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President's Message

The Affordable Care Act: Are You Ready?

Stefan G. Hofmann, *Boston University*

In 1883, the influential and conservative German statesman Otto von Bismarck instituted a program called the Health Insurance Bill. This bill provided mandatory universal health care coverage for the majority of German workers. Since then, most wealthy nations in the world have adopted a similar plan and embraced the notion that access to health care is not a privilege, but a human right.

The U.S. has been one of the few developed nations in the world that has left a large portion of its population without any health care coverage. At the same time, the U.S. has been spending more money on health care than any other comparative nation. For example, in 2008, the U.S. spent a whopping 16.0% of its gross domestic product ($7,538 per capita; Squires, 2011) on health care. In comparison, the median health care expenditure of its peers was only 8.7% of the gross domestic product ($2,995). Despite this, the average American has a shorter life expectancy and poorer health than people living in Australia, Canada, Japan, and most other European countries (Woolf & Aron, 2013).

The mental health care system has been particularly problem-ridden. It has been difficult for people with mental health problems to find affordable care, let alone quality care. Recently, the U.S. Supreme Court decided to uphold the Patient Protection and Affordable Care Act (ACA). Mental health care will benefit much like general health care under this new law. Here are a few implications of this law for us:

[continued on p. 135]

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The Mental Health Care Parity Law that was passed some years ago required many insurers to cover treatments of mental disorders, just like other health problems. However, the poor and uninsured could not get treatment. The new law will make health care, including mental health care, much more affordable. Plans that offer coverage for dependents are required to extend this coverage until the dependent reaches the age of 26. There will also be no more lifetime cap on benefits, and families cannot exhaust their coverage. It will now become illegal for insurance companies to deny or cancel health care coverage to anybody based on preexisting conditions. In the past, substance use and other mental health problems were considered a preexisting condition by some insurers. Under the new law, mental health care and substance use disorder treatments will become part of the essential benefits package, which is a health care service category that must be covered by the insurance plan. New health exchanges will be required to cover these treatments. Also, more people, including low-income adults without children, will be eligible to receive Medicaid or will be able to buy coverage through these new health exchanges.

The implications of the Medicaid expansion for mental health care are not yet known, but its impact is likely going to be significant. A recent study has found that State Medicaid expansion to cover low-income adults was associated with reduced mortality (by 25.4 deaths per 100,000) and greater self-reported health (Sommers, Baicker, & Epstein, 2012). The mortality reduction was greatest among adults between 35 and 64 years of age, minorities, and residents from poor neighborhoods. Some of these findings were consistent with results of a randomized controlled trial of Medicaid in Oregon, which showed improvement in self-reported health during the first year (Finkelstein et al., 2011). In this study, a group of low-income adults was selected by lottery to be given the chance to apply for Medicaid. The study randomly assigned 29,834 individuals to Medicaid and 28,816 to the control condition. In the year after random assignment, the Medicaid group had higher health care utilization, lower out-of-pocket medical expenditures and medical debt, and better self-reported physical and mental health than the control group.

The ACA is also designed to effect better overall health care coverage by offering incentives to providers who deliver high-quality, integrative care to patients, including prevention and health maintenance, rather than only focusing on acute symptoms or disorders. Because of the new law, it is expected that 30 million more Americans will receive health care coverage and approximately 68 million Americans will finally have access to mental health care and addiction treatment services.

This obviously means more potential clients for many of our ABCT members as long as we make ourselves known. The empirical evidence is clear: Providing adequate psychological care for mental illnesses reduces the inappropriate use of non-mental-health services and other indirect costs. Therefore, not treating mental disorders is substantially more expensive than providing adequate care, such as CBT. This is particularly true if the indirect costs are high, and treatments are efficacious and cost-effective. Mental disorders are very costly to society and CBT is highly cost-effective.

It will take years to implement the law. But some components are already in place (e.g., coverage for patients with preexisting conditions). The implementation is complicated; each state is expected to tailor some elements of the plan to meet the needs of its residents, whereas other elements must be standardized for the full potential of this change to be realized. Interestingly, the current gun-control debate might facilitate this process (Peters, 2013). Since the school shooting in Newtown, lawmakers have been working on plans to improve mental health care. This legislation would make more Medicaid dollars available for mental health care, finance construction of community mental health centers, support suicide prevention programs for traumatized students, and give training grants to teachers to detect early signs of mental illness in students, among other things.

There will almost certainly be many roadblocks ahead. Nevertheless, the ACA is a landmark achievement, and arguably the greatest achievement for mental health care for the U.S. in our lifetime. Are you ready for it?

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How to Actualize Your Ideas in a Steep Funding Climate: Experiences of Diverse Researchers

Idia B. Thurston, *University of Memphis*
Elizabeth R. Pulgaron, *University of Miami*
Jessica M. Valenzuela, *Nova Southeastern University*

Ethnic Minorities and Research

In the U.S., the number of individuals from diverse backgrounds is growing exponentially. In 2011, 50.4% of the U.S. population under the age of 1 were ethnic minorities (United States Census Bureau, 2012a). It is estimated that by 2043 ethnic minorities will constitute over 50% of the population and the U.S. will be considered a majority-minority nation; while the non-Hispanic White population will remain the largest single group, no individual group will make up a majority (United States Census Bureau, 2012b).

The changes in U.S. population demographics highlight the importance of including ethnic minorities in research and of promoting ethnic minority researchers. Historically, individuals of diverse backgrounds have been underrepresented in research studies. There is research evidence to support that this lack of participation is not due to individuals of diverse backgrounds refusing to participate, as had been previously posited (Wendler et al., 2006). Instead, other reasons for lack of participation should be explored, including whether ethnic minority individuals are aware of and eligible for research studies, are unable to participate due to external demands (e.g., work and family responsibilities, distance from research site, financial barriers), or if language barriers impede participation. Even the most rigorously designed research and clinical trials have limited applicability if they are not tested on the sample they are intended to be used on.

In addition to underrepresentation in research, individuals of diverse backgrounds are also highly underrepresented in the field of psychology. Increasing the number of psychologists (clinicians and researchers, alike) from ethnic minority backgrounds will be important for research development efforts and clinical service delivery. Ethnic minority researchers are often interested in issues relevant to minority populations. Their own personal experiences, combined with an innate sense of cultural sensitivity, heightens their awareness of issues that may be affecting the community for whom the research is intended (Kumanyika, Prewitt, Banks, & Samuel-Hodge, 2010). Therefore, the two issues of increasing participation of minority populations in research and increasing the number of psychologists from minority backgrounds are often intertwined.

The need to include ethnic minorities in research and to develop psychologists from diverse backgrounds has started to be recognized. However, individuals of diverse backgrounds have experienced many barriers to obtaining funding for their research (Shavers et al., 2005). As a result, there are specific efforts and funding resources available from various institutions to promote the recruitment and retention of ethnic minority psychologists in research, clinical service, and training. Specific funding resources include diversity-focused university and hospital internal grants, individual APA society grants (such as the APA Division 54 Diversity Grant), private and nonprofit foundation funding (e.g., the American Cancer Society and the Robert Wood Johnson Foundation), and awards from several institutes in the National Institutes of Health. The rest of this article will focus on strategies and personal experiences with identifying, applying, and obtaining funding to promote research related to ethnically diverse populations by ethnically diverse researchers.

Overview of Funding Sources

Many universities, hospitals, and professional organizations offer small grants targeted at conducting research with ethnic minority populations. These awards can be very helpful for obtaining pilot data that can support larger grant applications. One such example is the Diversity Grant offered by the Society of Pediatric Psychology (APA Division 54) Diversity Committee. This grant is available to students, fellows, or early career faculty who are members of Division 54 and interested in conducting pediatric psychology research that highlights issues of diversity (such as race/ethnicity, culture, sexual orientation, socioeconomic status, religiosity, gender, and language) in research and clinical care. While this is one example of a professional organization funding source for researchers from or interested in issues impacting ethnic minorities, other organizations often have similar sources that can be accessed by contacting the faculty development office at your institution or membership office of the APA division to which you belong. These sources are often easier to access and slightly less competitive given the smaller pool of applicants; accordingly, they offer a great source of funding for acceptability and feasibility data to make a larger grant application that is much more competitive in this steep funding climate.

Certain private and nonprofit organizations, as well as several government-supported institutes, have funds dedicated for research with ethnic minority populations and/or to develop and support psychologists from ethnically diverse backgrounds. Some of these funding mechanisms have restricted budgets and shorter time frames while others can provide substantial support for up to 5 years of career development. An example of a project-specific, shorter time frame funding source is the American Cancer Society's current call for applications focused on psychosocial/behavioral and health policy/health services research that address cancer-related health disparities. On the other hand, the Robert Wood Johnson Foundation has the "New Connections Program," which provides funding centered on developing and training individuals from diverse backgrounds for the health care field. Within the

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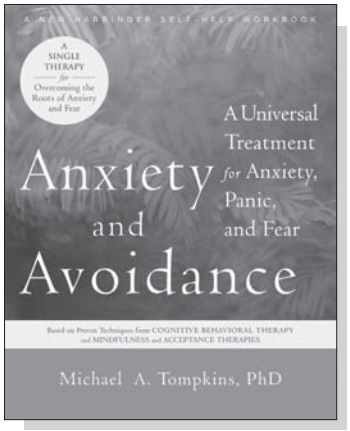

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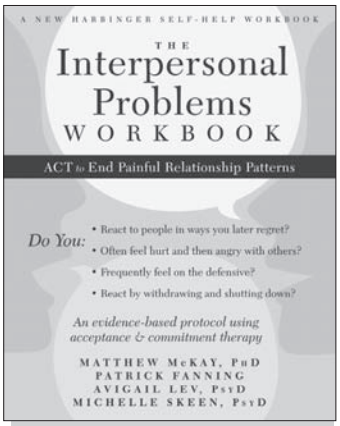

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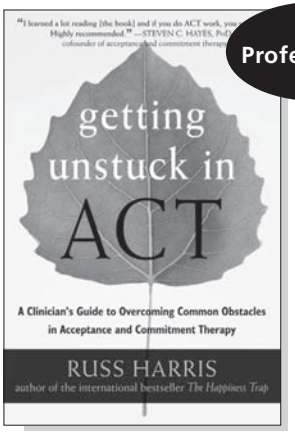

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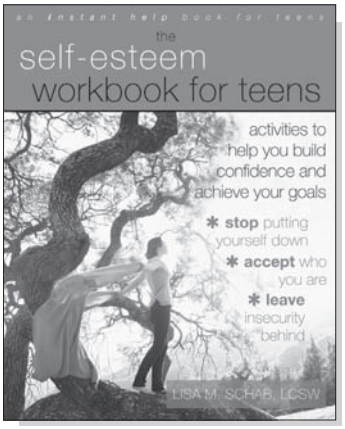

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National Institutes of Health (NIH), there are examples of both types of funding mechanisms (i.e., those designed to support research with racial/ethnic minority populations and those to support the career development of investigators from ethnically diverse backgrounds). Further, these funding sources are available for individuals at various stages of training, from high school students to early career investigators. Specifically, NIH sponsors diversity-focused F31 awards for predoctoral students; research supplements to promote diversity in health-related research at the high school, predoctoral, postdoctoral, and early career levels; and career development grants (K-awards) to increase diversity in specific research topic areas, such as neuroscience. Despite the growing range of diversity-focused research funding opportunities, in this funding climate, the questions are often asked: Is this something I can do? Can I really get a grant? Yes, you can! Below are personal success stories of how we (who often thought we could not) were successful in obtaining NIH-funded diversity research grants.

Funding as a Predoctoral Student

Beginning at the predoctoral level, NIH provides opportunities for students to apply for dissertation research funding and individual fellowship funding. The Minority Dissertation Research Grant (R03) is offered by the National Institute on Aging (NIA) and the National Institute of Mental Health (NIMH). This award provides grants to doctoral candidates from underrepresented racial and ethnic groups in an accredited program in biomedical, behavioral, and social sciences to pursue research careers in any area relevant to the supporting institute. The award provides support to facilitate completion of the candidate's doctoral research and dissertation. NIMH and other institutes and centers at NIH participate in providing funding for graduate students through the Ruth L. Kirschstein National Research Service Award (NRSA). In 2009, NIH provided over 1,600 predoctoral fellowship positions and 42 million dollars in funds to students through the F31 mechanism (NIH, 2013). While the success rate for F31 applicants is competitive (29% in 2012), over 450 fellowship positions were awarded for predoctoral students by NIMH in 2012 alone (NIH, 2013). These NRSA opportunities include a specific award (F31) aimed to "Promote Diversity in Health-Related Research." The goal of this program is to ensure the availability of a diverse pool of highly trained scientists in order to address the country's research needs. A diverse pool is defined as individuals from underrepresented racial and ethnic groups as well as those with disabilities. These awards are unique among NIH awards because in addition to describing a solid research plan, the grant application requires a strong focus on the mentorship available to students and the student's proposed training plan. This training grant includes funding for a training stipend for the student, and covers tuition and fees.

Third author Jessica Valenzuela had the following to say about her experience with the NRSA as a predoctoral student:

In my experience as a predoctoral graduate student, I became aware of the F31 award through the encouragement of a faculty member teaching a grant writing course. She encouraged me to speak to my advisor about applying for the NRSA training award and use my dissertation proposal for the research plan. Applying for the NRSA provided me with excellent learning experiences from grant preparation skills to actualization of the funded research, both of which have served as important stepping stones to future research opportunities in my career. My own background as an underrepresented racial/ethnic minority interested in research and my dissertation research goal of understanding health disparities in minority youth diagnosed with diabetes were a great fit for NIH's mission in carrying out the F31 training grant. In addition, my advisor helped me craft a training plan that included training in advanced statistical methods and conducting research with diverse populations.

As a predoctoral student there are many advantages to participating in a training program that supports your independent research ideas and provides you with opportunities for advanced training in research. As a new faculty member in a university setting, I now take it upon myself to encourage predoctoral students with even the slightest interest in developing careers in research to consider this grant mechanism. It was an excellent starting point for learning about grantsmanship and it provided financial security and ongoing support for research training that was critical in my early training years.

Funding at the Postdoctoral Level

At the postdoctoral level, NIH offers several opportunities for underrepresented racial and ethnic minority researchers. Institutional training awards (T32), some of which are focused on training ethnic minority researchers while others are aimed at increasing research on ethnic minority populations, are accessible at certain institutions. A specific mechanism aimed to support ethnic minority researchers are the NIH-funded "Research Supplements to Promote Diversity in Health-Related Research." These diversity research supplements are aimed at funding a researcher to conduct an independent, mentored, research project that is tied to an existing large-scale grant (such as an R01) called the "parent grant." This award allows an investigator to develop and actualize his or her independent research ideas while harnessing the existing resources already funded to the parent grant. Accordingly, while the diversity supplement typically provides a limited amount of funding to implement the research project and/or cover some travel costs (e.g., to present at conferences), the primary costs of actualizing the research project is expected to be absorbed by the parent grant. The majority of the funds provided by the diversity supplement are limited mostly to salary support. Additional restrictions on the use of award funds depend on the specific institute to which the applicant is applying. The diversity supplement is primarily a training award, focused on providing mentorship experiences for the candidate and opportunities for advancing his or her career while collecting pilot data for a larger research project. Finally, the aims of the applicants' research project must complement, but not overlap with, the parent grant aims.

First author Idia Thurston described her experience with the diversity supplement as a postdoctoral fellow:

In my experience as a diversity supplement awardee at the postdoctoral level, I became aware of this funding mechanism while completing my clinical internship and seeking postdoctoral training opportunities. I expressed interest in working with a faculty member who had an R34-funded project focused on the adaptation of an HIV prevention program for South African parents and adolescents. While I had a strong background in HIV clinical-service delivery for children, adolescents, and their families, my research experience in this area was limited. I always had strong interests in conducting internationally based research but had been unable to fund such endeavors or obtain mentorship in this area. Thus, I worked with my mentor and applied for the NIH diversity-supplement to focus on unique aims and contribute to the parent grant's intervention adaptation process. Specifically, I carved out research questions to examine whether the intervention had an effect *on parental awareness of adolescent risk behaviors. This was a distinctive but complementary addition to the parent grant. Given that these parents and adolescents were already being recruited and*

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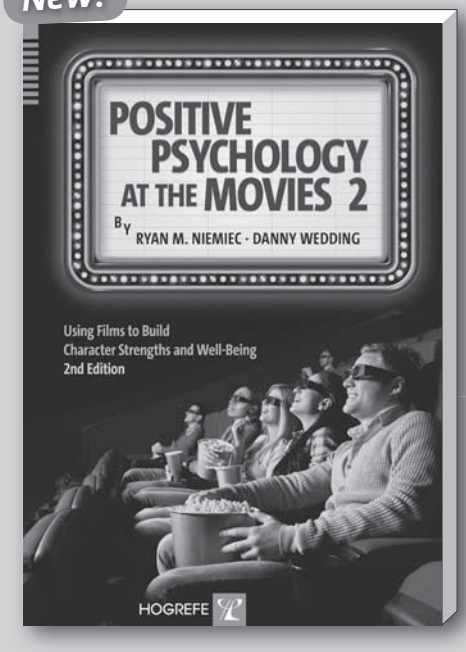

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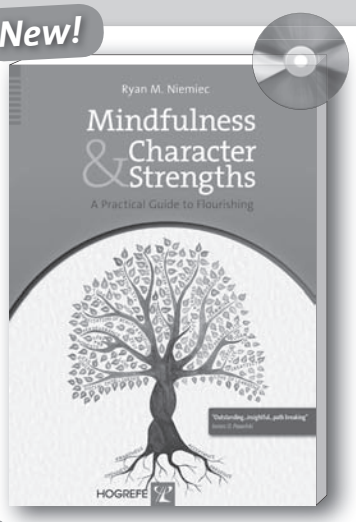

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My career trajectory has been significantly impacted by the funding and opportunities afforded to me as a successful recipient of the postdoctoral diversity supplement. First, my dream of conducting international research became a reality and, through the grant-writing skills I developed, I secured two internal grants to provide extra support for my international travel and research assistance. The process of applying for the supplement was incredibly daunting, especially because I had never successfully secured a grant. However, my own background as an ethnic minority researcher, my passion for global health research, my experience working with children and families affected and infected with HIV, and my strong mentorship team made my application a great match for NIMH's overarching goals. As an early career ethnic minority psychologist who just secured a faculty position in a university setting, I have no doubt that the knowledge, skills, and abilities I gained through the diversity supplement not only made me competitive for this faculty position but will also be invaluable to my continued growth, development, and success in my new position.

Funding as an Early Career Psychologist

One of the most popular grant-funding mechanisms for early career research psychologists is the career development award (a.k.a. K-award). Through many of their institutes and centers, NIH offers up to 5 years of funding for early career biomedical, behavioral, or clinical science researchers. While there are several different types of K-awards that are supported by varying institutes and centers (see resource link), there are a few diversity-focused K-awards offered by three institutes. The National Cancer Institute (NCI) offers diversity-focused K01, K08, K22, and K23 awards. The National Institute of Neurological Disorders and Stroke (NINDS) offers diversity-focused K01 and K22 awards. The National Heart, Lung, and Blood Institute (NHLBI) offers two diversity-focused K01 awards (one for faculty at an institution that promotes diversity and another to promote faculty diversity and reentry in biomedical research). Other diversity-focused NIH funding mechanisms for early career investigators include the "Small Grants for New Investigators to Promote Diversity in Health-Related Research (R03)" offered by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), NIMH, and the Office of Dietary Supplements (ODS). This R03 funding mechanism offers support for new investigators from underrepresented racial and ethnic backgrounds who are seeking funding for various small projects that can be completed within a brief period of time with limited resources, including collecting pilot and feasibility data, secondary data analysis, and development of new research methods or technology.

The above described diversity focused grant mechanisms typically require a prior track record of conducting research in the area for which one is seeking early career funding. Diversity research supplements are another mechanism for those investigators who might require additional training in order to be competitive for early career awards. Although these awards are described above as an option for postdoctoral trainees, supplement awards are also available to early career investigators. As described above, these awards are strategic for investigators who want to pursue independent research funding but need additional research mentorship, are investigating a new area of research, or could benefit from opportunities to bolster his or her curriculum vitae (CV). The diversity supplement at the early career level may include collecting pilot or feasibility data for a grant application, secondary data analyses, and/or increasing publications. Similar to K-awards, diversity supplements at the early career level also include a primary mentoring component, which is as important as the proposed research project. The mentoring plan includes opportunities to work with senior investigators on the parent grant, plans for participating in scientific meetings and developing writing skills, and a time line with milestones that will be accomplished along each stage of the supplement process. Notably, obtaining a diversity supplement award at the faculty level does not render an individual ineligible for a K-award; on the contrary, it can actually enhance one's academic portfolio for a K-award. Investigators may also use the diversity supplement as a stepping stone to gather preliminary data and prepare for submitting a larger scale NIH grant.

