiCole T. Buchanan, Isis H. Settles, Kristen Miles, & Nkiru Nnawulezi. Finally, this workshop represented a collaboration across divisions as well as our

efforts toward actively mentoring and guiding future psychologists of color. Our section, in collaboration with Division 35, Section 1, Division 27 and APAGS hosted this workshop to illuminate the process of the academic interview and job talk in order to help students understand the structure, dos, don'ts and unspoken rules of how to present themselves and their work in a strong job talk and interview. During this workshop, participants learned how to give and rehearsed their 30 second and 2 minute "elevator speeches," reviewed the formal job talk and overall interview structure, and discussed special considerations for those whose research is considered "non-traditional" in the field (e.g., research on lesbian youth), and those that embody marginalized identities (e.g., women of color). This was the first year this program was offered and it was very well attended and well received. As such, we plan to submit a proposal to offer this workshop again at future conventions.

Moving Forward:

In addition to our convention programming and plans for APA 2016, members of Division 12, Section VI have also been active in national discussions of the findings from the Hoffman Report and in guiding considerations for future policy. One contribution from our members that has been particularly strong is the mandate that examination of the Hoffman Report always include thoughtful consideration of the ways in which culture, race, gender, religion, power and bias intersect to influence the behaviors highlighted in the report as well as our national outrage, or lack thereof.

References:

Dinh, K. T., Holmberg, M. D., Ho, I. K., & Haynes, M.C. (2014). The relationship of prejudicial attitudes to psychological, social, and physical wellbeing within a sample of college students in the United States. Journal of Cultural Diversity, 21(2), 5666.

Leong, F. T. L., Chandra, M. and Chandra, S. (in press). Applying the Portfolio Model of Adaptability: A Career Guide to Managing Academic Environments and Departmental Politics. In Dana S. Dunn's (Editor) The Oxford Handbook of Undergraduate Psychology Education. New York: Oxford University Press.

Section VII: Emergencies and Crises

Submitted by Marc Hillbrand, Ph.D.

Since its inception, Section VII has promoted enhancing graduate education in violence and suicide risk assessment and management. The APA Committee on Accreditation is about to issue a call for public comments on new regulations in the training for graduate students in clinical and counseling psychology and other applied psychological specialties. Section VII is planning to provide comments regarding the improvement of graduate training in violence and suicide risk assessment and management. Any interested party was invited to respond to the call for public comment starting 9/15/15. These will be posted on the accreditation website along with the Implementing Regulations for the Standards of Accreditation including profession-wide competencies. The call was open for 30 days, and closed on 10/15/15.

Section VII used its hour of APA convention programming to sponsor a symposium on Saturday, August 8, 2015, entitled Dangerousness and the restriction of access to lethal means – Clinical and legal standards of care. This topic is an extremely important and current one for those of us who deal with patients at risk of suicide and/or violence. The noted expert on suicide risk management and former President of Section VII, Bruce Bongar, Ph.D., was the invited speaker. Dr. Bongar has now initiated a Clinical Crises and Emergency Research Team at Palo Alto University where he is the Calvin Professor of Psychology. The symposium topic is one of the the initial issues that his research team is investigating. Section VII Advisor, Dr. Phil Kleespies, served as both chairperson and discussant for the symposium.

Working in collaboration with Susan Lazaroff, JD, from the APA Office of State Advocacy, Section VII also presented a two hour symposium that was part of APA's new collaborative programming. The symposium was entitled The seriously mentally ill: Perpetrators of violence or victims of suicide and violence. It was co-sponsored by Divisiond 12, 9, 18, and 56. Dr. Phil Kleespies and Susan Lazaroff served as co-chairs and there were three presentations. Daniel Murrie, Ph.D., of the University of Virginia School of Medicine presented on Risk of violence among those with serious mental illness, while Sarah Desmarais, Ph.D.,

from North Carolina State University presented on Shadows of violence: Victimization and mental illness, and Dr. Kleespies spoke on The mentally ill: Victims of suicide. Given the recent and ongoing national debate on violence and the mentally ill, this symposium was also very current. Both of these Section VII symposia were well attended.

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, Ph.D., ABPP

The Association of Psychologists in Academic Health Centers (APAHC) continues to thrive with an energetic and creative Board, as well as numerous volunteers who help manage the day to day needs of the organization. President Ronald T. Brown, PhD, ABPP continues to lead the APAHC Board and all initiatives.

APAHC is proud to announce the 2015 Award Winners: Please join us in congratulating these outstanding psychologists!

