

- You can have a really interesting career if you choose very fine people to work with and are willing to work very hard. When you don't do something well, find someone who does and work closely with them.
- Build a pyramid to manage your time and projects in academic research—undergrads work for master's students who work for doctoral students and postdocs who work for and with you.
- Listen to the entire team, no matter their status—some of the best ideas come from those in the trenches.
- Our clients/patients are great teachers—listen to them carefully.
- Pay close attention to your doubts, even the niggling little ones. If something seems amiss, it probably is. Better to find it than let it fester.
- Bias is everywhere and the truth is hard to find—keep looking.
- Keep it simple—go for the most parsimonious explanation.
- Keep the channel open, even for the most challenging of colleagues, collaborators, and clients—the noisy ones bear listening to for the kernels of truth that lies therein.
- “I wish I'd worked harder,” said no one on his/her deathbed—always prioritize family and friends. I hope your closest colleagues are among them.

I'm sure there is more to say, and that many of my colleagues will say it better, but that's it for the moment. I'm proud and grateful that as my professional home for 40 years now, ABCT has done so much to foster my career, especially as a social work clinical researcher who grew up among wonderful psychology and social work mentors and colleagues. I look forward to trying to be articulate in my Presidential Address in San Diego about some of these matters, and hope you will join me there for a great conference in the fall.

...

Correspondence to Gail S. Steketee, Ph.D., Boston University School of Social Work, 264 Bay State Rd., Boston, MA 02215; steketee@bu.edu

Advances in Cognitive Behavioral Treatment Design: Time for a Glossary

Maya M. Boustani, Resham Gellatly, Jonathan G. Westman, Bruce F. Chorpita, *UCLA*

AS THE FIELD OF DISSEMINATION and implementation has highlighted the importance of fit between treatments and the context of community-based settings, there has been an increasing focus on specifying aspects of treatment designs that could better address such challenges. These design innovations have in turn popularized an accompanying new vocabulary. For example, there has been increasingly formalized research on modular treatment approaches in the past 10 years, with a focus on cognitive behavioral treatments in particular (Chorpita, Daleiden, & Weisz, 2005b; Weisz et al., 2012), and there are currently at least two dozen child or adult treatments that could be considered modular, transdiagnostic, or both (e.g., Kolko et al., 2009; Wetherell, Sorrell, Thorp, & Patterson, 2005). The primary purpose of this article is to suggest clarifying terminology regarding emerging treatment design (modular, transdiagnostic, flexible). A glossary allows treatment developers and providers to understand the various qualities of these new treatment designs, along with their applicability in different contexts. In addition, we provide an overview of recent findings relevant to innovative treatment designs for youth. Finally, we discuss future directions of relevance to modular treatment approaches, including exciting research challenges ahead.

Terminology

The terms *common elements*, *modular*, *transdiagnostic*, and *flexible* often appear in the literature in reference to treatment design and are often used interchangeably. Although these terms are ostensibly used to describe treatment designs that may have one or more overlapping qualities, we contend they are conceptually different. We aim to clarify what each of these terms means and how they are related. In addition, we hope this article will facilitate the use of a consistent language in order to decrease the risk of confusion, while facilitating the dissemination of clinical and

research knowledge surrounding these treatment designs.

Common Elements

The Distillation and Matching Model (DMM), sometimes referred to as the “common elements approach” (e.g., Barth et al., 2012), was proposed by Chorpita, Daleiden, and Weisz (2005a) as a literature analysis procedure that (a) identifies specific practice techniques and strategies common across a defined set of selected treatments (e.g., evidence-based treatments) and (b) identifies contexts in the literature in which practices have characteristic profiles (e.g., a high prevalence of the use of exposure in the context of treating anxiety). This procedure presents a view of the literature that aggregates across all treatments relevant to a particular context (e.g., adolescents with depression), as opposed to limiting inferences to lines of research specific to a single protocol or laboratory. *Common elements* are not to be confused with *common factors*. Although these approaches share the aim of improving the understanding of treatment content and composition, particularly in the context of evidence-based practice delivery, each conceptualizes two important but different aspects of therapy. The common elements approach focuses on analysis of specific components of treatments, typically with the aim of estimating how often discrete procedures occur when aggregating across many effective treatments. This approach allows for a view of what procedures are common among effective treatments and thus allows analyses of practice to aggregate across many different treatment approaches that may emanate from different laboratories and even different schools of thought. In contrast, the *common factors* framework (e.g., Duncan, Miller, Wampold, & Hubble, 2010; Sparks & Muro, 2009) highlights the importance of nonspecific factors of therapy that characterize many psychosocial interventions. Common factors including therapeutic alliance, client goals and motivation, and

