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Contents

President's Message

Prescription Privileges and Cognitive-Behavior Therapy

Dean McKay, ***Fordham University***

This special issue of *tBT* covers a highly controversial issue, namely, prescription privileges (RxP) for psychologists. The policy of pursuing RxP for psychologists is an important one for the entire mental health community, and for the practice of cognitive-behavior therapy (CBT) specifically. The articles that appear in this issue cover both the pro and con sides of the arguments regarding the value of RxP. In addition to this, the results of a membership-wide survey on attitudes toward RxP are provided.

Close to 20 years ago, *American Psychologist* ran a special issue focusing on the positive and negative aspects of RxP. At the time of the publication of this special issue, the center of gravity around this issue was tilting in its favor. There had been many prior articles emphasizing the virtues of RxP as a means to provide better care for our clients (i.e., DeLeon, Fox, & Graham, 1991). Shortly after the appearance of the special issue of *American Psychologist*, articles appeared asserting that the biological underpinnings of psychopathology was reaching a point of sophistication that we could feel confident in the value of medication for psychiatric illness (Hines, 1997).

We are now at a point where an entire generation of mental health professionals has been raised on the virtues of RxP, with comparably little debate about the relative merits, and the potential downsides of this practice. These

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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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professionals may be less acquainted with both sides of this discussion, instead being exposed primarily to positive messages about the role medication could play in the lives of our clients. We also live in an age of medication. In 1997, rules regulating the advertising practices of pharmaceutical companies were relaxed, and the era of television promotion of medications began in earnest. This direct-to-consumer approach to marketing medications has significantly altered the landscape, and creates incredible pressure on providers to meet the medication demands of clients. The demands of consumers have, however, been shifting. In the early years of television marketing of medication, consumer attitudes toward brand medications observed in advertisements were generally favorable, whereas by 2012 these attitudes began to tilt in the negative direction. That is, as consumers were exposed to more advertisements about medications, the more negatively they viewed these medications (Wood & Cronley, 2014). In a cautionary note for the public, spending on medication marketing is directly related to amount spent on individual drug development (Sood, Kappe, & Stremersch, 2014). In other words, total spending on medication research results in greater drug promotion, while spending on marketing is not necessarily a result of the drug's efficacy.

Make no mistake: medication for psychiatric problems has a seductive allure for practitioners and clients alike. How many times have you said to yourself, "I know this client could benefit from <medication X> for her/his <diagnosis Y>. If I could just prescribe it myself rather than wait for her/him to get an appointment with the psychiatrist, we could finally really make progress on <CBT protocol/approach Z>." And how often have you faced questions like "Doctor, do you think I could use <medication X>? I saw it advertised during the morning news, and the symptoms described sound just like me." The marketing is intense, the biases from the images difficult to dispute, and possibly your own desire to provide more rapid relief all can conspire to create a powerful impetus to prescribe the psychoactive substance in question. Complicating matters further for our profession is that direct-to-consumer advertising biases the public away from nonpharmaceutical treatments (Lacasse, 2005). The message therefore is clear: Ignore the pleas for medication, or even attempt to persuade against medication, at your professional peril. Better to join 'em than debate or go against 'em.

Of course, if we are to be truly empirical in our approach, the truth is far more complex than the advertisements and client requests would suggest. Many clients arrive in our offices already taking medication but with symptoms that have not remitted, and possibly have worsened (Whitaker, 2011). The palliative benefits of medications in some cases can also work at cross-purposes with our interventions. Consider the following example: If one begins treating a client for an anxiety disorder employing exposure treatment and the client is concurrently taking a benzodiazepine, clinicians may seek to have the benzodiazepine removed from the prescription protocol in order to facilitate the elicitation of arousal necessary for good outcome in exposure. Once this process is started, there are hurdles to overcome in the care of this client, including the management of withdrawal effects (such as rebound anxiety effects; Dell'osso & Lader, 2013) and the possible worsening of symptoms on the way to providing relief. The problems associated with benzodiazepine use for anxiety disorders, to round out this example, are sufficiently extensive that it has prompted some to ask if this class of medications should be used at all for this group of diagnoses (Baldwin & Talat, 2012). This is but one isolated example where certain classes of medications can potentially delay the efficacy of CBT, and includes costly additional interventions to manage some of the unhelpful aspects of the pharmacological agent. This aspect of prescribing is underappreciated in many circles. There is also comparably limited recommendations on medications that are contraindicated for specific psychosocial interventions.

The issue of possible negative medication interaction with planned CBT intervention is not the sole reason we should be hesitant about RxP. The basic tenets of CBT emphasize personal agency in mastering emotional distress. We want our clients to feel that their efforts at directly managing their symptoms resulted in relief. So what does it mean to the client who experiences emotional relief to ascribe that benefit to a medication? What does it reflect about our practices if clients are in CBT treatment concurrent to receiving medication and they begin to experience relief? One could reflect that it means that our interventions are somehow less efficacious. On this note I urge you to be sure and be familiar with not only the efficacy data on CBT, but be familiar with the obtained effect sizes for CBT versus medications. If you do so, you will be surprised at the disparities. Consider this one example: CBT for obsessive-compulsive disorder results in large effect sizes for symptom reduction (defined as a $d > 0.8$; i.e., Olatunji et al., 2013), while medication for obsessive-compulsive disorder has a generally lower effect size, in the small to medium range (d from 0.3 to 0.5) and with CBT showing greater efficacy in direct comparisons (Kobak et al., 1998). It is exactly this kind of comparison that needs to be examined in order for us to make an informed and eyes-wide-open decision about the virtues of RxP as it relates to CBT practice. And yet, many clinicians are unfamiliar with these head-to-head comparisons or comparable efficacy findings. As an anecdote that I will acknowledge I cannot back up with research findings, I have supervised many students who have said things like, "It appears the medication is finally working for <client>." This statement always happens at a point in the trajectory of care where the client has also begun to engage in CBT more fully, and where the medication has been prescribed for a long time. I always follow up this statement with something like, "Why would you say that? Do you have so little regard for your own work?" It is at this point an analysis of why a statement about "the medication finally kicking in" not only makes little to no sense, practically speaking, but is also at odds with research on comparable efficacy.

The articles in this special issue are sure to be thought provoking for our members, both those in favor and opposed to RxP. Your view on this matter is sure to deepen and be enhanced by the perspectives offered by the contributors, as they cover the gamut from the policies and history of RxP, the legislative efforts underway and the associated politics, proposed training models for professionals to attain RxP, and the philosophical impact of ascribing a biomedical view of psychiatric illness in light of the state of our diagnostic tools.

I'd like to end by noting something that *tBT* editor Brett Deacon discusses in greater length in his accompanying editorial to this issue. In advance of the publication of this issue, I shared with Dr. Deacon my evolving stance on RxP. As a graduate student, I was strongly in favor of RxP, and I'll readily acknowledge that the aforementioned seductive allure was what had me in its grip. It was not until I was exposed to a variety of opinions on the relative merits of RxP, and its attendant risks, that my view began to shift to what it is now, which is decidedly opposed. Whatever position you hold on this matter, it is my hope that this special issue will help you hold this position on the

basis of a fuller appreciation of the range of opinion and data underlying the RxP movement.

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I am indebted to Brett Deacon for helpful comments on a prior draft of this column.

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SPECIAL ISSUE

Prescriptive Authority for *Psychologists*

Introduction

Brett Deacon, *University of Wollongong*

Since its inception in 1996, the American Psychological Association's (APA) campaign for prescriptive authority for psychologists (RxP) has been a contentious and polarizing issue among relevant stakeholders. Practice-oriented psychologists within the APA have championed the campaign, and science-oriented professional psychologists have vigorously opposed it. Patient advocacy groups like the National Alliance on Mental Illness (NAMI) have not supported RxP, and staunch resistance from psychiatric and general medical organizations has helped defeat mote than 150 RxP bills to date. Yet, RxP bills have passed in New Mexico, Louisiana, and Illinois, and the APA will continue to promote and fund state-by-state RxP legislative efforts for the foreseeable future.

Supporters view RxP as the natural evolution of psychology and believe APA-approved training programs are sufficient to ensure the safety and efficacy of pharmacotherapy provided by psychologists. Critics contend that the APA has aggressively promoted RxP without encouraging adequate debate among its membership regarding its scientific legitimacy and practical consequences, and without adequately considering enhanced collaboration with existing prescribers as an alternative. One issue about which both sides agree is that RxP has profound implications for the future of professional psychology with regard to education and training, science, and practice.

ABCT has remained neutral regarding RxP, and this topic is rarely featured in ABCT journals or discussed at ABCT conventions. Unfortunately, our relative inattention toward RxP is disproportionate to its importance to our field. Accordingly, this special issue of *the Behavior Therapist* is intended to promote scholarly dialogue on RxP. Because open and critical discussion of RxP has often been discouraged owing to the intensely political nature of APA's RxP campaign, readers are likely to have been primarily exposed to one side of the debate. A secondary goal of this special issue is to provide a forum for critics of RxP to present their case.

This issue features five articles on RxP. Former APA president James Bray and colleagues present the pro-RxP position, whereas Timothy Tumlin and former ABCT president Robert Klepac present the case against RxP. Both articles discuss the history of the RxP campaign and its current status and future directions. Sean Ransom describes the consequences of RxP from his firsthand experience as a prescribing psychologist in Louisiana. Phillip Hickey critically analyzes issues related to the biomedical model of mental health upon which RxP is founded. Lastly, I present the results of a comprehensive survey of attitudes toward RxP among the ABCT membership. On behalf of *the Behavior Therapist* and ABCT, I extend my sincere gratitude to the authors who contributed their time and expertise to this special issue.

Finally, I echo the sentiments expressed by Dean McKay in his presidential column. Like Dr. McKay, I supported RxP early in my graduate school career and accepted that it represented the natural evolution of professional psychology. I now oppose RxP on the basis of a thorough analysis of both sides of this issue. Whatever your own position on RxP, I trust you will find the articles in this special issue useful in contributing to a more informed opinion on this very important topic.

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Prescriptive Authority for Psychologists: Current Status and Future Directions

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Michael Tilus, *Indian Health Service*

Christina Vento, *New Mexico State University*

Marie Greenspan, *Indian Health Service*

Greg Wilson, *Student Representative of the American Society for Advancement of Pharmacotherapy (ASAP), Division 55 of the American Psychological Association*

Morgan Sammons, *National Register of Health Service Psychologists*

Psychologists trained in psychopharmacology have been prescribing psychotropic medications *as part of the treatment* they offer their patients for over 25 years through both federal and state programs (DeLeon, Fox, & Graham, 1991; DeLeon & Wiggins, 1996; Fox, 1988). Psychologists with specialty training in psychopharmacology also regularly consult with physicians and help them properly diagnose their patients and make recommendations for psychotropic medications (American Psychological Association [APA], 2011). Further, psychologists with training in psychopharmacology routinely teach medical residents, such as family medicine and pediatrics, on how to diagnose mental disorders and how to prescribe medications for their treatment (Bray, 2010). Additionally, three states and one territory allow the psychologists the independent ability to prescribe psychotropic medications and the majority of state psychology licensing laws are permissive regarding the ability of psychologists to consult with patients and other providers regarding psychopharmacological regimens. *These facts make the question of whether we should prescribe medications moot*.

This paper represents the perspectives of both psychologists and graduate-level students who have been involved in legislative advocacy for prescriptive authority, including a wide array of individuals in varying stages of their careers. Specifically, this paper includes psychologists who have training in psychopharmacology and are licensed to prescribe medications (M.S., M.T, C.V., M.G.), psychologists who are not licensed to prescribe (J.B.), and a graduate student who aims to seek the necessary training to prescribe (G.W.). In this paper we will address several issues concerning the current status of prescriptive authority for appropriately trained psychologists and future directions in the context of health care reform and the move to integrated health care services. It is clear that psychologists and psychology students feel passionate about this issue, with strong proponents and strong opposition to the progression and evolution of our profession.

