Workshops

ABCT's workshops provide participants with up-to-date integration of theoretical, empirical, and clinical knowledge about specific issues or themes. Participants in these courses can earn 3 hours of continuing education credits per workshop.

Friday, 9:00 a.m. – 12:00 noon

Workshop 1

Working with Bipolar Disorder in Children and Adolescents: Clinical Presentation, Assessment Strategies, and Treatment

Eric Youngstrom, *University of North Carolina at Chapel Hill*

Melissa Jenkins, *University of North Carolina at Chapel Hill*

Moderate level of familiarity with the material

Until recently, bipolar disorder was rarely diagnosed in youths. The rate of diagnosis has exploded more than 40-fold in the last fifteen years, with “bipolar” becoming the most common diagnosis for psychiatrically hospitalized youths. There is concern that bipolar disorder is being over-diagnosed and over-medicated in children. Fortunately, there has been a surge of evidence about the validity of the bipolar diagnosis in youths, along with better evidence-based tools for assessment, diagnosis, and treatment. Key issues will be discussed, including: How bipolar disorder manifests clinically, how it appears similar or different in children versus adults, how to use specialized self-report and parent-report measures to aid in differential diagnosis, and how to use cognitive behavioral therapy (CBT) techniques to address the specific needs of children and adolescents dealing with bipolar disorder. Often challenging conventional wisdom will be presented. New evidence from NIMH grants that can be applied immediately in practice.

You will learn:

1. The similarities and differences between the typical presentation of bipolar disorder in children and the classic adult presentation
2. What assessment procedures are available to aid in differential diagnosis and measuring response to treatment, and what the evidence base is that supports them
3. Which symptoms and risk factors are helpful in recognizing bipolar disorder, and which may be “red herrings”
4. How often bipolar disorder might be occurring in children and adolescents in different settings, such as

public schools, outpatient services, forensic settings, and inpatient units
5. A framework for applying cognitive behavioral techniques with adolescents who have bipolar disorder, including specific techniques for use in session

Recommended Readings:

Kowatch, R. A., Fristad, M. A., Birmaher, B., Wagner, K. D., Findling, R. L., & Hellander, M. (2005). Treatment guidelines for children and adolescents with bipolar disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 44, 213-235.
Youngstrom, E. A. (2009). Definitional issues in bipolar disorder across the life cycle. Clinical Psychology: Science & Practice, 16, 140-160.
Youngstrom, E. A., Birmaher, B., & Findling, R. L. (2008). Pediatric bipolar disorder: Validity, phenomenology, and recommendations for diagnosis Bipolar Disorders, 10, 194-214.
Youngstrom, E.A., Freeman, A.J., & Jenkins, M.M. (2009). The assessment of bipolar disorder in children and adolescents. Psychiatric Clinics of North America, 18, 353-390.
Youngstrom, E., Van Meter, A., & Algorta, G. P. (2010). The Bipolar Spectrum: Myth or Reality? Current Psychiatry Reports, 12, 479-489. McKay, D., Abramowitz, J., Calamari, J., Kyrios, M., Radomsky, A., Sookman, D., Taylor, S., & Wilhelm, S. (2004). A critical evaluation of obsessive-compulsive disorder subtypes: symptoms versus mechanisms. *Clinical Psychology Review, 24*, 283-313.

Friday, 9:00 a.m. – 12:00 noon

Workshop 2

Enhancing Treatment Outcomes in Dialectical Behavior Therapy for Borderline Personality Disorder

Shireen Rizvi, *Rutgers University*

Advanced level of familiarity with the material

Dialectical Behavior Therapy (DBT) has become a widely used, evidence-based treatment model for individuals with borderline personality disorder (BPD) and other individuals with significant emotion dysregulation problems. Despite its strong empirical support, DBT obviously does not have positive outcomes for all individuals. Research studies on DBT indicate a drop-out rate of 15-30%. Moreover, many individuals continue to engage in severe, problematic behaviors following a year of treatment.

Taken together, these outcomes suggest that further efforts must be made to better understand and treat the core problems in BPD.

In this workshop, didactic material, clinical examples, and experiential learning exercises will be utilized to help audience members develop new methods for enhancing clinical outcomes in their own DBT practice. The DBT approach to the notion of "treatment failure" will be discussed as it informs this process. Analyses of possible reasons for treatment failure, as they apply to DBT cases broadly, will be offered. The importance of relevant outcome monitoring will be stressed and options for doing so will be introduced. Further, idiographic approaches to the assessment and reduction of persistent, treatment-resistant, severe behaviors will be offered. A focus on solutions for problems that arise within the context of DBT will be emphasized and ways to minimize these problems from re-occurring will be offered. This advanced workshop is designed for clinicians who have direct clinical experience conducting DBT with clients who meet criteria for borderline personality disorder.

You will learn:

1. The DBT stance on treatment failure
2. Methods for monitoring treatment outcome in DBT as a means of enhancing clinical outcomes
3. How to apply an idiographic treatment approach to overcome challenges and enhance treatment outcomes

Recommended Readings:

Linehan, M.M. (1993). Cognitive behavioral treatment of borderline personality disorder. New York: Guilford Press.

Rizvi, S.L. (in press). Treatment failure in Dialectical Behavior Therapy. Cognitive and Behavioral Practice.

Rizvi, S.L. (2011). The therapeutic relationship in Dialectical Behavior Therapy for suicidal individuals. In K. Michel and D. Jobes (Eds.), Building a therapeutic alliance with the suicidal patient. Washington, DC: American Psychological Association.