Second author Elizabeth Pulgaron provided a description of her experience with the diversity supplement as an early career psychologist:

In my experience, a current mentor at my institution received a multisite R01 from NHLBI on Hispanic children's health, with an emphasis on cardiometabolic risk factors. At the time, I was completing a research fellowship in minority health disparities. My research interests were on the grandparents' role on children's weight status. The connection between my mentor's R01 (the parent grant) and my ongoing research project was strong. Thus, I applied for a diversity supplement award in order to collect data from the grandparents of the children who would be involved in the parent grant study. The parent grant was already collecting an extensive amount of data on nutrition, physical activity, and health behaviors from children and parents involved in the study. I did not have the resources to obtain the caliber of data being obtained from the parent study. However, the opportunity to connect my research questions to the parent grant through the supplement enabled me to access the parent grant data and relate it to the grandparent data that I added to the protocol. Through the diversity supplement, I was able to obtain professional development training opportunities. Specifically, I successfully identified a local mentoring team to help develop my writing and statistical analysis skills. I utilized the multisite nature of the parent grant to gain access to researchers across the country who specialized in various aspects of child health. I also applied for and attended the "Programs to Increase Diversity among Individuals Engaged in Health-Related Research" (PRIDE) summer institute, which was geared toward developing researchers in Latino Health Disparities.

Overall, the protected research time and professional development support allotted by the early career diversity supplement has enabled me to further develop my research and writing skills. By the end of the supplement funding period, I will have obtained pilot data and enhanced my skills as a researcher in order to pursue independent funding to advance this line of research. The mentorship I have received both within and outside of my institution has been instrumental in my first years as an early career psychologist.

Conclusion

Throughout this article we have provided a rationale regarding the importance of funding research on ethnic minority groups and promoting the careers of ethnic minority researchers. A thorough, but not exhaustive, list of research funding sources for ethnic minority predoctoral, postdoctoral, and early career psychologists has been summarized. Case examples of success stories at various professional levels (predoctoral, postdoctoral, and early career) have been described to illustrate how trainees and early career investigators can apply for and successfully obtain sources of funding in a steep funding climate.

As an ethnically diverse researcher or researcher interested in issues impacting racial/ethnic minority populations, it is important to highlight your unique contributions when applying for grants, especially those grants with a diversity focus. Write about the unique contributions you can bring to the process of research design, project implementation, and dissemination of study findings. For example, you can explain how your bicultural heritage provides you with insightful ways to recruit hard-to-reach populations or how your bilingual skills can address language barriers. When applying to diversity-focused grants, in addition to describing how well you "fit" with the goals, vision, and mission of the grant and funding agency, highlighting experiences with cultural competency or cultural sensitivity could also be an asset.

In closing, we would like to emphasize the three P's of obtaining research funding early in your career: practice, preparation, and perseverance. *Practice*— we cannot overemphasize the importance of applying for as many grants as possible; the more grants you write, the better you become at grant-writing. We have all had experiences of grants (and papers) being rejected and it can sometimes be very difficult to go through the process again. However, the only way to recover is to dust off your pen and write another grant (or paper). A research career is not for the light-hearted or thin-skinned: ethnic minority trainees and psychologists may be especially vulnerable to rejection and messages of failure due to the impact of microaggressions (Sue et al., 2007). However, only the strong survive in this grant-writing business so it is important to remind yourself of the need for practice and remember that each rejection only provides additional opportunities for practice.

Preparation is very important—your highest chance of success as a grant applicant comes from being well prepared. It is important to not only consider general grant-writing challenges but to also prepare for potential challenges and barriers you may experience as an ethnic minority researcher. Some of these unique challenges include internal and external negative messages about intellectual abilities and the propensity to persevere in research, which can often be fueled by experiences with microaggressions and prejudice. Additionally, ethnic minorities might have limited exposure to strong mentorship relationships, which could lead to lack of preparedness for writing strong grant applications, limited opportunities for publications and presentations, and inadequate exposure to a wide network of colleagues who can help promote your career. Strategies to prepare yourself and overcome these challenges include developing a strong network of mentors and colleagues who can support your research goals—it is especially important to identify multiple mentors who are not only successful at getting grants but who are willing to teach you how to get grants. Being active in summer training institutes such as PRIDE, Diversity Special Interest Groups, and other diversity-focused organizations can provide researchers (from ethnically diverse backgrounds or those interested in working with diverse populations) with networking opportunities and support regarding grantsmanship. When possible, strive to find other ethnic minority investigators who can help you navigate the personal and professional maze of becoming a researcher.

Other strategies for overcoming barriers and increasing competitiveness include taking the time to read the request for applica-

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Resources

APA Division 54, Society of Pediatric Psychology, Diversity Research Grant:
http://www.apadivisions.org/division-54/awards/diversity/index.aspx

APAGS Resource Guide for Ethnic Minority Graduate Students
http://www.apa.org/apags/resources/ethnic-minority-guide.pdf

American Cancer Institute, Health Disparities Focused Research
http://www.cancer.org/research/researchprogramsfunding/fundingopportunities/indexofgrants/newinitiatives/priority-focus-in-cancer-control-and-prevention-research-program-health-disparities-research

National Institute of Health, Career Development Awards
http://grants.nih.gov/training/careerdevelopmentawards.htm

National Institute of Health, Diversity Focused R03
http://grants1.nih.gov/grants/guide/pa-files/PAR-13-074.html

National Institute of Health, Diversity Supplement
http://grants.nih.gov/grants/guide/pa-files/PA-12-149.html

National Institute of Health, Graduate Programs for Underrepresented Minorities
http://www.ncbi.nlm.nih.gov/books/NBK22667/

Programs to Increase Diversity Among Individuals Engaged in Health-Related Research (PRIDE) Summer Institutes
http://www.biostat.wustl.edu/pridecc/about-pride/

Robert Wood Johnson New Connections Program
http://www.rwjf-newconnections.org/

tions (RFA) thoroughly so you can aptly present yourself as a great fit to the funding agency, ensuring appropriate access to the populations being proposed for health disparities work, and obtaining some preliminary data that indicates prior success in recruiting ethnic minority populations and emerging expertise in the study area. Strive to always be the strongest applicant you can be by taking advantage of every training, workshop, or professional development opportunity offered inside and outside your institution. The resource list highlights programs/guides aimed at supporting ethnic minorities in research careers.

Finally and most importantly, perseverance is key. Remember that even the most well-funded researcher was and likely still is frequently rejected for grants. Apply for each grant with the expectation that it will not be funded on the first round (if it is, celebrate; if it is not, you won't be disappointed). Use the feedback provided as a tool to enhance your grant and resubmit.

As three early-career ethnic minority psychologists who are still on the journey to becoming independently funded investigators, we know firsthand how difficult the road ahead can be. We persevere because failure is not an option—an increasingly large percentage of ethnic minorities are represented in many health risk behaviors and poor health conditions and outcomes. As ethnic minority researchers we feel we can bring unique perspectives to help understand health risks in ethnic minority communities. Thus, in spite of the formidable task of obtaining grant funding in the ever-narrowing funding climate fraught with fears of sequestration and budget cuts, we are proof that it is possible!

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An Idiographic Evidence-Based Approach to Addressing Cultural Factors in Treatment: A Case Example

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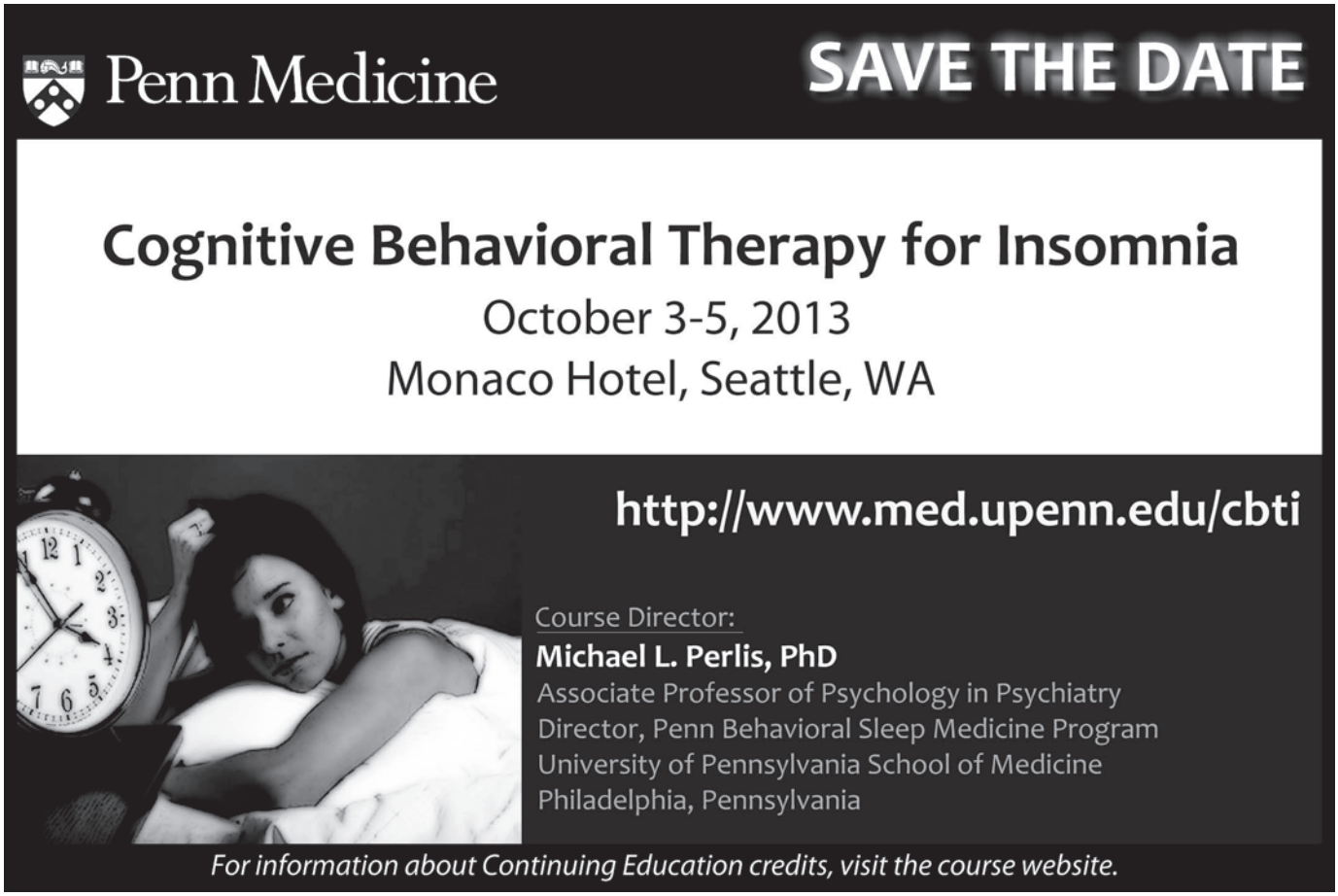
Although different frameworks have been offered on how to address cultural factors in therapy (e.g., Bernal, Jimenez-Chafey, & Rodriguez, 2009; Hwang, 2006; Zayfert, 2008), researchers and clinicians continue to struggle with questions about the cultural applicability of existing treatment models and how to adapt interventions in ways that do not reify stereotypes or undermine the integrity and efficacy of existing empirically supported treatments (for review see Sue, Zane, Hall, & Berger, 2009). One strategy has been to increase the accessibility of treatment protocols (e.g., language translations, use of culturally relevant examples or imagery; for review see Sue et al., 2009; Voss Horrell, 2008). Another has been to develop recommendations or theoretical frameworks on how treatments may be adapted for specific populations (e.g., Bernal, Bonilla, & Bellido, 1995; Hall, Hong, Zane, & Meyer, 2011; Hwang; Lau, 2006). Another promising alternative has been to actively modify existing treatments to incorporate known cultural differences in beliefs and values, and test the effectiveness of these modifications on the target populations (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Pan, Huey, & Hernandez, 2011). For example, Hinton and colleagues (2012) describe 12 key ways they adapted CBT for PTSD to be more culturally sensitive to traumatized refugees and ethnic minority populations, and cite data supporting the effectiveness of these adaptations (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011; Hinton et al., 2004).

Recommendations of integrating relevant cultural factors into treatment, while important, speak little to the difficulty of applying such adaptations to large, heterogeneous ethnic groups. For example, the label Asian American represents hundreds of ethnoculturally unique groups of individuals that vary by national origin, language, and customs. Moreover, the heterogeneity of the group is further complicated by differing levels of acculturation to Western cultural norms. Given this, it is unlikely that specific adaptations will consistently be indicated in the treatment of all Asian Americans or other large ethnic minority groups. While researchers acknowledge the diversity within ethnic groups, and even warn against overgeneralizing cultural constructs (e.g., Hwang, 2006), practicing clinicians are left with little guidance on how to address cultural factors at the individual level.

To address symptoms at the individual level, Zayfert (2008) proposes a more idiographic approach to responding to cultural concerns. This approach has the clinician asking the client a series of questions to assess



the relevance of his/her ethnocultural context on his/her symptoms. Zayfert presents example questions within the context of treating PTSD (e.g., What is the individual's perspective on … the role of women's sexuality? … the centrality of family over the individual? … the meaning of seeking professional help outside of the family?, etc.), and asserts the importance of assessing domains shown to vary culturally and are relevant to the development and treatment of a particular problem or disorder. This approach provides a framework within which a clinician can culturally adapt treatments on a case-by-case basis and in a systematic manner. Zayfert also highlights how this framework lends itself well to larger scale studies that could clarify the domains most relevant to an ethnocultural idiographic assessment for a particular disorder and, thus, provide guidance to clinicians on ways to adjust treatment delivery.

Despite its advantages, a limitation to the proposed idiographic approach is the assumption that clients will have adequate psychological insight to respond to questions about their ethnocultural values and context, and provide enough data to determine how to structure the entire treatment plan. Most individuals do not spend time thinking about their cultural values and how they may be related to their problems. This is particularly true for individuals raised in cultural contexts that are more collectivistic (e.g., those in East Asia) and do not promote self-evaluation or personal psychological awareness.

How, then, is a clinician committed to evidence-based practice to address the role of culture in treatment at the individual level? In the present paper, I describe three strategies to individually tailor a culturally responsive treatment plan, while remaining empirically driven. First, as a way to address the difficulty of directly assessing an individual's cultural values, I offer the alternative of using standardized measures of constructs that are relevant to the presenting problem and may be influenced by the client's ethnocultural context. This approach allows the clinician to collaboratively review the assessment data and discuss the functional and cultural meaning of score elevations with the client. Second, I highlight how clinicians can draw from research on specific cross-cultural differences to tailor their treatment interventions. Finally, I describe how to collect data throughout treatment and collaboratively work with the client to adapt treatment based on the data collected. These proposed strategies are illustrated by the following case example and the treatment interventions used to treat the client's depression.

Case Background

John* is a 44-year-old Chinese-American male who lives with his Chinese-American wife of nearly 15 years, and two young children. John is the youngest of three children, and was born and raised in the San Francisco Bay Area. John's parents immigrated to the United States from China shortly before their eldest son, John's brother, was born. At the time of treatment, John and his entire extended family (his parents, his brother and family, and his sister and family) all lived within 5 miles of one another, and jointly owned several drycleaners and buildings in the area. In addition to the family business, John and his siblings had their own jobs. John, with a master's degree in business administration from a top-tier university, worked for several years at a high-profile consulting firm before quitting to work as a part-time freelance financial consultant. John explained the reason he chose freelance work was to reduce his work stress and have time to explore career path options. Although John described his work as part-time, he admitted to often working over 60 hours in one week, and finding himself "obsessing" over the details of a project.

John initially sought treatment after noticing increased episodes of irritable outbursts towards his family (both immediate and extended), and reduced engagement in activities he used to enjoy. Further assessment indicated ongoing difficulties with reduced appetite, poor sleep, and hopelessness about the future, and confirmed a diagnosis of major depressive disorder. John also reported growing resentment towards his parents for being "hyper-controlling and unable to respect personal boundaries." As examples, John described how his parents frequently asked him about his financial situation and assets, and rarely left a conversation without expressing their disapproval of him leaving a stable, high-paying position to become a freelance consultant. John's parents also frequently called John asking what he had eaten that day, or would come unannounced with groceries or food his mom had prepared for him and his family. According to John, his parents also expected him to cater to their needs immediately when asked and appeared to disregard the importance of his existing obligations when they had a request for him. John perceived his parents as being highly intrusive, critical, and demanding.

John described himself as having high standards, and said others would often complain about the amount of time he spent ensuring his work and home projects met these standards. John also admitted frequently feeling frustrated when others, including his children, failed to meet his expectations, and then feeling guilty for being unable to "stay in control" of his emotions. At intake, John expressed feelings of exhaustion and low self-worth from his perceived failures, and hopes that CBT would teach him skills to make fewer mistakes and be more emotionally stable.

Culturally Informed Symptom Assessment

When working with clients who, like John, primarily identify with Western norms, identifying and presenting the possible role of Asian-based beliefs and values in their problems can be tricky. First, clinicians may be prone to biases based on a client's ethnic background and make assumptions that certain beliefs or behaviors are culturally normative, and may overemphasize or dismiss the clinical relevance of what is observed. Second, the topic of cultural identity is a sensitive one, and clinicians are at risk of offending the client by labeling behaviors as culturally based or assuming certain treatment modifications are necessary based solely on a client's ethnocultural background. Finally, even with self-report data on a client's acculturation level, the clinician has little guidance on how to use these data to individualize the treatment plan.

One way to circumvent some of these complexities is to provide standardized measures of constructs shown to be elevated in certain cultural populations and tend to be related to symptoms of distress. Several lines of research suggest Asians and Asian Americans are prone to self-criticism and perfectionistic beliefs (DiBartolo & Rendon, 2012; Heine, Kitayama, & Lehman, 2001; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997). By providing a measure of perfectionism and/or self-criticism, the clinician can objectively assess for potential elevations, and initiate a discussion about any elevations found and their implications for treatment.

John evidenced significant elevations in various aspects of perfectionism and self-criticism. Before discussing the measure results, I asked John what he thought the measure assessed, and he replied "Asian values?" Intuitively John was able to identify

*Patient name and identifying information have been changed.

aspects of perfectionism that may be promoted in Asian cultures (e.g., a self-critical orientation) but likely would have denied the role of culture in shaping his current difficulties. When discussing John's score elevations, we considered the meaning of the elevations to him, and how his perfectionism may be contributing to his depressive symptoms. We identified several examples of how John's excessively high standards increased his vulnerability to feelings of anger and frustration. From that discussion, we added the goal of targeting John's inflated standards of performance and had a metric for assessing change in this area. We also used this discussion to rework John's goals for treatment to becoming more comfortable with making mistakes (rather than making less of them) to help achieve feelings of emotional stability and engagement.

Although John agreed that his perfectionism significantly contributed to his depression, other Asian clients I have treated showing elevations in perfectionism have argued against its relevance to their symptoms and will even defend their beliefs as being culturally normative. In these instances, the relevance of their elevated scores to their distress is framed as hypothesis to be tested with treatment. Having such measures to develop treatment hypotheses (rather than the clinician pointing out perceived problematic processes) protects the therapeutic relationship and promotes a sense of collaboration between the clinician and therapist. As treatment progresses, data are collected to see if reductions in distress are related to reduced personal standards. For some clients, the relationship is not supported and mechanisms other than perfectionism are found to be driving their distress symptoms.

Culturally Informed Treatment Interventions

One common area of treatment concern related to culture is the intergenerational cultural conflict between immigrant parents and their U.S.- or Canadian-born children. In this instance, research findings from cultural psychology provide a rich evidence base for psychoeducation on stark East-West cultural differences. When presented with this information, clients are able to contextualize their parents' behaviors (or parents are able to contextualize their children's behaviors) and depersonalize the meaning of their actions.

John frequently mentioned his dissatisfaction with his relationship with his parents and how he had spent much of his childhood wishing his parents were similar to his Euro-American friends' parents. I presented John with research findings on how East Asian cultures promote markedly different views of the self and personal boundaries, relationships with family and others, and the functional role of self-criticism. We then reviewed the many examples in which John felt angered or hurt by his parents' behavior and translated the behaviors within the Eastern framework presented. For example, John's parents' insistence on asking him if he had eaten was no longer seen as an effort to control or infantilize him, but, rather, translated to mean "I care about you." John continued to practice translating his parents' behavior and increased his efforts to accept the cultural framework within which they operated. Over time, John found that not only did his relationship with his parents improve, but he could also "actually spend an entire day with them without wanting to tear all [his] and their hair out."

Collecting Practice-Based Evidence

Although the intervention of putting his parents' behavior in a cultural context worked well for John, there are other clients for whom the intervention may be less helpful or relevant. One way to address these individual differences is to approach treatment interventions as behavioral experiments to be tested by collecting progress and self-monitoring data. Although this recommendation is not new, and is implicit in empirically supported treatment protocols, it is particularly important when working to address cultural factors that are uniquely influencing an individual and when there is little external data on appropriateness of certain interventions.