William "Bill" Robiner, PhD, ABPP, University of MN Medical School: The Joseph D. Matarazzo Award for Distinguished Contributions to Psychology in Academic Health Centers. Dr. Robiner was selected for his outstanding work within an academic health center for most of his career and the role he has played to enhance the opportunities for psychologists in education, research and clinical care.

Richard "Rick" Handel, PhD, Eastern Virginia Medical School: The Bud Orgel Award for Distinguished Achievement in Research. Dr. Handel's research has made significant contributions to the advancement of research and scholarship within academic health centers.

APAHC continues a productive relationship with the AAMC (The Association of American Medical Colleges) with a variety of projects and the opportunity to impact medical training as well as the involvement of psychologists in medical school settings. The APAHC Research Committee recently presented a poster at the AAMC Workforce Conference in May/Washington, DC. In addition, the committee has a paper published in Academic Psychiatry on residency shortages.

APAHC continues to enhance resources available on our website at: http://www.div12.org/section8/, including those related to teaching, writing, conducting research, and grant writing in the Behavioral Sciences. APAHC members place high value on the resources provided as a membership benefit. Of note, Drs. Ed Christophersen and Zeeshan Butt developed the Promotions Primer with a focus on career advancement and academic promotion. This resource was also highlighted through a recent publication in the Journal of Clinical Psychology in Medical Settings, December 2012, Vol 19 (4), 349-352: Introducing a Primer for Career Development and Promotion: Succeeding as a Psychologist in an Academic Health Center.

APAHC has also recently re-invigorated a Consultation Program, co-lead by Drs. Zeeshan Butt and Cheryl Brosig-Soto. Experienced consultation is available to APAHC members regarding career development, dealing with institutional or workplace opportunities, challenges, and barriers, and other professional development issues of concern.

Members continue to benefit from valued APAHC publications, including the Grand Rounds newsletter, and our flagship journal: Journal of Clinical Psychology in Medical Settings. APAHC welcomes new members, including student members. Membership dues are low and this is a great way to add to the benefits offered as a Division 12 member. For further information about APAHC/Division 12 Section 8, please check our website at: http://www.div12.org/section8/index.html or contact me directly at Sharon.Berry@childrensMN.org.

Section X: Graduate Students and Early Career Psychologists

Submitted by Jennifer Sweeton, Psy.D.

Section 10, Graduate Students and Early Career Psychologists, has had a successful year thus far! The section coordinated and moderated two sessions at APA in Toronto, including a diversity panel and internship panel, both of which were well-received by attendees. Also, the section hosted a social hour for Section 10 members. This was a fantastic opportunity for members to get to know one another and discuss new ideas for the section and reflect on recent developments. APA went great for the section this year and we are already in the program proposal planning stage for next year's convention in Denver!

Additionally, Section 10 recently completed their last quarterly Board call of the year. These calls, and the convention in-person Board meeting, have been productive, and have largely focused on preparing for some exciting changes occurring in the near future. Specifically, starting in January 2016, Section 10 will be charging $10 for membership (or $5 when they sign up for dual membership with D12). In return, members will enjoy the following benefits:

- Awards: apply for cash prize competitions for best poster and best paper presentation at the Annual Convention
- Mentorship: participate as a mentor or mentee in our mentorship program
- Publications: gain a publication by contributing a brief article to our blog, and enjoy reading what others have published on issues relevant to you
- Internship resources: tap into our network of early career psychologists who have recently completed internships across the country, via an internship database and interview question bank that are currently in development
- Leadership: run for a position on the Board or pilot a new project
- Listserv: gain access to announcements that advertise professional opportunities
- Convention programming: attend symposia that we have designed specifically for graduate students and early career psychologists

Mentioned in this list is the new internship database that Section 10 members have been working on for several months! This large database, which is scheduled to be released in Summer 2016, will contain the contact information of hundreds of psychologists who recently completed internship, and who have agreed to be available to answer questions from/consult with future internship applicants regarding their experiences at their respective internship site. It is hoped that this resource will be valuable to Section 10 members applying for internships.

