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THE CLINICAL PSYCHOLOGIST

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President Column

Giving Thanks

Donna LaPaglia, PsyD, ABPP

As I reflect on the past year for SCP, 2024 proved to be an amazing year with just the right confluence of factors--collective input from membership, innovative initiatives, and consistent effort aligning to produce positive growth and beauty within our community.

SCP has grown in all membership categories, with the largest increases seen in *early career* and student membership. This is something to be excited about! Our strategic plan prioritized increasing the SCP community with new and diverse members and our SCP conference further focused on building community and creating opportunities to gather and learn from one another.

SCP also focused on a few firsts—this was year one of the strategic plan, the first SCP conference, and the LEAD program. In addition, the revised bylaws passed and our policy and procedure manual is under revision. All this work is the result of past efforts by so many of our colleagues who have invested time and care in our division, whose investments over time continue to guide and fortify our priorities for the future. In addition to the technical workings of SCP the true force behind the work is the dedicated and talented people that carry the spirit of SCP forward and I feel lucky to have served along side you this year.

I need to thank all those who contributed and served on behalf of SCP. The list is long and it includes our current officers (Jordan Wright, Kim Penberthy, Paul Arbisi, Damion Grasso); our council reps (Helen Coons, Lynn Collins Nancy Sidun, Randy Salekin); and Member at Large

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Vivianna Padilla Martinez; our section reps Clinical Geropsychology (2)-Amy Fiske, Science and Practice (3)-Sue Raffa, Psychology of Women (4)-Elaine Burke, Emergencies and Crises (7)- Marc Hillbrand, Association of Psychologists in Academic Health Centers (8)-Joanna Yost, Assessment Psychology (9)-Paul Ingram, Graduate Students and Early Career (10)- Jill Morris. It also includes the editor of our journal Art Nezu, the editor of our newsletter Lily Brown; Associate Editor Yiquin Zhu, and our website editor Matt Southward. And the chairs of our committees-(Membership, Finance, Awards, Science and Practice, Education and Training, CE, Mentorship, Publications, Elections, and Diversity). I also had the pleasure of working first hand with our section Presidents of 2,3,4,6,7,8,9, and 10. And a major shout out to Tara Craighead, our executive director who works tirelessly on behalf of SCP, linking our past and present in the service of our collective future!

And of note--many of the individuals listed above actually served in multiple capacities rolling up their sleeves and doing whatever needed to be done. They are the best team ever!

As a mostly volunteer organization, it takes commitment to carry forth the mission, as well as new leaders to step up and serve—please consider joining us. And with that I welcome our incoming president for 2025-Jordan Wright!

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SMART Goals, Directionless Therapy?

Stephen M. Lange[1], PhD, HSP

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Abstract

The goals of this paper are to introduce the reader to Goal-Setting Theory and to highlight how goal-setting is an often-neglected element in psychotherapy. The paper suggests that goal-setting can be a creative, collaborative, and important early task in psychotherapy.

Keywords: Psychotherapy, Goal-setting

I started working in mental health in May 1983. During the second half of my career, I have reviewed numerous charts of psychotherapy patients. This professional work has included reviewing charts for process improvement and compliance, as well as for completing psychological evaluations that include chart reviews. In both roles, I am always struck by how a significant opportunity for patient growth is overlooked: The creative, collaborative act of goal-setting. I frequently read treatment plans with goals that do not seem individualized, relevant, or to have been developed through therapist-patient collaboration. Sometimes, goals from a given facility or agency are repeated across multiple patient charts and are selected by pointing and clicking in a computerized treatment plan generator or electronic medical record. This reduces goal-setting to clerical task.

To illustrate the point, I am going to tell a couple of anecdotes, with identifying information edited to preserve anonymity.