As a way to monitor progress, John completed weekly symptom measures and weekly logs tracking various behaviors and interactions we identified as relevant to his treatment goals (e.g., number of hours slept, number of hours worked, overall stress levels). With each problem behavior or reaction, we worked to identify the processes that appeared to be maintaining the problem and considered and tested alternate ways to respond to triggering events. When he reported beliefs or behaviors commonly reported by Asian Americans (e.g., difficulties with assertiveness and expressing negative emotions), we first normalized the beliefs and behaviors by discussing the different social goals and processes promoted in Asian cultures, but then questioned whether they interfered or helped him move towards his treatment goals. When the answer was unclear, we would devise behavioral experiments to test the helpfulness of an alternate behavior and review data collected from the experiment.

For example, with John, we found increasing his ability to be mindful of negative emotions and willingness to experience them proved to be highly helpful in improving his relationships with family members. We also found that John's active choice to not express his anger felt more empowering to him than his past reactions of feeling forced to not express his anger, or the alternative choice of expressing his frustrations. This example highlights how cultural variables may have influenced the strategies that worked best for John and how the use of behavioral experiments allowed the discovery of these strategies without cultural biases or assumptions. By the end of treatment, John showed significant reductions in levels of perfectionism and self-criticism, reported improved relations with his wife and extended family, no longer met criteria for major depressive disorder, and prided himself on being more engaged, mindful, and flexible in his life.

The strategies presented in this paper offer a flexible framework in which clinicians can incorporate empirically based treatment strategies (e.g., exposures, mindfulness training, cognitive restructuring) while working with an individualized, culturally sensitive case formulation. Although John's treatment did not follow a specific protocol, the emphasis on ongoing assessment and data-driven interventions reflects the ethos of empirically supported treatments and allows for the incorporation of cultural factors at the level of the individual. The case also illustrates the importance of taking a curious stance to therapy, and the benefits of addressing the role of cultural factors collaboratively with the client and through data collection. Rather than assuming particular cultural constructs are relevant to a client, the clinician and client work together throughout treatment to collect data and collaboratively decide whether a particular belief or behavior is culturally adaptive or functionally impairing.

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Treatment for American Indians and Alaska Natives: Considering Cultural Adaptations

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American Indians and Alaska Natives (AI/ANs) are citizens of sovereign tribal nations and comprise 1.7% of the U.S. population (5.2 million; U.S. Department of Commerce, 2012). They represent a multitude of tribes and traditions and have endured genocide, forced assimilation and relocation by colonizers and the U.S. government (Shelton, 2001). AI/ANs face significant health disparities, including increased rates of diabetes, PTSD, substance use disorders, infant mortality, and suicide (Beals et al., 2005; Chinitz & Christian, 2009). The U.S. has a responsibility to provide health care to AI/ANs based on agreements in which tribes ceded land to the U.S. government in exchange for health care, yet health services for AI/ANs remain chronically underfunded (Chinitz & Christian). What can therapists and researchers do to address these injustices? One urgent need is to ensure that available mental health treatment is appropriate for and acceptable to AI/ANs. Cultural adaptations of evidence-based treatments (EBTs) make important advances in this direction.

What Is Cultural Adaptation?

Cultural adaptation has been defined as "the systematic modification of an EBT or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Cultural adaptations include changes to treatment processes or content such as additions or deletions of treatment components, changes in the intensity of treatment, translation or use of local language and cultural idioms (Bernal, 2009). A meta-analysis of 76 culturally adapted treatments found that the most common adaptations involved the integration of cultural values and concepts and resulted in interventions that were more effective than unmodified EBTs (Griner & Smith, 2006).

When to Develop or Use Cultural Adaptations

Interventions for AI/ANs should integrate cultural knowledge and traditional practices with the best available science from their inception (Gone, 2004; Trimble & Mohatt, 2002). Some AI/AN researchers posit that returning to indigenous ways of knowing and traditional healing practices may be an effective solution to mental health problems (Gone & Calf Looking, 2011). However, the time and financial resources needed to develop, implement, and test interventions in partnership with AI/AN communities are sometimes not available, or treatment is needed before an

evidence base has been established. In addition, mental health practitioners often must use interventions shown to be efficacious in randomized clinical trials (RCTs) to receive reimbursement (Miller, Zweben, & Johnson, 2005). In these cases, AI/AN clients may benefit from culturally adapted versions of existing interventions.

Lau (2006) argues that adaptation of EBTs should be systematic, selective, and directed, focusing only on areas where there is an observed mismatch between a particular EBT and an ethnocultural community. Data-driven indications include cases when there are noted ethnocultural group disparities in treatment outcomes, when between-group differences in mediators and moderators of treatment outcome are documented, or when there is a need to improve the social validity of an EBT (Lau). Social validity refers to the "acceptability and viability of an intervention when implemented in a community setting" (Lau, p. 299). Social validity affects treatment outcomes via treatment enrollment, engagement, and attrition. Examining the social validity of an EBT is crucial when preparing to implement the intervention in an ethnocultural group that was not represented in the initial validation studies. Research examining social validity examines potential participants' perceptions of the acceptability, relevance, feasibility, and effectiveness of treatment goals and strategies (Lau). Socially valid interventions are more efficacious, and EBTs may require cultural adaptation to enhance their social validity (Lau).

Caveats of Cultural Adaptations

An argument can be made that there is more to consider than social validity related to engagement and attrition and data-driven decisions from within a Western framework when implementing evidence-based programs within AI/AN communities. The Institute of Medicine (2012) has put forth a framework for valuing community-based prevention programs and policies. The framework stresses that programs and policies should account for benefits and harms in three domains: health, community well-being, and community process. This framework acknowledges that community-based prevention can create value not only through improvements in the health of individuals but also by increasing the investment individuals in the community are willing and able to make in themselves, in their family and neighbors, and in their environment. Community-based prevention involves decisions among groups of people about the "right way" to live in society; in essence, the right way they are to act within the physical and societal environment that surrounds them. The question remains within EBT research, however, as to who has the privilege of defining what is "right" for AI/AN people?

Given colonization's purpose of removing the AI/AN voice from this nation's development, many existing EBT target values will unwittingly stand in direct contradiction to deeply held indigenous beliefs, values, and traditions. At times it may be the overall focus of the intervention that is contradictory. For example, assertiveness training for American Indian women may cause harm if this training requires improper use of social norms with elders (LaFromboise & Rowe, 1983); women can lose a protective factor of cohesiveness with elders that community can bring. At other times, it may be the specific skill being taught within a program that is contradictory. For example, the Western concept of "time-out" within parenting programs removes or isolates children from the situation and places parents in an external position of power and control over the child (e.g., determining when they leave time-out). This focus, as a means of correcting child behavior, may conflict with the value placed on the indigenous concept of "all my relations," wherein relationships serve as an important part of helping children to walk the right path in life. For many AI/AN parents, it is important for their child to reflect on how their behavior affects relationships in the world around them (i.e., to all born to the community of Mother Earth) as well as in the world within them (i.e., to the ancestral community). It is this introspection that serves to guide the child's behavior in the right way. As such, the child would not necessarily be separated from others but rather guided by an adult to reflect on the importance of their behavior in supporting and carrying forward these relationships within them in a good way as they walk through life. In essence, the Western way can be seen as shaping behavior through external means of power and control, the indigenous way through internal means of strengthening relationships.

Though the two examples above represent a contradiction in worldview, it must be acknowledged that both perspectives seek to shape and strengthen behavior in the "right" way; there is this common goal. However, whose "rightness" should be valued and followed to achieve this goal? If we as researchers stringently hold to the belief that we must implement current EBTs as they are, with their set definitions and processes, might we do more harm than good if it further unravels the values within the community that serve as strength for AI/AN people? If voices in a community tell researchers and others in power what they can or cannot do, what they should or should not do, will this voice truly be heard? Will the decisions have the legitimacy—added value—that comes from an open and inclusive group decision-making process that is not prestructured to stay within an existing EBT or research agenda, process, or set of definitions? The process by which interventions are decided upon and implemented should be treated as a valued outcome, even when the decisions arrive at a place where existing evidence-based practices, processes, or definitions are deemed wrong.

Clearly, the decision of whether or not to modify an EBT can be complex and confusing. Some researchers have come to feel strongly that there needs to be a deeper level of consideration when deciding to use an EBT and culturally adapt it (e.g., Lau, 2006). The process needs to start at the beginning to allow the community voice to be part of the defining process relative to (a) what intervention fits for the community, allowing for the possibility that no existing program truly fits relative to focus (e.g., assertiveness) and constructs (e.g., "time-out") included and (b) how an intervention should be implemented, allowing for a different approach to teaching any skill that is important for protecting children (Davis, Dionne, & Fortin, in press). "Social validity" requires a deeper understanding of how we arrive at a meaningful and culturally strong approach within AI/AN communities to strengthen families; we must begin a process with communities wherein we protect "who they are," not what we think they should be. Otherwise, we risk asking AI/AN families and communities to abandon protective practices in lieu of reinforcing Western ways of dominance and control, which, for many, may reinforce reactive patterns of internalized oppression (Sparrow et al., 2011).

Culturally Adapting EBTs for AI/AN Populations

Although American Indian and Alaska Native are broad terms that encompass a multitude of cultures, there are some common constructs that should be considered in the adaptation of EBTs for indigenous peoples. Some of these constructs include collectivism or interdependence, respect for elders, importance of spirituality, and re-

spect for nature. AI/AN peoples also share a common history of colonization and face issues of racism and discrimination. The following examples illustrate the diversity in the level and types of adaptations that can be undertaken while covering a variety of mental health issues.

Examples of Cultural Adaptations

Suicide prevention. The annual suicide attempt incidence rate among Apaches 15 to 24 years old is 3.5%, approximately 17 times the rates observed in methodologically similar studies (~0.2%; Mullany et al., 2009). Apache surveillance data indicate only one-quarter of youth attempters referred for services make contact and just one-third of those attend their first session (2001-07). Thus, an Emergency Department (ED) intervention for youth who made suicide attempts (Asarnow et al., 2011; Donaldson, Spirito, Arrigan, & Weiner Aspel, 1997; Rotherman-Borus et al., 1996) was chosen for adaptation by the White Mountain Apache (Apache) and Johns Hopkins Center for American Indian Health because it was (a) evidence-based, (b) brief, (c) providing youth with some immediate coping skills post-attempt, (d) facilitating youth help seeking and connections to available care, and (d) potentially filling a gap in the continuum of care.

The original intervention included a training workshop for ED providers, a videotape aimed at modifying families' treatment expectations, and an on-call therapist. The new intervention, named New Hope by the community, was adapted by an Advisory Board and future New Hope interventionists from the community. The intervention was modified from a professional-delivered model to a home- and family-based, paraprofessional-delivered model, which was the most feasible and culturally appropriate delivery mode in this community. New Hope is a 2- to 4-hour intervention conducted over one to two visits, and consists of a brief video and skills-based curriculum, including a newly developed training guide for staff and accompanying workbook for youth. New Hope focuses on problem-solving barriers to treatment initiation and adherence, and provides brief exposure to key psychoeducational skills to reduce risk and promote safety, including emotion regulation, cognitive restructuring, seeking social support, impulse control and self-efficacy. The adapted curriculum's video and graphics depict familiar Native characters, styles, environments, and cultural practices. The video also includes powerful messages from Apache elders to youth in the Apache language.

Pilot data have shown that participants were satisfied with the interventionists and program, and that Apache paraprofessionals can be trained to deliver the intervention with fidelity. Results also show promise that the intervention may lead to self-reported decreases in depression, negative cognitions, and suicidal ideation, but an RCT is needed to test the effect of the program on suicide-related behavioral outcomes.

Substance use disorder treatment. In 2007 the principal investigator (sixth author) began meeting with the Southwest Pueblo tribal council to obtain permission to conduct an RCT of two EBTs compared to treatment as usual. After the Puebloan counselors were hired and completed 4 days of training in motivational interviewing (MI) and the Community Reinforcement Approach (CRA), we began the process of adapting the EBTs to be more culturally congruent and hopefully effective for the Puebloan participants. The goal was to maintain fidelity to the EBTs while expanding the focus to include social forces such as discrimination and worldviews of spirituality. Adaptation efforts centered on the assessment and clinical forms as well as addressing appropriate communication style for specific skills, such as drug refusal skills. A pilot of eight participants completed the 16-week course of therapy and 4- and 8-month follow-ups and revealed significant improvements in percent days abstinent from alcohol and drugs (Venner & Lupee, 2012).

Many psychological therapies focus almost exclusively on the individual to assess for behavioral health problems, conceptualize the case, and design treatment goals. For people who have a strong group identity, such as AI/ANs, it is important to assess salience of group identity and assess for social factors such as discrimination, oppression, and poverty that may be impacting their behavioral health. Therefore, we included cultural identity (Scale of Ethnic Experience; Malcarne, Chavira, Fernandez, & Liu, 2006) and discrimination assessments (Microaggressions Distress Scale; Chae & Walters, 2009). Given elevated rates of poverty among AI/ANs in general, we assessed annual income, level of education, and employment status.

Another shortcoming of many EBTs for members of oppressed groups is the omission of spirituality. Traditional practices have been found to help AI/ANs resolve alcohol problems (Torres Stone, Whitbeck, Chen, Johnson, & Olsen, 2006) and maintain sobriety (Bezdek & Spicer, 2006; Hazel & Mohatt, 2001). Therefore, we included spirituality on the CRA forms of happiness scales, functional analyses, and treatment goals. Consulting tribal religious leaders and tribal council, we also adapted the Daily Spiritual Experience Scale (Underwood & Teresi, 2002) specifically for this AI tribe.

This Southwest AI community is a traditional tribe that has high rates of fluency in their native language and strong tribal religious groups and ceremonies. The counselors and tribal council have embraced these culturally adapted EBTs and are looking forward to the results of the RCT with hopes for improved substance use outcomes in their community. Because the AI counselors are from this community, the EBTs will be sustainable when the grant funding ends. Adapting EBTs is not the only way to address substance use disorders, but it is one way to help those who are willing and bicultural or acculturated.

Parenting. Dionne, Davis, Sheeber, and Madrigal (2009) overlaid a cultural context (the SPIRIT project) onto the Incredible Years Program (Webster-Stratton, 1994), an evidence-based parenting program. The SPIRIT project was implemented within a large Southern California community consisting of 33 AI reservations and a large urban AI population. The cultural overlay came from within the community and evolved over a decade with AI leadership, through completion of focus groups, pilots, and a larger-scale RCT. In both the pilot trial (Dionne et al., 2009) and larger RCT (Davis, Dionne, Madrigal, Sheeber, & Taylor, 2013), significant positive changes were found for parenting behavior and child functioning, and the program was found to be acceptable with high levels of engagement and satisfaction (Davis, Dionne, Madrigal, & Fortin, 2010). Within these trials, adaptations sought to bring forth strength in the ancestral story for each participant and use this strength as motivation for subsequent change to protect the children (Dionne & Dishion, 1998). Within the intervention, prior to teaching parenting skills (e.g., child-directed play), each skill was placed within an indigenous framework (e.g., respect) through cultural video and discussion with the parent.

Although the approach seemed to be helpful when looking at proximal indicators (i.e., child and parenting behavior at postintervention), discussions within the AI community indicated that a deeper focus at the

level of worldviews and values was needed. Without such focus there stood a chance of imposing Western values and worldview onto the AI culture, continuing colonization, and further eroding the protective nature of cultural strength. For example, the definitions of important parenting constructs (e.g., limit setting) can inadvertently be colonized to fit into Western definitions of what is "good," thereby devaluing the wholeness of AI traditional concepts around childrearing.

The National Indian Child Welfare Association's Positive Indian Parenting (Cross & Hansel, 1986) curriculum defines "noninterference" as an important American Indian parenting value. Respect for elders, family, and community leads to a value of noninterference: to behave in a way that does not interfere in the choices of others. Parenting styles are often a result of the high value placed on noninterference. When viewed from a Western worldview and thereby many existing parenting approaches, noninterference can be misinterpreted as permissiveness or lack of discipline since children are allowed to make mistakes and learn from those mistakes without interference. From this perspective, noninterference is not a desirable parenting skill. Clearly, in today's society, wherein many societal risks and illnesses reside, noninterference from this Western perspective is not protective. However, the Western definition defies the traditional value of "why" noninterference is important to strength in AI life. The traditional "why" reflects a larger cultural strength found in interconnectedness of the child to this world and the ancestors, relationship strengthening between the child and others around them and respect for the child's position within the world and their journey to identity. It is the associated strength of this larger and internal "why" that should be preserved within parenting constructs for their culturally based protective nature.

If we were to speak of a Western concept of "limit setting," but allowed recognition and discussion of this construct within the deeper and internal nature of the traditional concept of "noninterference," what would this new parenting construct look like? How would it be defined, and how would it be taught? Would this type of deeper "why" discussion lead to a new construct perhaps of "protective noninterference" for today, one that recognizes the dangers present in society but also honors the cultural view of the internal strength that traditional noninterference can build within children to also protect them and their cultural identity? Moreover, can such an approach to parenting serve to strengthen parents' own cultural identity, countering the impact of colonization that sought the elimination of the "why" within AI communities? These questions are important, but typically never discussed when attempting to "move forward" based on existing, already defined, parenting constructs within EBTs.

From this deeper perspective, a new approach has evolved to strengthen parenting skills in order to protect AI children today. Rather than simply taking an existing EBT, wherein parenting constructs and processes have already been defined within the dominant worldview, the goal is to start at the beginning— to take important parenting concepts from the literature known to be protective and define them within an indigenous perspective both in terms of conceptualization as well as teaching method. Only in this way will the cultural identity, worldview, and values of AI families, parents, and children be honored and true strengthening occur (Davis et al., in press).

In addition to a deeper focus on parenting concepts that reflect AI/AN worldview and values, there is also need for a motivational approach to precede program implementation in order to provide parents with the cultural strength and understanding to take on these parenting skills as "good medicine" for their children (Dionne et al., 2009; Dionne & Dishion, 1998). "Starting at the beginning" within this motivational approach, it is recognized that the impact of differing worldviews and values today must be acknowledged. To truly bring forth strength, families and children must find balance between the strength of their ancestral story and the weight of the mainstream (Western) story that surrounds them (Davis et al., in press). Because of colonization, many AI/ANs are not aware of their own ancestral story; the why of their being, targeted for elimination during colonization, has been weakened or, for some, hidden away in blindness. As a result, even if parenting programs resonate from within an AI/AN worldview, motivational conversations with parents need to find ways to place difficulties they may be experiencing within an historical and mainstream context where the weight of continued, and sometimes subtle, dominance may be pressing down and affecting their balance. The goal is to help families find strength in their ancestral voice and worldview and to use this ancestral strength for balance in walking through a society that as yet does not truly acknowledge and understand them for who they are. Within this balance, ancestral strength can be the guide and resounding voice for parents to take up skills and move through their journey in a strong way to strengthen and protect their children (Davis et al., in press).

Limitations and Challenges of Cultural Adaptation

Cultural context affects treatment processes and outcomes (e.g., Canino & Alegría, 2008) and culturally competent practice requires clinicians to match treatment approaches to their clients' characteristics and needs, yet ethnic minority participants are often underrepresented or completely unrepresented in efficacy studies of EBTs (Barrera, Castro, & Holleran Steiker, 2011; Bernal & Scharrón-del-Río, 2001; Miranda et al., 2005). Therefore, practitioners are challenged to deliver the "active ingredients" and proper dosage of EBTs in a respectful way that will be culturally acceptable and appropriate, frequently in the absence of research literature or community input to guide them (Castro, Barrera, & Martinez, 2004). However, treatment modifications frequently are conducted intuitively in the absence of empirical and community-driven support to guide the adaptation. Adapting EBTs to improve social validity may result in increased acceptability and satisfaction among ethnic minority clients, but may also pose a risk to the fidelity of the EBT (Castro et al., 2004; Lau, 2006). If one adapts an intervention significantly, it may become a different treatment altogether, resulting in an intervention that may or may not be efficacious (for an example of cultural adaptation that reduced effectiveness, see Kumpfer, Alvarado, Smith, & Bellamy, 2002). Resolving these tensions between fidelity and fit has been the topic of community-based public health research (e.g., Castro et al., 2004) with recommendations provided to carefully incorporate the best science (fidelity) with cultural legitimacy (fit).

Future Directions and Summary

The cultural adaptations described above are a sampling of the work that is currently being done to improve available treatments for AI/AN populations. Several themes are evident: (a) adapting treatments with the guidance and/or partnership of AI/AN people is critical to success; (b) treatment adaptations should be community-based, reflect community values, and be delivered in creative ways (e.g., by paraprofessionals) to increase their reach, acceptability, and effectiveness; (c) cultural

adaptations are only one place to start. Treatments may more truly reflect AI/AN worldviews if they are built from the ground up. As appropriate, indigenous healing practices can be incorporated into Western settings or used in tandem with adapted EBTs (Hartmann & Gone, 2012).