Friday, 9:00 a.m. – 12:00 noon

Workshop 3

Designing Contingency Management Interventions for Health Behaviors

Jeremiah Weinstock, *St. Louis University*

Carla Rash, *University of Connecticut Health Center*

Basic level of familiarity with the material

Contingency management (CM) is an effective behavioral intervention that provides tangible reinforcement when target behaviors are completed and objectively verified. A large body of literature supports the use of CM for treating substance use disorders (SUDs). For example, a recent meta-analysis of psychological treatments by Dutra et al. for SUDs found that contingency management had the largest effect size. Many applications of CM in treating SUDs focus on abstinence, providing vouchers (exchangeable for retail goods and services) or prizes when clients provide objective evidence of abstinence from drugs (e.g., urine samples). Contingency management has also been adapted successfully to reinforce other behaviors, including treatment attendance, medication adherence, treatment-related activities (e.g., submitting job applications, attending medical appointments), exercise, and therapeutic homework. Despite strong empirical support, CM has not been widely disseminated.

In this workshop the application of CM to promote positive behavior change in various health behaviors will be reviewed. Attendees will learn how to design and implement a CM program using guidelines that can be adapted to a variety of target behaviors. Specifically, we will describe 1) the theoretical underpinnings and supporting empirical literature, 2) different types of CM programs (i.e., voucher, prize), 3) effective design features, 4) common barriers to and problems with implementation, 5) how to calculate costs of a CM program, and 6) how to implement CM programs in individual and group settings.

You will learn:

1. How to select, monitor, and reinforce target behaviors in a CM intervention
2. How to distinguish between voucher- and prize-based CM
3. How to recognize effective features of CM reinforcement schedules
4. How to design and calculate costs for a prize-based contingency management intervention
5. How to implement CM in both individual and group settings

Recommended Readings:

Higgins, S.T., Silverman, K., & Heil, S.H. (Eds.). (2008). Contingency Management in Substance Abuse Treatment. New York, NY: Guilford Press.

Stitzer, M. & Petry, N. (2006). Contingency management for treatment of substance abuse. Annual Review of Clinical Psychology, 2, 411-434.

Friday, 9:00 a.m. – 12:00 noon

Workshop 4
Brief Management of Suicide Risk

Craig Bryan, *University of Texas Health Science Center*

Basic level of familiarity with the material

This training will focus on the development of core competencies specific to the assessment and management of suicidal patients within the rapid, high-volume context of primary care settings. This type of management could be applicable in many time-limited settings where suicide risk must be managed. The format of the workshop will include didactic instruction to develop a knowledge base in the science of suicidology and its direct application to time-limited settings, including explanation, discussion, and demonstration of empirically-supported approaches to risk assessment and intervention. Participants will receive documentation templates, handouts, and intervention tools that can be used in actual clinical practice.

You will learn:
1. How to efficiently and accurately screen for and assess suicide risk a time-limited, high-volume setting.
2. How to rapidly formulate risk based on assessment data to guide treatment and interventions.
3. How to use brief empirically-supported strategies and interventions to manage suicidal patients.

Recommended Readings:

Bryan, C.J., Corso, K.A., Neal-Walden, T.A., & Rudd, M.D. (2009). Managing suicide risk in primary care: practice recommendations for behavioral health consultants. Professional Psychology: Research and Practice, 40, 148-155.
Rudd, M.D., Cordero, L., & Bryan, C.J. (2009). What every psychologist should know about the FDA black box warning label for antidepressants. Professional Psychology: Research and Practice, 40, 321-326.
Bryan, C.J., & Rudd, M.D. (2010). Managing Suicidal Risk in Primary Care. New York: Springer.

Friday, 9:00 a.m. – 12:00 noon

Workshop 5

An Integrated CBT Approach for Anxiety and Depression Co-morbidity

Neil Rector, *University of Toronto*

John Riskind, *George Mason University*

Moderate level of familiarity with the material

Anxiety and depression are the most commonly comorbid conditions faced by clinicians. Such comorbidity presents complex challenges and require clinical practitioners to possess more sophisticated intervention skills in order to effectively treat the disorders. Previous approaches to comorbidity have included the targeting of one disorder while limiting the impact of secondary disorders or alternatively, treating the shared higher-order features of comorbid conditions. The approach outlined in this workshop will focus on a novel sequential strategy that emphasizes the treatment of different patterns of anxiety and depression comorbidity with existing disorder-specific empirically supported treatments. It will aim to provide clinicians delivering CBT in hospital and community practices hands-on clinically-oriented integrated CBT strategies for the assessment, conceptualization, and treatment of distinct mood and anxiety comorbidity patterns. Attention will be given to formulation-based approaches that outline the timing and sequencing of step-by-step strategies for treating different patterns of comorbidity. An integrated CBT perspective will be illustrated through didactic presentation, case examples and discussion, videotaped demonstrations, and a question and answer period.

You will learn:
1. How to formulate anxiety-depression comorbidity within an integrated CBT perspective
2. The nature and timing of specific strategies for the early, middle and late phases of treatment of different patterns of comorbidity
3. How to identify and overcome common challenges associated with treating anxiety-depression comorbidity

Recommended Readings:

Whisman, M. A. (2008). Adapting cognitive therapy for depression: Managing complexity and comorbidity (Ed.). New York, NY.: Guilford Press.

Friday, 1:30 p.m. – 4:30 p.m.