Clinical Anecdote One

I completed a psychological evaluation for a 17-year-old male who was receiving in-home psychotherapy and applied behavioral analysis deep in the US heartland. This high and costly level of service required psychological evaluations every six months to determine readiness for stepping down to a less intensive service or the need to continue the current level of treatment for another six months. The patient was an intelligent, shy, but friendly older adolesecent. His mental health diagnosis was Obsessive-Compulsive Disorder (OCD). He was sensitive and reacted to bullying; in fact, he had been a target of bullying at his local high school. To avoid litigation, his school had agreed with his parents' request that he complete his senior year of high school at the local community college. He drove himself there daily. He was not bullied there but he did not form friendships either. Reading his chart, the notes gave the impression that he was making some progress, but not enough progress to be discharged to a lower level of care. The message was clear: Continue services as presently billed and delivered. But progress toward what goals? His treatment plan listed his goals as complying with his parents' rules without defiance and attending school daily. These were goals frequently found in this agency's treatment plans because most patients it served met criteria for disruptive behavior disorders. Few were anxious or depressed without also being hyperactive and impulsive, or oppositional. I asked this young man if he was attending school daily, and of course the answer was "yes." I asked the patient and his mother whether he cooperated with house rules and parental directions, and of course the answer was "yes." Success! He met his two goals! Time to celebrate and discharge this young man. Of course, I am being facetious. And of course, the goals were cut and pasted.

When I asked this patient about how his OCD affected his life, he shared that he had intrusive obsessions about contamination from germs and that this prevented him from going places where he had little control over the environment. He could repetitively clean at home, but could not for example, at a restaurant or movie theater. I asked him if he ever dated, and he blushed. He said that he wanted a girlfriend but did not think that this could be possible. I asked whether this was because of his fear of potentially germ-ridden public spaces, social anxiety, or something else and we ended up talking about how hard it is to make out with someone if you fear their germs. Goals must be individualized and relevant. Relevant goals are those that are related to the patient's diagnosis, developmental expectations, and most importantly to the patient's quality of life. He and I developed goal statements around his ability to go places other than school and home, his ability to form friendships, and his love life. These made it into the recommendation section of his evaluation report. He was agreeable to switching to outpatient mental health treatment, even though that meant going to someone's possibly contaminated office.

Clinical Anecdote Two

I read a computer-generated treatment plan of an early adolescent girl discharging from an acute inpatient mental

health unit. Her goals were to attend all her therapies, follow unit rules, and adhere to her medications. Of these three, only medication adherence has any relevance to a patient's readiness for discharge and avoiding readmission. In the worst case scenario, staff view treatment planning as a chore; in that case, every patient has the same goals, and that no one ever looks at the treatment plans once completed. When every treatment plan is the same, they are considered a waste of time. But they did not have to be.

To personalize the treatment plan, the clinician can begin with a discussion with the patient and her family about how she came to be admitted, and what would need to change to avoid readmission. This conversation might lead to a very productive session or two, depending on the patient's and family's readiness for a conjoint session. Similarly, discussing how this patient wants her quality of life to improve would be productive. This collaborative and creative process could lead to insights and understanding, and meaningful goals against which to measure progress. Goal-setting would need to focus on individualization, collaboration, and a shared definition both of the problems the patient faces and what the outcome of this treatment episode should look like. This discussion might also lead to the identification of personal and systems obstacles to progress. For example, imagine that during a collaborative discussion about meaningful goals, this girl disclosed that her goal was to remain hospitalized as long as possible, because the hospital was the safest environment she experienced. How dramatically would this change the direction of treatment?

Is this process unfriendly to point-and-click computer programs? Yes. Is this investment of time and effort worthwhile? Sure. Imagine how empowering it is to an adolescent – who, like adolescents generally, probably believes no one is listening to be an equal partner in planning treatment. Imagine the power of goals to point treatment, the patient, the family, and the staff in a unified direction that everyone participated in planning.

Clinical Anecdote Number 3

When I was a predoctoral intern discussing the importance of goal-setting, a supervisor asked me whether I thought every patient can participate in setting goals. I responded that I did not know about every patient; for example, someone with Autistic Spectrum Disorder, Level 3, with Intellectual and Language Impairments might have difficulty. On the other hand, I imagined aloud that everybody he would see for individual psychotherapy could. He then gave me a challenge: How would I set goals for one of his patients, a 24-year-old male patient with Schizophrenia who told his intern-therapist that he wanted to marry a specific famous pop star? Could I make that into a goal through collaboration with the patient? We brainstormed.