Division 12 would like to congratulate the 2015 APA Convention Student Poster Award Winners:

Alainna Wen, University of Calgary, BS (undergraduate)
Faculty Mentor: Dr. Keith Dobson
Katerina Rnic, University of Western Ontario, first year graduate student
Faculty Mentor: Dr. David Dozois
Fallon Kane, Adelphi University, Senior undergraduate
Faculty Mentor: Dr. Robert Bornstein
Mary Katherine Howell, Howard University, 2nd year graduate student
Faculty Mentor: Dr. Thomas Mellman
Won Jin Seo, Duksung Women's University, South Korea, Clinical Health MA
Faculty Mentor: Dr. Mirihae Kim

Much appreciation to the Division 12 Members who helped with reviewing the student poster awards:

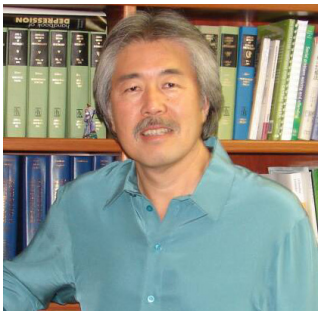
Marc Hillibrand, PhD
Alexandra Greenfield
Danielle Burchette
Brian Yochim, PhD
Susana Urbina, PhD
Brandee Goodwin, PhD
Sharon Berry, PhD, Coordinator

Congratulations to our 2015 award winners!

The *Award for Distinguished Scientific Contributions to Clinical Psychology* was presented to **Jalie Tucker, Ph.D., M.P.H.** Dr. Tucker is a clinical psychologist with public health experience who is Professor and Chair of the Department of Health Education and Behavior, at the University of Florida, Gainesville. She also serves as Director of the UF Center for Digital Health and Wellness. She has held academic positions at four Carnegie-designated Research Universities with very high (University of Florida, 1980-85, 2014-; Wayne State University, 1986-89; University of Alabama at Birmingham, 2000-2014) or high (Auburn University, 1989-99) research activity. Dr. Tucker received her Ph.D. in clinical psychology from Vanderbilt University and an M.P.H. in healthcare organization and policy, emphasizing mental health economics, from the University of Alabama at Birmingham.

Dr. Tucker has conducted 30 years of extramurally funded research on substance abuse and related risk behaviors, including HIV/AIDS. Her research focuses on understanding influences on help-seeking for substance-related problems, which is uncommon, and how positive behavior change can occur through different pathways, including natural resolutions. The research is guided by behavioral economics, bridges clinical and public health perspectives, and involves longitudinal investigation using clinical and community samples and telehealth systems of the changeable course of substance misuse and contextual risk variables that also change through time. Additional interests include advancing evidentiary pluralism for evidence-based practice and coordinating clinical and public health intervention strategies. Funding sources have included awards from NIAAA, NIDA, CDC, and SAMSHA/CSAT. She has contributed to 3 books and over 100 journal articles and book chapters and has been assistant or associate editor for three scientific journals and an editorial board member for eight journals.

Her extensive APA service record includes chairing both the Board of Scientific Affairs and the Board of Professional Affairs; serving as the first elected President of the Division on Addiction Psychology (50); and 4 terms as Division 50 Representative to the APA Council of Representatives. She is a Fellow of six APA Divisions (General Psychology, Clinical Psychology, Behavior Analysis, Psychopharmacology and Substance Abuse, Health Psychology, Addiction Psychology) and the American Psychological Society. She has received three awards for distinguished service to Division 50, including the Division Medal of Honor for exceptional and sustained service to Division 50 – Addictions, 1993-2012.



The *Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology* was presented to **Arthur M. Nezu, PhD, DHL (Hon), ABPP.** Dr. Nezu is Distinguished University Professor of Psychology, Professor of Medicine, and Professor of Community Health and Prevention at Drexel University in Philadelphia. He received his PhD in clinical psychology from Stony Brook University and is board certified in cognitive and behavioral psychology, clinical psychology, and clinical health psychology. He was previously president of both the Association of Behavioral and Cognitive Therapies and the American Board of Cognitive and Behavioral Psychology. Dr. Nezu is currently Editor of the Journal of Consulting and Clinical Psychology, Associate Editor of the Archives of Scientific Psychology and was recently as Associate Editor for the American Psychologist beginning in 2016. Based on his professional contributions regarding issues of diversity, the American Board of Professional Psychology created an annual Dissertation Award for Research in Diversity bearing his name. In addition, he has received multiple awards including an honorary doctoral degree from the Philadelphia College of Osteopathic Medicine. His research has been supported by the National Cancer Institute, the National Institute of Mental Health, and the Department of Veterans Affairs. Dr. Nezu has contributed to over 225 scholarly publications, is co-editor of the Oxford University Press Book Series on Specialty Competencies in Professional Psychology, and has served on numerous NIH grant review panels. He