Decreasing mental health disparities among AI/AN communities requires careful implementation and assessment of EBTs while engaging with communities equitably in the research process. Successful cultural adaptations of EBTs will incorporate the available scientific as well as community-based expertise toward the development of effective, feasible, accessible, sustainable, and ultimately healing options for AI/AN communities and individuals. Researchers and clinicians need to be aware of the potentially colonizing and harmful effects that implementing an EBT may have and why partnership with AI/AN communities is crucial to these endeavors. Finally, addressing the social and structural determinants of health (e.g., poverty, education, discrimination) is an essential adjunct to cultural adaptations of treatment and prevention approaches (Williams & Sternthal, 2010).

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Recruitment of Ethnoracial Minorities for Mental Health Research

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To ensure a complete understanding of mental disorders and their treatments, it is essential that research samples include all segments of society. As the percentage of ethnoracial minorities in the United States is increasing, there is an urgent need to clarify whether therapeutic methods are effective across populations (Harris et al., 2003). Inclusion is important because assessing the effects of treatment on ethnoracial minorities may help establish the external validity of research in psychotherapy, determining the generalizability of certain therapeutic approaches (Hohmann & Parron, 1996). This is particularly vital when considering the growing elderly population that is most in need of psychological care, many of whom are minorities (Arean & Gallagher-Thompson, 1996). However, ethnoracial minorities continue to be underrepresented in mental health research. By excluding minorities, mental health professionals are not learning the best ways to care for them, which means they are not making full efforts to promote their well-being and are possibly even causing harm.

The Belmont Report (Department of Health, Education, and Welfare, 1979) explains the unifying ethical principles that form the basis for the inclusion of human subjects in research. The three fundamental ethical principles are respect for persons, beneficence, and justice. The principle of respect for others states that individuals should be treated as if they are autonomous, unless they are found to be otherwise. This includes taking into consideration each autonomous individual's opinions and choices, and only excluding them if they need protection. Thus, excluding ethnoracial minorities who are not in need of protection violates the principle of respect for persons. While minorities are being protected from potential harm in research, they are also being deprived of potential benefit. In addition, the principle of beneficence states that treating a person ethically involves maximizing benefits, preventing harm, and "making efforts to secure their well-being." In terms of justice, the Belmont principles outline the idea that benefits and burdens of research should be fairly distributed. Research findings that are not inclusive of ethnoracial minority participants mainly benefit the majority who are being researched, because treatment approaches become tailored based on their results. In order to fully benefit these groups, research must be conducted in order to determine what works best with different groups. Americans of all races and ethnicities contribute to the costs of research through tax dollars that pay for studies funded by agencies such as the National Institutes of Health (NIH), National Science Foundation (NSF), and Department of Defense (DoD). Thus, it is critical that findings benefit all groups as well.

In 1989, the NIH encouraged research proposals to include women and minorities and provide a rationale if they were excluded. To facilitate this process, Congress legally mandated inclusion through the NIH Revitalization Act of 1993, and researchers were instructed to include in their proposals strategies by which they would achieve diversity in their samples. By 1994, the NIH had revised its policy to require that women and minorities must be included, and by 1995 the NIH refused to fund any project that did not adhere to these policies (U.S. Department of Health and Human Services [USDHHS], 2002).

According to the Outreach Notebook for the NIH Guidelines on Inclusion of Women and Minorities as Subjects in Clinical Research, "it is imperative to determine whether the intervention or therapy being studied affects women or men or members of minority groups and their subpopulations differently" (USDHHS, 2002, p. 103). The USDHHS states that "sufficient and appropriate representation of minority groups to permit valid analyses of differential intervention effect" must be included in the study design, unless it is apparent that including minorities will not resolve any crucial public health issues (USDHHS, p. 25). This rule usually requires researchers to include a higher percentage of minorities than what would be

seen in a nationally representative sample in order to attain sufficient statistical power to be able to examine whether group differences are present in important outcome variables.

Despite some strong words from Congress and the NIH, clinical studies frequently lack adequate minority participation. As of the last available NIH report, ethnoracial minorities constituted 28.1% of enrollment across all U.S. domestic clinical studies, which is unchanged over the last 10 years (USDHHS, 2011). This is less than representative as ethnoracial minorities are 36.6% in U.S. population and 50.4% of all births (U.S. Census Bureau, 2011, 2012), but high enough to illustrate that these groups can and do participate in clinical research.

Most mental health researchers recognize the importance of including diverse samples in their research studies but are often unsuccessful in recruiting adequate numbers. For example, Mendoza and colleagues (2012) found that 82.7% of participants across 19 studies of panic disorder were non-Hispanic White; ethnoracial minorities included 4.9% African Americans, 3.4% of Hispanic origin, 1.1% of Asian origin, and 1.4% of another ethnoracial group. Wetterneck et al. (2012) found even lower rates of inclusion among Latino Americans in OCD clinical studies; of 46 trials surveyed, only 8.6% of participants were non-White. In another OCD-related study, Williams, Powers, Yn, and Foa (2010) found similar low rates of minority inclusion, with 91.5% European American participants in 21 studies. Only 1.3% were African American, 1.0% Hispanic, 1.6% Asian, and 1.5% other.

Based on information compiled from a review of many studies involving recruitment of ethnoracial minorities, there are several possible solutions to the problem of underrepresentation in mental health research. These solutions may be useful across cultures and should be taken into consideration when attempting to recruit a diverse sample.

Training in Cultural Competence

It is vitally important that study personnel have a genuine commitment to minority mental health and have been adequately trained in culturally informed assessment and treatment techniques. Although most clinicians are now receiving some sort of diversity education in training programs (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009), practical skills in interacting with specific ethnoracial minority groups are not typically included. When clinicians and researchers lack the needed skills and education for effective cross-cultural interactions, they may rely on a color-blind approach. Color-blindness is the ideology that different ethnoracial groups should all be treated the same, without regard to cultural differences (Terwilliger et al., 2013). Minorities are treated as if they lack characteristics that make them different from the dominant majority. Although the intent of color-blindness is to create fairness, it often causes confusion and can actually increase prejudice (e.g., Richeson & Nussbaum, 2004). When the idea of "treating everyone the same" is proposed, it is typically from the perspective of the dominant majority, implying that everyone should be treated as if they were culturally European American. From a clinical standpoint, color-blindness could unintentionally result in negative consequences for an ethnic minority patient if a therapist were to suggest that the patient engage in behaviors that are generally deemed as "adaptive" according to European American psychological tradition but that may in fact be culturally incongruent. The goal, therefore, is not to treat participants as if they were European American, but as they want to be treated, based on the norms and practices of their particular culture. This approach, called multiculturalism, embraces the differences, strengths, and uniqueness of different ethnoracial groups.

Americans are socialized not to acknowledge race and ethnicity, perhaps out of concern of appearing biased or racist (Gaertner & Dovidio, 2005). However, this socialization contributes to difficulty in recognizing, discussing, and adapting to differences (Terwilliger, Bach, Bryan, & Williams, 2013). Thus, it is vitally important that researchers understand culture-specific differences, which can range from amount of eye contact to culture-bound idioms of psychological distress. Researchers are also charged with the dual mandate to avoid stereotyping, as ethnoracial group members are not homogeneous and vary in their levels of acculturation. There are too many different groups for any one person to have an in-depth understanding of all, so the focus of staff trainings should be on the specific ethnoracial groups targeted for study inclusion. Yancey, Ortega, and Kumanyika (2006) recommended the inclusion of sufficient numbers of at least one minority group to conduct subgroup analyses.

Development of Racial Consciousness

Before undertaking any serious cross-cultural efforts, some introspection may be in order. Researchers must consider the possibility that low minority participation could be the result of systemic exclusion due to discomfort working with ethnoracial minorities and/or the unspoken assumption that such individuals may not be good research participants (e.g., Joseph & Dohan, 2009). For example, one large review of minority participation in medical research, involving over 70,000 potential participants, found that minorities were just as willing and eligible to participate as their non-Hispanic White counterparts (and in some cases, more willing), but were significantly less likely to be invited as study participants (Wendler et al., 2006).

Researchers may be selectively excluding participants they believe would be poor candidates based on beliefs that minorities may drop out prematurely, be unable to follow directions properly, or fail to follow study rules and procedures. Thus, it could be that bias on the part of researchers is a contributing factor to underrepresentation (e.g., Joseph & Dohan, 2009). Therefore, study personnel should conduct critical self-assessments to ensure they do not harbor negative feelings, perhaps unwittingly, about ethnoracial minorities that could be resulting in an implicit selection bias. Those who become aware of such biases can improve through the deliberate cultivation of cross-cultural personal relationships and ongoing multicultural education (McKinney, 2006; Okech & Champe, 2008). Additionally, study coordinators should encourage team members to focus on treating their minority participants with respect and appreciation, rather than simply to avoid bias (Gaertner & Dovidio, 2005).

Diverse Staff

Several studies have documented having adequate staff members from diverse groups as key to successful efforts at minority recruitment (Chao et al., 2011; Gallagher-Thompson, Solano, Coon, & Areán, 2003; Jackson et al., 2004). Creating multicultural project teams helps extend cultural awareness and competence so that all staff can learn from new issues as they are raised (Gallagher-Thompson et al., 2003).

According to a report of the U.S. Surgeon General, "research documents that many members of minority groups fear, or feel ill at ease with, the mental health sys-

tem" (USDHHS, 1999). Therefore, it could make a critical difference in participation, willingness, and overall comfort level for several important members of the research team to be actual members of the targeted minority communities. It is reassuring and makes the outcome of the study more personally relevant when participants see people like themselves invested in the research program and occupying key leadership roles.

Additionally, research participants may feel more comfortable discussing psychological problems with someone of the same ethnoracial background (e.g., Jackson et al., 2004), and some minorities may answer questions about symptoms differently when ethnoracially mismatched (e.g., Williams & Turkheimer, 2008). In most cases, therapists conducting assessment interviews should be matched by race and ethnicity. For example, Hispanic Spanish-speaking participants should be matched to Hispanic evaluators who will be able to conduct assessments in Spanish, if desired, as this can improve diagnostic accuracy (Malgady & Costantino, 1998). Given that cultural matching is not always possible or desirable from a participant's perspective (e.g., could be viewed as "forced segregation"; Pole, Gone, & Kulkarni, 2008), cross-cultural training is essential for all clinicians. Mental health professionals must learn to make culture an integral part of each assessment as it influences patterns of communication between clinician and patient and subsequent diagnostic and treatment outcomes.

Community Outreach

Community outreach is an important part of a successful recruitment effort and should be undertaken extensively. For African American and Hispanic participants, research has shown that community involvement by project staff is particularly important for study retention (Yancey et al., 2006). Study personnel should invest in making and maintaining personal connections with important people and organizations within the communities of interest, such as church leaders and local officials (Clay et al., 2003; Gallagher-Thompson et al., 2003; Meinert et al., 2003). One or more study team members should regularly participate in community organizations and maintain regular contact with organizations and health centers via phone calls, mailings, and visits. Research assistants can work with project investigators to organize educational lectures about the topic under study at local churches, public schools, community colleges, and community mental health organizations to raise awareness about the study and at the same time provide a valuable educational opportunity for attendees. Research assistants can also help by acting as liaisons to local media outlets and arrange faculty interviews on local TV news and talk shows, radio shows, and in community newspapers (Jackson et al., 2004).

At the Center for Mental Health Disparities (CMHD) at the University of Louisville, we are in the process of recruiting Black, White, and biracial participants for our new multiracial family study. In preparing for this effort, we had a team brainstorming session of all avenues for recruitment we could think of to find diverse families of various socioeconomic backgrounds. We are recruiting from several local sources, including Jefferson County Public Schools, Seven Counties Services (community mental health center serving Jefferson county and the six surrounding counties), African American churches, the Lincoln Foundation, and 2not1.org (an organization serving community fathers and their families). Additionally, free parenting workshops for which parents select the topics are conducted at these organizations to facilitate recruitment. The CMHD has established several community partners and a Community Advisory Board that serves diverse families from the community and assists with recruitment for studies.

Professional Referrals

Individuals report being most willing to participate in a medical research study when recommended by their own doctor, and this is true for African American, European American, and Hispanic American study participants (Katz et al., 2006). Thus, community family physicians, psychiatrists, and mental health center staff are an important outreach source (Sweeny, Robins, Ruberu, & Jones, 2005). In one study of Asian Americans, researchers successfully recruited Chinese senior citizens by establishing outreach clinics in Chinatown, where local practitioners could refer patients for specialty evaluations (Chao et al., 2011).

Mental health providers may learn about studies through professional organizations such as the Association of Black Psychologists, Society of Indian Psychologists, Asian American Psychological Association, and the National Latina/o Psychological Association. Local members should be sent mailings about the study, followed by a personal contact to ensure receipt and promote the study. Drs. Williams and Chapman are both members of the Kentucky Psychological Association (KPA), which has in the past been receptive to mental health disparities research, and both investigators were invited speakers at a recent diversity-themed conference for the organization. This opportunity raised awareness about the study efforts among the membership of the KPA, generating professional interest and referrals.

If study personnel are licensed clinicians, that creates another avenue for community connections. For example, at the CMHD, Dr. Chapman receives numerous referrals through local churches and other community mental health providers. Dr. Williams receives regular inquiries from people with OCD due to educational articles she has written about the topic for the general public that are posted on the internet. ABCT and other organizations that have provider directories are a source of contact for treatment-seeking individuals who might also be interested in research studies—but keep in mind that these avenues are traditionally good sources of non-Hispanic White participants and may not be adequate for identifying minorities.

Paid Advertising

Advertisements are most effective when they are culturally specific (e.g., Gallagher-Thompson et al., 2003). Study staff should carefully develop culturally appropriate advertisements by featuring photos of the minority group of interest to facilitate a more positive impression about the study among these groups (Avery, Hernandez, & Hebl, 2004). If researchers are interested recruiting people who are likely to be nonnative English speakers, it is important to translate ads and include appropriate language and culturally specific terms for mental health symptoms. Materials should be developed and revised using feedback from early participants (e.g., first few subjects, focus groups, pilot/feasibility studies).

Because of historical abuses and ongoing discriminatory experiences, African Americans may be particularly mistrustful of researchers; therefore, advertisements should clearly state the purpose of the study, participant burden, incentives, and sponsoring organization, when space permits (Clay et al., 2003; Hatchett, Holmes, Duran, & Davis, 2000). The term "research" should be avoided in favor of other, less incendiary terms, such as "project" and "study," to distance recruitment efforts from associations with past research abuses, such as the Tuskegee Syphilis Study. For Hispanic par-

ticipants, advertisements should be available in both English and Spanish and separate phone numbers should be listed for English and Spanish speakers.

Less acculturated groups may be unfamiliar with DSM-defined disorders. Therefore, advertisements can also be educational in nature and describe specific symptoms in culturally appropriate terms. In a medical study of Native Americans by Stoddart and colleagues (2000), researchers met with the community and tribal leaders to obtain feedback and help develop the protocol. Due to the population involved, questions regarding income and alcohol were specially considered, and questions related to money did not necessitate writing in an exact dollar amount. For terms related to psychosocial variables, some of the Native American consultants stated that tribe members may not understand certain words or they may take offense. Specifically, words and phrases such as "stress" and "feeling blue" were changed because they did not translate well (Stoddart et al.).

Researchers should utilize multiple advertising venues to reach the widest range of participants. Keep in mind that members of any ethnoracial group will include people from every background and SES, so it is important to cast a wide net to increase heterogeneity and thereby improve generalizability of findings. Colorful fliers about the study should be placed in areas with a high proportion of minorities. Fliers should feature attractive photos of the ethnoracial group targeted for recruitment. Mass mailings about the study can be sent to households in neighborhoods that are predominantly African American or Hispanic. To accomplish this, it is possible to purchase mailing lists from survey research companies, specifying specific demographics (e.g., neighborhoods with 50% or greater Korean American residents). As a single mailing is unlikely to be effective, mailings should be sent out several times in varied formats (letter, postcard, etc.), followed by a phone call from a research assistant, as needed (Dillman, 2000; Yancey et al., 2006). Electronic methods, such as email and text messaging, should also be considered.

As many groups have their own preferred newspapers (Clay et al., 2003), advertisements can be placed in local newspapers that are typically read by ethnoracial minorities. For example, recent studies conducted in Philadelphia have had good success recruiting African Americans with ads in specific free newspapers (Foa & Williams, 2010; Williams, Proetto, Casiano, & Franklin, 2012). Advertisements can be placed on buses, subways, trolleys, and regional rail systems. Such an ad campaign will have a broad reach to all ethnoracial groups; however, African Americans and Hispanic Americans are disproportionately disadvantaged and are therefore more likely to rely on public transportation than others, making this an important medium for urban areas.

The Internet can be an effective means of reaching a diverse population. Advertisements can be placed on minority-specific sites (i.e., BlackPlanet.com, DisgrAsian.com, American Arab Forum) and other similar venues, with a link to the study website. It is possible to expand the use of Google ads by introducing targeted keywords for specific minority groups of interest. Researchers should carefully review their own study websites, add information specific to these groups, and ensure that multicultural images of people appear who are similar to the target participants (e.g., CMHD at www.mentalhealthdisparities.org). Research suggests that minority participants recruited via the Internet may be of a higher SES than the general population (Im & Chee, 2005), but this may appropriately offset the fact that other proposed advertising techniques may disproportionally target lower-income participants. We have also found Internet advertising to be a good way to recruit students from all ethnoracial groups.

Radio ads were not a cost-effective means of advertising in our most recent study (Williams et al., 2012). However, no-cost media outlets may be utilized to generate interest in study, including guest appearances on local television and radio shows. For example, Dr. Chapman has been featured on statewide and regional talk shows, including "The Power to Change," hosted by an African American local personality, Charla Young, and the Kentucky Education Television (KET) show "Health 360" describing cognitive-behavioral therapy.

Keep in mind that advertising efforts can be expensive, so be sure to include adequate funding in grant proposal budgets. This expense can be justified by the need to realize diversity goals, such as those outlined by the NIH Outreach Notebook (USDHHS, 2002).

Incentives

Incentives can be offered to potential participants to make study participation more likely. Underrepresented minorities are more likely to be disadvantaged, making it more difficult to participate, as practicality dictates that inadequate compensation from the time spent in a study is outweighed by other responsibilities, such as a job or taking care of a family (Fisher et al., 2002). Therefore it is important to provide meaningful and adequate compensation to participants for their time and show appreciation for their participation (Williams, Beckmann-Mendez, & Turkheimer, 2013).

When possible, participants should be offered personalized feedback about the results of their participation. Participants from our prior studies have found the feedback helpful and informative (Chapman, Petrie, Vines, & Durrett, 2012; Williams et al., 2012). For example, if conducting a comprehensive psychological evaluation, offer to provide a report of results to the participant and/or their mental health provider to facilitate treatment.

If participants are not receiving adequate mental health care, provide quality referrals for providers accepting insurance, Medicare, and low-cost options. Consider providing treatment directly to participants when needed, and cultivate relationships with a diverse array of local providers who would be willing to see participants after their study participation is over.

Screening

In our study of African Americans with OCD, less than a third of those screened ultimately had lifetime OCD (Williams et al., 2012). Research assistants expended considerable effort contacting and screening potential participants, and a high number of ineligible participants poses a financial and practical burden that must be taken into account. One of the greatest difficulties in recruitment involved responding to potential participants who left a message for study personnel. Many of these calls were not returned as participants often left non-working phone numbers, numbers with no voice mail, or no numbers at all. To improve the acquisition of eligible participants, it is recommended that a qualified screener be available at all times to take such calls. If this is not possible, early morning and late evening calls could be routed to a cell phone that is rotated among study staff.

Environment

A comfortable environment has been identified as an important factor in the ability to recruit and retain research participants. Participants can be put at ease if the study is conducted in a private, peaceful environment that is clean and well-main-

tained (Williams et al., 2013). Consider making participants feel welcome by including ethnically themed magazines and artwork in the waiting room (e.g., *Ebony* magazine, *Vanidades*, *Hyphen* magazine). Williams, Chambless, and Steketee (1998) struggled to recruit African American participants for an OCD outcome trial in Washington, DC, which has a substantial African American population, and deduced that Black participants felt uneasy traveling to an affluent and largely White part of the city. Therefore, it may be preferable to conduct the study within the participants' community in order to avoid the discomfort associated with a setting that is outside of their usual experience, such as a university laboratory. Having the data collected in the minority community and thereby collaborating with community members demonstrates that study organizers have an actual connection with that community, which will help engender trust and improve recruitment through increased awareness (Chao et al., 2011; Hatchet et al., 2000; Meinert et al., 2003).