This patient was a young man who developmentally should want an intimate relationship (Goal 1). His disorder means that he has positive and negative symptoms that prevent this, meaning that he needs skills (Objectives for Goal 1). He wants a partner who is special, attractive, and someone he can admire, and needs to know how to appreciate these qualities in women he is likely to date (Goal 2). He needs to have the judgment and insight to realize that not everyone he admires can be his partner. He also needs to know the consequences of reaching out to a celebrity (Goal 3). Finally, he needs to grieve the loss of his unrealistic and dangerous ideal partner (Goal 4). Of course, the patient was not present, so these were hypothetical goals for the purpose of explaining goal-setting to a skeptic, not actual goals.

Note that collaboration around goal setting does not mean that the patient dictates and the therapist passively records what the patient wants. Collaboration goes in both directions. Part of the discussion about this patient's goals for an intimate relationship would have to focus on what the patient probably does not want but needs anyway – to give up the fantasy of marrying the famous pop star. However, this patient would have had the opportunity to pick the life domain to focus on, namely intimacy. This might mean that the patient learns to maintain hygiene, to adhere to medications, to accept "no" as an answer from a woman, and other skills of interest to his treatment providers – all in service of the patient's goal of finding a partner.

How SMART Goals Can Result in Directionless Therapy

I would guess that if you have attended an in-service training about goal setting, it focused on a preferred format for goals, SMART goals. Here is the problem: You can take the most thoughtless goal imaginable and write it perfectly in a standardized format. Sometimes, I think we become too closely wedded to the format. If the treatment goals are going to be reviewed for compliance or as a measure of your performance based on format, then you will produce SMART goals, even if they are unhelpful. Compliance gets what compliance measures. We spend a lot of time discussing SMART goals without delving into the literature. In the literature, there is no empirical support for SMART goal formatting in terms of patient outcomes, persistence in treatment, or satisfaction with treatment.

There is, however, a literature about goal-setting,

and specifically Goal-Setting Theory. It does not focus on the format for writing goals but on qualities of goals. This literature originated in industrial-organizational psychology, and this is not a literature familiar to most clinicians. To illustrate this point, Goal-Setting Theory has its roots in improving the productivity of wood pulping workers. I seldom devote time to reading about the psychology of wood pulping, and I do not think that I am alone. The father of Goal-Setting Theory is Dr. Edwin Locke, who is a Professor Emeritus at the University of Maryland. His research, very briefly summarized, indicated that goal-setting is motivating when the person responsible for achieving the goal (in our case our patient) can appreciate the rationale for their goals, when goals are challenging and both difficult and attainable, when the criteria for success is "doing your best" rather than meeting a specific and objective measure of performance, when the patient is taught strategies for attaining their goals, and when the goals are specific and relevant to the context in which the goal is to be attained. Further, goals are motivating when progress towards goals is reviewed, and feedback offered about what is working well (Locke and Latham, 2019). Consequently, goal-setting is not a once-and-done exercise.

The issue of goal difficulty is interesting. As a student in both psychology and education classes, I was taught that task analysis was an extremely important tool because it permitted development of small, easily attained steps towards a larger goal. In contrast, Goal-setting Theory, and research that has tested this theory, suggest that when goals are moderately difficult, people will develop more alternative strategies for meeting the goal. In contrast, this skill is unimportant if a patient is given baby steps to complete.

The person who will work towards the goal brings to the exercise their own personality and level of cognitive complexity. Is the patient conscientious? Does she have a belief in her own efficacy? Does she succeed at developing alternative strategies? (Locke & Latham, 2019). Addressing these mediating variables can represent meta-goals as part of treatment as well.

One of Locke's findings is pertinent to relevance of the context in which the patient works towards a goal (Locke & Latham, 2019), or ecological relevance. I tend to think of relevance in the context of lifespan development. My 17-year-old patient with OCD was at the first moments of early adult transition. This transition involves completing education, making vocational decisions, becoming more autonomous, achieving financial independence, living independently, developing his own friendships, and forming intimate attachments (Levinson, et al 19xx). As with every stage of development in Western Culture, the task of separation and individuation is the underlying direction of maturation. However, this patient's original goals to be more compliant were at odds with developmental expectations. Relevance also means relevant to the individual including his or her mental disorder and skill deficits and strengths. Finally, goals should be relevant to quality of life issues. The sole purpose of treatment cannot be to reduce symptom severity, although this is of great importance for alleviating suffering. Treatment should also improve quality of life. It is very likely that each patient has a private image of what quality of life means that is different from each therapist. This is why individualization and collaboration are so important to goal setting.