is also a member of the APA panel to develop clinical practice guidelines for the treatment of depression. Along with Dr. Christine Maguth Nezu, Dr. Art Nezu is the co-developer of contemporary Problem-Solving Therapy, a transdiagnostic, psychosocial intervention. This was the basis for several programs he further co-developed for the Department of Veterans Affairs and the Department of Defense that are geared to foster resilience and enhance the quality of life of Veterans and active service members. He also served on the Special Medical Advisory Group, the committee that advises the Under Secretary for Health of the VA. Dr. Nezu has additionally contributed to the field of clinical psychology on an international basis, having served as a consultant to the University of Hong Kong, was Chairman of the Board of the World Congress of Behavioural and Cognitive Therapies, was appointed as both Special Professor of Forensic Mental Health and Psychiatry and Special Professor of Community Health Sciences at the University of Nottingham in the United Kingdom, served on the International Consensus Panel for the Development of the CONSORT Guidelines for Social and Psychological Interventions, and currently is the International Editorial Advisor for the Australian Psychologist.

The *Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology* was presented to **Guillermo Bernal, Ph.D.** Dr. Bernal is Professor of Psychology at the University of Puerto Rico and Director of the Institute for Psychological Research. He was principal investigator of the NIMH Carrier Opportunities in Research for 23 years and directed the NIMH Research Infrastructure Support Program for 18 years. His most recent RO1 was a randomized clinical trial of a parent intervention and cognitive behavioral therapy with depressed adolescents. His work has focused on research, training, and the development of mental health services for ethno-cultural groups. He is an early contributor to the dialogue on cultural adaptations of EBTs. Since 1992, his team has generated evidence on the efficacy of culturally adapted evidence-based treatments, carried out translations and development of instruments, and published on factors associated to vulnerability of depression. He received his Ph.D. form the University of Massachusetts/Amherst (1978). Bernal is a Fellow of APA Divisions 45, 12, and 27, and 29 and a member of 43, is vice president of the Carribean Alliance of National Psychological Associations, and Editor of the Puerto Rican Journal of Psychology. He has received numerous awards for his research; the most recent is the Stanley Sue Award for distinguished contributions to diversity from the Society of Clinical Psychology (2015).

The *Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology* was presented to **Lizabeth Roemer, Ph.D.** Dr. Roemer is Professor of Psychology at the University of Massachusetts Boston, where she has been a faculty member since 1996. She received her Ph.D. from The Pennsylvania State University in 1995, under the supervision of Dr. T. D. Borkovec, and completed an internship and postdoctoral fellowship at the National Center for PTSD – Behavioral Sciences Division at the Boston VA. At U Mass Boston, she mentors clinical psychology doctoral students, provides clinical supervision to doctoral students in their first clinical practicum, teaches Clinical Research Methods and Ethics and Cognitive Behavioral Theory and Therapy, and mentors junior faculty members, in addition to teaching undergraduate courses. She also serves as the On Campus Practicum Coordinator and recently received funding from the Society for the Science of Clinical Psychology for a newly developed on campus practicum.

Dr. Roemer has an active, productive research career, including publishing over 100 journal articles and book chapters and co-editing two books on the role of emotion regulation, mindfulness, and experiential avoidance in anxiety and other disorders, and the use of acceptance-based behavioral therapies. In collaboration with Dr. Susan Orsillo, she has developed an acceptance-based behavioral therapy for generalized anxiety and comorbid disorders and examined its efficacy and mediators and moderators of change in a series of studies funded by the National Institute of Mental Health. They are co-authors of Mindfulness- and acceptance-based behavioral therapies in practice and The mindful way through anxiety, both published by Guilford Press, as well as a new forthcoming self-help book tentatively titled “Dare to live the life you want.”

The *David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology* was presented to **Rebecca Kathryn McHugh, Ph.D.** Dr. McHugh received her B.A. in Psychology from Harvard College and her Ph.D. in Clinical Psychology from Boston University. She is currently an Assistant Professor at Harvard Medical School and a clinical psychologist in the Division of Alcohol and Drug Abuse at McLean Hospital. She engages in a program of clinical and translational research focusing on the nature and treatment of anxiety and substance use disorders. She is particularly interested in the study of affective vulnerability factors, such as distress intolerance, that are common across psychological disorders, with a focus on those that can be modified with treatment. Additionally, Dr. McHugh conducts research on the dissemination and implementation of evidence-based treatments, with a particular focus on behavioral therapies. She has published more than 75 articles and book chapters, and her work has been funded by Harvard Medical School and the National Institute on Drug Abuse. She is currently conducting a 5-year clinical trial of a novel behavioral therapy for opioid use disorder and co-occurring anxiety disorders funded by the National Institute on Drug Abuse. She also specializes in cognitive behavioral therapy for the treatment of anxiety, depressive, and substance use disorders.