From Psychosocial Fixation to the Biopsychosocial Model

With advances in neuroscience, genetics, behavior-genetic interactions, and expansions of translational research, psychology is more relevant than ever and there are many new opportunities for our profession (Bray, 2010; Collins, 2006, 2010). Indeed, Department of Labor projections for the profession as a whole predict a healthy growth rate for clinical psychologists of approximately 12% over the next decade (U.S. Department of Labor, 2012), indicating that the profession as a whole is on a very solid trajectory for the medium-term future. These new opportunities are also created by federal health care reform through the Affordable Care Act (U.S. Congress, 2010). Although the mechanics for the provision of mental health services under the health care exchanges in the Affordable Care Act remain largely uncharted, it is clear that expanded coverage for new and preexisting mental health services will require an expansion of the mental health workforce. One of those growth opportunities is for appropriately trained psychologists to prescribe psychotropic medications.

The fixation on behavior and psychosocial issues by some psychologists is dated and does not fit with current scientific evidence about the integral biopsychosocial nature of human beings (Kaslow et al., 2007; McDaniel, Campbell, & Seaburn, 1990). Thus, psychologists need to adapt to these new understandings and implications for practice or we will soon be left out of the rapidly changing health care scene. As Bray (2010) stated in his presidential address:

> While psychologists are experts at change, it appears that we are not unlike other humans in our resistance to changing our ways and evolving to meet the current needs of our profession and the people we serve. A recent example is the fight for and against prescriptive authority for appropriately trained psychologists. This seems similar to the fights that occurred during my early training between psychoanalytically oriented psychology and the move toward behaviorally oriented psychology. In both cases psychologists who voiced opposition to change argued that it would ruin our profession and destroy our field. Too often we block our own progress with this type of infighting. (p. 356)

The progression of evidence-based psychotherapies has improved our overall profession, and has not ruined it as suggested by some. There is no evidence in states or federal programs where psychologists can prescribe that the profession has fundamentally changed or "turned us into junior psychiatrists." Despite the infighting, the benefits that patients have received under the care of prescribing psychologists, particularly in underserved areas such as the Indian Health Services, illustrate the need to further examine where more trained prescribing psychologists can be strategically placed to not only meet the growing demands and complexities of health care, but to work towards ameliorating health care disparities by increasing the number of providers trained in a biopsychosocial framework to provide services in multidisciplinary settings.

In the current graduate training of psychologists, psychopharmacology is often not a required course needed to matriculate from a doctoral institution. Instruction in this field is not a required standard by the APA's Commission on Accreditation, and while many graduate programs offer coursework in psychopharmacology, such courses are usually elective. Here the profession of psychology is lagging behind other mental health professions. For example, in the state of California, master's-level clini-

cians trained as licensed professional counselors and as marital and family therapists have curricular requirements for course work in psychopharmacology. As graduate student membership continues to decline within professional organizations for a plethora of reasons, it is paramount that outreach to graduate trainees occur at a more rapid pace so that the future of prescribing psychologists remains solvent to meet the ever-increasing demands of integrated health care.

A fear among some psychologists opposed to prescriptive authority is that if we prescribe medications, we will lose our psychotherapeutic, relationship-focused style of interacting with patients (APA, 2011). We will become every negative stereotype of psychiatry and indifferently dole out pills assembly-line style. But a prescription pad is not a personality transplant. In fact, what happens is that we retain the well-developed psychotherapy, interpersonal attunement, and assessment skills when we gain the prescription pad. This is a huge boon to patients, many of whom have been treated poorly by previous prescribers and universally appreciate a prescriber who listens to their concerns, values their input, and considers all modes of treatment instead of "a pill for every ill." In addition, one of the advantages of having prescriptive authority is the power to take people off of medications and use effective behavioral interventions in their place (Sammons & Schmidt, 2001).

One application of this is the adoption of a shared decision-making model, a relatively new medical paradigm for patient empowerment and participation in their own care (Barry & Egdman-Levitan, 2012). The shared decision-making model is imbedded in health care reform and the move to integrated health care. This model is highly collaborative, in opposition to the traditionally authoritarian mode where "the Doctor always knows what's best," unilaterally making most treatment decisions with minimal input from the person who will experience it. Shared decision making requires more communication between the patient and provider, explaining the risks and benefits of different treatment options for the patient to choose. It also reduces the typically large power differential between prescriber and patient. Each is seen as bringing something valuable to the relationship. While not all prescribing/medical psychologists explicitly use shared decision-making models in their practice, it is illustrative of ways that psychotherapy can positively color and inform the "med-check" experience.

For example, when initiating an antidepressant, the dose typically needs to be started at a subtherapeutic level and increased gradually to minimize initiation side effects such as headache, gastrointestinal disturbance, sleep disruption, and transient increases in anxiety. This can be done "conservative and low and slow,'" which reduces chances of side effects but may delay symptom relief, or "ASAP or aggressive," which does the opposite. Both are reasonable options for most patients, but unless the prescriber asks the patient which he or she prefers, the prescriber ignores the single most important factor in deciding how to structure the titration. When the patient's input is solicited, it conveys many psychotherapeutic things: their opinion, preference, and feelings are important and meaningful, the prescriber is concerned for their comfort and speed of recovery and that they have ownership in what is happening to their own bodies. Unfortunately, the state of mainstream medicine is such that when a prescribing/medical psychologist asks this kind of question, the patient's mouth sometimes gapes open in surprise at being asked about her preference, as it is such a novel experience.

Some prescribing/medical psychology patients are in traditional individual psychotherapy with the prescriber, some work with a different psychotherapist as well, and others only receive mental health treatment in the context of a medication management session. Prescribing and medical psychologists adapt their integrated treatment approach to each patient's preferences, circumstances, and needs. When a patient is also working with an outside psychotherapist or is not in individual psychotherapy, the prescribing/medical psychologist incorporates psychotherapeutic interventions into the medication management session (Sammons & Schmidt, 2001). They focus on various supportive techniques (i.e., motivational interviewing around barriers to self-care, brief, solution-focused CBT for topics such as panic attacks, depressive thinking, and insomnia) and educating about mental health conditions and symptoms. Communication with the individual psychotherapist is typically ongoing and mutually beneficial.

Brief History of Prescriptive Authority for Psychologists

The APA policy to support prescriptive authority for psychologists was explored, debated, and decided in 1995 by the APA Council of Representatives (APA, 2009; Weiner, 2012). APA policies are created by the APA Council of Representatives and are often shaped by collaborating with APA boards and committees within the organization. APA staff are charged with carrying out the policies of the association. Since it is the policy of the APA to support prescriptive authority for psychologists, APA resources and staff are used to promote and support these efforts. This includes educational, legislative, and legal and regulatory issues (APA, 2009, 2011). Since the policy decision to support prescriptive authority for psychologists was made, some have tried to reverse the policy but have not succeeded. In some ways, continued efforts to reverse this policy is like the current Republican House of Representatives voting over 50 times to stop the implementation of the Affordable Care Act or health care reform. The issue was debated and decided and it is the law of the land.

Because of the APA policy supporting prescriptive authority for appropriately trained psychologist, divisions within APA cannot openly argue against prescriptive authority. However, groups within APA can and do remain neutral in whether or not they choose to help advocate and utilize their resources to promote prescriptive authority. The American Psychological Association of Graduate Students (APAGS) is the largest graduate student group for psychology students worldwide. Membership for graduate students in APAGS has ranged from 41,841 members in 2001 to 31,510 members in 2012 (APA, 2012). In 1991 APAGS established the APAGS Campus Representative Program to, "among other goals, advocate for prescription privileges for psychologists" (Dingfielder, 2013). This is particularly impressive given that APA had not passed a policy on prescription privileges for psychologists until 1995, illustrating that our graduate trainees are an essential part of creating and furthering systemic change within our health care system.

The first prescribing psychologists were those trained through the Department of Defense Psychopharmacology Demonstration Project. Those enrolled in the program began prescribing early in their clinical training while on the inpatient wards at Walter Reed Army Medical Hospital, and

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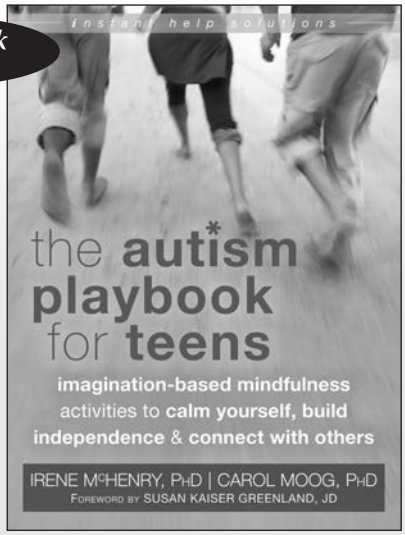

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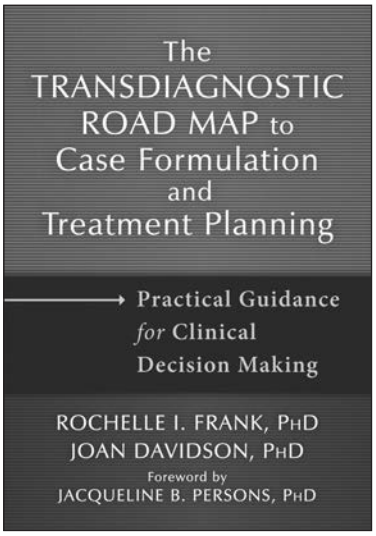

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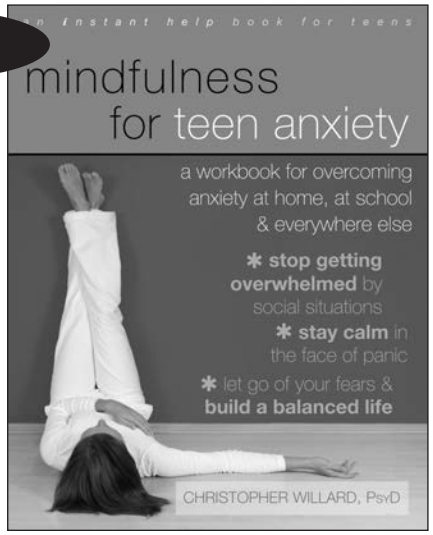

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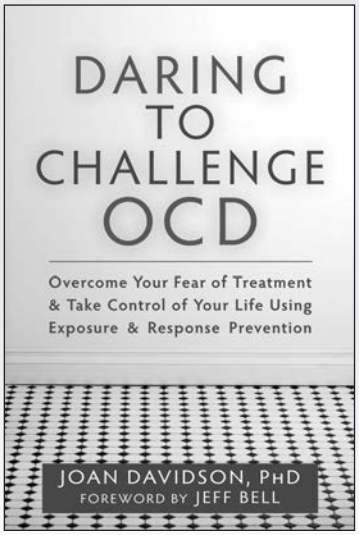

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began prescribing independently shortly after completing their fellowship in 1994. New Mexico passed enabling legislation for psychologist prescribing in 2002. Louisiana followed with its law in 2004, and most recently Illinois passed a psychology prescribing law in 2014. Psychologists are currently authorized to prescribe medications in New Mexico, Louisiana, Illinois, and Guam, in the U.S. Department of Defense and in the U.S. Public Health Service. In addition, state legislatures in Hawaii and Oregon voted to grant prescriptive authority to psychologists, but the governors in each state vetoed the bills. It is estimated that about 1,500 psychologists have gone through the rigorous psychopharmacology training through a variety of postgraduate training programs (McGrath & Sammons, 2011). Many other states are working on legislation to give psychologists prescriptive authority, and it is only a matter of time until more states pass such laws. Because of this policy, and the extensive training requirements for psychologists to prescribe, they safely and effectively prescribe psychotropic medications each day. Psychologists have been safely and successfully prescribing psychotropic medications for over 25 years.

Current Status of Prescriptive Authority for Psychologists

There are 45 prescribing psychologists credentialed through the New Mexico Board of Psychologist Examiners and 83 who are licensed through the Louisiana Board of Medicine (Vento, personal communication, March 2014). Of the approximately 15 prescribing psychologists working in various branches of the military, some are credentialed through New Mexico, some through Louisiana, some are among the original 10 Department of Defense Demonstration project graduates, and some may be credentialed in accordance with other specific military requirements. The 6 prescribing psychologists currently employed by the Indian Health Service are credentialed through New Mexico.