Ongoing Review of Efforts

The research team should hold regular meetings to review recruitment technique effectiveness. Team members should review goals and how well these have been achieved based on enrollment to date. A self-correcting process can be implemented whereby methods that are not effective are reduced and those that are effective will be retained and/or increased (Clay et al., 2003).

Conclusion

Without adequate representation of ethnoracial minority groups in scientific studies, mental health researchers cannot completely understand or treat psychopathology cross-culturally. Current recruitment methods are resulting in less-than-representative proportions of ethnoracial minority participants and imbalanced reports of findings. Important strategies to increase participation and retention include formal training in cultural competence, development of multicultural awareness, a diverse staff, community outreach, professional networking, careful advertising, meaningful incentives, a comfortable environment, and ongoing review of efforts. Such strategies should be put in place to ensure that mental health research is adequately and appropriately addressing the needs of ethnoracial minority groups.

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DISCLOSURE STATEMENT: Dr. Monnica Williams is a speaker for TZK Seminars.

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Cognitive Behavioral Therapy's Mindfulness Concepts Reflect Both Buddhist Traditions and Native American Medicine

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While clicking through the many photographs of the American Indian Select List of our National Archives in 2008, I found my face on a Kiowa chief named Satanta. Having grown up with all connections to my Native American ancestors severed, I was fascinated by this photograph that looked so much like me, and I immersed myself in learning more. Along the way, it became apparent that Native American medicine shares many important ideas with Buddhism (and others have written on this subject; for example, see http://taramandala.org/article/buddhism-native-american-practices).

Interestingly, some of these shared ideas, such as compassionate mindfulness, have recently been embraced by modern Western psychology, such as with cognitive behavioral therapy. I find this development to be very exciting for its potential as portending a cultural paradigm shift from an every-man-for-himself perspective to a we-are-all-connected perspective.

Such a shift would be in alignment with the larger brewing group process—if social media is an accurate gauge (e.g., the Occupy movement). Others, however, wonder if it is just the latest passing fad (Gerald C. Davison, verbal communication, April 2013). According to Steven Hayes (blog comment, June 27, 2013), perhaps there is room for both mindsets:

> If the data hold up it seems more likely that both flavors will hang around a long time and people will vote with their feet based on what they find most useful. But that issue of usefulness includes another hidden issue: what do people really want. Acceptance and mindfulness work is not just another means to an end—to some degree its a different end. My guess is that the modern world has changed that part of the equation and people are yearning for peace of mind, with connection to others and a sense of purpose. That is a bigger agenda than pain reduction and it fits the acceptance and mindfulness work far more deeply. (Hayes, 2013)

Stressful events in the modern world (e.g., September 11, 2001) do seem an important factor in having set us up for this awakening of moving toward a "we are all in this together" perspective that includes such expanded goals.

The Buddhist practice of mindfulness asks us to practice waiting silently at our internal center—to compassionately observe and accept our own internal flow of thought and emotion, and to practice stepping back from that flow, in nonjudgmental detachment (or acceptance). The Buddhist mandala is a Sacred Circle that symbolizes an enlightened mind, and depicts four directions with a center. Like the practice of mindfulness, both the Buddhist mandala and the Native American Medicine Wheel direct us to go inside ourselves (to our center) to wait in silence and observe with compassion:

> Walking, I am listening to a deeper way. Suddenly all my ancestors are behind me. Be still, they say. Watch and listen. You are the result of the love of thousands
>
> —Linda Hogan, Chickasaw Nation

The concept of the Medicine Wheel seems to be archetypal, and derived from early descriptions of circles (e.g., the "circle of life") and cycles (e.g., seasons) in nature. The Native American Medicine Wheel or Sacred Circle is a compass for living in mindful balance on the Red Road or spiritual path. By finding our current position on the Medicine Wheel (which describes our true animal nature and includes our strengths and weaknesses), we can know in which direction we need to travel in order to find balance. Although which particular animal guardian represents which particular direction on a Medicine Wheel varies a great deal among Native American cultures, the basic structure of seven principal directions (i.e., north, south, west, east, above, below, and self or spirit at the center) is shared by all. Note the traditional layout of the Zuni-style Medicine Wheel (Fig. 1).

As with any compass, every direction on the Medicine Wheel is of equal value to the whole. At the center of the Medicine Wheel is the desired place of balance and of awareness of our interconnectedness with all that is (e.g., Mitakuye Oyasin is a Lakota prayer that expresses this concept). This awareness reminds us of our duty to care for all our relations—because at the center of the Sacred Circle, we understand that what is done to one, is done to all.

Among many other things, a Medicine Wheel tells us that we all have something in particular to teach (which reflects gifts of our true animal nature) and something to learn (from those who are most unlike ourselves in their animal nature). For example, a northern position teaches self-discipline (and self-denial) and is associated with emotional coldness and wariness of others. The animal guardian associated with the northern position is Spirit Mountain Lion. Those with Mountain Lion nature are rational and literal, not easily offended, and have difficulty understanding why others are easily offended. Whereas the southern position, associated with Spirit Badger (as well as others of the smaller animals, including otter, fox, coyote, beaver, and rabbit), is linked with intense bursts of emotion and impulsive aggression. This position is akin to a kindergarten run amok—learning about the laws of nature and relationships through undisciplined, joyful, and free-wheeling play.

The western position is guarded by Spirit Bear and teaches us to go within ourselves when change is needed for healing. Bears (and especially white bears) are revered in many cultures as healers and shamans. In the western position, attention is focused on caring for others, often at the expense of caring for oneself. On the opposite side of the Medicine Wheel, the eastern position is guarded by Spirit Wolf, whose medicine includes learning to use stealth to find our path and to always care for ourselves first, before turning to help others, so as to protect our personal resources.

When we have found our place on the Medicine Wheel, we can better understand our gifts and our needs for learning. With this knowledge, we can seek to move toward middle ground to find balance, at the center of the Medicine Wheel. Balance and health are found at the center, between opposite poles, which are evident as opposite directions on a Medicine Wheel: North and South, West and East, and Above and Below. The health of the whole requires celebration of individual differences and equal respect for all.

In Buddhism, as in Native American medicine, centered balance means acceptance of what is—that no matter what comes, "it is all good," and it is all temporary. Let it go, observe its flow. Wait it out and soon you'll know . . . balance and *tohi* (a Cherokee concept that says when you are at peace with all around you, that is health). This is a very different approach than CBT's standard of reaching into the flow and pulling out all of those negative thoughts to examine, challenge, and unravel, as defined causes of one's suffering. Whether this traditional Western approach will eventually fade into the background, or whether compassionate mindfulness will burn itself out as just the latest passing fad in CBT practice remains to be seen. Perhaps there will continue to be support for both. I, for one, am rooting for a paradigm shift that supports interconnectedness, in alignment with Buddhist and Native American principles.

Reference

Hayes, S. C. (2013, June 27). Re: Is mindfulness therapy just a fad? Cognitive behavioral therapy's mindfulness "infatuation" [Web blog post]. Retrieved from http://spiritbearcreations.blogspot.com/2013/04/is-mindfulness-therapy-just-fad.html

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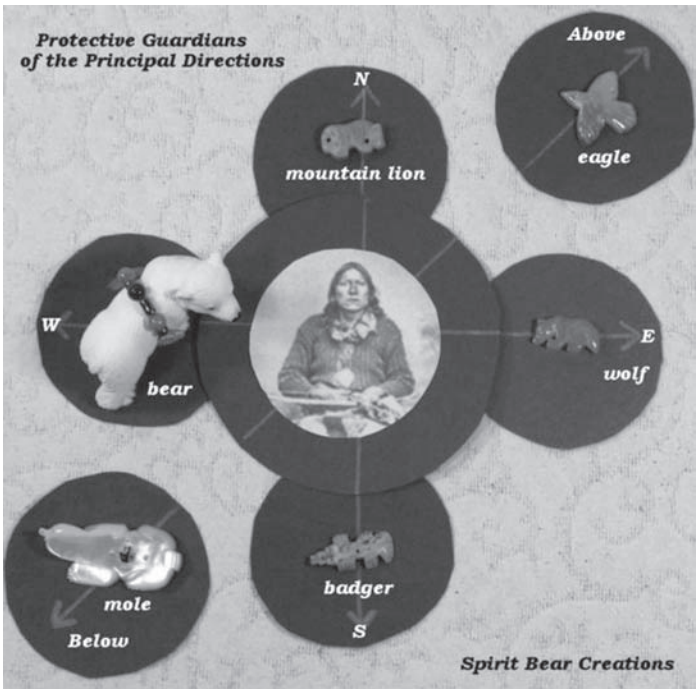

Fig. 1. Medicine wheel (*reprinted by permission of Sandra G. Coffman*)

SIG Spotlight

Closing the Gap Between Science and Practice: Report From the Neurocognitive Therapies/Translational Research Special Interest Group

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This is an exciting time in psychopathology intervention research. The continuing development of more powerful and minimally invasive technologies has dramatically increased our understanding of the brain and its relationship to behavior over the past two decades. These technologies are increasingly and rapidly leading to clinical translation through the development of innovative approaches to intervention. This article discusses a few of these translations as a prelude to a number of upcoming events that will promote this orientation.

Application of Neuroscience-Based Techniques to Psychopathology

A more comprehensive understanding of the underlying interactions between biological, cognitive, and environmental factors may be useful in ongoing efforts to increase understanding of complex psychological disorders and facilitate development of effective treatments. This notion is prominently reflected in the current shift in interest from discrete diagnoses to the assessment of specific underlying brain processes (Insel et al., 2010). Thus, the continuing search for the organizing principles of psychopathology may be facilitated by breakthroughs in the domain of neuroscience. Consistent with this focus, various neuroimaging approaches, such as functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) have begun to reveal mechanisms of disorder that are beginning to suggest new and promising avenues for treatment. Moreover, knowledge of the brain has enhanced and specified use of behavioral methods that reverse the deleterious effects of psychiatric disorders and syndromes (e.g., cognitive problems accompanying major depression).

For example, a finding that has been observed in response to negative information in depression and in response to threat in some anxiety disorders is increased activation in limbic regions, implicated in generating emotional responses, and decreased activation in prefrontal cortical regions, implicated in regulating these responses (Etkin & Wager, 2007; Fitzgerald, Laird, Maller, & Daskalakis, 2008; Siegle, Thompson, Carter, Steinhauer, & Thase, 2007). De Raedt and Koster (2010) developed a process-oriented framework of depression in which they propose mechanisms to explain how decreased prefrontal control, impaired attenuation of limbic activity, and prolonged activation of the amygdala in response to stressors in the environment increase vulnerability to the disorder. Each new depressive episode may lead to a further decrease in prefrontal control, culminating in reduced disengagement from negative information and decreased inhibitory control over elaborative self-referent thinking such as rumination. Similarly, Hofmann, Ellard, and Siegle (2012) proposed a cognitive-neurobiological information-processing model of fear and anxiety, wherein hyperactivation of limbic structures and rigid or deficient recruitment of prefrontal structures leads to increased vigilance and attentional bias towards threat and avoidant processing of information.

These emergent conceptualizations of mood and anxiety disorders as the product of corticolimbic dysregulation have improved understanding of the ways in which traditional interventions such as CBT and medications target these mechanisms (DeRubeis, Siegle, & Hollon, 2008) and have facilitated the development of newer interventions that attempt to more directly target them. Some such "neurocognitive interventions" are formulated to address symptoms of anxiety and mood disorders such as negative biases and sustained processing of negative information by targeting prefrontal function, with the goal of increased emotion regulation abilities and decreased vulnerability. Interventions range from direct neuromodulation (tDCS; Nitsche et al., 2008) or neurostimulation (rTMS; Pascual-Leone, Davey, Rothwell, Wasserman, & Puri, 2002) of the prefrontal cortex, to the use of training paradigms to train attentional/cognitive processes related to the neurocircuitry of emotion regulation, or their combination (Price, Paul, Schneider, & Siegle, in press; Vanderhasselt et al., 2013). These procedures can be applied in a repetitive schedule to facilitate new adaptive learning. Moreover, these procedures can be combined with CBT to enhance treatment outcomes (Siegle et al., in press; Siegle, Thompson, et al., 2007).

In this same vein, Siegle, Ghinassi, and Thase (2007) developed Cognitive Control Training (CCT), a computer-based intervention to target dorsolateral prefrontal (DLPFC) function through repeated practice on selective attention and working memory tasks. The DLPFC is implicated in initiating top-down emotion regulation through mediating pathways that connect the DLPFC to limbic regions such as the amygdala. The specific theorized neural mechanisms of CCT (DLPFC activation, amygdala deactivation) have been validated in an fMRI study of healthy volunteers following a depressotypic mood induction (Price et al., in press). Preliminary clinical data from depressed individuals suggests that adjunctive CCT, in comparison to treatment as usual, can produce clinical outcomes such as acute reductions in rumination (a key cognitive feature of depression), decrease disruptions in DLPFC and amygdala function and physiological indicators of task engagement, and reduce usage of intensive outpatient services over a 1-year follow-up period (Siegle et al., in press; Siegle, Ghinassi, et al., 2007). When

compared to an active placebo condition (peripheral vision training), CCT has also been shown to decrease depression in nonclinical dysphoric subjects (Calkins & Otto, 2013) and negative affect in OCD patients (Calkins et al., submitted). The promise and initial conclusion of this work is that neurocognitive substrates can be targeted through behavioral intervention, improving mood symptoms mechanistically.

Another point of clinical leverage for neurocognitive approaches lies in their potential to predict treatment responses. The addition of simple mechanistic tests such as dichotic listening (Bruder et al., 1997), easy psychophysiological assessments such as pupillary motility (Siegle, Steinhauer, Friedman, Thompson, & Thase, 2011), or neuroimaging using fMRI (Fu et al., 2008; Siegle, Carter, & Thase, 2006; Siegle et al., 2012) or PET may significantly improve treatment outcomes for certain patients, to the extent that they identify which treatment approach might be better suited for a particular individual. For example, a recent PET study (McGrath et al., 2013) reported that brain glucose metabolism in the right anterior insula, a region implicated in translating visceral experiences into subjective emotional states, could be used to predict whether a patient would benefit from medication (escitalopram) or CBT. Biomarkers such as this could be particularly useful in depression and other affective disorders because the maximally beneficial treatment modality could be identified on the basis of a brain scan, rather than on the basis of a failed treatment effort, thus saving time, money, and effort on the part of both patients and treatment providers.

A common objection to this argument is that it is less expensive to try multiple treatments even if the first one fails. We suggest this is not true. A typical treatment course, even with antidepressants, costs approximately $2,000 to the health-care system (Croghan, Obenchain, & Crown, 1998). The summed total cost of every assessment we have described other than PET scans is less than $1,000. Thus, there would be significant savings for every correct prediction. More poignantly, the modal number of antidepressant treatments and modal number of psychotherapy sessions that a typical patient engages in is one (Gibbons, Rothbard, & Farris, 2011). Thus, if the initial prescription is incorrect, it is unlikely the provider will be able to try another.

That said, the field has a long way to go. For example, examined assessments (e.g., PET) are often not yet affordable, technologies (e.g., fMRI) are difficult to standardize across sites, and biologically based prediction algorithms are rarely published in a way that would lend themselves to being used clinically. Thus, we have our work cut out for us. In an upcoming book (Mohlman et al., in press), we describe standards that will help push the field towards this clinical translation.

Once specific neural or cognitive mechanisms are identified, lower-tech methods can be used to address them. For example, commercial software Attention Process Training–II (APT-II), developed by Sohlberg, Johnson, Paulie, Raskin, and Mateer (2001), relies on audio discs and stimuli that are administered verbally by the clinician, and does not require the use of a computer. This package was developed for use with traumatic brain injury patients and addresses four attentional domains: sustained, selective, alternating, and divided attention. Such low-tech approaches might be especially appropriate for use with specific clinical subgroups, such as those who cannot operate a computer due to motor or visual limitations (e.g., Parkinson's patients, blind or low-vision patients), yielding a model of in-office, possibly higher-tech assessment combined with portable, lower-tech home-based interventions. In a pilot study of APT-II adjunctive to CBT for the treatment of older adults with GAD, combined treatment with APT-II and CBT resulted in enhanced clinical outcomes compared to CBT alone, including greater improvement in executive functioning and greater reductions in worry (Mohlman, 2008).

Bridging Science and Practice

Despite preliminary evidence suggesting that using neuroscience-informed interventions may be a promising approach to enhancing our treatments for anxiety and mood disorders, bridging the science-practice gap continues to be a challenge. Clients presenting to psychology and psychiatry clinics are often diagnosed and treatments are recommended based on subjective assessments that do not use science or algorithms. Many potential explanations for the disconnect between available technologies and practice have been proposed, from the lack of sufficiently large and replicated randomized controlled trials to the lack of incentives for incorporating better science into treatment.

One factor is that there is no precedent – no major health system has ever done the experiment of incorporating biomarkers and neuroscience into ongoing mental health care and seeing how well it works in the "real world." Such an experiment, if done using currently available technologies combined with available low-cost predictors, could prove both efficient and patient-friendly. But to promote this experiment, the science will need to change. No longer can scientists simply assess all-relevant variables or use esoteric practices and hope for adoption, as these strategies do not translate to the clinical environment. Rather, publishing clear prediction algorithms (e.g., with quantitative thresholds for decision making, ideally accounting for "usual" moderators such as age and education), attending to cost (e.g., that require only the most ambiguous patients to be scanned – not everyone), complexity, and ease of implementation (e.g., using assessments and analyses that could be accomplished by other sites), distributing methods (e.g., using publicly available software), and "prediction manuals," and encouraging replication using open-source models may be key to traversing the "hopefully temporary gap that now separates the clinician from the research worker" (Zubin, 1955).

Dissemination of Techniques and the Neurocognitive SIG

The ABCT Neurocognitive Therapies/Translational Research (NT/TR) Special Interest Group (SIG) is comprised of scientists, practitioners, and students who have an interest in techniques falling under the broad umbrella of neurocognitive intervention. In light of the gulf between clinical needs and implementation of neuroscience-based techniques, a particular goal of our SIG is promoting realistic discussion of dissemination strategies. To that end, we take a multipronged approach at facilitating interactions among stakeholders that has culminated in a number of events, publications, and activities that we hope will be of interest to both current and potential ABCT members. First, several of our SIG members have recently published two books focusing on the application of neurocognitive principles to clinical science and practice (Mohlman, Deckersbach & Weissman, in press; Reddy, Weissman, & Hale, 2013). We are also pleased to invite all 2013 convention attendees to our preconvention Institute, "Neurocognitive and Translational Interventions," to be held in Nashville, on Thursday, November 21, from 1:00 to 6:00 P.M. The Institute will provide attendees with a mix of hands-on demonstrations, how-to guides, and presentations of original data. Our official brochure with more details and a roster of

speakers is available for download at www.scanlab.org/NTTR_institute_brochure.pdf. We also welcome any and all interested members and students to attend our SIG-sponsored events at the convention, including our poster session, social/networking hour, and official SIG meeting. The only requirements for membership are an open mind and an interest in discussing translational research with like-minded colleagues in a collegial atmosphere. More information is also available on our website (www.neurocognitive-therapies.com).

Conclusion

We have highlighted that, as a field, we have much to learn from the recent advances in neuroscience research and the rapid development of new technologies. More research and dissemination are needed to promote the usefulness of the neurocognitive approach for the full range of emotional disorders. Additionally, a goal of future work in this area is to assess whether specific neurocognitive treatments can be catered or matched to specific patients with disease states that are characterized by the neurocognitive features the treatment explicitly targets. Thus, we are at an exciting juncture in psychopathology and intervention research.

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November 21–24, 2013 | Nashville

ABCT's 47th Annual Convention

Cognitive and Behavioral Therapies: Harnessing Synergy Among Multidisciplinary Sciences

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Welcome From the Program Chair | Justin W. Weeks, *Ohio University*

As the 2013 Program Chair, I hope to see you in Nashville for ABCT's 47th annual meeting. Nashville is a lively and diverse city, with an endless array of music, food, and sightseeing opportunities to explore in between meeting activities. Our Local Arrangements Committee, chaired by Kirsten Haman, will no doubt see to it that you experience the very best that Nashville has to offer!

Many thanks to President Stefan Hofmann and the ABCT Board for inviting me to serve as Program Chair. It has been both a privilege and a pleasure to organize this convention, along with the many other dedicated members who have worked so hard to bring you what I am confident will be a marvelous meeting.

The theme this year is "Cognitive and Behavioral Therapies: Harnessing Synergy Among Multidisciplinary Sciences." Cognitive and behavioral therapies (CBT) are grounded in empiricism and the scientist-practitioner model. Given its overarching scientific emphasis, it is not surprising that numerous and multifaceted methodologies have proven useful for both measuring and conceptualizing the changes CBT can yield for patients. However, utilizing diverse methodologies to evaluate CBT-related outcomes represents only one direction of effect. As a scientific discipline, CBT also stands to inform these independent disciplines in valuable ways. In line with this theme, the focus of the 47th meeting includes presentations that highlight the integration of a broad range of methodologies, including some disciplines that do not traditionally interface directly with health care.