therapist characteristics have been identified as facilitators of therapy and therapeutic outcome, regardless of type of treatment protocol or element employed (Barth et al.). One principal difference between these two approaches is that the common elements model is explicitly silent on the effectiveness of elements, noting that common elements analysis only characterizes how common particular practices are among treatments that are effective in their complete forms (Chorpita, Becker, & Daleiden, 2007), whereas the common factors model attests that nonspecific effects are responsible for treatment outcomes, at least in part.

Like any literature analysis, DMM can be used to inform treatment design. Yet the DMM was not proposed as a model of treatment; it is merely an analytic framework for summarizing practice knowledge. Hence, according to the model, a “common elements treatment” is potentially a misnomer. Although the term could refer to a treatment whose constituent procedures were informed by a DMM analysis, in and of themselves, a collection of elements is *not* a treatment (Chorpita et al., 2007). For example, relaxation and exposure are practice elements common among evidence-based treatments for anxiety in youth. However, we contend that there is no “common elements model” that suggests relaxation and exposure are sufficient to yield a full treatment comparable to those from which its elements were derived. The addition of theory or a logic model for how these common elements are to be organized and delivered is essential to moving from a set of isolated elements to a treatment. Finally, “elements” as conceptualized in the DMM need not refer to component practices, but in fact could refer to any features of treatment, such as format (e.g., group, individual, self-directed), or logic (e.g., linear sequence, conditional sequence), or audience (e.g., child, family, parents). Thus, we see value in conceptualizing the “common elements” framework principally as a literature analysis tool, which can merely inform treatment development through a summary of common features of successful treatments specific to a given context (e.g., depression, or adolescents, or schools) or some combination of contexts (e.g., depression in schools).

Modularity

Chorpita et al. (2005b) outlined a model of treatment design that articulated four principles about modular treatments: (a) they are partially decomposable (i.e., a

modular treatment can be divided into independent units or subunits); (b) each module should have its own goal and purpose, independent of other modules; (c) modules have an interface that allows them to connect to other modules in a standardized way (i.e., they are immediately compatible when linked); and (d) a module should be self-contained, such that all the information needed to deliver that module should be contained internally and not dependent on another module. Chorpita et al. (2005b) argued that these principles should allow for increased efficiency and simplified scalability in overall treatment design, all things being equal.

Although modules are commonly thought of as practices (e.g., a “session” or a “unit” that structures a specific therapeutic activity), modularity applies to any aspect of a protocol, such as a flow module that governs the practice order (e.g., a coordinating module could dictate that practice A must be followed by practice B; it could in turn be nested in a higher-order flow that states practices A, B, and C are to be used for youth, whereas D, E, and F are for adults). Note that one flow could be replaced without impacting the other, and any practice modules from A through F could be replaced without affecting the others and without affecting either flow module. In other words, a module is not defined by its content, but rather by its structure and design. Although modules are often made up of therapeutic strategies (e.g., “relaxation module”), they can just as well be therapeutic guides that inform the order of delivery of strategies, such as flow charts, or guides on how to address cultural barriers or engagement problems. Such modules provide information about how to deliver treatment (interface with other modules) but are also independent (do not rely on other modules for delivery). Interested readers may consult Chorpita et al. (2005b) for a detailed account of what constitutes modularity.