Workshop 6

Modern Cognitive Behavior Therapy

Stefan Hofmann, *Boston University*

Moderate level of familiarity with the material

Cognitive-behavioral therapy (CBT) is a simple, intuitive, and transparent model that has evolved into a mature and empirically-supported treatment approach. Although the core assumption of CBT remains the same — changes in cognitions causally predict changes in psychopathology — the specific treatment techniques have changed and will continue to change as basic research on psychopathology progresses. This workshop will provide an introduction to modern CBT for the most common mental health problems, including anxiety disorders, mood disorders, addiction, sexual dysfunctions, sleep problems, and pain disorders. In addition to traditional CBT techniques, such as exposure techniques and cognitive restructuring, a review of recent innovations will also be provided. Some of these innovative approaches include mindfulness, loving-kindness meditation, emotion regulation skills, and attention retraining exercises.

You will learn:
1. Psychological factors that maintain mental disorders.
2. How to identify these factors in individual patients.
3. How to implement these techniques in practice.

Recommended Readings:

Hofmann S. G. (2012). An Introduction to Modern CBT: Psychological Solutions to Mental Health Problems. Oxford, UK: Wiley-Blackwell.

Friday, 1:30 p.m. – 4:30 p.m.

Workshop 7
Assessment and Treatment of Late-Life Depression

Dimitris Kiosses, *Weill-Cornell Institute of Geriatric Psychiatry*

Jo Anne Sirey, *Weill-Cornell Institute of Geriatric Psychiatry*

Victoria Wilkins, *Weill-Cornell Institute of Geriatric Psychiatry*

Basic level of familiarity with the material

Late-life depression may contribute to detrimental consequences for patients and their families. It negatively affects quality of life, disrupts interpersonal relationships, and increases utilization of medical services, morbidity and mortality. Finally, late-life depression is the most common psychiatric diagnosis in attempted or completed suicides in older adults.

Despite its detrimental consequences, late-life depression is underdiagnosed and undertreated. Reasons for the underdiagnosis of late-life depression include: a) similarities of depression symptoms with those of medical illnesses; b) many depressed older adults do not report depressed mood but rather lack of interest or pleasure in activities; c) stigma; and d) aging stereotypes. Even when depression is diagnosed correctly, the psychotherapeutic treatment of late-life depression is complicated by disability, cognitive deficits, and medical burden.

As the elderly population significantly increases and as baby boomers start reaching age 65 in 2011 (a cohort that is associated with higher suicide rates than other cohorts), clinicians need to be prepared to meet the mental health needs of this population. This workshop will help clinicians and students assess depression in older adults, take into consideration the complexities of medical comorbidity, cognitive impairment, and disability, and highlight the challenges of applying cognitive behavioral approaches (including Cognitive Behavioral Therapy and Problem Solving Therapy) to late-life depression.

You will learn:

1. How to diagnose late-life depression in older adults and assess suicide ideation
2. How to apply cognitive behavioral approaches (including Problem Solving Therapy, Cognitive Behavioral Therapy) to the treatment of late-life depression, and especially in the presence of cognitive difficulties, disability, and medical illnesses
3. How to utilize caregiver participation in treatment
4. About the challenges of disseminating treatments in non-traditional settings where most of the older adults are or seek treatment

Recommended Readings:

Alexopoulos, G.S., Raue, P.J., Kiosses, D.N., Mackin, R.S.,, Kanellopoulos, D., McCulloch, C., Areán, P.A (2011). Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction: effect on disability. Archives of General Psychiatry, 68:33-41.

Kiosses, D.N, Arean, P.A., Teri, L., Alexopoulos, G.S. (2010) Home-delivered problem adaptation therapy (PATH) for depressed, cognitively impaired, disabled elders: A preliminary study.American Journal of Geriatric Psychiatry, 18:988-98.

Areán, P.A., Raue, P., Mackin, R.S., Kanellopoulos, D., McCulloch, C., Alexopoulos, G.S.

(2010). Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction. American Journal of Psychiatry, 167:1391-8. Epub 2010 Jun 1.

Friday, 1:30 p.m. – 4:30 p.m.

Workshop 8
Treating Narcissistic Personality Disorder: The Patient That We Like to Dislike

Arthur Freeman, *Midwestern University*

Moderate to Advanced level of familiarity with the material

Many patients have narcissistic characteristics including those with Narcissistic Personality Disorder (NPD). A belief in their invulnerability, superior intelligence, more clever schemes, and the need to be seen as better than others that has resulted in their multiple negative life experiences. These individuals are often among the most difficult in the therapist's caseload inasmuch as their problems are (1) pervasive, (2) persistent, (3) seen as a problem of others, and (4) comorbid depression and anxiety. They may require more time in therapy and greater therapist energy than other patients while making less progress or change. Although they may enter treatment for the treatment of depression or anxiety, the narcissist often does not see their situation as a result of their overvalued view of self.

Therapists sometimes “like to dislike” these patients, in that they frequently arouse intense negative therapist reactions. Often misunderstood or poorly conceptualized, narcissistic patients will be discussed through the lens of a Cognitive Behavioral (CBT) focus. The treatment must be short-term, focused, structured, skill-building or enhancing, and time-limited and perceived by the patient to be of value. This presentation will briefly review the theoretical, conceptual, and developmental issues in the etiology and treatment of NPD and proposed changes for DSM V.

Topics covered will include: assessment and diagnostic criteria; concomitant psychological problems; treatment planning using Freeman's Diagnostic Profile System; issues of non-compliance with therapeutic regimen; treatment success and failure, and therapist response. In addition, various “types” of narcissistic style and character will be discussed.