Of the 135 psychologists currently credentialed to practice, safety data regarding the few prescribing psychologists who are not among those credentialed through either New Mexico or Louisiana is not currently known. However, it is known that no complaints have been filed regarding any prescribing psychologist credentialed through either New Mexico or Louisiana (Vento, personal communication, March 2014), nor are there any records in the military health care system of prescribing psychologists operating outside established standards of care. Opponents of prescriptive authority for psychologists have not unearthed any licensing complaints or lawsuits against prescribing psychologists, yet often use this as a crutch in their argument to discredit the momentum that prescribing psychologists have gained over the recent decades (one oft-cited case of a patient suicide has been erroneously ascribed to a prescribing psychologist while in fact the treating provider was a nurse practitioner, but the use of this argument belies the inherent risk of dealing with severely depressed, potentially suicidal patients with any modality).

It is estimated that prescribing psychologists have written more than a million prescriptions since the inception of this specialized practice, with no evidence of unsafe or unsatisfactory results, if the absence of Board actions and lawsuits or entries into the National Provider Databank are used as indicators. Prescribing psychologists have been frequently criticized by opponents for not producing data regarding the safety of their practice, *but of course a negative cannot be proven*. The absence of indications of any safety issues as evidenced by Board complaints or lawsuits should be of some comfort to skeptics. The power of the "dog in the night-time" argument (Levant & Sammons, 2003), which contends that the fiercely vigilant opponents of this practice would noisily point out any unusual event ascribable to psychologist prescribing, cannot be underestimated, and it is quite simply the case that such events have not occurred.

Fully credentialed prescribing psychologists licensed through either New Mexico or Louisiana practice collaboratively with medical providers, including physicians, nurse practitioners and physician assistants, but their practice is not supervised or dictated by any other professional. With regard to professional liability, prescribing psychologists are responsible for their own behaviors. Professional activities for those in private practice are underwritten by the American Psychological Association Insurance Trust that includes a special rider for prescribing activities. Those who are employed by the military or in the federal government are insured additionally for professional malfeasance by their employers. The vast majority is accountable to their respective licensing boards for their professional activities.

Future Directions for Prescriptive Authority for Psychologists

Currently, there are a number of states working on RxP legislation at various stages of development. In addition, there are international efforts in progress. The province of Ontario in Canada is working on legislation, as are the countries of New Zealand and Australia. Because of the shortage of psychiatrists and other physicians, the New Zealand Ministry of Health is promoting prescriptive authority for appropriately trained psychologists, as discussed in a symposium at the 2013 APA convention. Further, there have been several cohorts of psychologists from the Netherlands trained in the U.S. to prescribe psychotropic medications as well.

Recently, U.S. Congressman Beto O'Rourke announced his intention to introduce federal legislation to give psychologists in the Veterans Administration prescriptive authority. Congressman O'Rourke stated, "I'm about to file a bill that will give VA psychologists the power to prescribe medications, which they don't have today. They have that in the Department of Defense. They have that in other branches of our government. They don't have that within the VA, and we desperately need it." He further stated, "Something is deeply wrong with the VA in El Paso. That is not to say that there's anything wrong with the doctors, nurses or the mental health practitioners there. There just aren't enough of them. We need more resources from the VA in D.C."

The Affordable Care Act has created unprecedented expansions of opportunities and service needs for mental health and substance abuse issues. Because of the increased access to care by millions of people in the U.S., there are great concerns about the lack of providers for these services. Both federal and state legislatures have studied these issues. Even in conservative states, these issues are being recognized to meet the unmet needs of the populous. In a recent legislative study report, *Mental Health Workforce Shortage in Texas* (2014) pursuit to House Bill 1023, the study group concluded the following: "Physicians might cede some of the simpler tasks and practice 'at the top' of their training, allowing other professions to fill in the gaps through role extension. . . . Federal programs (Caccavale, Reeves, & Wiggins, 2012) and the states of New Mexico and Louisiana have granted prescriptive authority to psychologists trained in psychopharmacology. . . .

Responsible role expansion should continue to be considered" (p. 20).

Integrated Health Care

Health care reform has also brought forth an increase in primary care and integrated health care systems (U.S. Congress, 2010). The growth areas for psychologist are not in traditional mental health settings, but in primary care and integrated health systems (Bray, 2010; Bray, Frank, McDaniel, & Heldring, 2004). Because of the increase in emphasis on primary care and the greater access to these services by newly insured people, it is estimated that there will be large workforce shortages (McGrath & Sammons, 2011; Texas Department of State Health Services, 2014). Psychologists are in a prime position to fill many of the service gaps by providing both psychological interventions and also providing pharmacotherapy interventions.

The patient-centered medical home (PCMH) model also implicitly acknowledges the importance of integrating psychological and behavioral services into the primary care setting (Bray, 2010; McGrath & Sammons, 2011). Having primary care psychologists also have advanced training for prescribing meets many of the needs within the PCMH. As McGrath and Sammons (2011) stated:

> A recent study found that approximately 60% of prescriptions for a psychotropic medication are written by primary care physicians (Mark, Levit, & Buck, 2009), even though more than 60% of family medicine residencies offer no formal training in clinical pharmacology let alone clinical psychopharmacology (Bazaldua et al., 2005). Psychologists with little formal training are already called upon to provide advice to PCPs on an appropriate medication regimen; psychologists with advanced training in pharmacotherapy will increasingly find physicians using their expertise. (p. 116)

Conclusions

Appropriately trained psychologists have the background, expertise, and legislative authority to prescribe psychotropic medications. They have been doing it safely and effectively for over 25 years and providing much needed services to people who would go without or wait unconscionable lengths of time to receive services. In addition, unlike psychiatrists and nurses who can prescribe, psychologists can also provide evidence-based psychotherapies and other behavioral interventions in addition to or instead of medications. *It is also important to remember that the power to prescribe is the power to unprescribe*. Graduate trainees are entering a particularly exciting time in their careers as psychologists gain the ability to prescribe in various settings and are able to witness firsthand how to integrate their training in a more comprehensive and integrative model to populations that need services the most.

As McGrath and Sammons (2011) stated, "Psychologists will help identify circumstances in which biological interventions should be ancillary to the psychosocial rather than vice versa" (p. 119). Finally, as DeLeon and Wiggins (1996) so clearly stated, "But again, history suggests that objective data have never persuaded those fundamentally opposed, or economically or emotionally threatened" (p. 225). In conclusion, we appreciate the opportunity to provide this update and expect that those who understand the future needs of our profession and the people we serve will hear our message and act accordingly for both the benefit of our profession and the public we serve.

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The Long-Running Failure of the American Psychological Association's Campaign for Prescription Privileges: When Is Enough Enough?

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For nearly two decades the American Psychological Association (APA) has conducted an expensive campaign to expand psychologists' scope of practice to include prescribing medications, a change that would alter the profession in ways that are arguably detrimental. This marathon effort continues despite an almost perfect record of costly failures over decades, and despite a lack of scientific support, a long trail of controversies, and failure to gain consensus within the profession.

Many psychologists and their colleagues have had little chance to fully examine the record of the prescription privileges (RxP) campaign and the details of its proposals, even though they could alter both the profession and the mental health treatment system itself. This review is intended to provide all stakeholders with an understanding of this divisive issue, and possibly prepare them to play a role in its course.

This article begins by examining the details of the education and training proposed in legislation to prepare psychologists to prescribe, and their practice conditions afterward. It also asks whether psychology needs to and should incorporate the practice of medicine at all, particularly in light of the risks and controversies and the existence of more reasonable alternatives. The legislative record of RxP, its origins and its political course within the APA are discussed, and several areas of controversy concerning RxP are illustrated. Case examples involving RxP activities in two states are provided.

Development of Training Models

A historical review of training standards for prescribing psychologists, followed by the current model proposed by the RxP political campaign and offered by commercial education programs, illustrates how these standards have been weakened to levels well below what is regarded as sufficient by the medical professions. The earliest exploration of training standards for RxP began in 1991 when the first of 10 psychologists entered a military pilot program known as the Psychopharmacology Demonstration Project (PDP). There was no evidence that additional prescribers were needed within the Department of Defense (DoD) but the project was ordered by Congress nonetheless. Instrumental in that decision was the influential U.S. Sen. Daniel Inouye of Hawaii, who employed on his staff Patrick DeLeon, Ph.D., who was, and remains, the leader of the RxP movement. Initially PDP participants underwent 2 years of classes at the Uniformed University of Health Sciences, but the program was later reduced to 1 year of didactics and 2,000 hours of practicum. The context in which the DoD prescribers practiced was unique. Only active-duty military personnel 18 to 65 years old who were already screened medically and found to be healthy were treated. They practiced only within medical settings, in which all care was provided without charge, in close collaboration with physicians and supervisors. An assessment of the program by the American College of Neuropsychopharmacology (ACNP; 2000) found the graduates to be competent when collaborating with a medical team but were considered weaker medically than psychiatrists.

Proponents of RxP nowadays routinely cite the PDP as evidence that their legislative proposals are scientifically supported, when in fact they are hardly comparable in the quality and quantity of training. It is noteworthy that, while they are regarded as trailblazers for psychologist prescribing, as a group these persons said they would not approve of diluted RxP training proposals such as those that have since been offered legislatively. The assessment of the PDP project stated: "Virtually all graduates of the PDP considered the 'short-cut' programs proposed in various quarters to be ill-advised" (ACNP, 2000). The DoD closed the demonstration project following an additional program evaluation, concluding that there was no need for the prescribing psychologists, and that expanding such training was cost-ineffective. The program cost $6 million to train the 10 psychologists (General Accounting Office, 1997).

In 1992 an APA Ad Hoc Task Force on Psychopharmacology issued recommendations that defined three levels of psychopharmacology training for psychologists (Smyer et al. 1993). Level 1 consisted of two graduate-level courses that provided basic knowledge in biopsychology and psychopharmacology. Level 2, labeled Training for Collaborative Practice, would prepare the psychologist for consultation-liaison relations with medical practitioners (summarized in Robiner et al., 2002). The Task Force's Level 3 training was designed for independent prescribing practice and called for undergraduate preparatory coursework in biological sciences as well as more extensive graduate training and a specialized internship in psychopharmacology. In all, Level 3 training would require about 4 years to complete, compared to the 6 years advanced-practice nurses are trained. Therefore, the doctoral program in clinical psychology that included this training would require about 10 years in all, similar to the amount completed by psychiatric physicians after the bachelor's degree

The APA ignored the Task Force's recommendations on collaborative practice training reflected in Levels 1 and 2, and focused instead on Level 3 for independent prescribing, but without adopting the prerequisites and graduate training recommendations for that level. In 2009 APA issued revised training standards which are substantially less rigorous than those of the PDP, calling for 400 hours of instruction. The APA also created the Psychopharmacology Examination for Psychologists (PEP) to be taken following the program. Advocates for RxP often extol the PEP as a "national examination," which suggests quality assurance standards set by a broadly based authority. However, they do not mention that the test comes exclusively from the same organization promoting lower training standards, and paying for RxP lobbyists to press for state legislators' acceptance of proposals authorizing psychologists to prescribe.

Current RxP Legislative Proposals

Concerns have arisen about the now-weakened proposals that would allow psychologists to prescribe. These range from questions about the lack of prerequisite edu-

cation to the conditions of professional practice. Psychologists are different from other health care professionals in that their graduate training does not require them to undergo coursework in basic biomedical sciences. And also unlike other health professions, psychologists admitted to RxP training programs are not required to complete any prerequisite coursework in medically relevant biological sciences before enrolling, or demonstrate prior competence in any of those domains through testing. Such coursework is necessary to understand the fundamental processes inherent in health and illness, and how the human body responds to medications (Heiby, 2010). As noted in the accompanying table, other health care professionals are required to obtain hundreds of instructional hours in prerequisite biological science education, oftentimes more instruction than what is required for the entire RxP training.

A training model for prescribers requiring as little as 400 hours – 26.6 semester credits – of instruction is a source of considerable concern. Master's degrees in the three psychopharmacology programs deemed appropriate by APA offer approximately 450 hours of instruction. This is approximately 20% of the training required of physicians, 33% of what is completed by advanced-practice nurses, and 50% of what was completed by the PDP psychologists. These RxP degrees cover some of the basics of chemistry and biology, substantially reducing how much is actually spent on learning advanced topics about medical practice.

Table 1. Biological Science Prerequisite Education of Other Prescribing Professions Expressed in Contact Hours, Consistent With RxP Training Programs

Prerequisite	Medicine 465	Dentist 474	Physician Assistant 214.5	Optometrist 421.5	Nurse Practitioner 160.5
Biology	120	127	73.5	109.5	45
Physics	115.5	114	7.5	121.5	52.5
Inorganic Chem	117	123	102	121.5	46.5
Organic Chem	112.5	109.5	31.5	69	16.5

Note. Adapted from Sechrest & Coan (2002).