Measuring Goal Progress for this Article

The objective for this article was to raise consciousness that goal-setting should not be seen as a compliance requirement, drudgery, or a clerical task, but as a creative therapeutic task that aids in building an alliance, giving treatment a direction, and motivating patients. Goal setting stimulates patients to develop strategies, and helps identify obstacles to progress including skill deficits, and personality traits that hold patients back.

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Evaluating and Improving Knowledge and Practices around Suicide Assessment

Assessment of suicidal thoughts and other related behaviors may be one of the most difficult areas for mental health professionals, both because this area can create feelings of anxiety and fear in the clinician and because many may feel they do not have adequate training in this area. Research suggests that psychologists are less likely to accept for treatment individuals who present with suicide risk factors (Groth & Boccio, 2018). Some recent journal articles have highlighted ethical considerations for psychologists that touch on important questions related to training and competence. For example, what are the ethical responsibilities of practicing psychologists in terms of being aware of and using evidenced informed assessment and care for suicide? Should suicide prevention be a considered an element under intervention and assessment competencies in the field? Given that the majority of mental health professionals will work with at least one individual who experiences suicidal ideation, should there be a minimal level of competence necessary for practicing psychologists?

A recent article by Cho, Martell and Cramer (2024) discussed the importance of suicide prevention training for both students and practicing psychologists and raised the question of whether it should be mandated education for all mental health professionals. This column will explore some of the barriers and possible considerations for psychologists in risk assessment and feature comments from an interview with one of the authors (Dr. Christopher Martel, University of Massachusetts Amherst). A separate article by Jobes and Barnett (also published in 2024) explored issues related to ethical responsibilities of psychologists in terms of evidence-based approaches to suicide assessment, prevention, and related care, and will also be discussed.

Barriers to Asking about Suicide

Several barriers in terms of asking about suicide and working with individuals who report suicidal thoughts and behaviors have been cited in the literature. It seems clear that provider concerns about perceived competence may be an important barrier. An empirical study by Groth and Boccio (2018) indicated that concerns about professional skill levels were frequently cited by participants who expressed unwillingness to accept a hypothetical patient/client who expressed suicidal ideation. Practicing within the boundaries of one's competence is a core ethical standard but, as Groth and Boccio noted, there can be difficult dilemmas, such as providing treatment in rural areas where there are few available providers or providing services in emergency situations. Both Cho et al. (2024) and Jobes and Barnett (2024) discussed the relationship between competence in terms of professional services related to suicide prevention. Professional competence maps onto several APA Ethics Code principles and standards, including 2.01 Boundaries of Competence, 2.03 Maintaining Competence and 2.04 Bases for Scientific and Professional Judgment (APA, 2017).

As Jobes and Barnett (2024) noted in their review of the research, studies suggest several barriers in effective suicide assessment, including clinicians avoiding asking about suicide (Roush et al., 2018) and patients/clients not reporting suicidal ideation because of fears of being hospitalized involuntarily (Blanchard & Farber, 2020). Cho et al. (2024) suggested several possible reasons clinicians may avoid asking, including fear and stigmatized beliefs about suicide among mental health providers. Concerns about professional liability have also been cited as a potentially important barrier that may lead to not asking about suicide (Jobes & Barnett, 2024). Lack of experience, particularly among early career psychologists who may not have had training experiences where they had opportunities to assess for risk, may also be a contributing factor. Finally, fears related to one's perceived incompetence can lead to avoidance in terms of asking or working with individuals who experience suicidal thoughts or behaviors. Dr. Martell explained, "I think people can be afraid of clients when they're suicidal. It brings up fears of incompetence. I also think sometimes the response from professionals can be anger and frustration because of that fear. None of us want to feel incompetent. A lot of people may be really afraid that they're sort of walking on thin ice if they have clients who express at least more than passive ideation."

Fear and anxiety may contribute to avoidance in asking about suicide, which, as Dr. Martell noted, can lead to potential missed opportunities to intervene and unintentionally place the clinician at more risk. He noted, "I think the way when the way people cope with it is to not ask. Avoidance is never a good coping strategy, you know, can lead to worse things and ironically, not asking, I think leads to more could lead to more liability."

What Can We Do to Improve Suicide-related Assessment and Care?