You will learn:

1. How to identify and describe the steps required to develop a CB treatment conceptualization for treating patients with NPD
2. How to use the Diagnostic Profiling System (DPS) to gather data and direct the therapy plan

3. How to define four areas of impediment to therapeutic progress

4. How to describe the rationale for using cognitive/affective and behavioral/environmental interventions

5. How to identify five cognitive interventions for treating patients with NPD

6. How to identify five behavioral interventions for treating patients NPD

Recommended Readings:

Beck, A. T., Freeman, A., Davis, D. D. and Associates (2004). Cognitive therapy of personality disorders. New York: Guilford.

Friday, 1:30 p.m. – 4:30 p.m.

Workshop 9

Civil Commitment: Ethical Breach or Prudent Care?

Wayne Bowers, *University of Iowa*

Arnold Anderson, *University of Iowa*

Janeta Tansey, *University of Iowa*

Basic level of familiarity with the material

Eating disorders (anorexia nervosa, bulimia nervosa) pose a particular challenge for medicine, ethics and human rights. Individuals with anorexia nervosa often refuse treatment for the disorder with a subset of individuals vehemently rejecting medical and/or psychological therapy. Rejection of intervention creates a potential dilemma for practitioners on how best to address the refusal and what steps to take to maintain the health and well-being of the individual. This workshop with look at the basic outline of commitment laws, address the ethical implications of involuntary treatment, and make recommendations about decisions making related to involuntary treatment.

You will learn:
1. A basic understanding of civil commitment law
2. The bioethics of civil commitment
3. Treatment issues related to civil commitment

Recommended Readings:

Carney, T. (2009) Anorexia: A Role for Law in Therapy, Psychiatry, Psychology and Law, 16, 41-59.
Goldner, E. (1989) Treatment refusal in anorexia nervosas, International Journal of Eating Disorder, 8, 297-306

Friday, 1:30 p.m. – 4:30 p.m.

Workshop 10

Facilitating the Development of Emotion Regulation Skills for Youth with Autism Spectrum Disorders: Focusing on Therapy Readiness and CBT Interventions

Shana Nichols, *ASPIRE Center for Learning and Development*

Samara Tetenbaum, *ASPIRE Center for Learning and Development*

Basic level of familiarity with the material

Youth with autism spectrum disorders (ASDs) often experience social and emotional difficulties that can lead to significant mental health issues including impaired self esteem, stress, anxiety and depression, post-traumatic symptoms and difficulties managing frustration and anger. It is these symptoms that lead youth with ASDs to frequently present for psychotherapy. These youth tend to be bright and highly verbal, and would therefore be expected to be able to play an active role in the therapy process. Expectations include being able to use behavioral as well as cognitively mediated strategies. However, given the nature of the impairments associated with ASDs, taking part in therapy can be challenging. Basic emotion identification and understanding are pre-requisite skills for cognitive-behavioral therapy (CBT), as is being able to think about thinking. With neurotypical youth of an appropriate developmental age, it is assumed that they possess the underlying skills necessary to begin CBT (e.g., can identify own and others' emotions, can label thoughts). With youth with ASDs, the discrepancy between ability and requisite skill often necessitates teaching these skills to increase "therapy readiness" and adaptation of treatment strategies.

Specific ways to adapt CBT for youth with ASDs will be presented. Video and case material will be used to demonstrate how to engage youth with ASDs in counseling, how to teach pre-requisite skills for therapy, and how the key components of cognitive behavioral therapy CBT may be adapted for use with learners with ASDs.

You will learn:

1. How the core deficits of ASDs pose challenges for emotion understanding and regulation and why such youth frequently present for therapy
2. Therapeutic approaches for teaching the pre-requisite skills needed for individuals with ASDs to successfully participate in CBT
3. Effective strategies for engaging youth with ASDs in CBT and tailoring therapy to meet individual needs

Recommended Readings:

Brookman-Frazee, L., Taylor, R. & Garland, F. (2010). Characterizing community-based mental health services for children with autism spectrum disorders and disruptive behavior problems. Journal of Autism and Developmental Disabilities, 40, 1188-1201.

Reaven, J., Blakely-Smith, A., Nichols, S., Flanigan, E., & Hepburn, S. (2008) Cognitive-behavioral group treatment for anxiety symptoms in children with high-functioning autism spectrum disorders: A pilot study. Focus on Autism and Other Developmental Disabilities, 24, 27-37.

Wood, J. J., Drahota, A., Sze, K., Har, K., Chiu, A., & Langer, D. A. (2009). Cognitive behavioral therapy for anxiety in children with autism spectrum disorders: A randomized, controlled trial. Journal of Child Psychology and Psychiatry, 50 (3), 224-234.

Saturday, 9:00 a.m. – 12:00 noon

Workshop 11

Interpersonal Psychotherapy for Depressed Adolescents: Techniques and Implementation

Laura Mufson, *Columbia University*

Jami Young, *Rutgers University*

Basic level of familiarity with the material

Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) has been demonstrated to be an efficacious treatment for adolescent depression in several clinical trials and is delineated in a published treatment manual. IPT-A was adapted from the adult model of IPT and similarly is based on the premise

that depression, regardless of its etiology, occurs in an interpersonal context. Treatment focuses on the patients' depressive symptoms and current interpersonal difficulties that may be contributing to or exacerbating their depression. The therapist helps the adolescents identify and label feelings, learn ways to express these feelings, and identify the interpersonal events or interactions that trigger these feelings so that they can identify when they need to communicate more effectively to improve their relationships. This improved communication is postulated to lead to improvements in the adolescents' mood. The workshop will provide participants with an overview of IPT-A, training in key IPT-A techniques, and a discussion of how IPT-A has been adapted for use in school-based mental health clinics and as a group treatment. Despite the documented efficacy of IPT and IPT-A, many clinicians are not familiar with this treatment approach. This workshop will introduce participants to the basic principles and techniques of IPT-A so that clinicians and researchers can consider utilizing this treatment in their own settings

You will learn:

1. Key techniques of IPT-A
2. How IPT-A has been modified to be used in different settings and modalities (e.g., school-based clinics, group, prevention)
3. How one might utilize IPT-A in your own clinical and/or research settings

Recommended Readings:

Mufson, L. Dorta K.P., Moreau D., Weissman, MM. (2004). Interpersonal psychotherapy for depressed adolescents (2nd Edition). New York: Guilford Publications.