Concerns about the depth of this curriculum may be illustrated by the attention such programs pay to prescribing for children and adolescents. Psychiatrists undergo a special 2-year fellowship in learning how to prescribe for this population, capped by specialized board certification. In contrast, the RxP course offered by the California School of Professional Psychology addresses

this area and several others in one single course of 36 online clock hours of instruction. The school's online course description (http://catalog.alliant.edu/preview_program.php?catoid=24&poid=2711&returnto=887) states that it covers "child/adolescent psychopharmacology, geriatric psychopharmacology (dementia, polypharmacy, and interactions between pharmacotherapy and age associated illnesses); developmental disorders; treatment of chronic pain disorders; psychopharmacological issues for individuals with chronic medical illness, victims of trauma, and patients with personality disorders."

Other concerns about the quality of the education relate to its format. The education component is primarily acquired online, a condition that RxP advocates fail to mention in any of their pronouncements. For example, one program requires students to watch recorded lectures and then discuss the material through online chats. The proposed context of training and practice for prescribing psychologists raises further questions. Many psychologists have been trained in settings outside of the medical health care system, such as schools, counseling centers, and social service agencies, and they also have practiced professionally apart from any medical contexts. In contrast, the training of other prescribing professionals typically includes long apprenticeships in hospitals and other similar settings, learning not only through didactic instruction but through extensive exposure to a wide variety of experiences and clinical sites. Therefore, it would seem reasonable to require aspiring psychologist-prescribers to practice what they have learned entrenched within the medical system to compensate for this. However, the opposite is true. Proposed legislation would allow psychologists trained online from a psychology school to undergo their practicum training under the guidance of another psychologist in a private, nonmedical office setting. Finally, current proposals would have prescribing psychologists practice under the regulation and licensing of the state psychology board, whose members typically have no medical training.

Therefore, the result of such proposals could be a class of psychologists who can prescribe all the psychoactive medications that a board-certified psychiatrist does in a private setting. Yet, the process which qualified them would consist of a biomedical education obtained online from a distant psychology school, meeting weakened training standards developed entirely by psychologists and certified through a test developed and administered by a psychology organization. These persons' practicum experience would be supervised by a fellow psychologist, and their regulation and licensing would take place under a board of psychologists. Such a new medical—and psychological—profession would thus have been created entirely by psychologists, separate from the medical professions, and without the support or approval of any medical authority on training and safe practice.

Issues over the quality of the proposed training of prescribing psychologists were underscored by comments posted on the ABCT listserv by a prescribing psychologist from Louisiana, Sean Ransom, Ph.D. (personal communication, April 25, 2014). He wrote that he felt his training was "woefully inadequate. . . . Were it not for my outstanding physician colleagues (including some extraordinarily charitable psychiatrists who reached out), my RxP certificate would have been a menace." While expressing the belief that RxP training could be valid and valuable, he conceded "RxP advocates are encouraging a faulty training model and are unnecessarily giving the advantage to RxP opponents who can truthfully claim that the basic training is not sufficient for best patient care."

Finally, an ethical and scientific concern about the RxP proposals, which arches over all others, is complete absence of empirical evidence to support them. The practices of such prescribers in New Mexico since 2002, and Louisiana since 2004, provide rich opportunities for study of whether these persons are prescribing safely and effectively for their patients and enhance access to care in their areas. However, in those collective 22 years, no such evidence has been produced. This is especially noteworthy since proponents have ample resources to produce such evidence and it would strongly bolster their legislative case, something desperately needed since RxP is a political failure. Brushing aside science, advocates claim that this model is safe because no psychologist has been sued for malpractice for prescribing. However, they fail to say that in New Mexico, and in Louisiana until 2010, consulting physicians have signed off on prescriptions written by those psychologists, thus providing a medical backstop to ensure safety.

The ascientific nature of RxP politics is consistent with its origins. This campaign came to prominence while APA's changing leadership tilted heavily toward a practice orientation, a shift that resulted in many scientifically focused psychologists leaving the organization to establish the Association for Psychological Science. The RxP campaign's roots took hold within organizations with a practice orientation, such as APA's division for psychologists in independent practice, rather than those which made science the primary determinant of professional activity, such as the Society for a Scientific Clinical Psychology, whose members oppose RxP. It is also noteworthy that commercial schools that have opted to develop such master's programs in prescribing are generally not those most deeply steeped in scientific training. Rather, they have been developed in programs espousing "practitioner scholar" models of training, and deemphasizing the scientific underpinnings of psychological practice, let alone the practice of medicine. In light of the noted reasons to be concerned that the practice of prescribing psychologists would be based on training that is lacking in so many respects, we wonder if it also becomes an important ethical question to allow them to continue without empirical support. Thus, the question is also raised as to whether APA and other proponents should continue to pursue RxP, given the risks inherent in prescribing psychoactive drugs.

Should Psychologists Prescribe Drugs?

The foregoing discussion assumes that training to prescribe medications is a goal towards which psychology as a profession should work. Many psychologists, however, express concerns about whether the profession should include prescribing drugs in its scope of practice at all. These concerns include whether expanding into medical practice is in the best interests of their profession and of the people they serve clinically, particularly since alternatives preferable to RxP in every respect do not get the attention and resources afforded this campaign. In addition, many psychologists raise questions as to whether RxP would lead to less emphasis on psychological practices, damage the mental health system by worsening the shortage of psychiatrists, harm the profession by exposing it to the financial influences of the pharmaceutical industry, and prolong the deep divisions within psychology already caused by RxP.

Proponents of RxP argue that weakening training standards for prescribing medication is necessary to address unmet needs for psychoactive medications. Setting aside questions of how much of that perceived need is real and how effective such medications are, there are several alternatives to RxP which address this in a manner that is far safer, more effective, immediately imple-

mentable, and noncontroversial. Among the most compelling alternatives is psychologists' collaboration with medical professionals (Robiner, Tumlin, & Tompkins, 2013). Combining the extensive training of 92,227 clinically trained American psychologists (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012) and 461,182 medically trained prescribers (U.S. Dept. of Labor statistics) would appear to safely and effectively provide excellent care, particularly if the psychologists obtained some basic psychopharmacologic training to enhance communication with their medical colleagues. This was the conclusion of the Canadian Psychological Association's Task Force on Prescriptive Authority for Psychologists in Canada (2010), which after 3 years of study noted that consultation-liaison is "the optimal standard for contemporary psychological practices." Meanwhile, the task force recommended not pursuing RxP legislatively. Collaboration is also encouraged by the Patient Protection and Affordable Care Act and it is regarded by the World Health Organization (2010) as a promising solution in regards to health care access.

Another viable alternative to RxP is for psychologists to obtain cross-training as advanced-practice nurses or physician's assistants. With such a credential, prescribing would not be limited to psychoactive medications. Advanced-practice nurses already prescribe independently in 17 states, while in others medical supervision is often minimal. Thus, cross-training programs would increase the number of states with independently prescribing psychologists more than eightfold, and give them greater latitude in treating patients more safely. A third way to enhance access to mental health care and medication is through telecommunications. The APA has adopted guidelines for the practice of telepsychology (July, 2013). The Federal Bureau of Prisons uses telepsychiatry to reach far-flung facilities and the Department of Veterans Affairs also does so to treat patients who cannot easily travel to a VA hospital. Telepsychiatry has demonstrated "significant potential to increase access to mental health treatment for several populations who, in the past, may have lacked appropriate care" (Deslich, Stec, Tomblin, & Coustasse, 2013).

Many psychologists voice concerns that incorporating the practice of medicine into the profession will open a Pandora's Box of influence by the pharmaceutical industry. The flood of money from drug makers could not only encourage practitioners to replace psychotherapy with medications, but also influence the direction of psychological research and offer inducements to compromise integrity, as has often been found in the field of medicine. Proponents argue that psychology will be more immune to undue influence than medicine. However, as noted herein, the RxP campaign itself shows signs of ignoring scientific and professional standards in the pursuit of these privileges. Also, in one state where RxP is law, secrecy, deceit, and a singular focus on obtaining additional political power by a prescribing psychology group appears to be commonplace. Thus, the argument that psychology will not be tempted to surrender its values to the political and financial potential of RxP appears to already have been voided.

In addition to commonly expressed concerns that prescribing psychologists, like many psychiatrists, will drift towards prescribing medications rather than treat patients with psychotherapy, there is also reason to believe that the burden of keeping abreast of developments in a separate profession such as medicine will undermine the ability to maintain proficiency in psychology. Such was the case for psychologist-psychiatrist Steven Kingsbury, Ph.D., M.D., who wrote: "Put most simply, reading on such topics as psychopharmacology, medical mimics of psychopathology, and laboratory testing must lead to less time available to study advances in areas of psychology I once followed. I personally believe that this redistribution is the most important point for psychologists to consider before rushing toward prescription privileges" (1992).

It is also projected that a successful RxP campaign could exacerbate the shortage of psychiatrists and harm the mental health care system. A law journal article on health care economics (Berland, 2013) argues that legislatures should oppose RxP because it will "diminish quality and reduce access to care, narrowing the scope of care available to mental health patients." Based on historic changes in other professionals' scope of practice, the author predicts that lesser-trained prescribing psychologists offering to work for less will replace psychiatrists and then limit patients' choices. Persons with half the medical training of nurse practitioners would become the predominant mental health prescribers of psychoactive medications and economically undermined psychiatrists would become far scarcer. Proponents of RxP in Illinois appear to be aiming for that projection. They have predicted that more than 1,000 of the state's psychologists would obtain prescribing privileges, based on reports that four prolific local private psychology schools are gearing up to create training programs if needed.

Finally, the RxP campaign has been deeply divisive within psychology and there is evidence that these internal divisions would not end even if this prescribing model becomes law. The RxP issue has long been the subject of debate and controversy within the profession. Opposing groups have included the Society for a Science of Clinical Psychology (2001); American Association of Applied and Preventive Psychology (1998); Committee Against Medicalizing Psychology (Pollitt, 2003); and, most recently, Psychologists Opposed to Prescription Privileges for Psychologists (POPPP; see www.poppp.org.) Psychologists have also opposed RxP's legislative initiatives independently. In Arizona psychologists unrelated to any of those organizations banded together to write legislators opposing a bill filed there. In Illinois 277 psychologists, joined by 50 students and other mental health professionals, independently signed a petition opposing legislation in that state. Other professions seeking prescribing authority have not experienced such dissension.

Surveys of psychologists' opinions of RxP have produced widely varying results, depending on the sample and how questionnaire items are worded. Percentages of respondents supporting RxP range from 17% of training directors to 94% of persons attending a seminar on RxP held at a conference hosted by a state association promoting RxP. A meta-analysis of surveys that did not specify training standards found that 52% of psychologists favored RxP in theory. Most often the surveys included in this meta-analysis ask only global questions, such as, "Do you support prescription privileges for psychologists?" without specifying the training that would be provided to those seeking such privileges. One exception is a survey by Baird (2007), which found that 78.6% of psychologists believe that prescribing psychologists should meet the same training standards as other non-physician prescribers. The APA training model used in currently proposed legislation is far from meeting that standard. Regardless of whether training standards are specified, only a small number of psychologists in these surveys, about 5% to 10%, have said they themselves would pursue RxP. Those numbers are similar to the proportions actually prescribing in New Mexico and Louisiana.

Even if RxP is successful and becomes law, there is evidence that the deep division it creates within psychology will not be healed, and may become more pronounced. The RxP campaign in Louisiana created what was called a civil war within the profession, illustrated below. However, even though RxP advocates there apparently attained all the success they have sought legislatively, they continue to operate as a separate political entity, gathering large sums of money for political expenditures, and endeavoring to take control of the state's psychology board to further their own agenda apart from the interests of other psychologists.