Given many mental health professionals may not feel competent in suicide assessment and treatment, there have been calls for increased education and training in risk factors as well as evidence-based assessment tools and treatment. Most graduate programs don't adequately cover evidence-based suicide prevention and assessment in their graduate programs and there's an acknowledged need for dedicated didactics in this area. Indeed, a recent survey of program and internship directors suggest strong support for mandated suicide training for trainees (Kleespies et al., 2023). There are also valuable opportunities to provide instruction and training (including in how to assess for risk) in practica, coursework, and internship. Adding to an already full list of competencies is not without its challenges; however, as Dr. Martell noted the importance of this topic overall in clinical psychology and the need to address not only student knowledge but also attitudes, in terms of "…training students to not be afraid of people who have suicidal thoughts and behaviors."

For practicing psychologists, filling training gaps and staying up to date with the latest methods in assessment and treatment may be addressed through education and training programs, including continuing education requirements through licensing boards. In fact, as Cho et al. (2024) discussed, several states have introduced requirements for training in suicide prevention. There is also a growing body of research on empirically supported training programs for professionals (e.g., Cramer, Long, Gordon, & Zapf, 2019; Stuber et al., 2023).

There are some important self-assessment considerations for psychologists working with individuals who experience suicidal thoughts or engage in related behaviors. One is to recognize one's own feelings about suicide and working with individuals who may be at higher risk. Are our feelings and beliefs contributing to an already-significant stigma around suicide and, importantly, do they lead to behaviors such as avoidance in terms of assessing risk?

Another consideration is to evaluate our training and competence in this area. This can be difficult for psychologists to evaluate one's competence in specific areas. Is being familiar with the literature and best practices to be able to effectively conduct a risk assessment and knowing how to respond to risk factors (which could include referrals and involving others in care) considered a baseline competence for practicing psychologists? Psychologists looking to learn more can draw upon the growing body of research in the area of prevention, assessment and intervention to learn more about which methods have empirical support and which do not. In their article, Jobes and Barnett (2024) provided an excellent overview of evidence-based assessment and treatment of suicide-risk behaviors and argued that understanding and using evidenced-based practices is both good care and serves as a risk management strategy. As Martell noted, "Suicide, suicidal ideation, and suicidal behaviors need to be treated directly. We learn how to treat depression. We learn how to treat anxiety disorders. Suicide, from the experts, is not just something tacked on to those things… There are direct interventions and we need to at least learn how to directly address this. Not being afraid in addressing this with clients, I think, validates for clients that they've come to a safe place." Finally, Jobes and Barnett (2024) described how specific risk management strategies, such as informed consent about limits in confidentiality and legal responsibilities, detailed documentation, and consultation with colleagues can be both effective risk management and beneficial for care.

Conclusion

These articles and discussion underscore the value for psychologists to identify and address their own feelings (including fears) and level of knowledge in working with individuals who may experience suicidal thoughts. It's interesting to think about how, in response to fears related to liability or lack of competence, we can sometimes engage in avoidance behaviors, which can actually worsen the situation, both for clinicians and potentially for those with whom we work. Identifying the reasons for and addressing our own avoidance in terms of learning more about effective assessment management techniques is also critical for practicing psychologists. As Dr. Martell concluded about individuals who may experience suicidal ideation, "They may feel hopeless but being in a therapist's office and having a therapist who's not freaking out as soon as you say something can, I think, begin to instill a little more hope that there can be a better life ahead."

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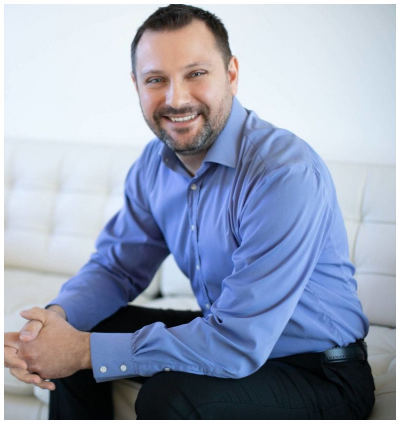
Fall 2024 Membership Spotlight

Misha Bogomaz, PsyD, ABPP



Misha Bogomaz, PsyD, ABPP

Please provide an overview of your work (e.g., clinical specialty and interests, research program, etc.).

My specialty is group psychology, leadership, followership, and group dynamics.