The *Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology* was presented to **Monica Williams, Ph.D.** Dr. Williams is Associate Professor of Psychological and Brain Sciences and Director of the Center for Mental Health Disparities at the University of Louisville in the Department of Psychological and Brain Sciences, where she is the first minority female to be tenured in the department's 108-year history.

Dr. Williams completed her undergraduate studies at MIT and UCLA. She received her Master's and Doctoral Degrees in clinical psychology from the University of Virginia, where she conducted research in the areas of psychopathology, tests and measurement, and ethnic differences. She completed her clinical internship at McGill University Health Centre, Montreal General Hospital Site, where she completed rotations in mood disorders, major mental illness, and sexual identity issues. Prior to joining the faculty at the University of Louisville, Dr. Williams was an Assistant Professor at the University of Pennsylvania School of Medicine in Philadelphia for four years, where she instructed medical residents, practicum students, and undergraduates. She received specialized training in the treatment of OCD and PTSD by Dr. Edna Foa.

Dr. Williams has published over 60 book chapters and peer-reviewed articles, primarily focused on anxiety related disorders and cultural differences. She has received grant funding from local, federal, and international organizations. She has served on the board of directors of the Delaware Valley Association of Black Psychologists, the National Alliance on Mental Illness (NAMI) Main Line chapter, and the OC Foundation of California. She is currently a member of the International OCD Foundation (IOCDF), where she serves on the Scientific Advisory Board, and the Association of Behavioral and Cognitive Therapies, where she serves as the Special Interest Group (SIG) leader for African Americans in Behavioral Therapy. She is on the editorial board of several scientific journals and is an Associate Editor of BMC Psychiatry and The Behavior Therapist. Her work on race-based stress and trauma has received national attention.

Dr. Williams is a licensed psychologist in two states, and provides cognitive-behavioral treatment for adults and adolescents with OCD, PTSD, and other anxiety disorders. She provides supervision and training to other clinicians and has published several didactic articles on treatment issues. She provides clinical trainings for mental health professionals at local organizations and national conferences.

The *American Psychological Foundation Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology* was presented to **Jonathan S. Comer, Ph.D.** Dr. Comer is an Associate Professor of Psychology and Psychiatry at Florida International University, and is Director of the Mental Health Interventions and Technology (MINT) Program, an interdisciplinary clinical research laboratory in the Center for Children and Families devoted to expanding the quality, scope and accessibility of children's mental health care. His program of research examines three areas of overlapping inquiry: (1) The development and evaluation of evidence-based treatments for childhood psychopathology, with particular focus on the development of innovative methods to reduce systematic barriers to effective mental health care; (2) The assessment, phenomenology, and course of child anxiety disorders; and (3) The psychological impact of disasters and terrorism on youth. Guided by a developmental psychopathology perspective, in which the study of normal and abnormal populations serve to mutually inform one another, Dr. Comer's research examines the complex interplay between psychological and socio-contextual aspects of disorders, and he conducts interdisciplinary clinical research devoted to expanding the quality, scope, and accessibility of mental health care. In recent years, Dr. Comer's work has expanded to consider biological markers of child psychopathology in order to clarify the neurodevelopmental underpinnings of children's emotional and behavioral problems, as well as identify mechanisms of treatment response. To this end, his work investigates disordered, high-risk, and community populations, embracing a diversity of inquiry methods, ranging from randomized clinical experiments and quasi-experimental designs to nationally-representative epidemiological surveys, longitudinal designs, meta-analyses, and single-case designs.

Dr. Comer has published over 100 scholarly articles in leading scientific journals and edited handbooks on the topics of mental health care and child psychopathology. His program of research has been recognized through receipt of several early career awards, and he has received current and past funding from federal and foundation sources totaling roughly $4 million, including a recently funded R01 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) examining Internet-delivered parent training for parents of preschoolers with developmental delay. Dr. Comer also recently completed a large study examining the psychological impact of the Boston Marathon bombing on Boston-area families, and he served as a consultant throughout the federal trial of United States v. Dzhokhar Tsarnaev.