Richard Davidson from the University of Wisconsin-Madison will kick off our theme this year with his invited address "Change Your Brain by Transforming Your Mind," in which he will review some of the ways in which meditation may change specific brain systems that are important for emotion regulation and attention. Anke Ehlers from University of Oxford will deliver her invited address, "Updating Trauma Memories: A Cognitive Approach to Treating PTSD" on core treatment procedures for PTSD.

Next, Varda Shoham (NIMH), in her address "Challenges and Promises of Experimental Therapeutics," will present on experimental therapeutics and why this shift in emphasis could bring us to a better science. And James J. Gross from Stanford University will offer insights on the process model of emotion regulation to clinical disorders, in his talk, "Emotion Regulation: Conceptual Foundations and Clinical Applications." Finally, in his Presidential Address, Stefan G. Hofmann will discuss implications of the DSM-5 and, in line with our conference theme, will review findings showing how neuroscience methodology can be used to predict, tailor, personalize, and enhance CBT for a given client.

This year we received the largest number of submissions to date, which provides continued testimony of ABCT's ongoing impact on our various professions. We received over 2,000 submissions—given our highly competitive peer-review process, we will be partaking in an exceptional meeting. With a terrific line-up of presentations contributing to this year's theme, the various sessions will be covering cutting-edge advances in research and clinical practice.

We are also pleased to debut a new presentation format at this year's meeting: Mini-Workshops. The intent of this new format is to expand the number of sessions that directly address evidence-based clinical skills and applications. These workshops are free of charge (i.e., included with the conference registration fee); address direct clinical care or training at a broad, introductory level; and are condensed to 90 minutes. We have a number of exciting Mini-Workshops to offer this year, and expect that this format will become a regular feature of our annual meetings.

All my best, and I look forward to seeing you in Nashville!

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About the Itinerary Planner

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2013 convention in Nashville. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner.

The Itinerary Planner is accessible on ABCT's website at www.abct.org/conv2013. To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can ***search*** by session type, or you can ***browse*** by day. (Keep in mind, the ABCT convention program book will only be mailed to those who preregister by **October 15**. Programs will be distributed on-site to all other registrants.) After reviewing this special Convention 2013 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

www.abct.org/conv2013

CLINICAL INTERVENTION TRAINING

WEDNESDAY | 8:30 a.m. – 5:00 p.m.
CLINICAL INTERVENTION TRAINING 1

A Day of Mindful Practice to Enhance Your Clinical Practice

Zindel V. Segal, *University of Toronto-Scarborough*

As a general operating principle, mindfulness-based clinical interventions require a capacity for self-observation, usually gained through sustained meditative practice, that informs a therapist's work with his or her clients. This Day of Mindful Practice is intended as an introduction to the formal and systematic practice of mindfulness of the body, the breath, thoughts, and emotions—the same foci of experience that clients are asked to attend to when learning how to regulate difficult affects. Conducted as a mini-retreat, the day will feature periods of silence with alternating sitting meditation, mindful walking and mindful movement, structured to enable participants to experience the cumulative effects of back-to-back practice. The final portion of the day will be devoted to guided inquiry and discussion so that participants can integrate their experiential learning with the particular treatment model that defines their clinical practice.

WEDNESDAY | 1:00 – 6:00 p.m.
CLINICAL INTERVENTION TRAINING 2

Acceptance and Commitment Therapy: A Radically Different yet Remarkably Familiar Approach to Behavior Change

James Herbert, *Drexel University*

As part of the broad CBT family, ACT is a psychotherapy model that will be very familiar to cognitive behavior therapists in many respects. Yet it breaks sharply with traditional models of CBT in other ways. The model is part of a larger scientific program known as contextual behavioral science (CBS). ACT suggests new insights into the treatment of particularly difficult or refractory conditions. In this training we will briefly explore the philosophical and theoretical roots of ACT and its similarities and differences from standard CBT, followed by a brief overview of the empirical literature on ACT. We will then explore the ACT model, including both general strategies and specific clinical techniques, through a combination of presentations, discussions, and role-played demonstrations.

THURSDAY | 8:30 a.m. – 5:00 p.m.
CLINICAL INTERVENTION TRAINING 3

Cognitive Behavior Therapy for Personality Disorders

Judith S. Beck, *Beck Institute for Cognitive Behavior Therapy*

Why do Axis II patients sometimes pose such a challenge in treatment? Why do they miss sessions, criticize the therapist, blame others, display hopelessness about change, fail to do homework, engage in self-harm, use substances, and engage in other kinds of dysfunctional behavior? Part of the answer lies in their negative, rigid, overgeneralized ideas (core beliefs) about themselves, their worlds, and other people, which they developed as a result of the meaning they ascribed to early adverse experiences. Once these beliefs become entrenched, patients begin to view their subsequent experiences through the lens of these powerfully negative ideas and they develop certain behavioral tendencies, or coping strategies, to get along in life.

When Axis II patients enter treatment, they often view their therapy experience through the lens of their core beliefs and employ their usual coping strategies, which can interfere with "standard" treatment.

In this Clinical Intervention Training, participants will learn the specific set of beliefs and coping strategies that characterize the various personality disorders in order to conceptualize the individual patient. They will learn how to use the conceptualization to plan treatment and solve therapeutic problems. They will also learn how to use specialized strategies to develop and maintain a strong therapeutic alliance, set goals, structure sessions, and help patients to focus on solving problems, learning skills, and completing homework. In addition, therapists will learn how to educate patients about their core beliefs, help them cope with schema activation, modify their core beliefs at both an intellectual and emotional level, and develop alternate beliefs, often using experiential techniques.

These skills will be demonstrated through discussion, role-play, video, and question/answer.

INSTITUTES

TICKETED

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

THURSDAY

—full day—

INSTITUTE 1
8:30 a.m. – 5:00 p.m.

***Mindfulness-Based Cognitive Therapy for Depression* (2nd Ed.): A Clinical and Research Update**
Zindel V. Segal, *University of Toronto*
Mark A. Lau, *University of British Columbia*

INSTITUTE 2
1:00 – 6:00 p.m.

Evidence-Based Assessment and Treatment of Bipolar Disorder in Children and Adolescents
Eric A. Youngstrom, *University of North Carolina at Chapel Hill*
Mary A. Fristad, *The Ohio State University*

—5-hour—

INSTITUTE 3
1:00 – 6:00 p.m.

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Core Treatment Strategies and Recent Developments
James F. Boswell, Shannon E. Sauer-Zavala, Todd J. Farchione, Matthew W. Gallagher, David H. Barlow, *Boston University*

INSTITUTE 4
1:00 – 6:00 p.m.

Psychotherapy for the Interrupted Life: An Evidence-Based Treatment for Adult Survivors of Childhood Abuse
Tamar Gordon and Christie Jackson, *NYU School of Medicine*
Susan Trachtenberg Paula, *Martha K. Selig Educational Institute*

INSTITUTE 5
1:00 – 6:00 p.m.

Parent-Child Interaction Therapy
Cheryl B. McNeil, *West Virginia University*

INSTITUTE 6
1:00 – 6:00 p.m.

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

INSTITUTE 7
1:00 – 6:00 p.m.

Empirically Based CBT Supervision: Making Supervision More Effective for Novice Trainees
Robert Reiser, *University of San Francisco*
Donna M. Sudak, *Drexel University*

INSTITUTE 8
1:00 – 6:00 p.m.

The Mindful Way Through Anxiety: An Acceptance-Based Behavioral Therapy for GAD and Comorbid Disorders
Lizabeth Roemer, *University of Massachusetts, Boston*
Susan M. Orsillo, *Suffolk University*

INSTITUTE 9
1:00 – 6:00 p.m.

Neurocognitive and Translational Interventions
Greg Siegle, *University of Pittsburgh*
Rudi DeRaedt, *Ghent University*
Rebecca Price, *University of Pittsburgh*
Michael Browning, *Oxford University*
Thilo Deckersbach, *Harvard University*
Sophia Vinogradov, *UC-San Francisco*

AMASS *Advanced Methodology and Statistics Seminars*

TICKETED

The AMASS program is a special series of offerings for applied researchers, presented by nationally renowned research scientists.

AMASS 1*
Introduction to Structural Equation Modeling
Scott A. Baldwin, Brigham Young University

AMASS 2*
Advanced Topics in Structural Equation Modeling
Scott A. Baldwin, Brigham Young University

**Attend both sessions at a discounted rate by registering as AMASS 3.*

MINI WORKSHOPS

NO TICKET REQUIRED

Mini Workshops address direct clinical care or training at a broad, introductory level. They are 90 minutes in length and presented throughout the meeting. These useful sessions are included with the conference registration fee.

MINI WORKSHOP 1

Addressing Functional Impairments in ADHD: Assessment and Treatment of Organizational Deficits in Children With ADHD

Richard Gallagher and Lauren Knickerbocker, *NYU Child Study Center & NYU School of Medicine*

MINI WORKSHOP 2

Taking Anxiety Disorder Treatment to the Next Level: Using Exposure and Response Prevention for Maximum Effect

Patrick B. McGrath, *Alexian Brothers Center for Anxiety and Obsessive Compulsive Disorders*

MINI WORKSHOP 3

Effectively Interacting With the Media

Simon A. Rego, *Montefiore Medical Center*

MINI WORKSHOP 4

Signaling Matters: New Skills-Based Approaches for Enhancing Social Connectedness

Thomas. R. Lynch, *University of Southampton*

MINI WORKSHOP 5

A Team Approach to Training and Clinical Care of Behavioral Problems in Primary Care

Patricia Robinson, Debra Gould, and Kirk Strosahl, *Community Health of Central Washington*

MINI WORKSHOP 6

Writing Productivity and the Academic Peer-Review Process: A Workshop for Graduate Students, Early-Career Professionals, and Academic Advisors

Andres De Los Reyes, *University of Maryland at College Park*

MINI WORKSHOP 7

Running Into Well-Being: Exercise for Mood and Anxiety Disorders

Michael W. Otto, *Boston University*
Jasper A. J. Smits, *Southern Methodist University*

MINI WORKSHOP 8

Psychopharmacology for Mental Health Providers: Mood, Medication, and Genetics

Sharon M. Freeman Clevenger, *Indiana Center for Cognitive Behavior Therapy*

MINI WORKSHOP 9

Introduction to Mindfulness-Based Cognitive Therapy for Children (MBCT-C)

Randye J. Semple, *University of Southern California*

MINI WORKSHOP 10

Cultural Competence in CBT: A Process, Skills-Based Model

Steven Lopez, *University of Southern California*
Gabriela Nagy, Maria Santos, and Jonathan Kanter, *University of Wisconsin-Milwaukee*

MINI WORKSHOP 11

How to Integrate Spirituality Into Cognitive Behavioral Therapy: A Brief Intervention

David H. Rosmarin, *McLean Hospital/Harvard Medical School*

MINI WORKSHOP 12

Core Competencies in CBT: Becoming an Effective and Competent Cognitive-Behavioral Therapist

Cory F. Newman, *University of Pennsylvania*

MASTER CLINICIAN SEMINARS

TICKETED

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

MASTER CLINICIAN SEMINAR 1
Optimizing Long-Term Outcomes for OCD Using an Inhibitory Learning Approach
Jonathan S. Abramowitz, *University of North Carolina, Chapel Hill*

MASTER CLINICIAN SEMINAR 2
Comprehensive CBT for OCD to Maximize Gains
Lata K. McGinn, *Ferkauf Graduate School of Psychology, Yeshiva University*

MASTER CLINICIAN SEMINAR 3
Integrating CBT Strategies Into Ongoing Clinical Practice
Michael W. Otto, *Boston University*

MASTER CLINICIAN SEMINAR 4
Assessment and CBT of Body Dysmorphic Disorder
Fugen Neziroglu, *Bio-Behavioral Institute*
Dean McKay, *Fordham University*

MASTER CLINICIAN SEMINAR 5
CBT for Children and Adolescents With OCD: Incorporating Parents in Treatment and Managing Complex Symptoms
Stephen Whiteside, *Mayo Clinic*
Eric A. Storch, *University of South Florida*

MASTER CLINICIAN SEMINAR 6
Treating Military and Veteran Couples: Clinical Approaches and Treatment Considerations
Steven L. Sayers, *Philadelphia VA Medical Center, University of Pennsylvania*

MASTER CLINICIAN SEMINAR 7
Detecting Assimilation in Cognitive Processing Therapy for PTSD
Patricia A. Resick, *National Center for PTSD, VA Boston Healthcare System and Boston University*

MASTER CLINICIAN SEMINAR 8
Supercharging CBT With Functional Analytic Psychotherapy: Maximizing Therapeutic Impact by Using the Client-Therapist Relationship
Mavis Tsai, *Independent Practice and University of Washington*
Robert J. Kohlenberg, *University of Washington*

Invited Addresses & Presidential

FRIDAY | 10:00 – 11:00 a.m.
RICHARD J. DAVIDSON
University of Wisconsin–Madison
Change Your Brain by Transforming Your Mind

FRIDAY | 12:30 – 1:30 p.m.
ANKE EHLERS
University of Oxford
Updating Trauma Memories: A Cognitive Approach to Treating Posttraumatic Stress Disorder

SATURDAY | 9:30 – 10:30 a.m.
VARDA SHOHAM
National Institute of Mental Health
Challenges and Promises of Experimental Therapeutics

SATURDAY | 12:45 – 1:45 p.m.
JAMES J. GROSS
Stanford University
Emotion Regulation: Conceptual Foundations and Clinical Applications

Presidential Address

SATURDAY | 5:30 – 6:30 p.m.
STEFAN G. HOFMANN, *Boston University*
MODERATOR: Dean McKay, *Fordham University*
The Future of CBT in the Age of the DSM-5

SPOTLIGHT RESEARCH

NO TICKET REQUIRED

This 60-minute session is intended for in-depth presentation of especially innovative or groundbreaking findings.

SATURDAY | 3:30 – 4:30 p.m.
Randomized Controlled Trial and 9-Month Follow-Up of an Emotion Regulation Group Therapy for Deliberate Self-Harm Among Women With Borderline Personality Pathology
Kim Gratz, *University of Mississippi Medical Center*

WORKSHOPS

TICKETED

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

WORKSHOP 1

Cognitive-Behavioral Treatment of Chronic Pain in Children and Adolescents
Gerard A. Banez, *Cleveland Clinic Children's Hospital*
Cindy Harbeck Weber, *Mayo Clinic*
Tonya M. Palermo, *University of Washington* and *Seattle Children's Research Institute*

WORKSHOP 2

Acceptance and Change in Couple Therapy: Integrative Behavioral Couple Therapy
Andrew Christensen, *UCLA*

WORKSHOP 3

Real-World Cognitive-Behavioral Insomnia Therapy for Those With Co-Occurring Conditions
Jack D. Edinger, *National Jewish Medical Center*
Colleen E. Carney, *Ryerson University*

WORKSHOP 4

An Interactive Training in the Unified Protocol for the Treatment of Emotional Disorders in Children
Jill Ehrenreich-May and Emily Bilek, *University of Miami*

WORKSHOP 5

The Compassionate Use of Exposure Strategies in ACT
John P. Forsyth, *University at Albany, SUNY*

WORKSHOP 6

Acceptance-Based Emotion Regulation Group Therapy for Deliberate Self-Harm Among Women With Borderline Personality Pathology
Kim L. Gratz and Matthew T. Tull,
University of Mississippi Medical Center

WORKSHOP 7

A Group Cognitive Behavioral Program for Preventing Depression in Adolescents
Judy Garber and Steven D. Hollon,
Vanderbilt University
Tracy R.G. Gladstone, *Wellesley College*

WORKSHOP 8

Treatment of OCD With Exposure and Response Prevention: Beyond Manualized Treatment
Jonathan Grayson, *Anxiety & OCD Treatment Center of Philadelphia*

WORKSHOP 9

Integrated Group CBT for Depression and Substance Abuse
Kimberly Hepner, *RAND Corporation*

WORKSHOP 10

Mastering the Art of Behavioral Chain Analyses in Dialectical Behavior Therapy
Shireen L. Rizvi, *Rutgers University*
Lorie Ritschel, *Emory University*

WORKSHOP 11

An Introduction to Mindfulness-Based Eating Awareness Therapy (MB-EAT): Theory, Research, and Practice
Jean L. Kristeller, *Indiana State University*

WORKSHOP 12

Adjunctive Mobile Technologies for Cognitive Behavioral Therapies
Frederick Muench, *Columbia University College of Physicians and Surgeons*
Edwin D. Boudreaux, *University of Massachusetts Medical School*
Ryan Hasen, *Ohio State University*

WORKSHOP 13

Understanding and Treating Hoarding Disorder: Sorting It Out
Jordana Muroff and Gail Steketee,
Boston University School of Social Work

WORKSHOP 14

Behavioral Activation for Depression: Extension to Coexistent Psychiatric and Medical Problems
Derek R. Hopko, *The University of Tennessee*
C. W. Lejuez, *The University of Maryland, College Park*

WORKSHOP 15

Imagined Ugliness: Understanding and Treating Body Dysmorphic Disorder
Sabine Wilhelm, *Harvard Medical School*

GENERAL SESSIONS

Clinical Round Tables, Panel Discussions, and Symposia are part of the general program: no tickets are required to attend these sessions.

Clinical Round Tables

Treatment-Resistant OCD and Spectrum Conditions in Children and Adults
Chair: Cheryl Carmin
Panelists: Jonathan Abramowitz, Martin Franklin, Randy Frost, Alec C. Pollard, Bradley Riemann, Gail Steketee

Exposure Therapy Revealed: Practical Solutions for Your Patients
Chair: Mitchell Schare
Panelists: Jonathan Grayson, Dean McKay, E. Moritz

CBT for Lesbian, Gay, Bisexual, and Transgender Individuals: How to Increase Your Competency
Chair: Trevor Hart
Panelist: Michael Newcomb, John Pachankis, Jillian Shipherd, Tyler Tulloch, Sarah Valentine

What Have You Changed Your Mind About?
Chair: Simon Rego
Panelist: Gerald Davison, Steven Hayes, Marsha Linehan

Enhancing the Cultural Sensitivity of CBT for Anxiety Disorders With Diverse Populations
Chairs: Sarah Hayes-Skelton, Shannon Sorenson
Panelists: Denise Chavira, Jessica Graham, Debra Hope, Monnica Williams

Evolution of the Revolution: Shifting Our Focus From Evidence-Based Treatments to Evidence-Based Training
Chair: Simon Rego
Panelists: Christopher Fairburn, Shannon Stirman, Donna Sudak, G. Terence Wilson

Cognitive-Behavioral Couple Therapy Around the Globe in the Real World
Chairs: Donald Baucom, Andrew Christensen
Panelists: Leonidas Castro-Camacho, Norman Epstein, Mariann Grawe-Gerber, Michael Worrell

OCD: Tailored Treatment Techniques and Difficult Differential Diagnoses
Chair: Kimberly Glazier
Panelist: Lata McGinn, Anthony Pinto, Michael Twohig, Eric Storch, David Tolin

Forensic CBT: Diverse Treatment Perspectives on a Videotaped Interview With a Justice-Involved Client
Chair: Damon Mitchell
Panelist: Ray DiGiuseppe, Arthur Freeman, Steven Hayes, Howard Kassinove, Raymond Tafrate

More Similar Than Different? Four CBT Approaches to the Treatment of a Client With a Complex Presentation of OCD
Chair: Roz Shafran
Panelist: Jonathan Abramowitz, Donald Baucom, Michael Twohig, Maureen Whittal

Panel Discussions

CBT in Community Settings: Models and Challenges for Implementing Evidence-Based Care for Youths
Chairs: Joan Asarnow, Marc Atkins
Panelist: Anne Marie Albano, Bruce Chorpita, Mary Fristad, Kimberly Hoagwood, Elizabeth McCauley

Treating Suicidality Across Service Delivery Settings: Risk Management for the Clinician
Chair: Erin McDonough
Panelists: Andrew Berger, Dana Boccio, Mark Lazarus, Andrea Macari, Robert Meyers

Developing and Integrating Biological, Behavioral, and Cognitive Indices in Treatment Research for Serious Mental Illness
Chair: Charlie Davidson
Panelists: Gregory Miller, Keith Nuechterlein, William Spaulding, Melissa Tarasenko, David Zald

Recruiting and Retaining Minority Families Into Research Studies
Chair: Miriam Ehrensaft
Panelists: Jennifer Langhinrichsen-Rohling, Thailyn Lopez, Erica Woodin

Combined Treatment for Depression and Anxiety: Identifying and Addressing Challenges to Enhance Cross-Disciplinary Collaboration
Chair: Kristy Dalrymple
Panelists: Richard Heimberg, Steven Hollon, Ivan Miller, Michael Otto, Mark Zimmerman