Transdiagnosticity

Transdiagnostic treatments such as the Unified Protocol (Barlow, Allen, & Choate, 2008) have the ability to address multiple diagnoses by using decision-rules to guide the use and dose of components based on symptom presentation and ongoing feedback (McHugh, Murray, & Barlow, 2009). The term “transdiagnostic,” first coined in 1977 by Steer, Shaw, Beck, and Fine, to describe overlap between depression and alcoholism, entered mainstream psychiatry after being introduced by Fairburn and col-

leagues in their work with eating disorders (Fairburn, Cooper, & Shafran, 2003). As highlighted by Sauer-Zavala and colleagues (2017), a treatment has to fall into one of three categories to be considered transdiagnostic: (a) *universally applied therapeutic principles* refers to treatments that use an identifiable school of thought to guide their therapeutic strategies, regardless of diagnosis or symptom presentation (e.g., humanistic, psychodynamic, cognitive-behavioral therapies); (b) *modular treatments* refers to treatments that are transdiagnostic by combining what we know works from multiple treatments into one treatment (it is important to note that not all modular treatments are necessarily transdiagnostic—a modular treatment can combine what we know from multiple treatment packages for one disorder into a modular approach); (c) *shared mechanisms treatment* refers to treatments that identify common processes that are believed to apply across disorders (e.g., negative emotions). The term “transdiagnostic” implies that a treatment must address multiple diagnoses. However, it is unclear if a treatment must address multiple diagnoses within one diagnostic category (e.g., generalized anxiety disorder and panic disorder within anxiety) or diagnoses in multiple domains (e.g., depression and anxiety) to be considered transdiagnostic. This matter is further complicated by changes in diagnostic criteria. For example, a treatment that previously focused on both generalized anxiety disorders and obsessive-compulsive disorders may not have been transdiagnostic under DSM-IV, but now is under DSM-5, as they are now classified in different chapters. Indeed, if we are to describe disorders on a dimensional construct, as encouraged by the National Institute of Mental Health’s Research Domain Criteria (RDOC; Insel et al., 2010), rather than disorder categories, then the term “transdiagnostic” may be misleading. For that reason, we prefer the term “multiproblem” to describe treatments with multiple foci and are reluctant to recommend how far a treatment has to branch out of a disorder category in order to be considered transdiagnostic. Nevertheless, transdiagnostic treatments have the advantage of allowing for heterogeneous symptom presentations and even the possibility to adapt the treatment for different individuals (McHugh et al., 2009).

Flexibility

Flexibility refers to the ability of a treatment to be adapted and individualized during its delivery (Chorpita et al., 2005b). Although flexible treatments can have manuals that provide guidance about the treatment approach, including recommended treatment goals at various phases of treatment, they need not dictate strict session-by-session content, scripts, or a prescribed number of sessions. Examples of flexible treatments include Multisystemic Therapy (Henggeler & Borduin, 1990), Multidimensional Family Therapy (Liddle et al., 2001), and some approaches to marital therapy (Jacobson et al., 1989). The most flexible treatments generally provide a philosophy of treatment and guidance while relying relatively more on clinical judgment than on a defined treatment structure. Researchers have consistently found that providers prefer flexible

approaches to serve their clients (Nelson, Steele, & Mize, 2006), and some developers have provided guidelines on ways to flexibly implement evidence-based manualized treatments (Kendall & Beidas, 2007). At the same time, there is mixed evidence regarding whether flexibility is associated with greater treatment efficacy (e.g., Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992).