The RxP Campaign Record

The RxP campaign has been almost entirely a failure and it has been a costly one. After 19 years of lobbying efforts, 175 legislative bills have failed in 26 states and one territory. Until recently, the campaign had only three legislative successes, with the last occurring in 2004. The Territory of Guam approved RxP in 1998 but none of the 14 psychologists there has ever prescribed, a fact that proponents don't disclose when claiming it as a success. Then in 2002 New Mexico approved an RxP bill but proponents later failed to ease the tight restrictions the bill imposes on prescribing psychologists. It requires a physician to sign off on each new and changed prescription, and sets a strictly limited formulary. Thirty-three psychologists are licensed to prescribe under those rules, and 16 more do so under even stricter conditional permits. Louisiana approved an RxP bill in 2004, which imposed the same tight restrictions as in New Mexico. The proponents there spent approximately $1 million to pass the bill, about half of it provided by the APA Practice Organization (APAPO). Approximately 71 psychologists currently prescribe there, an undetermined number of them independently. Therefore, legislatively the RxP campaign's legislative success rate is about 2.2%, counting Guam.

In May, the campaign achieved success in a third state, Illinois, a Pyrrhic victory that left advocates disconsolate and may signal the demise of the RxP movement altogether. Advocates' dismay over the new law was made public in an email from the president-elect of APA's division for RxP to Illinois activist Marlin Hoover, Ph.D. Published on the Illinois association's listserv, the email shows that RxP sympathizers were highly critical of the bill and also questioned the wisdom of the Illinois RxP leader, Beth Rom-Rymer, Ph.D. The email, written by Michael Tilus, Psy.D., stated, "I've fielded 11 calls today, all from practitioners, who are essentially seeing the IL RxP bill as a 'total loss' to the national RxP objectives; indentured servanthood (*sic*); and ultimately a 'political decision', for 'Beth', but a lhuge oss (*sic*) for practice and a massive step backwards. Not sure if you are willing, but it may be useful to have your points thrown out in the Div 55 list serve as counter punches..." (personal communication, May 30, 2014). The RxP national leader also told Dr. Hoover, "I personally feel extremely disillusioned with what I perceive was given up for what we got...."

The Illinois bill was criticized by proponents because it repudiates all the training and practice standards heretofore advocated. Facing certain defeat, RxP leaders including Dr. Rom-Rymer amended their bill to call for training at the level of a physician assistant (PA). This rejected the controversial online psychopharmacology degrees and other staples of the RxP proposals. Desperate for success at any cost, RxP representatives agreed to every demand of negotiators representing psychiatrists and other medical organizations. Those required undergraduate education in basic sciences, pharmacology training three times longer than formerly proposed, and a fivefold increase in practicum to a full-time apprenticeship of 14 months through multiple clinical rotations. They also agreed that psychologists could only prescribe for patients who are not pregnant, between 17 and 65 years old, without major medical illnesses, and without developmental and intellectual disabilities. The bill also forbids them from prescribing any benzodiazepines or Schedule II medications, and many others in Schedules III-V. It also requires collaborative agreements with physicians whose practices involve prescribing psychoactive medications.

The Illinois bill may become recognized as the new standard for proposed laws in other states, which may deter if not prevent other campaign efforts. While the proposed training is approximately that of a PA, the psychologists' scope of practice would be far more limited than what PAs enjoy. That is likely to dissuade many from seeking the RxP training if full PA practice opportunities require about the same preparation. Additionally, since only 6% to 8% of psychologists in two states with far lower standards have sought prescribing privileges, it is also unlikely that many in Illinois will undergo the greater training and stricter practice parameters anyway.

Advocates of RxP have also tried to obtain prescriptive authority quietly through government administrative routes rather than open hearings. As noted above, the congressional order for the military demonstration project of the 1990s was made possible by the powerful Sen. Daniel Inouye, the employer of RxP's widely regarded leader, Patrick DeLeon, Ph.D. The appearance of a small number of prescribers in the military coincides with the Democrats' return to a Senate majority in 2001, and Sen. Inouye's regaining the chairmanship of the powerful Senate Appropriations Committee and its Defense Subcommittee.

The number of prescribers in the military is difficult to ascertain, and even APA does not know because there is no way to track it (D. Baker, personal communication, June 8, 2011). However, the vice chair of the U.S. Army reported that there were three prescribing psychologists in his branch of the service, which has approximately 540,000 active-duty personnel (Gen. P. Chiarelli, personal communication, March 17, 2017). The Surgeon General of the US Air Force said there were three present among that branch's 333,000 members (Lt. Gen. C.B. Green, personal communication, March 28, 2011). Some are reportedly prescribing on Indian reservations, using licenses issued in New Mexico or Louisiana, although the Indian Health Service refused to disclose the number. Therefore, the best available estimate is that there are 120 psychologists licensed to prescribe in the United States under this training model. This represents about 0.1% of the clinically trained psychologists nationally.

The principle rationale RxP advocates cite for obtaining prescribing rights is to increase access to medication for the underserved. However, setting aside the issues of scientific validity and safety, it is difficult to see RxP as successful if 120 persons, presumably prescribing part-time while also working as psychologists, would have a meaningful impact. Louisiana and New Mexico together have a total of 8,000 medical professionals who can prescribe those medications as well (Department of Labor Statistics). Thus, it is difficult to assume that the campaign has been successful in achieving this goal despite almost two decades of effort.

The cost of getting this privilege for those 120 psychologists has been high in several ways. The APA has spent $3 million on RxP lobbying efforts through grants to state associations, or 23% of the grant money sent to state associations since 1988, according to Katherine Nordal, Ph.D., Executive Director of APA's Practice Directorate (Dec. 17, 2013, personal communication). That alone equals $25,000 for each known prescriber. This does not include other APA expenses such as when the organization sent a delegation to Ontario to encourage psychologists there to seek an RxP law, or the personnel costs associated with APA's maintaining an office of a Director of Prescriptive Authority. Funds have also been raised locally, including about a half million dollars in Louisiana. A secret RxP fund in Illinois is estimated to have received between $500,000 and $1 million so far. State associations also use the services of their own lobbyists when attempting to pass an RxP bill in their legislatures. Less calculable is the loss to programs and initiatives that did not receive some of the ample resources given to RxP or were pushed aside because alternatives were political competitors. Also difficult to calculate is the harm done to psychological practice by the world's largest psychology organization as it campaigns to increase access to medications as a solution to what its lobbyists call a crisis in the mental health care system.

The liability for the RxP campaign and other political activities grew substantially for APA when it was discovered in 2010 that a 10-year-old advocacy assessment for licensed psychologists was being collected under controversial—many said misleading—circumstances. The controversy began in 2000 during the presidency of RxP leader DeLeon when the APA Practice Organization (APAPO) was created as an instrument for collecting and spending more money on political activities. Because APAPO was a separate organization, APA could not legally force members to donate money to the new organization. However, the vast majority of APA members believed that paying the assessment was required for membership and evidence from past APA websites and dues statements supported claims that the members were misled. Raising $5 million annually this way, APAPO helped fund the RxP campaign and still does. However, a furor erupted when members learned in May of 2010 that the assessment is voluntary. The following year APA's membership dropped by nearly 7,000 (http://www.apa.org/about/apa/archives/membership.aspx). Two class-action lawsuits alleging fraud have been filed against APA.

There is also no evidence that RxP has accomplished its goal of enhancing access to medication for the underserved, especially those in rural areas, a point made frequently and strongly in attempts to persuade legislators to legalize RxP. As already noted, there is no empirical evidence as to the safety and efficacy of RxP. Data on the location of prescribing psychologists clearly indicates that those persons tend to practice in nonrural areas, as most professionals do. A review by members of POPPP found that 85.6% of the Louisiana prescribers and 66% of those in New Mexico were practicing in nonrural areas. The opportunity to help the rural underserved is also less likely. An Illinois survey by Baird (2007) found "the fact that almost no psychologists prac-

tice in true Illinois rural counties." While proponents claim that RxP has increased the access to psychotropic medication in New Mexico by 25%, this seems hardly plausible. A maximum of 49 prescribers may be practicing in that state, which has 4,100 medical providers capable of prescribing those drugs.

The RxP movement did not begin in response to calls for enhanced access to health care from other health professions or consumer groups (Lavoie & Barone, 2006). Instead, it was characterized as a scope-of-practice expansion. The APA has been alone in this endeavor, working through and funding affiliated state associations, and receiving mild support from a spinoff group, the National Association of Professional Psychology Providers. No other professions have supported it. Many have opposed it, particularly medical groups, and consumer organizations. The American Psychiatric Association and the American Medical Association have consistently opposed RxP legislation, although conceding that they would not object to psychologists practicing within already-accepted training standards such as those required of nonphysician prescribers. In addition, a statement by the International Society of Psychiatric-Mental Health Nurses (2001) said nurses have an "ethical responsibility" to oppose RxP. In Illinois, the state's nursing association and the society of advanced-practice nurses publicly opposed the RxP bill there when it embodied the APA model.

While proponents of RxP tend to dismiss concerns coming from physicians as little more than "turf issues," consumer groups such as the National Alliance on Mental Illness (NAMI) do not support RxP either, but instead have recommended that primary care physicians collaborating with other professionals are best qualified to help meet the public's needs for psychotropic medications (Andrews, 2011). In Illinois, the state chapter of NAMI formally opposed the RxP bill when it called for training according to the APA model, calling for collaboration instead. The Utah NAMI chapter opposed a bill there and in Montana the fight against an RxP bill was led by the state NAMI chapter's executive director.

Influences Driving the RxP Campaign

It is puzzling to many that advocates for RxP continue to pursue prescribing authority in light of the campaign's many failures, lack of scientific support of their model, internal opposition, and superior alternatives for meeting the ostensible goal of increasing access to psychoactive medications. Opponents to RxP argue that this tenacity is driven by potential financial and political benefits of RxP. Prescribing psychoactive medications can be lucrative both for individual practitioners and for organizations. In 2006, data from Vermont and Minnesota showed that psychiatrists received more financial benefits from drug companies than practitioners of any other medical specialty (Carey & Harris, 2009). A year later ProPublica reported (2010) that of 384 physicians in America who had received more than $100,000 in payments from drug companies, 91of them were psychiatrists. The *New York Times* has reported (Harris, 2007) that about 30% of the American Psychiatric Association's finances came from drug companies, through journal advertisements, exhibits, and fellowships, among other methods. However, psychologists and organizations expecting a windfall in the future may be somewhat disappointed. ProPublica reported in March that payments to physicians for speaking fees to promote their products among other beneficial arrangements have dropped 40% to 62%, thanks to a new law requiring public disclosure of payments.

Some RxP proponents have maintained that the campaign's goals are altruistic. For example, Illinois RxP leader Rom-Rymer wrote in the *Chicago Tribune* (May 18, 2013) that "our sole motive" is "to provide help to patients who too often now aren't receiving it." Nevertheless, other campaign leaders have acknowledged the apparent financial benefits of prescribing for psychologists. Writing in the newsletter of the New Jersey Psychological Association (2011), Robert McGrath, Ph.D., said that RxP will provide the market share expansion that will save psychology, which he suggests would otherwise face a steep decline. "My goal is to make the case that unless psychologists aggressively pursue prescriptive authority (RxP), our profession is in danger of becoming increasingly irrelevant," he wrote.

Another set of interests that may serve to maintain the campaign despite so little reinforcement may be those of the small group of individuals leading it. For example, three persons who are highly active in promoting the proliferation of RxP through legislative means have connections to private schools that offer the master's degree in psychopharmacology necessary for prescribing privileges. One such proponent for RxP serves as the dean of the California School of Professional Psychology (CSPP), one of the first schools to offer the psychopharmacology degree required for RxP. Another proponent is the organizer and president of the Southwest Institute for the Advancement Psychotherapy, which also offers RxP training. The third is the director of a similar RxP training program at New Jersey's Fairleigh Dickinson University. Those three individuals regularly travel to states where legislation is proposed or considered, speaking and testifying in support of such legislation. The agenda of a meeting in 2009 in which APA and RxP leaders spoke with Ontario (Canada) Psychological Association representatives about extending RxP there noted that all three of these proponents were present for the discussions.

Issues of the RxP Campaign in Two States

The conduct of the RxP campaign in two states—Louisiana where RxP has been the law for 10 years, and Illinois where the issue is hotly contested—illustrates the concerns held by many opponents. Among those concerns is a lack of transparency or inclusion in the process of pursuing prescriptive authority. Some actions seem to be governed by bare-knuckled political rules, rather than the standards psychologists tend to observe when deliberating important professional issues among colleagues. While much of the RxP campaign is played out on a political stage, we would assume that professional standards of conduct would prevail because the outcome affects the profession and the patients we are obligated to serve ethically. Additionally, the APA Ethical Principles of Psychologists and Code of Conduct counts "policy development" among the professional activities that fall under the code's principles, one of which begins: "Psychologists seek to promote accuracy, honesty and truthfulness" (APA, 2014).