The *American Psychological Foundation Theodore Millon Award* was presented to **John Edens, Ph.D.** Dr. Edens is a Professor and the Director of Clinical Training in the Department of Psychology at Texas A&M University, where he is also a Cornerstone Faculty Fellow in the College of Liberal Arts. He received his Ph.D. in clinical psychology from Texas A&M University in 1996 and then completed a two-year post-doctoral fellowship in forensic psychology at the University of South Florida. In terms of research and applied interests, Dr. Edens' work primarily focuses on the interface between the fields of mental health and law, particularly the role of personality assessment in criminal and civil cases. In 2001, Dr. Edens was the recipient of the Saleem Shah Award for Early Career Contributions to Law and Psychology, jointly awarded by the American Psychology-Law Society and the American Academy of Forensic Psychology. He is also a fellow of the Association for Psychological Science and is identified in Thompson Scientific's "Essential Science Indicators" as in the top 1% of cited researchers in the psychology/psychiatry field over the past 10 years. Dr. Edens currently serves as an Associate Editor for two journals (Psychological Assessment, Journal of Personality Assessment) and also serves on the editorial board of numerous psychology journals (e.g., Journal of Abnormal Psychology, Journal of Personality Disorders, Law & Human Behavior). He is also the lead author of the Personality Assessment Inventory Computerized Interpretive Report for Correctional Settings (Edens & Ruiz, 2005).

The *Distinguished Student Research in Clinical Psychology Award* was presented to **Brian Feinstein, Ph.D.** Dr. Feinstein is a Postdoctoral Scholar at Northwestern University Feinberg School of Medicine, where he works with the IMPACT LGBT Health and Development Program. Dr. Feinstein received his Ph.D. in Clinical Psychology from Stony Brook University in 2015 after completing an APA-accredited internship at the University of Washington School of Medicine. During his graduate training, he was awarded a National Science Foundation Graduate Research Fellowship to develop his program of research focused on risk and protective factors related to psychopathology among sexual minorities. He is particularly interested in understanding how different types of stress (e.g., discrimination, internalized stigma, rejection sensitivity) influence different types of psychopathology (e.g., depression, anxiety, substance use) and how these associations differ for specific groups of sexual minorities (e.g., bisexual versus gay/lesbian individuals). As a postdoctoral scholar, Dr. Feinstein is working on various projects related to stress, health, and relationship functioning, including a relationship education program for same-sex male couples and an online HIV prevention program for young men who have sex with men.

The *Distinguished Student Service in Clinical Psychology Award* was presented to **Lauren Breithaupt**. Lauren Breithaupt is a doctoral student in George Mason University's Clinical Psychology program, working with Dr. Sarah Fischer. Lauren received her Bachelor of Science in Psychology from Baker University in Baldwin City, KS. Lauren's research broadly focuses on neurological mechanisms involved in attitudinal and behavioral changes through cognitive dissonance, understanding eating and weight related behaviors from a cognitive and neurobiological perspective and the prevention of eating disorders. Currently, Lauren is assisting with the following studies in the Impulse Lab: 1) examining the relationship between stress and craving utilizing fMRI and Ecological Momentary Assessment; 2) exploring the behavioral mechanisms involved in cognitive dissonance prevention to increase body-esteem; 3) understanding implicit and explicit attitude shifts in cognitive dissonance interventions for weight stigma reduction. Her research is funded through the National Science Foundation, American Psychological Association, and the Zeta Tau Alpha Foundation.

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Jonathan S. Comer, Ph.D. - Editor

Clinical Psychology: Science and Practice

A one-on-one conversation with the journal's Editor-in-Chief about the scope, mission, and exciting changes for the journal

J. Gayle Beck
CP:SP Editor-in-Chief

Clinical Psychology: Science and Practice (CP:SP) is the flagship journal of the Society of Clinical Psychology, and has long served as one of the leading scholarly homes for systematic reviews and expert commentaries. For over two decades now, the articles and scholarly debates that have filled the pages of CP:SP have launched, and powerfully shaped, the conversations that our field has been having on the most critical topics that shape our discipline. Needless to say, we were delighted that the journal's current Editor-in-Chief, **J. Gayle Beck, Ph.D.,** agreed to speak with us for a brief Q and A about the journal, including some exciting new changes on the horizon.

JC: How would you describe the mission and scope of Clinical Psychology: Science and Practice?

JGB: The aims and scope of Clinical Psychology: Science and Practice are stated on the masthead as presenting "cutting-edge developments in the science and practice of clinical psychology by publishing scholarly topical reviews of research, theory, and application to diverse areas of the field, including assessment, intervention, service delivery, and professional issues". This has been the tradition of Clinical Psychology: Science and Practice since its inception in 1994. Each Editor has worked to highlight emerging trends within the field, combining submitted manuscripts, commentaries, and special series.

JC: What type of papers is a good fit for Clinical Psychology: Science and Practice? What do you look for in papers when making decisions about publication?

JGB: The majority of the papers that Clinical Psychology: Science and Practice publishes are reviews, both quantitative (meta-analytic) and narrative reviews. We do publish a small number of empirical papers, typically those that focus on training in clinical psychology or less commonly, emerging trends in treatment.