Our use of the term *flexibility* in this context should be distinguished from the kind of microsocial-level flexibility that is commonly a part of “bringing a treatment to life,” so to speak, even a highly structured one. In other words, with few exceptions (e.g., some technologically delivered treatments), there is always some degree of adjustment according to provider style and client preferences. This “flexibility within fidelity” has long been described as an important tenet of implementing manual-

based treatments (Kendall, Chu, Gifford, Hayes, & Nauta, 1998; Kendall, Gosch, Furr, & Sood, 2008). In this context, flexibility is encouraged in order to develop a stronger therapeutic relationship, which leads to better treatment outcomes (Creed & Kendall, 2005). Therapists are also encouraged to address client concerns rather than ignore them to deliver content from the manual (Kendall et al., 2008). That said, our use of the term “flexibility” refers more generally to a coarse-structure flexibility that would involve such parameters as highly variable length of treatment, the ability to add or omit particular practices altogether, the option to repeat some practices based on client response, etc. Of course, the term “flexible” (and for that matter, “modular” and “transdiagnostic” as well) is a binary simplification of a dimensional construct, simplified to promote communication about design; treatments can be more or less flexible, modular, or transdiagnostic.

Table 1. Treatment Design Definitions and Examples

	Transdiagnostic A transdiagnostic program targets multiple disorders	Modular A modular program is made up of modules, or partially decomposable, independent units, that interface to create a treatment.	Flexible A flexible program can be adapted and individualized during its delivery.
Attachment-based family therapy (Diamond et al., 2010)			✓
Acceptance and Commitment Therapy (Hayes et al., 1999)	✓		
Modular Approach to Therapy for Children (Chorpita & Weisz, 2009)	✓	✓	✓
Modular CBT for childhood anxiety (Chiu et al., 2013)		✓	✓
Multisystemic Therapy (Henggeler & Borduin, 1990)	✓		✓

Examples of Modular, Transdiagnostic, and Flexible Evidence-Based Treatments

A brief review of the literature reveals a recent proliferation of treatments described as transdiagnostic, modular, or flexible. Some treatments fall under one of these categories, whereas others fall under more than one. Table 1 highlights how various treatments fall into one or more of the treatment design categories (modular, transdiagnostic, or flexible) and provides a definition for each treatment design. There are many treatments that address multiple problems and can be considered *transdiagnostic*. For example, traditional CBT, which has been proven to be effective for depression, anxiety, and multiple other disorders, is *transdiagnostic* but not necessarily *modular*, as content from later sessions often builds on knowledge gained in earlier sessions (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is another example of a *transdiagnostic* treatment indicated for multiple problem areas that is not *modular*, although there have been recent calls for a modularization of ACT (Villatte et al., 2016).

Building Confidence is a treatment approach that was adapted from a manualized CBT treatment for children with anxiety disorders (Chiu et al., 2013). Providers select and sequence modules based on their client’s presenting concern and administer

treatment for 1 to 16 sessions, depending on the child's needs and ongoing symptomatology. Hence, this treatment is both *modular* and *flexible*, but probably not *transdiagnostic*, as it is meant to treat anxiety disorders only. However, one could argue that the treatment works across multiple anxiety diagnoses, and is thus transdiagnostic, but that is in part a reflection of the level of analysis of the chosen diagnostic nosology, as we have previously discussed. Building Confidence showed promise by outperforming a waitlist condition in elementary-aged children, such that children who received the intervention had less severe anxiety symptomatology (Chiu et al.).

In another study, Kolko et al. (2009) examined how a modular treatment approach for children with conduct disorder or oppositional-defiant disorder performed in a clinic versus a community-based setting. Seven treatment modules were derived from a variety of evidence-based treatments such as CBT, parent management training, family therapy, and case management. An algorithm was used to determine the nature of the modules to be delivered and their order. Children assigned to a community-based setting had higher attendance, and outcomes comparable to clinical settings, despite prior research indicating more difficulty engaging families in community settings (e.g., Southam-Gerow et al., 2010). This treatment is *modular* and could also be considered *transdiagnostic*, because it treats both conduct and oppositional-defiant disorders—even though they are both disruptive behavior disorders.