Civilian/Military Research Collaborations: Keys for Successful Partnerships
Chair: Keith Renshaw
Panelists: Craig Bryan, Jeffrey Cigrang, Marjan Holloway, Shannon Kehle-Forbes, Stacey Young-McCaughan

Giving the People What They Want: Recent Innovations and Future Directions in Direct-to-Consumer Marketing of Evidence-Based Psychological Treatments
Chairs: Tommy Chou, Aubrey Edson

Panelists: Anne Marie Albano, David Barlow, Carolyn Becker, Kaitlin Gallo, Muniya Khanna

Statistics, Methodology, and Publishing: The View from Authors, Journal Editors, and Reviewers
Chair: David Atkins
Panelist: Scott Baldwin, Scott Compton, Aaron Fisher, Michael Young

Avoidance, Emotion, and Well-Being: New Thinking About Old Ideas
Chair: Thomas Lynch
Panelists: David Barlow, Adele Hayes, Douglas Mennin

Developing Web-Based and Mobile Applications for Mental Health Interventions: Benefits, Challenges, and Recommendations
Chair: Erica Yuen
Panelists: Per Carlbring, David Cooper, David Mohr, Lee Ritterband, Shireen Rizvi, Ken Ruggiero

Time for a Change: Challenges and Solutions in Fulfilling the Potential of Computerized Interventions for Behavioral Change
Chairs: Marsha Linehan, Anita Lungu
Panelists: Linda Dimeff, Hunter Hoffman, Marivi Navarro, Raphael Rose, Zachary Rosenthal

Fusing Cognitive-Behavioral Research and Extramural Funding: Opportunities for Graduate Students, Early Career Psychologists, and Mentors
Chair: Mitchell Prinstein
Panelists: Daniel Bagner, Christopher Campbell, David DiLillo, Lawrence Elledge, Rosy Maldonado

Cognitive Bias Modification for Treatment of Anxiety Disorders: Big Picture Considerations for Implementation in the Clinical Setting
Chairs: Michelle Capozzoli, Debra Hope
Panelists: Nader Amir, Yair Bar-Haim, Courtney Beard, Bethany Teachman, Willem Van der Does

Sharing Multidisciplinary Success Stories: Creating a Coordinated Community Response to Interpersonal Violence
Chair: RaeAnn Anderson
Panelists: Ana Bridges, Alesia Hawkins, Melanie Hetzel-Riggin, Nora Keenan, Mandy Rabenhorst, Heather Risser

Establishing Multidisciplinary Links Between Physicians and Behavior Specialists in Mental Health and Well-Being: A Focus on Sleep Medicine
Chairs: Megan Crawford, Jason Ong
Panelists: Colleen Carney, Jamie Cvengros, Rachel Manber

Standards for Empirically Supported Therapies: Is It Time for a Revision?
Chair: Dean McKay • *Panelists*: Raymond DiGiuseppe,Marvin Goldfried, E. Klonsky, Thomas Ollendick, David Tolin

Learning to Speak One Another's Language: Approaches and Challenges to Interprofessional Training in CBT
Chair: Barbara Kamholz
Panelists: Cindy Aaronson, Robert Goisman, Gabrielle Liverant, Cory Newman, Donna Sudak

Anxiety Disorders: Navigating Legal and Ethical Dilemmas
Chair: Katia Moritz
Panelist: James Herbert, Jonathan Hoffman, Mitchell Schare

Is Time-Out Relevant to 21st-Century CBT?
Chair: Stacy Shaw
Panelists: Patrick Friman, Cheryl McNeil, Mark Roberts, William Warzak

Beyond the Intent to Reach: Recruitment of Couples for Intervention Research
Chair: Katherine Baucom
Panelists: Donald Baucom, Brian Doss, Kristina Gordon, Richard Heyman, Scott Stanley, Tea Trillingsgaard

Science-Driven Policy
Chair: Lynn Bufka
Panelists: Rhonda Beale, Robert Heinssen, Katherine Nordal, Antonette Zeiss

Watson (1913): "Psychology as the Behaviorist Views It": A Centennial Celebration
Chair: Mitchell Schare
Panelist: Gerald Davison, Raymond DiGiuseppe, Kurt Salzinger, W. Edward Craighead

Best Practices in Forensic CBT Across Treatment Environments
Chair: George Ronan
Panelists: F. Bishop, Christopher Eckhardt, Eva Feindler, Frank Gardner, Raymond Tafrate

Sustainable Methods for Identifying Internalizing Youth in School Settings
Chair: Daniela Colognori
Panelists: Marc Atkins, Brian Chu, Steven Evans, Carrie Warner, Jami Young

Doors Closing or Windows Opening? Forging an Academic Career at a Liberal Arts College
Chair: Patricia DiBartolo
Panelists: Carolyn Becker, Sarah Markowitz, Casey Schofield, Erin Sheets

Leveraging Learning Communities to Facilitate the Dissemination and Implementation of Evidence-Based Therapies
Chair: Linda Dimeff
Panelists: Bruce Chorpita, Melanie Harned, Kelly Koerner, Shannon Stirman

Symposia

Breaking Down Brief Treatments: Mediators, Moderators, and Predictors of Outcome in Intensive Treatments for Childhood Anxiety Disorders
Chairs: Meredith Elkins, Priscilla Chan
Discussant: Jonathan Comer

Fear Generalization as a Core Mechanism in the Development of Anxiety Disorders: Clinical and Lab Findings
Chair: Dirk Hermans
Discussant: Michelle Craske

Beyond the Horse Race: What Factors Predict and Explain Treatment Response to CBT for GAD?
Chair: Michel Dugas
Discussant: David Fresco

Evidence-Based Assessment for Feasible Quality Improvement in Real-World Service Settings
Chair: Aaron Lyon
Discussant: David Langer

Impaired Parenting and Dysfunctional Cognitions in the Intergenerational Transmission of Anxiety and Depression
Chair: John Riskind

Repetitive Behaviors Across the Disorders: A Transdiagnostic Framework
Chair: John Richey
Discussant: Sabine Wilhelm

Mechanisms Underlying Tobacco and Marijuana Use and Cessation
Chairs: Kimberly Avallone, Alison McLeish
Discussant: Sherry Stewart

New Methods and Approaches in Investigating the Therapeutic Alliance
Chair: Daniel Strunk
Discussant: Stephen Shirk

Characteristics of Men Who Engage in Nonsuicidal Self-Injury
Chairs: Barent Walsh, Tatyana Kholodkov
Discussant: Carolyn Pepper

No Clinician Left Behind (in the 20th Century): Fusing Psychotherapy With High-Tech Interventions
Chair: Daniel Hoffman

New Directions in Computer-Based Psychological Interventions: How We Got There and Where We Are Going
Chairs: Matthew Carper, Philip Kendall
Discussant: Muniya Khanna

Integration of Behavioral Health Services Into Primary Care Settings
Chairs: Lisa Uebelacker, Risa Weisberg
Discussant: Jeffrey Goodie

The Role of Mindfulness Practice in Mindfulnes-Based Treatment
Chair: Lance Hawley
Discussant: Ruth Baer

The Many Faces of PTSD: A Comparison of Active-Duty Military Personnel, Veteran, and Civilian PTSD Sufferers
Chair: Carmen McLean
Discussant: Patricia Resick

ACT and CBT for Anxiety: Comparing Process and Outcome Within Brief Interventions
Chair: Joanna Arch
Discussant: Maureen Whittal

Amplifying and Dampening Positive Emotional States: Implications for Emotional Disorders
Chair: Thane Erickson
Discussant: Todd Kashdan

Evidence-Based Clinical Decision Making: From Laboratory to the Clinic
Chair: Amanda Jensen-Doss
Discussant: Thomas Ollendick

The Influence of Sleep Adequacy on Symptom Expression and Treatment Outcomes in Anxiety and Mood Disorders
Chair: Alexandra Kredlow
Discussant: Daniel Taylor

New Frontiers in Social Norms Research
Chair: Dana Litt
Discussant: Mary Larimer

The Role of Criminal Thinking in Offender Responsiveness to Treatment and Risk for Recidivism
Chair: Raymond Tafrate
Discussant: Christopher Eckhardt

Understanding Processes of Change: What Matters in Cognitive Therapy for Depression and to Whom?
Chair: Robert DeRubeis
Discussant: Kathleen Gunthert

Recent Research on the Effectiveness of the Prevention and Relationship Enhancement Program
Chair: Galena Rhoades

Contextual Factors in Maladaptive Eating: Novel Research Findings and Implications for Treatment
Chair: Samantha Moshier

Increasing Access and Capacity to Deliver CBT: Online- and Book-Based Research and Practice
Chair: Mark Lau
Discussant: Steven Hollon

Patterns and Profiles of Impairment in College Students With ADHD and the Development of Interventions to Address Their Needs
Chair: Joshua Langberg
Discussant: Laura Knouse

Adapting CBT Across Ethnic and Global Contexts: PTSD in Egypt, South Africa, and Among Cambodian Refugees
Chairs: Devon Hinton, Baland Jalal
Discussant: Richard McNally

How Can Cognition Help to Explain the Course of Illness in Bipolar Disorder?
Chairs: Andrew Peckham, Jonathan Stange
Discussant: Lauren Alloy

Evaluations of Self and Others in Social Anxiety: New Research Bridging Cognitive and Interpersonal Models
Chairs: Tatiana Bielak, David Moscovitch
Discussant: Lynn Alden

Interventions to Reduce Disordered College Student Gambling
Chairs: Ty Lostutter, Jessica Cronce
Discussant: Maureen Greeley

Meaningfully Interpreting Discrepant Assessment Outcomes Within Multi-Informant Assessments of Adult Psychopathology
Chair: Andres De Los Reyes
Discussant: David Cole

Early, Preventative, and Low-Intensity Relationship Interventions
Chairs: Lisa Benson, Emily Georgia
Discussant: Galena Rhoades

Maternal Depression: Psychosocial and Physiological Mediators and Moderators of Transmission Risk in Children of Depressed Mothers
Chair: Ilya Yaroslavsky
Discussant: Jeremy Pettit

Comorbidity of Anxiety and Depression: Moving Beyond Description to Explain Why and How Comorbidity Occurs
Chair: Ayelet Ruscio
Discussant: Varda Shoham

Sociocultural Influences of Eating Pathology: The Roles of Anxiety and Social-Evaluative Concerns
Chairs: Andrew Menatti, Lindsey DeBoer
Discussant: Jasper Smits

Psychological Inflexibility and the Onset and Treatment of Psychiatric Disorders: Prediction and Mediation Models
Chair: Chad Shenk
Discussant: Ruth Baer

Child/Adolescent Anxiety Multimodal Study: Five Years Later
Chair: Nicole Caporino
Discussant: Anne Marie Albano

Innovations in the Treatment of Obsessive-Compulsive and Related Disorders
Chair: Kiara Timpano
Discussant: Alec Pollard

Examination of Acceptance in Chronic Pain and Chronic Illness: Past, Present, and Future Directions for Meaningful Application
Chair: Abbie Beacham
Discussant: Patricia Robinson

Harnessing the Synergy of Technology and Training in Evidence-Based Practices
Chair: Charmaine McMillan
Discussant: Shannon Stirman

Exploring the Role of Child Routines and Externalizing Disorders Across Childhood: Implications for Prevention and Intervention
Chairs: Sara Jordan, Monique LeBlanc
Discussant: David Reitman

ADHD Symptoms and Impairment in Adult Women: New Findings and Implications for Future Research and Practice
Chair: Heather Jones
Discussant: Andrea Chronis-Tuscano

Putting Addictions Into Context: Expanding Theoretical Models of Additive Behavior by Integrating Knowledge of Contextual Factors
Chairs: Matthew Keough, Roisin O'Connor
Discussant: Jennifer Read

Multidisciplinary Perspectives on Disturbances in Emotion Regulation: Clarification of Models and Definitions
Chair: Andrada Neacsiu
Discussant: Ann Kring

Interpersonal Processes and Depression: New Methodologies and Findings
Chair: Josephine Shih

Brain Matters! Application of Novel Translational Research Findings to Anxiety and Depression
Chair: Angela Fang, Amanda Calkins
Discussant: Thilo Deckersbach

Family Involvement in the Treatment of Obsessive-Compulsive Spectrum Conditions
Chair: Aubrey Edson

Early Life Trauma and Major Depressive Disorder: Effects on Biological, Neurological, and Affective Processes
Chair: Lindsey Sankin

Perceptual Bias of Competence in Youth With ADHD: Clinical Presentation and Treatment Implications
Chair: Yuko Watabe
Discussant: Julie Owens

Efficacy of Transdiagnostic Protocols for Eating, Mood, and Anxiety Disorders for Patients With Co-Occurring Borderline Personality Traits
Chair: Christina Boisseau
Discussant: Melanie Harned

Stress Generation: Biological Factors, Developmental Roots, and Diverse Outcomes
Chairs: Evan Kleiman, Lisa Starr
Discussant: Joanne Davila

Mindfulness-Based Cognitive Therapy for the Prevention of Perinatal Depression: A Novel Integration of Multiple Disciplines
Chairs: Sona Dimidjian, Sherryl Goodman
Discussant: Marina Lopez-Sola

Trajectories of Posttraumatic Stress Responses Following Trauma Exposure
Chair: Angela Nickerson
Discussant: Richard Bryant

Dimensional Constructs and Neural Correlates of CBT Treatment Outcome in Anxiety Disorders
Chair: Steven Bruce
Discussant: Thilo Deckersbach

Treating Sleep Problems in Adolescents and Adults: New Treatments and New Outcome Data
Chair: Allison Harvey
Discussant: Kenneth Lichstein

Psychosocial Comorbidities Among HIV-Infected Substance Users: Health Outcomes
Chairs: Aaron Blashill, Conall O'Cleirigh

Using Assessments to Guide Early Identification and Intervention for Young Children With Externalizing Behavior Problems
Chairs: Paulo Graziano, Daniel Bagner
Discussant: Alice Carter

Interdisciplinary Work With Family Law: Empirically Testing Mediation and Parent Education Interventions for Separating Parents
Chair: Amy Holtzworth-Munroe
Discussant: Daniel O'Leary

New Directions in the Understanding, Prediction, and Treatment of Suicidal Behaviors
Chairs: Randy Auerbach, Matthew Nock
Discussant: Michael Armey

Developing Linguistic Models of Motivational Interviewing: An Interdisciplinary Collaboration
Chairs: Zac Imel, David Atkins
Discussant: Theresa Moyers

Developments in the Role of Positive Emotions in SAD: Using Multimodal and Multisensory Assessment to Guide Treatment
Chair: John Richey
Discussant: Richard Heimberg

Neurobehavioral Facets of Emotion Regulation in Normative, Disordered, and Treatment Contexts
Chairs: David Fresco, Katherine Shepherd

Applications of Treatment Integrity Research to Dissemination and Implementation Research
Chairs: Michael Southam-Gerow, Bryce McLeod
Discussant: Ann Garland

Bipolar Disorder: Novel Treatment Applications for a Debilitating Illness
Chair: Jason Lee
Discussant: Eric Youngstrom

Biological Factors Associated With Response to PTSD Treatment
Chair: Patricia Resick

Advancing the Science of Sexual Minority Stress: Measurement Issues, Mental Health Associations, and Implications for CBT Treatment
Chair: Michael Newcomb
Discussant: David Pantalone

New Developments in Trichotillomania Treatment Research
Chairs: David Haaga, Martha Falkenstein
Discussant: Michael Twohig

Breaking the Intergenerational Transmission of Violence Across Educational, Medical, and Justice Settings
Chair: Alisha Wray

Sudden Gains in CBT: New Findings and Updated Theory
Chair: Courtney Beard
Discussant: Robert DeRubeis

Price of Perfection: A Transdiagnostic Factor Across Social Anxiety, Depression, and Eating Disorders
Chair: Cheri Levinson
Discussant: Roz Shafran

Understanding the Role of Anger in Intimate Partner Violence Among Men and Women: Implications for Interventions
Chair: Erica Birkley
Discussant: Howard Kassinove

Measurement of Teacher Behavior in the Classroom Setting: Implications for Behavioral Intervention and Consultation
Chairs: Alex Holdaway, Clifton Mixon
Discussant: Marc Atkins

Using Technology to Improve CBT for Youth Anxiety
Chair: Nicole Caporino
Discussant: Golda Ginsburg

Approaching Care From a Transdiagnostic Perspective
Chair: Ariel Lang
Discussant: Michelle Craske

Measuring and Modifying Attentional Bias Across Psychopathology
Chairs: Christine Cha, Matthew Nock
Discussant: Richard McNally

The Use of Mindfulness Meditation for the Treatment of Insomnia and Stress-Related Sleep Disturbance
Chairs: Jason Ong, Sheila Garland
Discussant: Zindel Segal

Moderators of Response to Psychosocial Treatment for Bipolar Disorder: Findings From the Systematic Treatment Enhancement Program
Chairs: Thilo Deckersbach, Louisa Sylvia
Discussant: David Miklowitz

Expanding the Focus in GAD: Understanding and Addressing Problems in Interpersonal Functioning and Their Impact on Treatment Outcome
Chair: Daniel Millstein
Discussant: Richard Heimberg

The Pediatric OCD Treatment Study for Young Children: Methods, Results, Moderators, and Lessons Learned
Chair: Jennifer Freeman
Discussant: John Piacentini

A New Intervention to Reduce Suicidal Behavior: Coping Long-Term With Active Suicide Program
Chair: Ivan Miller
Discussant: Gregory Brown

Predictors of Intervention Response in Youth With Autism Spectrum Disorders: Psychosocial Treatments for Core and Comorbid Psychopathology
Chair: Matthew Lerner
Discussant: Bryce McLeod

New Frontiers in the Study of Emotion Regulation: Innovative Laboratory-Based Methods of Emotional Responding and Regulation
Chairs: Matthew Tull, Katherine Dixon-Gordon
Discussant: Kim Gratz

New Insights From Modern Methods: Use of Alcohol Protective Behavioral Strategies Among College Students
Chair: Matthew Pearson
Discussant: Matthew Martens

Does Our Field Need Better Public Relations? Perceptions of Psychiatric Symptoms and Treatment Options
Chair: Casey Schofield
Discussant: Meredith Coles

Considerations for Dissemination and Implementation of Evidence-Based Practices and Assessment in School-Based Settings
Chair: Elizabeth Connors
Discussant: Brian Chu

Utilizing Single-Case Experimental Designs for Research Funding: NRSAs, K Awards, and Studies of Mechanisms
Chair: Kate Bentley
Discussant: David Barlow

Current Status and New Directions in Suicide Research: Interpersonal-Psychological Theory of Suicide and Beyond
Chair: Evan Kleiman
Discussant: Thomas Joiner

Intimate Relationships and Treatment of Psychopathology: Partner and Patient Outcomes in Individual and Couple-Based Interventions
Chair: Philippe Shnaider
Discussant: Douglas Snyder

Treating PTSD Among Individuals With BPD: Emerging Evidence Across Diverse Treatment Settings and Clinical Populations
Chair: Melanie Harned
Discussant: Elizabeth Hembree

Augmenting Therapeutic Learning in CBT: Efficacy of D-Cycloserine for Enhancing the Outcome of CBT for Panic Disorder
Chairs: Michael Otto, David Tolin
Discussant: Jasper Smits

At the Intersection of Psychology and Medicine: Understanding the Relationship Between PTSD and Health Outcomes
Chairs: Meghan Cody, Gayle Beck
Discussant: Terence Keane

Mindfulness-Based Relapse Prevention: Outcomes, Mechanisms of Change, and Treatment Engagement After a Randomized Trial
Chairs: Katie Witkiewitz, Sarah Bowen

SAD: New Insights From the Laboratory for the Clinic
Chair: Richard McNally

Translating Evidence-Based Assessment and Treatments for Youth for Deployment in Community Settings
Chair: Rinad Beidas
Discussant: Michael Southam-Gerow

Optimizing Treatment Selection: Using Moderators to Inform Treatment Selection
Chair: Steven Hollon

Beyond PTSD: Testing the Breadth of Trauma-Focused Therapy
Chair: Cassidy Gutner
Discussant: Patricia Resick

Moving Beyond Risk Factors in the Study of Adolescent and Emerging Adult Suicidal Behavior: Role of Mediators and Moderators
Chairs: Adam Miller, Karen Schaefer
Discussant: Mitchell Prinstein

Elucidating Mechanisms and Moderators of Meditation-Enriched Treatments at the Confluence of CBT, Affective Science, and Contemplative Practice
Chairs: Kathrine Shepherd, David Fresco

Integration of Diverse Methodologies and Sampling Approaches to Examine Etiological Models of Trauma and Substance Use
Chairs: Erin Berenz, Rita Dykstra
Discussant: Scott Coffey

Cultural Issues in the Assessment and Treatment of Ethnic Minority Youths
Chair: Omar Gudino
Discussant: Esteban Cardemil