JC: What types of papers are not good fits for Clinical Psychology: Science and Practice?

JGB: Most empirical reports are not a good fit for Clinical Psychology: Science and Practice. Traditionally, the journal has emphasized reviews, particularly reviews that address current hot topics in any of the varied domains within our field. The tradition of Clinical Psychology: Science and Practice is to provide thoughtful (and thought provoking) reviews. Reviews may provoke controversy or generate additional dialog. As such, I have continued the tradition of inviting commentaries to be published alongside a review, in order to provide multiple perspectives and scholarly dialog.

JC: Are reviews published in Clinical Psychology: Science and Practice typically invited or unsolicited?

JGB: What a good question, Jon. I think there are some misconceptions about Clinical Psychology: Science and Practice – and this is a great opportunity to clear some of these up! The majority of the reviews that we publish are unsolicited; articles come from individuals in many different sectors, not just academics. One of the best features of Clinical Psychology: Science and Practice is that it publishes a broad array of topics. Commentaries, when present, are invited.

The journal also occasionally publishes special series (or special issues, depending on their length). The articles within these special pieces are invited and undergo peer review, much as unsolicited submissions do. The peer review process is an essential component of Clinical Psychology: Science and Practice and ensures that published articles are complete, balanced, and scholarly.

JC: Are there special series on the horizon that we should look for?

JGB: There are two special series in the works. One focuses on evidence-based assessment; we are very fortunate to have some of the luminaries in the assessment literature contributing to this series. I am co-editing this series with Dr. Paul Aribsi and it is planned for publication in 2016. Also in development is a special issue on the long-term effects of childhood adversity, which I am co-editing with Dr. Marylene Cloitre. Both of these series are very exciting and I trust will be interesting and invigorating to the readership. Also, I am open to ideas about topics for special series that would be of interest.

JC: What are some of the most important articles and special issues that have been published in recent years in Clinical Psychology: Science and Practice that are starting to have a meaningful scholarly impact in the literature?

JGB: Looking at our recent bibliometrics, several articles are clearly having a large impact on the literature. For example, "Evidence-Based Treatments for Children and Adolescents: An Updated Review of Indicators of Efficacy and Effectiveness" By Chorpita and colleagues (Vol. 18, issue 2, pp. 154-172) is very well-cited. Likewise, "The Presentation and Classification of Anxiety in Autism Spectrum Disorder" by Kerns and Kendall (Vol. 19, issue 4, pp. 323-347) has begun to re-shape how emotional processes are conceptualized in people with Autism Spectrum Disorders. And more recently, a fantastic special series came out in June of this year, focused on defining competence when working with sexual and gender minority populations (edited by Dr. Jillian Shipherd). This series contains three primary reviews, each of which is accompanied by a thoughtful commentary. I anticipate that this series will impact how training for work with sexual and gender minority populations is designed and implemented, at all levels of training (doctoral, post-doctoral, and beyond).

JC: Are there anticipated changes on the horizon for Clinical Psychology: Science and Practice?

JGB: Two changes are anticipated. First, a major change on the horizon involves members of the Society of Clinical Psychology. Beginning in January of 2016, you will automatically receive your journal digitally. Many of us are moving to a paper-less environment, having discovered how much easier it is to receive information in this format. This change that is coming means that if you are receiving a print copy and wish to continue this option, you will need to opt-in for that resource (by contacting Tara Craighead, Division Administrator). Everyone else will be switched to online-only access (or continue with online-only if you were already receiving the Journal that way). If you have any questions, please contact Tara Craighead at <division12apa@gmail.com>.

A second change includes a new service that is offered for authors who publish in Clinical Psychology: Science and Practice. KUDOS is a web-based service that helps authors explain, enrich, and share their published work for greater readership and impact. Once an article is accepted for publication, authors are invited to sign up for KUDOS via registering for Wiley Author Services and opting into the mailing list. KUDOS increases the likelihood of your article being found, read, and cited, in addition to providing direct access to altmetrics and citations of your article. This service will enable authors to network with authors of related work, in addition to boosting the visibility of articles that are published in Clinical Psychology: Science and Practice.