Where did you complete your training (graduate school and area of emphasis, internship, post doc, etc.)?

Graduate school: Illinois School of Professional Psychology (clinical psychology); Internship – Florida State University Counseling Center. Post doc: University of Pittsburgh Center.

What is your current position/occupation?

Director of University of North Florida Counseling center.

Can you describe the ways that your career has taken shape over time? How did you get to where you are today?

My career shifted from being primarily a clinician to being an administrator

How long have you been a member of SCP? Please indicate any past or present roles in SCP (e.g., leadership, committees, task forces, etc.)?

Maybe about 6 years with a break in between. I was the president of Div12 Section 10. Currently I am co-chair of Education and Training committee

Please describe any roles you have with APA or other national, state, or local organizations.

President (until December 31 2024) – American Board of Group Psychology

Treasurer (until December 31 2024) – Group Specialty Council

Board-member-at-large – Florida Group Psychotherapy Society

What do you see as an important direction for the field of Psychology?

Focus on enhancing competence for psychologists after licensure; distinguishing psychologists from other mental health practitioners; addressing low reimbursement rate;

What are your hobbies?

Spending time with my wife and our pets. Getting together with friends. Reading. Playstation. Learning to dance

What led to your interest in clinical psychology and/or area of interest?

My specialty in group dynamics is mainly due to believing we are social creatures who function, most of the times, in groups.

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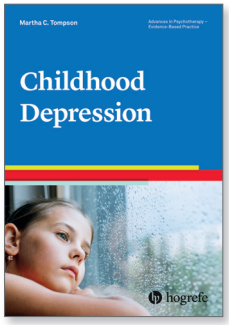
New releases



Martha C. Tompson

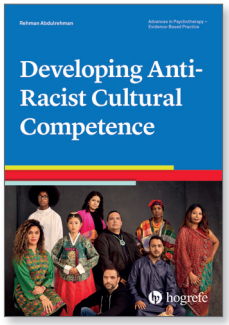
Childhood Depression

Vol. 54, 2024, viii + 116 pp.
ISBN 978-0-88937-518-5
Also available as eBook

This volume provides the reader with an up-to-date, evidence-based introduction to the assessment and treatment of childhood depression, including major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and adjustment disorders. After exploring the latest knowledge on the diagnosis, course, theories, and contributing factors of childhood depression, the author presents a step-by-step description of family-focused treatment for childhood depression (FFT-CD), which integrates CBT and family therapy goals.

"The bad news is that childhood depression is on the rise. The good news is that Dr. Tompson has built upon her expertise as a childhood depression researcher, clinician, and educator to create an invaluable resource for clinicians. I highly recommend this book to all therapists who work with depressed children!"

Mary A. Fristad, PhD, ABPP, Dir, Academic Affairs and Research Development at Nationwide Children's Hospital Big Lots Behavioral Health Services, Columbus, OH



Rehman Abdulrehman

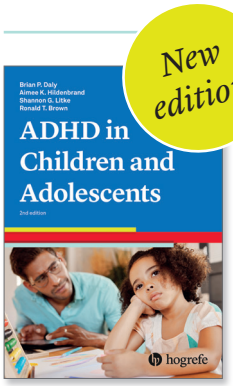
Developing Anti-Racist Cultural Competence

Vol. 53, 2024, xvi + 106 pp.
ISBN 978-0-88937-515-4
Also available as eBook

In today's society, anti-racist cultural competence is an essential skill everyone needs to develop, and not something meant only to be addressed by some. Abdulrehman provides a direct, no-nonsense, and practical approach to this challenging and complex topic, using real-life examples to help the reader to approach sensitive cultural issues confidently and humbly. He looks in detail at how we can understand our biases and how they impact our engagement and trust with marginalized people of color.

"I am proud to endorse Dr. Abdulrehman's book. It not only provides essential knowledge but also serves as a testament to his own commitment to advancing our collective understanding and promoting equity."