MATCH-ADTC (Modular Approach to Treatment for Children with Anxiety, Depression, Trauma and Conduct problems; Chorpita & Weisz, 2009), is an example of an evidence-based treatment that falls under all three of these treatment designs: it is *modular*, *transdiagnostic*, and *flexible*, and has demonstrated to be effective in two randomized effectiveness trials in community settings (Chorpita et al., 2013, 2017; Weisz et al., 2012). MATCH is modular because it is made up of various units that may be administered independently to respond to each individual client's needs. MATCH is a full manual and includes scripts, worksheets, and a sequence of modules, along with flowcharts to guide treatment decisions and treatment planning depending on symptoms and interferences. The treatment is flexible because the provider is free to pick which modules to deliver based on the

client's current needs and responses to prior modules, as indexed by progress monitoring and feedback. Finally, MATCH is transdiagnostic because it can be used to address any of several presenting problems commonly seen in children and adolescents (anxiety, depression, conduct problems, traumatic stress). The research on MATCH indicates that as a modular, transdiagnostic and flexible approach, it was more effective, more efficient, and more popular than treatment as usual, and in some cases more than standard (nonmodular, less flexible, and single diagnosis) evidence-based treatment designs (Chorpita et al., 2013, 2017; Weisz et al.).

Another example, MAP (Managing and Adapting Practice), is a system of resources that clinicians use to design, deliver, and evaluate treatment (Chorpita & Daleiden, 2014). MAP provides clinicians access to a database of research on evidence-based treatments to inform their treatment design. From this searchable database, practitioners can identify treatments that have been proven effective in clinical trials for certain populations with specific problems. Furthermore, practitioners can discover the most common elements found in those treatments, along with practice and process guides (modules) to facilitate implementation of individualized content. Finally, clinicians can develop a clinical dashboard for each of their cases to track progress and practices delivered into a visual summary (Chorpita et al., 2008). Because MAP is not a treatment, but more of a toolkit for clinicians to select an existing treatment or build a new one from a set of knowledge resources, it has only been tested in open trials in large mental health systems. However, those demonstrations have shown that it is highly scalable, well-liked by providers, and yields large effect sizes (Daleiden et al., 2006; Southam-Gerow et al., 2014). Once therapists have designed a treatment using MAP, it could be qualified as *modular*, *transdiagnostic*, and *flexible* (although it is theoretically possible to design a static sequence of practices with a single treatment focus only).

Why Is a Glossary Needed?

The examples of innovative treatments highlighted above suggest the value of attending to a consistent design vocabulary to describe them. That is, if we discover that new interventions (or new arrangements of the old interventions) offer advantages, there is some practical benefit

to having a shared terminology to understand what may have produced those advantages. Recent research suggests that these new treatment designs may indeed afford advantages, at least in situations that must contend with cost or training constraints, unpredictable aspects of treatment context, comorbidity, or background complexity and life stress. If these new treatment designs are to become mainstream in mental health, we need a common and consistent language to establish meaning and avoid confusion. We believe that there is already enough evidence that these designs have potential; hence, we seek to provide clarity to our members about these treatment designs. Using MATCH as an example of a treatment that is *modular*, *transdiagnostic*, and *flexible*, we highlight a few advantages of these novel treatment designs.

They Can Be Effective

In randomized effectiveness trials conducted in ethnically diverse community settings, participants receiving MATCH experienced more rapid improvement of internalizing and externalizing symptoms than individuals enrolled in comparison groups (usual care or standard evidence-based treatments; Chorpita et al., 2013, 2017; Weisz et al., 2012). MATCH also yielded steeper reductions in non-study service utilization and breadth of psychotropic medication use than comparison treatments, suggesting that MATCH is an effective stand-alone treatment for a wide range of presenting problems (Chorpita et al., 2017; Park et al., 2016). Finally, the effectiveness of MATCH in diverse community settings was better than standard evidence-based treatments, which often perform better in controlled laboratory studies (Southam-Gerow et al., 2010; Weisz, Jensen-Doss, & Hawley, 2006).

They Can Be Efficient

MATCH and other transdiagnostic treatments can target comorbidity without resorting to a second treatment. When comorbidity occurs, the sequence of treatment is adjusted by selecting modules that address the comorbidity (Weisz et al., 2012), allowing for a continuous treatment flow without referring to another treatment or continuing with interventions that are not addressing comorbid issues. In addition, the average duration of MATCH, which does not have a prescribed treatment length, was significantly shorter than that of usual care (Chorpita et al., 2017; Weisz et al.). The potential to address comorbid-

ity and provide a shorter duration of treatment suggests that MATCH may be more efficient than treatment as usual and traditional manualized evidence-based treatments.