Psychopathic Traits: Mechanisms and Treatment Implications for Antisocial Behavior
Chair: Bradley White
Discussant: Scott Lilienfeld

Understanding and Treating Obsessive-Compulsive and Related Disorders: Methods, Meaning, and Maximizing Treatment Gains
Chair: Maureen Whittal
Discussant: Roz Shafran

Psychotherapy Integration Research in Naturalistic Psychiatric Settings
Chair: Courtney Beard
Discussant: Randy Auerbach

Dissemination and Implementation of Mental Health Interventions in Pediatric Primary Care Settings
Chairs: Michelle Rozenman, Robin Weersing
Discussant: Joan Asarnow

Social Anxiety and Hazardous Drinking: Illuminating the Mechanisms of Comorbidity
Chair: Ruth Cooper
Discussant: Alexander Gerlach

Updates in the Phenomenology of Tourette Disorder: New Directions for Treatment
Chair: Joseph McGuire
Discussant: Sabine Wilhelm

Myth-Busting Exposure Therapy
Chairs: Nicholas Farrell, Joshua Kemp

A Tale of Sciences: Utilizing Other Disciplines to Advance Child and Adolescent Depression Research
Chairs: Dikla Eckshtain, Jenny Herren
Discussant: John Curry

Romantic and Sexual Behaviors of Young Adults: Implications for Mental and Physical Health
Chair: Sarah Whitton
Discussant: Joanne Davila

Next Steps for Comprehensive Behavioral Intervention for Tics
Chair: Shannon Bennett
Discussant: Joel Sherrill

Peer Victimization and Emotional Reactivity: Risk Factors for Anxiety and Depression From Childhood to Early Adulthood
Chairs: Julia Langer, Cheri Levinson
Discussant: Thomas Rodebaugh

Sexual Trauma and Sexual Risk: Approaches to Understanding and Treating Sexual Risk Behavior of Sexual Violence Survivors
Chair: Conall O'Clereigh
Discussant: Jillian Shipherd

Status Update: Using Online and Real-Time Tools to Study Disordered Eating
Chair: April Smith
Discussant: Kerri Boutelle

Understanding Emotion Dysregulation in Children
Chair: Amy Roy
Discussant: Michael Southam-Gerow

Emotion Regulation and BPD: What Works, in What Context, and for Whom?
Chairs: Brianna Turner, Alexander Chapman
Discussant: Shirley Yen

Sluggish Cognitive Tempo in Youth and Adults: Relations to ADHD, Internalizing Disorders, Impairment, and Treatment Response
Chairs: Stephen Becker, Stephen Marshall
Discussant: Keith McBurnett

Neural Mechanisms of Attention Bias and Attention Bias Modification: Cognitive Neuroscience Meets Cognitive-Behavioral Theory
Chair: Rebecca Price
Discussant: Greg Siegle

The Role of Exercise and Sleep: Multidisciplinary Perspectives on Improving Quality of Life and Functioning
Chairs: Louisa Sylvia, Thilo Deckersbach
Discussant: Jasper Smits

Military Personnel and Veterans in College: Working Across Professions
Chair: Craig Bryan
Discussant: Ted Bonar

Behavioral and Neural Mechanisms Underlying Major Depression in Youth
Chair: Randy Auerbach
Discussant: Sherryl Goodman

Body Image Disturbance Across Medical Populations: Implications for Interventions
Chair: Aaron Blashill
Discussant: Sabine Wilhelm

REGISTRATION / HOTEL

Preregister on-line at www.abct.org or, to pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the preregistration deadline of October 15, 2013. **Only those individuals who register by midnight, Wednesday, October 15, will be mailed the convention program book. All other attendees will receive their program book on-site.** To receive discounted member registration fees, members must renew for 2014 before completing their registration process.

Preconvention Activities

The preconvention activities will be held on Wednesday, November 20, and Thursday, November 21. All preconvention activities are designed to be intensive learning experiences. Preregister to ensure participation.

Preregistration for preconvention activities closes October 15. Tickets will be mailed to preregistered attendees.

All open preconvention activities (Clinical Intervention Training Sessions, Institutes and AMASS) will be on sale at on-site Preconvention Registration:

- Wednesday: 7:30 a.m. to 9:30 a.m.
- Thursday: 7:30 a.m. to 1:00 p.m.

To Register

To receive members' discounted rates, your ABCT dues must be paid through October 31, 2014. The ABCT membership year is November 1 to October 31. If your membership has lapsed, use this opportunity to renew.

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

Registering On-Line

The quickest method is to register on-line at www.abct.org. Use this method for immediate feedback on which ticketed sessions you will be attending.

Registering by Fax

You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will likely cause double payment. For preregistration rates, please register BEFORE the deadline date of October 15.

Registering by Mail

All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, New York, NY 10001. For preregistration rates, forms must be postmarked by the deadline date: October 15. Forms postmarked October 16 through October 24 will be processed at on-site rates.

Refund Policy

Refund requests must be in writing. Refunds will be made only until the October 15 deadline, and a $40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 15.

Confirmation

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

Payment Policy

All fees must be paid in U.S. currency on a U.S. bank. Any bank fees charged to the Association will be passed along to the attendee. Please make checks payable to ABCT.

Hotel

Gaylord Opryland Hotel in Nashville
2800 Opryland Drive
Nashville, TN 37214
phone: 877-491-7397

To reserve your room go to
http://www.abct.org/conv2013
and click HOTEL RESERVATIONS

If reserving by phone, please use the code AAB for our special discounted rates.

call *for* Continuing Education Sessions

48th Annual Convention | November 20–23, 2014 | Philadelphia

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at www.abct.org.

Workshops and Mini Workshops

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

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

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

Barbara Kamholz, *Workshop Committee Chair*
workshops@abct.org

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.
Please limit to no more than FOUR presenters.

Lauren Weinstock, *Institute Committee Chair*
institutes@abct.org

Master Clinician Seminars

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

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

DEADLINE *for Submission : February 1, 2014*

Convention 2013

Nashville Welcomes ABCT

Kirsten Haman, *Local Arrangements Chair*

Hey, y'all, welcome to Nashville. For the first time in ABCT history! This article offers some basic information about the convention, the site, and the surrounding areas and activities, to make your trip planning as easy as possible.

Before we get to the logistics, however, some essential information:

1. "Y'all" is indeed the appropriate greeting for a group of two or more, used by everyone, even people not from the South, in any situation where "*vous*," "you guys," or perhaps "youse" would be acceptable. Therefore, please feel free to address your friends and comrades as *y'all*, as in "Are y'all going to the Master Clinician Seminar, or the poster session?"

There is one caveat: "Y'all" is always and only plural. If you are heard directing "y'all" to just one person, we the people who live in the southern states will smile kindly at you and say "bless your little heart"; by this, we will have just horrifically insulted you.

2. We are a car town. We have no trains, no subways, few bike lanes, a fairly rudimentary but navigable bus system, and taxis that you have to call for if you are not at the airport or a hotel (i.e., they won't be driving around looking for customers). The convention hotel, the Gaylord Opryland Resort and Convention Center, has transportation of its own (see below) and there are several walking-distance shops and restaurants, but to get to some of the venues I'll be mentioning, it will be helpful to have access to a vehicle or a taxi service phone number.

3. Stars of music and film are everywhere in Nashville. Much to my chagrin, however, they generally look like regular people rather than their sequin-studded celebrity selves, so you have to look closely (although there are a few notable exceptions—remind me to tell you about the time Dolly Parton was in the Vanderbilt Psychology building). Coffee shops and any of the music venues are good places to catch a famous person in the wild. Which leads me to my final point...

4. Like many cities, Nashville has a number of faces—one for visitors, another for locals, still another for hipsters, etc. All the Nashvilles have something in common, however: music. Known as Music City for a reason, this city is filled with people who are thinking about, talking about, writing and playing music of all types, all the time. One of our primary missions as the Local Arrangements Committee is to help you experience as many of the music opportunities as possible while you are visiting.

Getting to Nashville and the Opryland Hotel

This is where we have a great advantage over many locations: We have only one airport, Nashville International Airport (code BNA), which is easily maneuvered. We are a major Southwest hub but all major airlines fly here. If perchance you are arriving on your private jet, you will still land at BNA.

Just to give you a sense of the airport layout, flights arrive and depart on Floor 3; baggage claim is on Floor 2; and ground transportation, including rental cars, shuttles, and taxis, is accessed via the ground floor of the airport. The Opryland complex is about 8 miles away, so you'll probably want some sort of vehicle to get you there.

Shuttles

Opryland Hotel: The resort has its own bus and will pick you up at the airport. The hotel shuttle costs $30 one way ($40 round trip), reservations are required, and the phone number is 615-883- 2211. Note that guests over 65 and under 13 receive discounts.

Gray Line also has shuttles to downtown hotels, but they don't go to the Opryland facilities.

Taxi Services

A taxi can be easily accessed at the airport, and will cost roughly $25 to the hotel.

Car Rental

All the major car rental agencies have counters at BNA; check the airport website for more information (http://www.flynashville.com/ground-transportation/Pages/rental-cars.aspx).

Gaylord Opryland Resort and Convention Center

The Opryland Hotel, named after the Grand Old Opry (for information on the Opry itself: http://www.opry.com), is vast and impressive. We traditionally bring visitors here to marvel at the indoor gardens and river. Because it has been the result of several expansions over many years, the property is composed of a number of different styles in different sections, and you will need maps to navigate (they give them to you at check-in). The resort has a wide variety of options when it comes to eating, drinking, and generally increasing your positive affect. Additionally, the resort is located directly next to an outlet mall (Opry Mills: http://www.simon.com/mall/opry-mills) with an excellent IMAX theater, and across the street from a tourist-oriented area (mini-golf, fried catfish, country music venues, etc.: http://nashvillemusicvalley.com). Thus, there will be plenty of things to do even if you never leave the area.

Parking: If you are driving, parking at the resort is $20 daily, and valet parking is $28 daily.

Things to Do at the Opryland Resort and Convention Center

Dining and Drinking

The resort itself has 10 different restaurants, plus a bar and a coffee house. The cuisines include Italian, sushi, Mexican, tapas, sports club (that's a cuisine, isn't it?), and Southern American, and choices include both fine and casual dining. The Old Hickory Steakhouse is a traditional venue for locals to celebrate events (anniversaries, birthdays, prom); the Cascades Café has a great location among the fountains and greenery, and is a wonderful place for a casual meal; and Jack Daniel's, named for one of Tennessee's most popular exports, has bluegrass music on the weekends and a menu of burgers, BBQ, and fried chicken. Also, you should probably drink some Jack Daniel's while you're there.

Health and Wellness Spa

The resort's Relache Spa offers a full menu of spa services, including signature massages, facials, body treatments, fitness classes, the indoor pool, and more. Spa guests have access to a variety of amenities, including the steam room, sauna, locker rooms and a co-ed Tea/Relaxation lounge. Reservations are required (615-458-1772).

Golf

I know nothing about golf and cannot speak to the quality of the links themselves, but if the weather cooperates, you could potentially play golf while you're here. Opryland has its own course (http://www.gaylordsprings.com), which is open year round, so feel free to bring your plaid pants and fancy clubs or whatever is involved and go hit something.

Greenway

The resort is located near a lovely city greenway, with a pedestrian bridge across the river which connects the Shelby Bottoms component to the Two Rivers Park component. Run, bike, or walk, and get a nice view of the east and west sides of town. You will need to get through the Opry Mills parking lot and up to the Two Rivers Parkway exit off Briley Parkway to get to the greenway; it's close enough to walk but it will be a little bit of a hike from the hotel just because of the mall's acreage (http://www.greenwaysfornashville.org/directions.htm). There is also a really well-kept playground, a disc golf course, and a skate park at Two Rivers Park for any children and skate punks you happen to be travelling with: http://www.nashville.gov/Parks-and-Recreation/Parks/Two-Rivers-Park.aspx.

Yoga

One thing the Local Arrangements Committee will be arranging are yoga classes within the hotel. More details will be available closer to the conference.

Shopping

The resort has a number of shops within the hotel, offering children's items (Sunny G), ladies' clothing (Savannah's), jewelry (Alexander Kalifano), and some serious country wear (Cowboys and Angels). Additionally, you will be walking distance from Opry Mills, which sells pretty much everything else you could possibly imagine.

General Jackson

The resort is on the Cumberland River, and a short walk from the hotel will lead you to the General Jackson Showboat dock. The 300-foot paddlewheel riverboat cruises out on the river during the day and evening, and features live music shows and meals. See the website at http://www.generaljackson.com.

Nashville, Music City Itself

If you do choose to leave the Music Valley area, you'll be on the East side of the Cumberland River, and will most likely want to go west into town. You will be about 15 minutes from East Nashville and downtown (it would be a lot less if you could just zip across the river, but you have to go around), and about 25 minutes from Green Hills.

Weather

Nashville is rather temperate, and even around Thanksgiving daytime temperatures average in the high 50s (nighttime temperatures can go down into the high 30s, Fahrenheit). The problem is unpredictability. We usually don't get the winter coats out until later December, but you'll want to have at least a jacket, and you would be wise to bring an umbrella or other rain gear if you plan to leave the resort. As we like to say, pretending that Mark Twain didn't say it first about New England, "If you don't like the weather, just wait a few minutes and it will change."

Things to Do in Nashville

Sights include the Country Music Hall of Fame Museum, the Broadway/2nd Avenue Entertainment District, and a wide variety of historical sites. The latter includes the Hermitage, former home of Andrew Jackson, our 7th president, whose life was filled with tragedy, romance, and fairly serious anger management problems, as well as a number of Civil War locations. Check out this thorough website for more information (http://www.visitmusiccity.com); additionally, the local "alternative" paper, *Scene*, is a great resource for activities (http://www.nashvillescene.com).

Food. Nashville has made tremendous leaps in the last 10 years in terms of foodieness. In addition to some serious dinner spots in various parts of town (Catbird Seat, City House, Lockeland Table, Silly Goose, Firefly Grille), some excellent casual places (Sloco, Burger Up, Pharmacy, Urban Grub, Marche), some traditional favorites (Loveless Café, Arnold's Country Kitchen) and a booming food truck community (I recommend Deg Thai and any of the Mexican trucks along Nolensville Road), we have a unique local specialty: hot chicken. You should really try some hot chicken somewhere; although locals are bitterly divided over who has the best, Prince's usually wins and is the only place to be recognized by the James Beard Foundation.

Because the restaurant scene is fast-paced and prone to changing, we will provide a more elaborate and up-to-date restaurant guide at the conference. Come to the hospitality table for dining recommendations and specific details.

Also, when you are at the convention, the Opry Mills outlet mall has a huge number of low-priced chain food options, and is within walking distance from the hotel. Aquarium, Rainforest Café, Chili's, Chuy's, Moe's, and a wide array of fast food (Panda Express, Which Wich, Burger King) is also available.

***Music*: *Ryman Auditorium*.** The Ryman, or "The Mother Church of Country Music," was the home of the Grand Old Opry radio show for many years. It currently hosts a variety of exhibits and tours, as well as being an active music venue with spectacular acoustics and rather uncomfortable seating. Check the Ryman website for concert schedule (www.ryman.com).

Downtown. The main streets of downtown Nashville are lined with music venues. The Opryland Resort runs a shuttle downtown, where they own the Wildhorse Saloon, which is a pretty awesome place even if you don't like country music and are afraid to line dance—they offer graded exposure in the form of dance lessons—and from there you would have access to Tootsie's Orchid Lounge, Margaritaville, Cadillac Ranch, the Hard Rock Café, Robert's Western Wear, and the Paradise Park Trailer Resort (that last one's not for everybody…). A short distance from the main Broadway stretch is the Station Inn, known for bluegrass.

Not Downtown. The Bluebird Café may be one of the most famous music venues in town, which you would never suspect because it is located in a strip mall in Green Hills. However, it is *the* place to hear singer-songwriters. The 12 South area has several music locations (such as the Douglas Corner Café), as does East Nashville (Family Wash, Mad Donna's, the 5Spot).

And If You Aren't a Country Fan… The music scene is dominated by country and its various family members, but rock, blues, some jazz, and other forms of music are easily found. East Nashville in particular is much less about the country and more about the alternative. The weekend of ABCT is *also* the weekend that the superb Nashville Symphony is presenting Beethoven's *Eroica* at the Schermerhorn. I would recommend that you check this out if you have a chance and any interest in classical music at all, because they are really excellent (http://www.nashvillesymphony.org/tickets/calendar#November_2013).

Sightseeing. We have a number of types of tours, ranging from those focused on

country music to … well, others focused on country music. One tour that gets rave reviews (even from locals) is the Nash Trash Tour, involving an extremely pink bus and a lot of entertainment. Gray Line also offers a variety of bus tours, guiding you to homes of the stars as well as historic Nashville, and a Trolley Hop. There are also walking tours of downtown and Music Row.

Shopping. In addition to the shops at the hotel, there are various malls; Green Hills trends toward the upscale and chichi (Nordstrom's, Tiffany, Restoration Hardware) whereas Opry Mills is a great location for factory stores. Smaller enclaves of cool shops are in various parts of town (Hillsboro Village, 12 South); just ask us at the conference, and we will point you in the right direction.

Sports. In November, we have football, hockey, and college sports. Sadly, the Titans will be out of town that weekend. If you must have an in-person sports fix, the Predators will be in town playing the Rangers (http://predators.nhl.com/club/schedule.htm).

Saturday Night With ABCT

Your ABCT conference planners have come up with some excellent party options for Saturday night, so please plan to check them out! The evening will start at the Wildhorse Saloon, and of course from there you have access to all of downtown. Be sure to come by the party and give your dance moves a warmup. If you don't dance, watching those who do provides endless entertainment.

Committee

The 2013 Local Arrangements Committee wants to make your visit to Nashville as easy and enjoyable as we can. We will have a hospitality table near the ABCT registration area, and we want you to ask us anything at all. We are working on yoga options, a restaurant guide, and a list of activities (concerts, events) that will be available while you are here. The hospitality table will be open on Thursday, November 21; Friday, November 22; and Saturday, November 23. Please drop by and say "Hey, y'all"—but only if there are at least two of us there, right?

. . .

Correspondence to Kirsten L. Haman, 1500 21st Ave. S., Ste. 2200; Nashville, TN 37212; Kirsten.haman@vanderbilt.edu

ABCT ONLINE CE

Learning doesn't need to stop at the Convention! ABCT is proud to provide online Continuing Education (CE) webinars for psychologists and other mental health professionals. Our webinars can be attended live or viewed online at your convenience. The webinar series offers opportunities to learn about evidence-based treatments and latest research while earning CE credits from the comfort and convenience of your own home/office.

Watch Instantly www.abct.org

Resick | **CPT for PTSD**
Cognitive Processing Therapy for PTSD: Does Child Sexual or Physical Abuse Make a Difference?

Herbert | **ACT**
Acceptance and Commitment Therapy: A Radically Different yet Remarkably Familiar Approach to Behavior Change

Albano | **CBT for Adolescent Anxiety**
Adolescents, Anxiety and Development: A Family-Focused CBT Approach

Harvey | **CBT for Insomnia (CBT-I)**
Cognitive Behavioral Therapy for Insomnia and Transdiagnostic Sleep Problems in Clinical Practice

Tirch | **Compassion-Focused Therapy**
An Introduction to Compassion Focused Therapy

Brown | **CBT for Child Trauma**
CBT for Traumatized Youth: Components of Evidence-Based Practice

WEBINARS *Earn CE all year long!*

Upcoming Webinars

Friday, September 20, 2013
11:00 a.m. EST
Jeffrey E. Barnett, Psy.D., ABPP
Ethical, Legal, and Clinical Considerations in Behavioral Telehealth

Friday, December 13, 2013
11:00 a.m. EST
Alec Miller, Psy.D.
DBT With Adolescents: Research and Clinical Developments

Thursday, February 6, 2013
11:00 a.m. EST
Jonathan Abramowitz, Ph.D.
Exposure Therapy for OCD Symptom Dimensions

ABCT's webinars empower and support you to learn and train enduringly, from the comfort of home or office.

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ABCT

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47th Annual Convention
Register now! If you register by October 15, you will receive your program book in the mail.
https://www.abct.org/conv13

in-press article

United We Stand: Emphasizing Commonalities Across Cognitive-Behavioral Therapies
"Making appropriate behavioral responses may be the difference between life and death and between love and loss."
Mennin, Ellard, Fresco, & Gross
Behavior Therapy 44(2)
doi:10.1016/j.beth.2013.02.004

archive

"Now the raccoon really had problems (and so did we). Not only could he not let go of the coins, but he spent seconds, even minutes, rubbing them together (in a most miserly fashion), and dipping them into the container.... The rubbing behavior became worse and worse as time went on, in spite of reinforcement."
Breland & Breland, 1961
"The Misbehavior of Organisms"
http://psychclassics.yorku.ca/Breland/misbehavior.htm

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