Louisiana

Prescribers created intense conflict within the profession in Louisiana in 2009 when they deceived the rest of the psychology community while replacing the 2004 RxP law there, a change that gave them more latitude in writing prescriptions. The deception included months of secret negotiations with the state medical board, which agreed to accept the prescribers under its licensing and regulation authority for both prescribing and practicing clinical psychology. About half the 70 prescribing psychologists, known as Medical Psycholo-

gists or MPs, have since given up their licenses under the state's psychology board and are exclusively regulated by the medical board. This arrangement is unique in the United States and the practice has been characterized as "playing with fire" by Stephen DeMers, Ed.D., Executive Director of the Association for State and Provincial Psychology Boards (ASPPB; *Psychology Times*, Sept. 1, 2011). Few psychologists outside of Louisiana are aware of this change, which essentially creates a new psychological or medical profession.

The MPs were able to deceive the membership of the Louisiana Psychological Association (LPA) because they had taken control of both the association's governance and the state's psychology board. While occupying the top LPA offices, the MPs publicly assured members that there was no noteworthy legislation pending. In reality, they were quietly moving their bill through the legislature and on to the governor's desk to be signed. Discovery of that deception after it became law triggered what has been called a civil war within the psychology community, and backlash groups were formed to wrest control of the association from the MPs. That struggle is continuing, 4 years later. "It is not so much the RxP—perhaps it could be anything—but it's the willingness of psychologists to engage in deceit that has troubled me the most here in Louisiana," said Julie Nelson, Ph.D., editor of the online newspaper *The Psychology Times* (personal communication, March 5, 2012).

The psychology board remains under the control of the MPs, who hold three of its five seats even though only 5% of the psychologists regulated by the board are prescribers. The political leverage that the MPs exercise was demonstrated when the governor, who has received political donations from the prescribers' political action committee (PAC), appointed an MP to the psychology board and ignored the traditionally heeded recommendation of the psychological association. Under MP control, the board has approved controversial policies that favor their prescribing colleagues. For example, they voted to allow psychology interns to be supervised by MPs who are no longer licensed by the psychology board. "The path that Louisiana is taking doesn't fit" all other jurisdictions the ASPPB covers, said Dr. DeMers. "The implications for people down the road could be catastrophic" (*Psychology Times*, Sept. 1, 2011).

The political success of the MPs was due in great part to the large sums of money collected for their PAC, which serves as the MPs' professional association, independent of the psychological association. In addition, some of the $526,000 that the APA Practice Organization sent to LPA for promoting prescriptive authority was used to pay the lobbyists who helped the MPs secretly pass their new law. Since then, the PAC's account has been replenished through a provision in the new RxP law that ends up requiring all MPs to annually donate $2,500 to the RxP political fund, the maximum legally allowed. The Louisiana law does so by making all MP's purchase from the PAC one quarter of the 45 CE credits required of prescribers. The RxP organization set the price of those credits at $2,500, to be deposited in their PAC account. Those CE credits can only be obtained by attending the PAC's secretive annual conference. The agenda of that conference is not publicly available. An MP who asked for an advance copy was refused. Since the 2010 law took effect, seemingly giving the MPs the prescribing freedom they wanted, the PAC has collected $468,000, which can be donated to legislators and used to pay lobbyists for political purposes that are not apparent.

Illinois

Attempts to pass RxP legislation in Illinois have failed regularly since 1999. About 2 years ago the campaign took a sharp turn in style and tactics, reminiscent of the Louisiana campaign. As an Illinois psychologist, the first author of this paper has been intimately involved in the recent campaign in that state. The Illinois campaign has gained significant influence over the state association's governance, exerted careful management of what the association tells its members, acted with secrecy in pursuing RxP legislation, and collected funds clandestinely. Additionally, when dissenters have spoken out, RxP proponents—many of whom hold leadership positions in the association—have resorted to threats and intimidation to suppress challenges, and they have refused to submit their proposals for public comment, open debate, or discussion outside venues they control.

The most noteworthy example of the lack of transparency in this campaign is that it is funded from a secret bank account operated by the Illinois Psychological Association (IPA). Even some of the organization's council members don't know what persons or organizations have donated to it. The RxP leader and IPA official who manages the account has refused to disclose who has that information. The account has paid for the secret hiring of eight highly regarded special lobbyists and two political communications firms, whose fees over the past 2 years are estimated to be extremely high. This money is in addition to $113,000 in practice assessment funds sent to IPA by the APAPO in the past 3 years to help pay for the RxP campaign. The IPA council used $18,000 of that money to secretly hire a ninth lobbyist in 2012 to ask the Illinois governor to change state rules in favor of RxP. That mission failed, and it remained secret from the association members. Secrecy and information management also includes withholding news of when RxP bills have failed, amendments were offered, and public opposition to the campaign. For example, members were not told that the very influential Illinois chapter of the National Alliance on Mental Illness, eight of Illinois' newspapers, the state's nursing and nurse-practitioners organizations, and the largest private mental health organization in the state, had all taken public stands opposing the RxP bill. Members were not told that a provision in the proposed bill, similar to that of Louisiana's, would require future prescribers to purchase a fifth of their continuing education credits from the association. Also, the association's council voted down a motion to survey the membership on their opinions of RxP, and members were not informed of that vote. The information management sometimes had a direct effect on the legislative process. The scheduling of the two legislative hearings on an RxP bill was not disclosed to association members or other psychologists throughout the state, effectively limiting dissenting opinion.

Another pattern of the Illinois RxP campaign concerns harassment and intimidation of dissenters by persons who are often both leaders of the RxP campaign and officers of IPA. One such person contacted a psychology school's administrators, urging them to cancel a faculty-scheduled colloquium questioning RxP even though she herself had conducted a pro-RxP program there earlier. Appalled, faculty members refused. Other examples abound. A psychology school faculty member who criticized RxP on a listserv was called by an RxP leader who harangued her so vehemently that months later she said she remained shaken and intimidated. Others report being called at their homes by such persons after publicly expressing doubts about RxP. In another response to public challenges to RxP practices, the association created spe-

cial IPA listserv rules that were posted on the RxP-promoting pages of the organization's website. Those rules were cited when RxP proponents, acting as IPA officials, threatened to silence an outspoken RxP opponent by barring him from the listserv. The statement, which they said was "patently false" and deserving of banishment, was that IPA denies its members information about RxP.

Summary

The American Psychological Association's political campaign to win prescribing rights for psychologists based on a plan of weakened training standards is approaching its third decade. The campaign has been costly in terms of financial losses, missed opportunities, alienation from allied professions, and diversion from the core mission of psychology. It has done nothing good for the organization, the profession, the mental health system, or society. The failure of the campaign is punctuated by its only recent "success" in the past 10 years, when every tenet of the campaign's proposed model was rejected and replaced with the higher standards of another profession. Initiated in a bygone era and driven by fervent political and financial interests, rather than data and consensus, the time has come to step back and ask if enough is enough.

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The RxP Conundrum: How Prescriptive Authority Makes (Some of) My Patients Better and My Practice Worse

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With the Association for Behavioral and Cognitive Therapies examining the pros and cons of prescription privileges for psychologists (or RxP, for short), the ABCT membership has been introduced to a starkly political debate. Prescribing advocates speak in glowing terms about the possibilities for patient care and access to treatment. They portray prescribing psychologists as a mental health lifeline for the rural dispossessed (see, e.g., McGuinness, 2012), but private conversations had among RxP advocates also point out the financial opportunities and need to best position one's own career in a changing health-care landscape. Opponents conjure demons saying, among other things, that RxP is a patient menace that would contribute to the ruination of the psychological profession generally (see Lavoie & Barone, 2006), though many RxP opponents—particularly the vocal and well-funded psychiatric groups—are also baldly defending their own economic interests.

I am a Louisiana prescribing psychologist, license number MP.0024. I can testify that RxP offers important, sometimes shockingly positive advantages for patients and for a psychologist's ability to care for them, but, despite these positives and despite my own early enthusiasm for the opportunity to become a prescriber, I have found that RxP has an inescapable dark side for psychologists individually, for our profession, and for some patients as well. This article is written in the hope that my experience may help inform the broader population of psychologists who are forming their views of what the direction our field should take and perhaps to provide an additional perspective for those who are considering the lengthy pathway to making RxP a part of their own practice.

I should also mention at the outset that, in addition to leading the private Cognitive Behavioral Therapy Center of New Orleans, I also have a clinical faculty (read: unpaid adjunct) appointment in the Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine. By virtue of this appointment I have had an opportunity to speak with numerous psychologists and psychiatrists who collectively hold a wide range of opinions on RxP. Opinions do not entirely align with one's professional license, with many Louisiana psychologists being vocally opposed and some individual psychiatrists being somewhat neutral. The reality is always different from the political caricature.

Meanwhile, change is happening and will continue to happen. This past June the Illinois governor signed into law a bill that provides a pathway to prescription privileges for psychologists in that state, making Illinois, by far, the most populous state to allow psychologists to prescribe (Garcia, 2014). Unfortunately, as I'll detail below, the Illinois law is so outrageously onerous that it is unlikely that many Illinois psychologists will wish to undertake the burden imposed by this law, so the number of prescribing psychologists in the U.S. will likely remain small.

According to a search of the relevant state licensing board websites, the number of prescribing psychologists in the U.S. appears to be just over 100, with 76 licensees in Louisiana (Louisiana State Board of Medical Examiners, 2014) and 33 in New Mexico (New Mexico Regulation and Licensing Department, 2014). One reason for the discrepancy is that Louisiana's RxP law is so lax that it merely serves to underline our state's legendarily insouciant approach toward propriety in general. New Mexico's stricter licensing law correspondingly has fewer prescribing psychologists. Until the Illinois law, these two states had been the lone outposts for RxP for the past 10 years (American Psychological Association [APA], 2014). (There are also a negligible number of prescribers in the U.S. territory of Guam.)

The passage of the Illinois law will surely energize RxP advocates in other states, whose decade-long run of frustration includes laws passed but then vetoed in both Oregon and Hawaii (APA, 2014). The debate at the state level, however, has been subtly eclipsed by the federal government's effective, under-the-radar use of prescribing psychologists that has the potential to tilt the debate decisively. Although there are no longer prescribing psychologists at the Department of Defense, which trained the first RxP cohort and which pioneered the concept (Newman, Phelps, Sammons, Dunivin, & Cullen, 2000), the federal Department of Health and Human Services now employs a growing number of prescribing psychologists who are licensed in an RxP state but who practice in states (such as Montana and Arizona) where most psychologists are otherwise unable to prescribe. These prescribing psychologists work in the Indian Health Service and the National Health Services Corps (McGuinness, 2012; Sutherland & Tulkin, 2012) and RxP advocates credibly assert that they are seen in those underrecognized agencies as qualified and valued providers.

With this model now taking root in various nooks and crannies of the heath care system, with the Affordable Care Act's emphasis on primary care services (U.S. Department of Health and Human Services, 2014), with a decreasing number of medical students entering into psychiatric residencies (Berhard, 2014; Smydo, 2014), and with a documented shortage of mental health providers in many places across the country (Fields & Dooren, 2014; Smydo, 2014), there is a feeling of inevitability that, like Illinois, additional states will join Louisiana and New Mexico in providing psychologists the right to prescribe, despite effective and well-funded opposition from psychiatric organizations and their allies. When they do, I believe things will almost certainly change for psychology in ways that will negatively disrupt our profession.

Training Models

Every RxP advocate states that there should be no patient safety concern over "properly trained" prescribing psychologists (e.g., Tilus, 2008). What "properly trained" means is the major definitional problem in this debate and the states that have legalized RxP vary widely in their training and oversight requirements. New Mexico has the most balanced approach. If you are currently a licensed, doctoral-level psychologist and you want to add prescription rights in New Mexico, you'll need to complete a postdoctoral master's degree in clinical psychopharmacology and pass the APA-developed national licensing exam, the Psychopharmacology Examination for

Psychologists (PEP). (Which, incidentally, is a well-done, difficult exam.) You'll also need an 80-hour practicum with a primary care physician (PCP), a 400-hour practicum prescribing for mental health disorders, and then a further 2 years under a physician's supervision while you practice with a conditional license. After that, you can prescribe for mental health conditions (and mental health conditions alone) in an unrestricted way.