Monnica Williams, PhD, ABPP, Canada Research Chair for Mental Health Disparities, University of Ottawa, ON, Canada

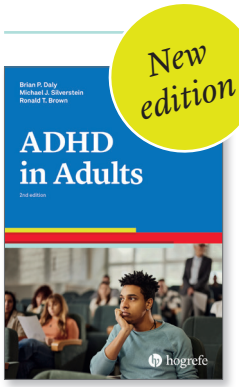


Brian P. Daly / Aimee K. Hildenbrand / Shannon G. Litke / Ronald T. Brown

ADHD in Children and Adolescents

Vol. 33, 2nd ed. 2024, x + 116 pp.
ISBN 978-0-88937-600-7
Also available as eBook

The updated new edition of this popular text integrates the latest research and practices to give practitioners concise and readable guidance on the assessment and effective treatment of children and adolescents with attention-deficit/hyperactivity disorder (ADHD). Practitioners will particularly appreciate new information on the best approaches to the ideal sequencing of treatments in multimodal care, and the important diversity considerations.



Brian P. Daly / Michael J. Silverstein / Ronald T. Brown

ADHD in Adults

Vol. 35, 2nd ed. 2024, viii + 90 pp.
ISBN 978-0-88937-599-4
Also available as eBook

The second edition of this popular text incorporates the latest research on assessment and treatment practices for adults with attention-deficit/hyperactivity disorder (ADHD). It is both a compact "how to" reference for use by professionals in their daily work and an ideal educational reference for students. This edition also explores how psychosocial adversity factors impact the development and functional impairments associated with ADHD and highlights strategies used in the multimodal treatment of ADHD in adults.

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*The National Register of Health Service Psychologists is approved by the American Psychological Association to sponsor continuing education for psychologists. The National Register maintains responsibility for this program and its content.

Free webinar

Decision-Making with the ESB: Advanced Interpretation

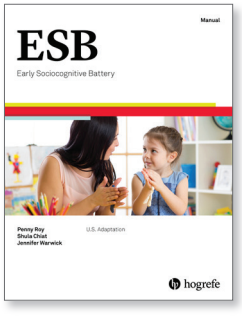
November 21, 2024
3:00 p.m. EST

Scan the QR Code to register

Join us during this free one-hour webinar for an overview of social skills measured by the new Early Sociocognitive Battery (ESB), a standardized, performance-based test with evidence that supports identifying children at risk for autism.

Whether you started using the ESB this past spring or you are new to the assessment, Hogrefe's team will use video demonstration to help attendees learn how to analyze observed behaviors for accurate scoring and to interpret various profiles. With a helpful report template, attendees will learn how to integrate standardized ESB scores and qualitative observations for decision-making.

Can't make the live webinar?
Register for the event and we will send you the recording to view when convenient.



Forthcoming volumes

Disorders strand
- Panic Disorder and Agoraphobia
- Adolescent Dating Violence
- Gambling Disorder 2nd ed.
- Opiate Use Problems
- Posttraumatic Stress Disorder
- Obsessive-Compulsive Disorder in Adults 2nd ed.
- Vaping and E-Cigarette Use and Misuse in Teens
- Acute Pain
- Integrated Primary Care
- Childhood Irritability
- Supporting Children After Mass Violence
- Interventions for Domestic Violence
- Borderline Personality Disorder

Methods and approaches strand
- Palliative and End-of-Life Care
- Pediatric Psychopharmacology

Content and Structure

1. Volumes on a Disorder or Group of Disorders
The contents of each volume are structured as follows:

Description:
- Terminology
- Definition
- Epidemiology
- Course and Prognosis
- Differential Diagnosis
- Comorbidities
- Diagnostic Procedures and Documentation

Theories and Models of the Disorder

Diagnosis and Treatment Indications

Treatment:
- Methods of Treatment
- Mechanisms of Action
- Efficacy and Prognosis
- Variations and Combinations of Methods
- Problems in Carrying out the Treatment
- Multicultural Issues

Case Vignette
Further Reading
References
Appendix: Tools and Resources

2. Volumes on Methods and Approaches
The contents of each volume are structured as follows:

Description:
- Terminology
- Overview

Theories and Models

Assessment and Treatment Indications Treatment:
- Method of Treatment
- Efficacy and Prognosis
- Variations of the Method and Combinations with Other Approaches
- Problems in Carrying out the Treatments
- Multicultural Issues

Case Vignette
Further Reading
References
Appendix: Tools and Resources

If you would like to suggest a book to publish, please contact the publisher at **editorial@hogrefe.com** or complete the online form at **www.div12.org/advances-in-psychotherapy-evidenced-based-practice-book-series-suggestion**

Order and price information

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