Young J. and Mufson, L. (2008). Interpersonal psychotherapy and prevention. In John R.Z. Abela and Benjamin L. Hankin (Eds.) Handbook of depression in children & adolescents (pp. 288-308). New York: Guilford Publications.

Baerg-Hall, E. and Mufson, L. (2009). Interpersonal psychotherapy for depressed adolescents (IPT-A): A case illustration. Journal of Clinical Child and Adolescent Psychology, 38, 582-593.

Saturday, 9:00 a.m. – 12:00 noon

Workshop 12

Acceptance and Change in Couple Therapy: Integrative Behavioral Couple Therapy

Andrew Christensen, *UCLA*

Moderate level of familiarity with the material

In an effort to improve the outcome of couples therapy, Andrew Christensen of UCLA and the late Neil Jacobson of the University of Washington developed Integrative Behavioral Couples Therapy (IBCT), which integrates strategies for promoting acceptance in couples with the traditional behavioral strategies for promoting change in couples. "Acceptance work" focuses on turning problems into vehicles for promoting intimacy and increasing couples' tolerance for what they see as each other's negative behavior. As couples let go of the struggle to change one another, change often occurs in response to natural contingencies. Several clinical trials have demonstrated the efficacy of IBCT. The most recent study showed that IBCT led to significantly greater improvement in couple satisfaction than traditional behavioral couple therapy for two years post treatment. IBCT has recently been adopted by the Veteran's Administration as one of their empirically supported treatments; extensive efforts to train VA therapists in IBCT are underway.
In this workshop, the theoretical foundation of IBCT and provide an overview of the assessment methods, clinical formulation, feedback session, and treatment strategies of IBCT will be outlined. Treatment strategies will be illustrated with video clips from treatment sessions of couples in one of the outcome studies or in Christensen's own work with couples. The results of the latest clinical trial of IBCT will also be briefly presented.

You will learn:
1. The theoretical and empirical basis for IBCT
2. The assessment methods, clinical formulation, and feedback techniques in IBCT
3. The treatment strategies of IBCT

Recommended Readings:

Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital Status and Satisfaction Five Years Following a Randomized Clinical Trial Comparing Traditional Versus Integrative Behavioral Couple Therapy. Journal of Consulting and Clinical Psychology, 78, 225-235.
Christensen, A. & Jacobson, N. S. (2000). Reconcilable differences. New York: Guilford.
Jacobson, N. S. & Christensen, A. (1996). Acceptance and change in couple therapy: A therapist's guide to transforming relationships. New York: Norton.

Saturday, 9:00 a.m. – 12:00 noon

Workshop 13

Psychotherapy for the Interrupted Life: An Evidence-Based Treatment for Adult Survivors of Childhood Abuse

Tamar Gordon, New York *University*

Christie Jackson, New York *University*

Susan Trachtenberg Paula, *Martha K. Selig Institute*

Marylene Cloitre, New York *University*

Moderate level of familiarity with the material

This workshop will present Marylene Cloitre's Skills Training in Affective and Interpersonal Regulation/Narrative Story Telling (STAIR/NST), a type of cognitive-behavior therapy specifically developed for individuals with complex PTSD. Participants will learn and practice new interventions for teaching skills that are often particularly comprised in individuals with multiple traumas, notably difficulties with emotional and interpersonal functioning. Training will also include the use of exposure therapy for treating PTSD in this population, and ways in which exposure may differ when dealing with complex trauma versus single-incident traumas, such as a motor vehicle accident. A basic familiarity with the impact of trauma on functioning is recommended, as well as knowledge of CBT. Teaching modalities will include powerpoint, video-clips, role-plays and other experiential exercises, as well as case presentations.

You will learn:

1. The theoretical foundations and research supporting an evidence-based treatment for complex PTSD
2. Trauma-sensitive techniques for improving clients' emotion regulation and interpersonal skills
3. How to integrate schema formulations into exposure therapy to treat complex PTSD

Recommended Readings: Cloitre, M., Cohen, L.R., & Koenen, K.C. (2006). Treating survivors of childhood abuse: Psychotherapy for the interrupted life. Guilford Press, New York, NY.

Cloitre, M., Stovall-McClough, K.C., Nooner, K., Zorbas, P., Cherry, S., Jackson, C.,Petkova, E. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. American Journal of Psychiatry, 167, 915-924.

Jackson, C., Cloitre, M., & Nissenson, K. (2009). Cognitive behavioral treatment of complex traumatic stress disorders. In C. A. Courtois, & J. D. Ford (Eds.). Complex Traumatic Stress Disorders: An Evidence-Based Clinician's Guide. New York: Guilford Press.