In Louisiana, you'll need all of that except the 80-hour practicum, or the additional 400-hour practicum, or the supervised practice. So with the postdoctoral master's degree and the PEP passed, you're ready to roll. If you become a Louisiana prescribing psychologist, it is perfectly within the realm of possibility that your first experience evaluating a patient for a medication is when you, by yourself, unsupervised, sit down with your very own patient and prepare to write your first live prescription. To be sure, until you get a certificate of advanced practice (which takes 2 years and the treatment of a minimum of 100 patients), you'll have to reach out, one-by-one, to each individual patient's primary care or attending physician (many of whom you will be cold-calling to explain yourself) and ask them to kindly approve your treatment plan. All of this combines to form a crazy, stress-inducing model that will almost certainly never be duplicated by another state. (And, even crazier yet, no Louisiana prescribing psychologist has ever been sued for malpractice or been subject to a board complaint, so maybe we're on to something here.)

Illinois' law solved the problem of Louisiana's laissez-faire approach by developing a model that is draconian to the extreme. If it becomes the model for future states, this approach will create a new profession that kind of resembles something like a psychologically trained physician's assistant. (The text of the recently signed Illinois state statute that legalized prescribing psychologists can be found at http://www.ilga.gov/legislation/publicacts/98/098-0668.htm).

Although attorneys have been known to parse legal language in various ways (see Noah, 1998, for a noted example), a plain reading of the text of the statute indicates that if you want to become an Illinois prescribing psychologist under the newly signed law, you will have taken microbiology, human anatomy, physiology, and several other biomedical courses as an *undergraduate*. You will have completed your doctorate in psychology and also completed an expanded master's in psychopharmacology. (Current postdoctoral programs accepted by New Mexico and Louisiana appear insufficient under the Illinois law.) You will also have completed a 14-month full-time medical practicum where you have rotated through Emergency Medicine, Family Medicine, Geriatrics, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatrics, and Surgery. This, despite the fact that you will, under current Illinois law, never be allowed prescribe for anyone under 18 (child psychologists, you're ruled out), or anyone over 65 (geropsychologists and neuropsychologists, take note), or anyone pregnant, or anyone with a "serious medical illness" (health psychologists, you're now seriously limited). After passing the PEP and getting your Illinois RxP certificate, you must then sign a collaborative agreement with a general practice physician, who will take authority over everything you prescribe, and you will never be considered competent by the state to prescribe independently.

Even under that physician's control, what you prescribe is limited to only a subset of useful psychotropics. Under the Illinois law, you may not prescribe DEA Schedule II medications, which means, for your purposes, you are banned from prescribing stimulants. (You may, however, for the appropriate patient, prescribe lithium, or injectable antipsychotics, or any number of much more dangerous medications that don't happen to be sold in the dorm rooms.) Of course, as RxP proponents are fond of saying, "The right to prescribe is also the right to unprescribe" (Smith, 2012, p. 36), but in Illinois, if your generalized anxiety patient is being amped up too much on stimulants because of misdiagnosed ADHD, you're not allowed to directly remedy that. The absurdity of the Illinois law is that psychologists would be among the best-placed and best-trained professionals to identify patients who would benefit from stimulants and to manage behavioral issues around stimulant misuse. In this and many other instances, the Illinois law simultaneously trains prescribing psychologists to develop a skill-set and then forbids them from actually using those skills. And the costs for this limited privilege are steep. All that time you spent in your OB/GYN rotation so you could learn about pregnant women for whom you will never be allowed to prescribe? That's time that you didn't spend learning how to master cognitive behavioral therapy or other evidence-based treatments for your patients.

Psychiatrists are prone to saying that if psychologists want to prescribe, they should go to medical school (e.g., Yates, Wiggins, Lazarus, Scully, & Riba, 2004). Yes, but then they wouldn't be psychologists. Illinois prescribing psychologists, when they arrive, do not appear to be really psychologists, either. They are hamstrung, less-qualified (and probably less well-paid) physician's assistants. (Indeed, much of the Illinois statute appears to be based on that state's rules for PAs.) But even physician's assistants can work across medical settings. The Illinois model not only strips psychologists from our professional autonomy in patient care, but by requiring a prescribing psychologist to be controlled by a PCP (and only a PCP) it also deliberately and needlessly strips prescribing psychologists from meaningful collaborative experiences with oncologists, neurologists, rheumatologists, and the vast array of other physician specialists who treat patients with comorbid medical and mental health conditions. Want to collaborate as an RxP on a stroke rehabilitation team, or in a cancer center, or in a pain and palliative care clinic? Not in Illinois.

And, finally, to be frank, precious few of the primary care physicians who would oversee an Illinois prescribing psychologist would have even a fraction of the 2 years of intensive psychopharmacology training that the Illinois prescribing psychologist will have, so the Illinois model overtly disrespects the training and expertise of psychologists by making them subject *for their entire careers* to primary care physicians who are literally less knowledgeable about the treatments. Illinois RxP advocates say they will advocate to fix the law, but that is not guaranteed. If Illinois is unwilling to allow prescribing psychologists a path toward developing clinical autonomy, then psychologists should not accept a compromise that strips not only our autonomy but also our own professional respect.

Report From the Field

I decided to obtain my prescribing certificate for what seemed, at the time, good reasons. A few years after graduating from a scientifically informed, CBT-oriented doctoral program, I was recruited to run a psycho-oncology program housed in a New Orleans medical center. Most of the patients were from urban, low-income minority backgrounds. My initial needs assessment showed that a lack of psychiatric coverage was a gaping hole in our psycho-oncology care. Financial decisions on the part of the hospital made hiring even a part-time psy-

chiatrist out of the question, but the hospital offered to help me obtain my RxP as a cost-effective way of addressing this need. From the outset, this appeared to be a fulfillment of what RxP advocates claim as a prime motivator—to open up access to care for a population without easy access.

Wary of stepping over boundaries, I approached several of the cancer center's oncologists. They were unanimously in favor, particularly after I showed them the course requirements. The training, they said, was much greater than what they, themselves, had received in psychopharmacology and they would welcome the collaboration. The plan was set. I would obtain prescription privileges and use my psychopharmacology training to collaborate closely with the oncologists in a tightly integrated medical setting with strong medical oversight.

Training Strengths and Training Follies

Because RxP models in all states require at least beginning prescribing psychologists to consult with and obtain approval from a physician prior to writing that prescription, a prescribing psychologist must be competent to collaborate with a physician. The training that the prescribing psychologist receives, therefore, must not only be credible, but exceptional. Given my position in the cancer center, I could not travel to an in-residence psychopharmacology program. Several clinical psychopharmacology training programs are mostly or exclusively online and RxP critics often use the online training model as an argument against prescribing privileges. Although I was also skeptical, my experience suggests that online education has the possibility of being even more effective than a live classroom, if done well. My experience also suggests that doing an online program well is a challenge that consists of more than just recruiting good faculty and creating good content.

As I engaged in the first few classes of my program, I found the lessons to be more interactive, more conducive to learning, and more invigorating than I had anticipated. I could pause video lectures to use the Internet for more in-depth study or rewind lectures to go over difficult points. I could print lecture transcripts and make the lecture experience a multisensory experience as I read along with the professor, creating my own marginalia in the lecture printouts.

The interpersonal interactions were also rewarding. Faculty members were generally experts in the field of psychopharmacology, well-informed, engaging, and accessible. Some were RxP pioneers. Textbooks and readings were excellent. On-line chats among the class members were lively, informative, and fun.

RxP critics within psychology argue that the mere fact of prescribing will endanger the culture of the profession. I was impressed that the program was strongly invested in creating a model of prescribing that stayed true to the role and mission of the clinical psychologist. Time after time, faculty would emphasize that the gold-standard treatment for various disorders was psychotherapy, particularly cognitive behavioral therapy. There were continual reminders that we, the students, were psychologists, not psychopharmacologists, and that medication is not the solution for many of the problems we see. Of all of the lessons I received in my training, the emphasis on psychotherapy and conservative judiciousness in psychopharmacological treatment planning was among the most powerful and long lasting. I credit the program I attended for helping create and maintain a culture that values and advocates psychotherapy as the first-line treatment for prescribing psychologists.

My positive view of the training took a great blow, however, with each exam. Exams universally consisted of a few dozen multiple-choice questions, open-book, open-note, unproctored, untimed. I had studied as if I were preparing for a medical board exam. I was being tested as if I were in a community college remedial class. As would be expected, the class average for most exams was in the high-90s. I tried to tilt the experience to force myself to learn—I would take exams as if they were proctored, closed-book tests. The amount of material to learn was truly massive and my test grades may have been acceptable given the amount of information I was trying to process—the physiology of the kidney, the biochemistry of drug absorption, multitudinous lists of cytochrome P450 interactions, and much, much, much more, but with my peers' average test grades all in the high-90s I soon started to check my answers before submitting the responses. Soon, test grades lower than 100 percent became blows to the ego. (The director of the program I attended contacted me prior to the publication of this article to state that the program's assessment strategies have been upgraded. If the testing now truly incentivizes student learning, this would be highly welcome news regarding an otherwise well-organized program.)

My career as a cancer psychologist had made me extremely cautious about my patients' well-being. Witnessing patients with cancer whose disease had previously been misdiagnosed as well as seeing patients under treatment who had suffered medical errors perpetuated by even some of the world's best health care teams made me cognizant of the need for constant vigilance and an exceptional knowledge base. While studying for the master's degree I was genuinely blessed to have two expert psychiatrist colleagues who laid aside their dubious views of RxP to have regularly scheduled one-on-one lunch discussions about the art and craft of psychiatric medicine. This provided me with insights into patient care that neither nonpsychiatric physicians nor academic book learning could have possibly provided.

I graduated from my program with a 4.0 GPA but with the difficult knowledge that my training was not to the standard of my psychiatrist colleagues. The licensing exam, as mentioned, was brutally difficult and I was relieved and encouraged to have passed on the first attempt. In the 2 years I had studied, however, the hospital administration where I worked had changed and new administrators had a different, less supportive vision for psycho-oncology. I left the cancer center to launch our region's first stand-alone, specialized CBT clinic. The physician support I had anticipated was gone. Two months following the completion of the master's degree, on the verge of becoming a prescribing psychologist, I was unexpectedly about to do it on my own.

The Art and Practice of Medicine

I wrote my first prescription for a young man who had come to see me for psychotherapy. He had experienced his first depressive episode the prior year and didn't want to go back to that dark place. He enthusiastically agreed to mindfulness-based cognitive therapy to avoid relapse, but soon a hair-raising family drama developed. His depression scores shot up. We amended the treatment plan to deal with the immediate crisis, but his mood worsened until the day he told me he was experiencing intrusive suicidal thoughts. This frightened him—he didn't want to kill himself—but he needed more help than he had been given up to that point. Ever cautious, I considered referring him to a psychiatrist, but my patient's suffering had an urgent quality about it. Fortunately, my patient attended a boutique primary care clinic that specialized in high-level patient service. The PCP personally answered my after-hours call and we agreed on a plan. I wrote the prescription

with great penmanship. "You don't do this a lot, do you?" my patient commented as I slowly spelled each word in unmistakably legible print. I looked him in the eye and, as professionally as possible as I handed him the prescriptions, said, "Heh-heh."

The treatment plan resulted in shockingly positive change. Standardized anxiety and depression scores came down nearly as quickly as they went up. Within a few weeks my patient's depression scores went from the severe to the minimal range and they stayed low and stable. Meanwhile our therapy continued. He began meditating with impressive discipline. His worldview changed. His social circle changed as he adopted a healthier lifestyle. Eighteen months later he continues to meditate and depression has not returned. He recently asked about getting off the medication. Given his recent lifestyle changes, a reasonable mental health history, and his desire, I cautiously agreed. He continues to do well.

There have been other successful cases—a woman who, 6 weeks into very successful prolonged-exposure treatment for PTSD, had a sudden depressive relapse that failed to respond to additional therapy. A medication change brought a total and lasting remission of symptoms that had eluded her for decades. Both medication and evidence-based psychotherapy were essential and available to her. Experiences like these show the possibility of RxP at its best.