JC: Thank you for the overview of our journal. Readers, if you have any additional questions concerning Clinical Psychology: Science and Practice, please feel free to contact Dr. Gayle Beck at jgbeck@memphis.edu. Ψ

CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

Vol 22 N3 • September 2015

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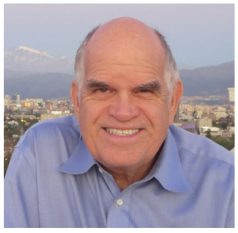

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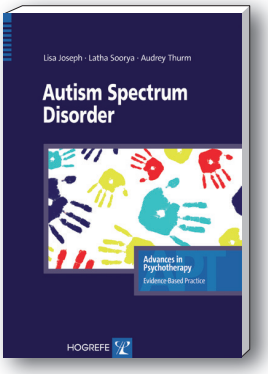


Lisa Joseph, Latha Soorya, & Audrey Thurm

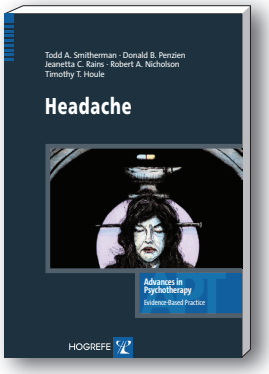
Autism Spectrum Disorder

Volume 29
September 2014, vi + 100 pp.,
ISBN 978-0-88937-404-1

Compact, authoritative guide to effective diagnosis and empirically supported treatments for autism spectrum disorder.

This latest addition to the series is a straightforward yet authoritative guide to effective diagnosis and empirically supported treatments for autism spectrum disorder (ASD).

The book starts by reviewing DSM-5 and ICD-10 diagnostic criteria, current theories and models, and prevalence rates for ASD and related neurodevelopmental disorders. It explains the differences between the disorders and changes in criteria and names (such as Asperger's syndrome, childhood and atypical autism, pervasive developmental disorder, Rett's syndrome) over time. It then provides clear guidance on evaluation of ASD and comorbidities, with practical outlines and examples to guide practice.



Todd A. Smitherman, Donald B. Penzien, Jeanetta C. Rains, Robert A. Nicholson, & Timothy T. Houle

Headache

Volume 30
October 2014, xiv + 112 pp.,
ISBN 978-0-88937-328-0

The conceptualization, assessment, and evidence-based behavioral treatment of migraine and headache – how to ensure optimal outcomes with two of the most common medical conditions in the world.

This book describes the conceptualization, assessment, and evidence-based behavioral treatment of migraine and tension-type headache – two of the world's most common medical conditions, and also frequent, highly disabling comorbidities among psychiatric patients.

Headache disorders at their core are neurobiological phenomena, but numerous behavioral factors play an integral role in their onset and maintenance – and many providers are unfamiliar with how to work effectively with these patients to ensure optimal outcomes.

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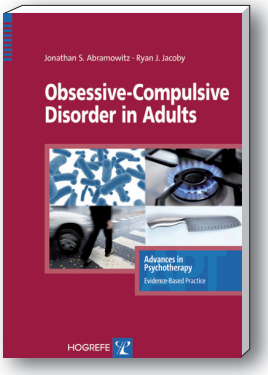


Jonathan S. Abramowitz & Ryan J. Jacoby

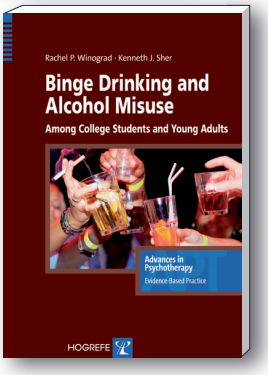
Obsessive-Compulsive Disorder in Adults

Volume 31
November 2014, viii + 106 pp.
ISBN: 978-0-88937-411-9

An essential resource for anyone providing services for individuals with OCD or anxiety disorders

Cognitive-behavioral therapy using the techniques of exposure and response prevention has helped countless individuals with obsessive-compulsive disorder (OCD) overcome debilitating symptoms and live fuller, more satisfying lives.

This volume opens with an overview of the diagnosis and assessment of OCD in adults and delineates an evidence-based conceptual framework for understanding the development, maintenance, and treatment of obsessions and compulsions.



Rachel P. Winograd & Kenneth J. Sher

Binge Drinking and Alcohol Misuse Among College Students and Young Adults

Volume 32
January 2015, viii + 106 pp.
ISBN: 978-0-88937-403-4

This book provides clear guidance about effective, evidence-based approaches to treating alcohol misuse in young adults.

Heavy drinking – and its associated problems – are an integral part of many college students' and other young adults' lives. Though some young drinkers are able to consume alcohol without incident, many face significant negative fallout from their excessive consumption. This volume in the series *Advances in Psychotherapy: Evidence-Based Practice* describes the nature of alcohol misuse, its epidemiology, its causes, and methods for treatment, specifically as they pertain to college students and other young adults. It provides practitioners and trainees with a range of evidence-based treatment approaches to help clients change their alcohol use habits.

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