Saturday, 9:00 a.m. – 12:00 noon

Workshop 14

Silence to Sound: Understanding and Implementing a Treatment Approach for Selective Mutism

Sandra Mendlowitz, *University of Toronto*

Suneeta Monga, *University of Toronto*

Moderate level of familiarity with the material

Selective Mutism (SM) is a psychiatric condition where children are capable of speech but are reluctant to speak in a number of social situations outside the home; most commonly at school. The reluctance to speak with teachers, and peers causes interference in academic and social functioning. SM usually begins in the preschool years with an insidious onset. Although most parents report their child as always shy and quiet, the average age of referral and diagnosis usually does not occur until the child reaches kindergarten or grade one where verbal skills are expected. SM is a complex disorder from both etiological and treatment perspectives; it is clear that a number of factors play a role in the inhibition of speech. SM is still poorly recognized and to date there is no definitive treatment approach for this condition(1). While the assumption that SM is a variant of social anxiety precipitated a move towards using similar evidence-based interventions for other anxiety disorders, they do not always respond in a similar manner to CBT interventions, with many more cases treatment resistant. Key assessment guidelines will be presented to help the clinician recognize and diagnose SM in children and adolescents. Various treatment approaches for children with SM will be presented including: psycho-education, CBT, school interventions, pharmacotherapy. Effective CBT strategies as well as modifications to CBT in combination with speech language therapy strategies can be effectively utilized to help support the SM child in developing speech with other people outside of the home environment.

You will learn:

1. How to understand the importance of recognition, key assessment tools and diagnosis in the treatment of Selective Mutism.
2. How to develop a Cognitive Behavioural Therapy approach.
3. How to recognize the importance of incorporating other treatment approaches including psycho-

education, school interventions and pharmacotherapy.

Recommended Readings:

Mendlowitz S, Monga S, (2007), Unlocking Speech Where There is None: Practical Approaches to Treatment of Selective Mutism, The Behavior Therapist Advances in Innovative Interventions for Anxious Youths Series 30(1):11-15.
AACAP (2007) Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders J Am Acad Child Adolesc Psychiatry 46:267-283.. Practice Parameters on Anxiety

Saturday, 9:00 a.m. – 12:00 noon

Workshop 15

Empirically based CBT Supervision: Making Supervision More Effective

Robert Reiser, *Palo Alto University*

Donna Sudak, *Drexel University*

Derek Milne, *Newcastle University*

Moderate level of familiarity with the material

What makes supervisors highly effective? What are some key differences observed in supervisor behaviors that are indicative of high levels of competence or best practices? What enhancements to supervision such as use of multiple learning modalities (symbolic, iconic and enactive methods) or an emphasis on behavioral experiments and experiential learning (role play, rehearsal and modeling of interventions) are particularly effective? This workshop will identify enhancements to CBT supervision based on a review of best practices and empirical evidence in the literature. A combination of didactic, observational (video and role-play) and experiential methods will be utilized and participants will have opportunities to practice key skills.
Cognitive behavioral therapy (CBT) has developed from a strong scientific tradition of prizing empirically-supported treatments and adhering carefully to techniques with a strong underpinning of research and science. Over 325 extant studies have supported the use of CBT with a range of populations and disorders. Unfortunately, the same rigorous scientific tradition has not been applied to developing our knowledge base and practice in assessing competence in CBT supervision. In a review published in 2006, Armstrong & Freeman indicate that “the base for efficacy [of CBT supervision] is very limited” (p. 349) and can be contrasted sharply with the strong evidence base for cognitive therapy. Most of what we know about best practices in CBT supervision has been summarized in two seminal works written over 10 years ago and in a recently updated review of CBT supervision (Padesky, 1996; Liese & Beck, 1997; Newman, 2010).

You will learn:
1. Specific techniques and strategies for making CBT supervision more effective
2. Appreciation for the evidence-base for making supervision more effective
3. How to recognize the need for modifications of supervision in the 'real world' within diverse community-based organizations serving multi-problem clients

Recommended Readings:

Beck. J., Sarnat, J.E., Barenstein,V. (2008). Psychotherapy-based approaches to supervision. In: Falender, C., & Shafranske, E. (Eds.), Casebook for clinical supervision- A competency-based approach. Washington, DC: American Psychological Association.
Liese, B.S. and Beck, J.S. (1997). Cognitive therapy supervision. In: Watkins, E. (Ed.): Handbook of Psychotherapy Supervision. NY: Wiley.
Milne, D.L.(2008). Evidence-based Clinical Supervision. Chichester: Wiley/Blackwell.
Newman, C.F. (2010). Competency in conducting cognitive–behavioural therapy: foundational, functional, and supervisory aspects. Psychotherapy Theory, Research, Practice, Training, 47, 12-19.

Saturday, 1:30 p.m. – 4:30 p.m.

Workshop 16

Exposure Therapy for Anxiety: Basics and Beyond

Jonathan Abramowitz, *University of North Carolina at Chapel Hill*

Brett Deacon, *University of Wyoming*

Stephen Whiteside, *Mayo Clinic*

Moderate level of familiarity with the material

Anxiety disorders are prevalent, chronic, and disabling. Patients with these disorders and with anxiety symptoms in the context of other disorders comprise a large proportion of many therapists' caseloads. Providing high quality evidence-based treatment requires expertise in the use of exposure procedures. This workshop is designed for participants to learn how to use exposure therapy—the intervention most associated with strong treatment outcomes for anxiety disorders. After reviewing the cognitive-behavioral model of anxiety, functional analysis, and rationale for exposure, the bulk of the workshop will focus on how to apply exposure techniques (situational, in vivo, interoceptive) to help patients manage a wide array of problems with pathological fear and anxiety, such as phobias, obsessions and compulsions, panic attacks and agoraphobia, posttraumatic stress symptoms, and social anxiety. Numerous case examples and video clips of recorded therapy sessions will be used to illustrate principles and practices associated with the optimal delivery of this intervention. Audience participation will be incorporated throughout the presentation to develop participants' ability to design therapeutic exposure exercises. Common pitfalls in treatment planning and implementing exposure therapy will be discussed, such as failure to provide an

adequate treatment rationale, patient noncompliance with treatment instructions, and extreme anxiety during exposure. The workshop will also cover how to apply exposure to more complicated cases such as working with children, patients on medication, and co-occurring anxiety or other disorders. Ethical issues in the use of exposure will also be discussed.