They Can Be More Likely to Be Adopted and Disseminated

The high cost of training providers in multiple diagnosis-specific manuals may be problematic for community agencies with limited resources that serve clients with heterogeneous symptom presentations (Barlow, Allen, & Choate, 2004; McEvoy, Nathan, & Norton, 2009). Modular and transdiagnostic treatments offer service organizations a potential solution that can address multiple problems, increasing their likelihood for adoption and dissemination, all other things being equal.

They Can Be Popular Among Providers

Despite research support for the efficacy of evidence-based treatments for children's mental health disorders (Weisz et al., 2006), manualized approaches remain underutilized (Riemer, Rosof-Williams, & Bickman, 2005). Some research shows that

providers' hesitancy to use evidence-based treatments may be more associated with concerns about their typically high degree of structure, rather than with the fact that they were developed through empirical testing (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009). Providers of MATCH, for example, reported increased engagement in treatment, in part because MATCH allowed them to flexibly adapt content to meet the individual needs of clients (Palinkas et al., 2013). However, in that same research trial, it did not appear that flexibility had a simple linear relationship with provider preference. For instance, in a study on therapist satisfaction, providers using MATCH gave higher satisfaction ratings than providers in the highly flexible usual-care condition (Chorpita et al., 2013), which suggests that there is an intermediate level of flexibility that is preferred. It is notable that such flexibility can easily be adjusted upward or downward from trial to trial with a modular treatment (i.e., simply by adding or removing constraints from the treatment flow). Thus, it may in fact be modularity that is primarily more important than flexibility

when attempting to address provider concerns about making treatment feel more individualized.

They Offer Individualized Content

By flexibly selecting modules that correspond to the client's needs, modular, flexible and/or transdiagnostic approaches provide an opportunity to individualize treatment for a particular client with unique symptom presentation, cultural background, learning style, and more.

Designs Are Options, Not Absolutes

Despite the successful performance of MATCH in clinical trials, we contend it is a misinterpretation to advocate for treatment arrays in service systems to be only modular in nature, or only transdiagnostic, or only flexible. Rather, such designs at best will provide options for particular audiences or contexts, such as settings with limited resources or heterogeneity in their diagnosis presentation. Even within those systems, there is room for providers and treatment consumers to have preferences for one kind of design over another, provided they are efficacious. Those prefer-



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ences could even be related to improved outcomes or sustained use in certain contexts. Thus, we argue that these innovations in treatment design should serve the aim of assembling arrays of services that offer best-fitting sets of options for the variety of providers and consumers that such systems will involve.

Conclusion

We have made great progress towards improving the mental health of youths through the development of evidence-based treatments, yet many challenges remain. As dissemination efforts succeed, many providers will encounter increased complexity, including issues such as the lack of available evidence-based treatments for a variety of common clinical presentations (Chorpita, Bernstein, & Daleiden, 2011), emergent life events that can shift or derail the focus of treatment (Chorpita, Knowles, Korathu-Larson, & Guan, 2014; Guan et al., 2017), cultural issues (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010), poor treatment engagement (Pellerin, Costa, Weems, & Dalton, 2010), or parent psychopathology (McLaughlin et al., 2012). In addition, we have a majority of children in low- and middle-income countries who do not have access to evidence-based treatments at all. An accompanying challenge for our field will be to extend the reach of our evidence-based treatments to countries that currently do not have the workforce or resources to implement and sustain such treatments (Saraceno et al., 2007).

Thus, as we gain better insights into strategies for dissemination and implementation, any resulting success will bring new problems. One part of addressing them will involve a continued focus on developing new treatments or making structural adaptations to existing treatments, so that we might boost their effectiveness and scope in these new contexts. These designs will likely involve a host of structural parameters that are worthy of experimental manipulation. Hence, we look forward to a time when we not only have a larger vocabulary for such designs, but also have a deeper understanding of which aspects of treatment design yield particular advantages in which contexts.