You will learn:

1. How to develop exposure therapy treatment plans for various anxiety disorders
2. How to implement situational, imaginal, and interoceptive exposure techniques
3. How to address common obstacles in the use of exposure therapy
4. The various ethical issues involved with using exposure

Recommended Readings:

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2011). Exposure therapy for anxiety: Principles and practice. New York: Guilford.

Saturday, 1:30 p.m. – 4:30 p.m.

Workshop 17

Regulation of Cues for Childhood Overeating: The Regulation Of Cues Intervention

Kerry Boutelle, *University of California, San Diego*

Basic level of familiarity with the material

Overweight and obese children may benefit from treatments targeting overeating, to ultimately influence obesity status. The externality theory of obesity suggests that obese humans are more reactive to external cues to eat (time, presence and quality of food, situational effects) and less sensitive to internal hunger and satiety signals than their lean counterparts. The Regulation of Cues (ROC) treatment targets both internal cues of hunger and satiety, and external cues to overeat, for overweight and obese children. ROC is based on two empirically-tested treatments designed to address these challenges for overweight and obese people; Appetite Awareness Training and Cue Exposure Treatment. Appetite Awareness Training focuses on improving sensitivity to hunger and satiety cues and Cue Exposure Treatment aims to reduce sensitivity to external cues (i.e the sight or smell of food). This workshop will provide practical, step-by-step training in how to deliver the ROC program, facilitate communication and parenting skills, and engage child participants. Two studies demonstrating the efficacy of these interventions with overweight and obese children will be presented, as well as feasibility and acceptability data. Workshop will incorporate clinical case material based on empirical trials and clinical experience.

You will learn:

1. About risk factors for obesity and eating in the absence of hunger in youth, including internal cues for

satiety and hunger
2. How to help families learn core ROC skills to reduce overeating, to ultimately influence obesity
3. How to deliver and adapt this type of intervention in clinical settings

Saturday, 1:30 p.m. – 4:30 p.m.

Workshop 18

New Thinking in Treatment Resistant Depression: Targeting Emotional Over-Control

Thomas Lynch, *University of Exeter*

Moderate level of familiarity with the material

An estimated 40–60% of unipolar depressed patients meet criteria for comorbid personality disorder (PD), with even higher rates among those with chronic or treatment resistant depression (TRD). The most common PDs among depressed individuals are Cluster-A (paranoid PD) and Cluster C (obsessive-compulsive and avoidant PD) — precisely those that respond less favorably to evidenced-based depression treatments. Compared with non-chronic major depressive disorder (MDD), chronically depressed individuals show greater self-criticism, impaired autonomy, rigid internalized expectations, excessive control of spontaneous emotion, and inordinate fears of making mistakes. Chronically depressed are rated more hostile and less 'friendly' than the acutely depressed. Based in part on findings from three pilot randomized controlled trials of dialectical behaviour therapy for TRD; this workshop will outline new approaches that target common problems in TRD and chronic depression, including over-control, rigidity, interpersonal aloofness, emotion inhibition and perfectionism.
Unlike standard DBT, developed primarily for use with dramatic-erratic, under-controlled and impulsive disorders (e.g. BPD); this new adaptation is informed by a biosocial theory that posits a biological predisposition to heightened threat sensitivity and diminished reward sensitivity, coupled with childhood invalidation emphasizing that "mistakes are intolerable" and that the child is "special" or "should be better" compared to their peers; results in an emotionally over-controlled coping style that limits opportunities to learn new skills and exploit positive social reinforcers. This workshop will review the major treatment adaptations of this new approach using role play and videotape case illustrations.

You will learn:
1. New DBT Radical Openness skills useful for treating TRD and emotionally over-controlled and risk-averse personality styles.

2. New strategies to maximize treatment engagement and identify new DBT treatment targets for working with aloof, distant, perfectionistic, and emotionally constricted individuals.
3. Loving-kindness forgiveness interventions and other methods designed to alter neuroregulatory responses by directly activating the parasympathetic nervous system.

Recommended Readings:

Lynch, T.R., Morse, J.Q., Mendelson, T., & Robins, C.J. (2003). Dialectical Behavior Therapy for depressed older adults: A randomized pilot study. The American Journal of Geriatric Psychiatry, 11, 1-13.
Lynch, T.R., Cheavens J.S., Cukrowicz K.C., et al. (2007). Treatment of older adults with co-morbid personality disorder and depression: A Dialectical Behavior Therapy approach. International Journal of Geriatric Psychiatry, 22, 131-143.
Lynch, T. R., & Cheavens, J.S. (2008). Dialectical behavior therapy for co-morbid personality disorders. Journal of Clinical Psychology, 64, 1- 14.

Saturday, 1:30 p.m. – 4:30 p.m.

Workshop 19

Paradigms for Disseminating Contextual Cognitive Behavioral Therapy Strategies

Patricia Robinson, *Mountainview Consulting Group, Inc.*

Moderate to Advanced level of familiarity with the material

Increasingly, behavioral health clinicians are beginning to practice in novel settings, such as primary care clinics and schools. The ability to apply powerful behavior change strategies in brief interactions with patients is critical to success in these new settings. This change challenges behavioral health clinicians to think through the requirements for optimal dissemination. What are the key ingredients to making contextual cognitive behavioral therapies, such as Acceptance and Commitment Therapy, transparent to new colleagues, such as physicians and nurses? What models encourage medical and other colleagues (1) to support behavior change strategies initiated by behavioral health clinicians and (2) to apply these strategies with patients who may never see a behavioral health clinician. This workshop suggests specific assessment and intervention strategies for using core processes supportive of psychological flexibility in

primary care and other brief intervention settings. Additionally, the workshop provides an introduction to Focused Acceptance and Commitment Therapy (FACT).

You will learn:

1. Strategies for disseminating contextual cognitive behavioral strategies to brief treatment settings
2. Case conceptualization and intervention methods for ACT in primary care settings
3. Fundamentals of Focused Acceptance and Commitment Therapy (FACT)

Recommended Readings:

Robinson, P. & Reiter (2007). Behavioral consultation and primary care: A guide to integrating services. NY: Springer.

Robinson, P., Gould, D., & Strosahl (2011). Real behavior change in primary care: Improving patient outcomes and improving job satisfaction. Oakland, CA: New Harbinger.

Strosahl, K. D., Gustavsson, T., & Robinson, P. J. (in press). Change now: Using focused acceptance and commitment therapy. Oakland, CA: New Harbinger.

Saturday, 1:30 p.m. – 4:30 p.m.

Workshop 20

Introduction to Cognitive Behavioral Therapy for Insomnia

Michael Perlis, *University of Pennsylvania*

Donn Posner, *Brown University*

Robert Meyers, *St. John's University*

Basic level of familiarity with the material

This workshop will provide an overview regarding the principles and practice of Cognitive Behavioral Therapy for Insomnia (CBT-I) which will be comprised of three components: A didactic (lecture overview); A case series review; and "2 chair" session directed at modeling difficult patient-therapist exchanges.

Generally, insomnia is defined as difficulties in initiating/maintaining a state of sleep or the inability to

receive qualitatively restorative sleep even when 'in bed' for a sufficient number of hours. CBT-I has been shown to be as efficacious and effective as sedative hypnotics during acute treatment (4-8 weeks), and more efficacious in the long term (following treatment discontinuation).
CBT-I consists of 6-8 weeks of therapy using a multi-component treatment approach based upon four essential components: Sleep Restriction Therapy, Stimulus Control Instruction, Sleep Hygiene guidelines, and Cognitive Therapy. This therapy has been "codified" in three separate manuals (Morin & Espie [2003], E Perlis, et al. [2005], Edinger & Carney [2008]).

The presenters will provide a review of the evidence-based research and treatment protocols, a look at the clinical practice of the treatment of insomnia, an in-depth case review and conclude with an interactive demonstration with attendees participating in aspects of the treatment protocol.

You will learn:

1. How to define insomnia according to ICSD-2, RDC and DSM criteria
2. How to recognize the basic biological and behavioral components of sleep structure
3. How to evaluate the issues involving the clinical course of insomnia
4. How to identify and explain the major theories related to etiology and pathophysiology of insomnia

Recommended Readings:

Edinger, J.D., Carney, C.C. (2008). Overcoming insomnia: A cognitive-behavioral therapy approach. New York: Oxford Press
Morin, CM, Espie, CA. (2004). Insomnia: A clinical guide to assessment and treatment. Morin, CM, Espie, CA., eds. New York: Springer
Perlis M.L., Jungquist C., Smith M.T., & Posner D. (2005). Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide. New York: Springer

Saturday, 1:30 p.m. – 4:30 p.m.

Workshop 21

Difficult to Treat? Not Anymore! Cognitive Therapy for OCD

Adam Radomsky, *Concordia University*

Moderate level of familiarity with the material

Obsessive-compulsive disorder (OCD) is a heterogeneous disorder; common symptoms include washing and checking behavior, as well as primary obsessions (i.e., repugnant, unwanted, intrusive thoughts, images and impulses). There has been a surge in recent research on each of these forms of OCD, with publications often based solidly in a variety of cognitively-based models. Although these models differ to some extent in their explanation of obsessional and compulsive phenomena, they share a number of important features that are consistent with broad cognitive principles. These have enabled a new, primarily cognitive conceptualization of contamination-based OCD, the assessment and treatment of which will be a main focus of this workshop. We will begin with a review of the theoretical and empirical work conducted on the psychopathology and treatment of different manifestations of OCD. The workshop will continue with practical instruction on the cognitive-behavioural assessment and treatment of a variety of forms of the disorder, with particular emphasis on obsessions, compulsive checking, and contamination-based OCD (mental contamination). Attendees will learn about cognitive case formulation, the importance of ongoing assessment, and specific therapeutic interventions, all following from cognitive-behavioural models of OCD. Although OCD remains a serious and often debilitating disorder, our ability to substantially improve the lives of those suffering from the problem has dramatically increased in recent years. This workshop will capitalize on these recent improvements through the emphasis of new cognitive and behavioural treatment strategies for this challenging disorder.

You will learn:

1. Information about the cognitive model of OCD and its effectiveness
2. How to assess and conceptualize OCD using a cognitive formulation
3. How to use behavioural experiments and other cognitive-behavioural techniques to successfully treat individuals suffering from various forms of OCD

Recommended Readings:

Radomsky, A.S., Shafran, R., Coughtrey, A.E., & Rachman, S. (2010). Cognitive-behavior therapy for compulsive checking in OCD. Cognitive and Behavioral Practice, 17(2), 119-131.

Rachman, S. (2003). The treatment of obsessions. NY: Oxford University Press.