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Correspondence to Maya M. Boustani, UCLA, Psychology, 1285 Franz Hall, Los Angeles, CA 90095; mayaboustani@ucla.edu



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CLINICAL DIALOGUES

On Becoming an Activist: Tips From Cognitive Behavior Therapy

Dara G. Friedman-Wheeler, *Goucher College*

Jamie S. Bodenlos, *Hobart and William Smith Colleges*

How wonderful it is that no one has to wait, but can start right now to gradually change the world! —Anne Frank (1944)

Working toward what one values not only brings a sense of satisfaction but changes what one becomes in the process.
—Al Bandura (2011, p. 11)

REGARDLESS OF YOUR PARTICULAR political views, you may be one of many Americans who has decided over the last few months to get more involved in social activism. Indeed, seeing the divides in political positions, opportunities, and lived experiences, many of us have recently declared that we cannot, in good conscience, passively wait for others to make the world a better place.

However, you may have found that, since these declarations, you haven't done a whole lot on this front. Or perhaps you've done some, but you're not sure which way to go to do more, to make more of a difference, without having to quit your job to become a full-time activist. Or maybe you're doing it, but some days it doesn't feel like you're making a difference.

Well, lucky for you, many of us have a variety of tools (along with those hefty student loans) from our years of graduate training that can help us become effective activists in whatever time we have to give. Activism is defined as “a doctrine or prac-

tice that emphasizes direct vigorous action especially in support of or opposition to one side of a controversial issue” (Merriam-Webster, n.d.). Activism can be focused on anything from the environment to civil liberties, and it can be explicitly political or can be aimed more broadly at making the world a better place.

Depending on your “cause,” activism may take a variety of forms. It could be anything from participating in a march or rally to writing letters to the newspapers to calling your senators and members of congress. You could clean up (or March for Science) on Earth Day. You could skip your morning latte and use that money as a monthly donation to an organization that is important to you. Haven't you been meaning to give up the extra sugar anyway? (Or just make sure you're buying that coffee from a company whose values don't directly contradict your own.) The reality is that there are many ways to make a difference — but sometimes we can get a little stuck.

Among the many challenges we face in making these changes to our behaviors: busyness, anxiety about particular forms of activism, and sometimes depressed mood or hopelessness about the situations you would like to address. Are you noticing what we noticed? We have lots of tools for

addressing these types of challenges, right in our CBT toolboxes.

Challenge #1: When on Earth Am I Supposed to Squeeze This in?!

This issue of busyness is very real (cf. Safi, 2014). Many of us wear a variety of “hats” in a day. From 6:00 a.m. to 8:00 a.m. you are sporting your parent hat, from 8:30 a.m. to 2:00 p.m. you are wearing a hybrid researcher/teacher hat, and maybe from 3:00 to 6:00 p.m. it's the clinician hat. Then, after you get in your car after seeing your last patient, you hurry up and shove the parent hat back on before you get home. It's not until around 8:00 or 9:00 p.m. that you get to take all of your hats off or at least put your pajamas on and do a little work before bed. Does this sound familiar? How would you be able to fit in one more thing into your already tiring and overscheduled day?

The best way to get started may be to monitor exactly how you spend your time (are you thinking “Oh yeah . . . !” You tell your clients this all the time, right?). As scientist-practitioners, we realize the importance of measurement, so let's take a look at how we are using each hour of the day. Spend a few weekdays and a weekend day measuring what you do with your time. After you have the data compiled, critically examine your data. Are you spending a few hours scanning Facebook at lunch and after the kids go to bed? Do you hang around the office a little later than needed to complain to colleagues about a student or even politics? While we wouldn't advocate giving up sleep or exercise, perhaps the hour or so that you spend on social media daily (perhaps reading news stories about issues that upset you) could be better used making a call or two to your senators or congress people or composing a letter or postcard. Or perhaps split that hour between the two.