But these experiences are exceptional for a reason. Most cases have less clear-cut successes and there are regular treatment failures. Collaborating primary care physicians who are amenable to initiating a patient on a medication can become squeamish when they are asked to approve yet another augmentation strategy, or medication switch, or dosage adjustment. Patients who were outside my particular area of specialist training as a cancer psychologist now come as referrals from other mental health professionals who believe I now have the expertise to medically manage seriously mentally ill patients—patients in an untreated hypomanic episode, or with emerging psychotic symptoms, for example. I continue to refer patients like these to psychiatrists. Unfortunately, these psychiatrists, especially the conscientious and well-trained ones who often look to collaborate with good CBT therapists, aren't always so quick to reciprocate. When it becomes known to a psychiatrist that I am also a prescriber, their psychotherapy referrals, for understandable reasons, suddenly cease.

My Old Friend the Psychiatrist; My New Friend the PCP

It makes sense why psychiatrists would find prescribing psychologists a threat to their livelihood. Ultimately, we compete for patients. There is no way around this fact—RxP advocates seem to suggest that prescribing psychologists will somehow gravitate to rural or underserved areas, which only proves that RxP advocates are subject to magical thinking. Prescribing psychologists will not be immune to basic economic facts; they will go to where there is the greatest opportunity and the most demand for their services. This means they will inevitably enter into the markets where psychiatrists are already established. (One prominent New Orleans hospital, for example, is notable for having transitioned its entire psychiatric staff over to prescribing psychologists.)

As much as I respect my psychiatrist colleagues and wish to maintain my referral sources, when patients referred by a psychiatrist colleague insist that they want to drop their referring psychiatrist and have me manage their mental health care entirely, I find myself caught between honoring my patients' autonomy and honoring the collegial relationships that I value with people more expert in psychopharmacology than myself, and who are, to be blunt, referring me patients who contribute to my being able to pay my bills. There is no obvious solution to these competing ethical imperatives. In some cases it is simply impossible to respect both. Our ethics codes teach us to avoid dual roles but RxP puts us in an insidiously complicated one.

This competitive relationship with psychiatrists, then, becomes a loss for me personally, for my patients, and for my practice, particularly when I need to collaborate closely with psychiatrists to make sure my patients have the most appropriate care. Many psychiatrists value good CBT therapists, but the goodwill built by CBT psychologists who provide proven treatment gets dashed in the psychiatric community when these same psychologists compete with them for medical management patients. This is not a good development for cohesiveness, collaborative relationships among health care providers, and is one of my biggest obstacles in building a well-respected CBT clinic.

Meanwhile, think insurance companies are going to pay you like a psychiatrist? More magical thinking. One prominent insurer flatly disregards the psychopharmacology add-on code for psychologists. Others reimburse at rather underwhelming rates. Maybe scheduling patients every 15 minutes will get you somewhere financially, but then you're not a psychologist. Or you could rely, like many psychiatrists, on self-pay patients. At which point you're no longer a mental health lifeline for the rural dispossessed.

As was foreshadowed by my oncology colleagues' warm responses to my RxP plans, however, becoming a prescriber has pushed me to create a series of highly collaborative relationships with nonpsychiatrist physicians (particularly PCPs) as I work with them to develop treatment plans for our joint patients. When I seek consultation for patients, a minority of PCPs refuse to work with medical psychologists as a rule and tell me that the patient should be referred to psychiatry, but others see the collaboration as highly valuable and the relationship becomes a rich experience of shared patient care. Rather than becoming a junior psychiatrist, my prescribing privileges have moved me toward becoming an adjunct mental health specialist in support of primary care providers. At one point our clinic started receiving calls from a number of middle-aged adults seeking ADHD evaluation and management. Because our clinic both assesses for and is able to treat ADHD, a local PCP determined that I was better placed to evaluate and manage these patients than he was. I had been working with this PCP for more than a year prior to that point and the relationship of trust that was built seems to have been a benefit for all involved.

Choose Your Own Adventure

The benefit ends, however, not necessarily at the end of your expertise but at the end of the expertise of the physician you collaborate with, who, it must be eternally emphasized, is not a psychiatrist and will sometimes not know as much as you, which is chilling because you won't know much yourself. Earlier this year another psychotherapist referred a young woman to me for evaluation and medication management of her mood swings. My evaluation suggested a fairly mild presentation of Bipolar II and I lined her up with a PCP. The PCP gave her a clean bill of health. Her mood swings were not severe, I felt comfortable managing her care, and the PCP and I agreed to start her on a trial of the mood stabilizer lamotrigine. Although rare, lamotrigine can cause a dangerous, life-threatening rash, so we started the medication at a

very low dose. It was a legitimate and well-considered choice.

The patient started on the medication. For a couple of days things were fine. New Orleans entered into the heart of Mardi Gras season and the city had generally stopped functioning. My patient contacted me. Her body was covered with an itchy rash from her toes to her neck, she said. She had a fever. What should she do?

Good question for a psychiatrist! I had not had a dermatology rotation in my training, sadly. Good question for the primary care doctor, who was not readily available. (Those familiar with New Orleans during Mardi Gras season might understand.) Good question for an emergency room physician, but only at a tremendous financial burden to this particular uninsured patient. I held off on sending her to the ER until I was more certain of the best approach.

She texted me a picture of her upper calf. It was definitely a lamotrigine rash. With city camped on the closed New Orleans streets as it waited for parades to pass, and while I waited on some word from the PCP, I was studying everything I could find from the medical literature regarding anticonvulsant hypersensitivities. The PCP had little experience with these types of rashes. Ultimately I recommended Benadryl and an OTC fever reducer and told her to go to the emergency room immediately if the rash moved to her face or mucous membranes. I checked in with her twice a day, the rash disappeared. Obscure readings I found deep in the medical literature suggested that internal organ involvement may sometimes occur with these reactions. Blood tests the day after Mardi Gras came back clean. She was clear.

As I talked later with a psychiatrist colleague about this case, my sympathetic M.D. friend made a perspective-giving comment. "I've had cases like this," he said, "and I don't think, all-in-all, that you did much different than I would do. The only difference is that if something goes wrong, I have the whole American Medical Association behind me." He was kind to leave unsaid the fact that I, decidedly, don't. Another psychiatrist colleague, an old-time psychoanalyst trained before psychoactives became prominent in psychiatry, shrugged when he learned about these stresses. "When you do therapy," he said, "you read your notes, you see your patient, you write your notes." There was no judgment on his part, simply an acknowledgment that in gaining some privileges we lose some others, and the things we lose are sometimes valued aspects of what we do and the life we want to live.

RxP gives us a tool to use for patient care, and it's a good one. Critics of medication ignore the research that shows medication is effective, particularly when combined with psychotherapy. Vast clinical experience shows that patients make important gains. (Yes, I know clinical experience isn't as reliable as research, but someone's shocking and unexpected recovery in front of you is hard to ignore.) For a psychologist who wishes to stay focused on evidence-based psychotherapies, however, I believe the cost of that tool is too high for a multitude of reasons. First, under many legal models, we psychologists lose our professional autonomy. Second, the extensive time needed to develop the expertise to become a competent prescriber means we lose the time becoming expert evidence-based psychotherapists. We also lose quality of life when we spend time calling pharmacies and insurance companies rather than spending time with patients. (And many of these are noncompensated responsibilities. You do not get paid for the time spent getting medication pre-approvals for patient after patient.) Although we gain professional collaborations with some physicians, we risk losing the collaborative relationships with the most skillful and highly trained of psychopharmacologists—good, well-trained psychiatrists—which are necessary if we wish to provide the most competent, comprehensive patient mental health care.

As a prescribing psychologist, I strive endlessly to be competent in all areas of my practice. No compromise on competence will be satisfactory. It takes extraordinary time and energy. But the knowledge needed to be expert in both areas is too vast and too specialized to entirely master. Best patient care is rendered when we work together with other experts and not try to do it all alone.

Ultimately, I believe our field has made a mistake in embracing RxP. We should have invested that time, energy, and political capital into promoting evidence-based psychotherapy as the first tool to use for most patients who need treatment. We should have found better ways to build better bridges between our field and the medical community, including the psychiatric community. We should have formed alliances to ensure that the work of psychologists is honored and that a well-defined, well-coordinated collaboration between individuals across disciplines is promoted as the standard of mental health care.

When we consider, as a profession, the idea of RxP, we have a set of bad choices before us. We can allow psychology to fragment into a profession where some of us will be miniature physician's assistants who gradually but inevitably lose the skill set to do psychology very well, and on the other hand we can futilely attempt to be experts in too much and in the process alienate the specialist physicians in psychopharmacology who should be our most natural colleagues and allies in mental health care. Neither of these sound like good choices. All psychologists should be knowledgeable about psychopharmacology, but—outside a very select few who truly wish to be mental health specialist physician's assistants in medical settings—I would encourage no psychologist to become a prescriber. Let's keep doing well what we already do well and let the physicians be the physicians.

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Prescriptive Authority and the Medical Model

Philip Hickey, *Retired Psychologist*

Prescriptive authority for psychologists is a controversial topic. The essential argument on the pro-side is that doctoral-level training in psychology *plus* training in the prescribing of psychotropic drugs is the ideal qualification for comprehensive competency in the mental health field (National Alliance of Professional Psychology Providers, 2006). It is also asserted that affording prescriptive authority to psychologists will expand the availability of psychiatric drugs in locations where there is a shortage of psychiatrists. On the opposing side there are three main contentions. The first, which is usually voiced by psychiatrists, claims that introducing psychoactive chemicals into the human body for prolonged periods is fraught with adverse potential, and should only be undertaken by a physician (Rettner, 2012). The second argument, often heard from psychologists, maintains that prescriptive authority will inevitably draw psychologists away from their traditional modalities and towards the kind of perfunctory "med check" practice that characterizes psychiatry today (Grohol, 2010). The third argument focuses on the adverse physical and psychological effects of the drugs, especially when taken for long periods.

In addition, the waters of this controversy are muddied by considerations of turf. Psychiatrists are trying to retain this remunerative occupational niche as their own, while psychologists are trying to gain a tangible, visible technology that would provide them an occupational advantage over master's-level counselors, social workers, etc. But perhaps the most fundamental issue in this debate, and, paradoxically, the one that receives the least attention, is that the pursuit and exercise of prescriptive authority entails an implicit endorsement of the medical model.

The Medical Model

The essential tenets of the medical model, as embodied in *general medicine*, are that (a) illness is a biological phenomenon with biological causes; (b) these causes are discoverable through scientific study; and (c) the illnesses are best ameliorated by addressing these biological pathologies.

The medical model is so thoroughly integrated into Western culture that it is seldom articulated in modern times, though in fact it represented a quantum leap forward in medical history. It was only when medicine abandoned its folklorish origins, and aligned itself squarely with science, that it began to acquire the success and credibility that it enjoys today.

The essential tenets of the medical model, as applied to *psychiatry*, are that (a) all, or virtually all, significant problems of thinking, feeling, and/or behaving are in fact mental illnesses (this is actually a paraphrase of the DSM definition); (b) these illnesses are located in the brain; and (c) the proper business of psychiatry is the amelioration of these illnesses through drugs and other biological interventions.

Until the 1950s, psychiatry played fast and loose with the medical model. The term "mental illness" was in common use, suggesting that the profession's subject matter was considered biological in nature, but in practice, most psychiatrists thought of themselves as treating more nebulous entities such as repressed emotions, relationship problems, etc. In the 1950s, the psychotropic drugs began to be available, and although there was some initial skepticism among psychiatrists, eventually their use became more or less universal. At the present time almost all psychiatric activity is driven by the medical model and is focused on the prescription of psychoactive drugs (Carlat, 2010; Gabbard, 2009; Lieberman, 2013; Mossman, 2010).

In passing it should be acknowledged that there is still some inconsistency in psychiatry's use of the term *mental illness*. For many, the matter is clear-cut: mental illnesses are brain illnesses, period. For others, however, the illness issue is simply a matter of definition. For these latter individuals, any problem of thinking, feeling, and/or behaving that entails significant distress or impairment is *by definition* an illness that calls for medical intervention (e.g., Pies, 2013). This is echoed in the DSM's definition of a mental disorder/illness. In DSM-IV (American Psychiatric Association, 1994, p. xxxi), there is no requirement of, or even an allusion to, physical pathology.

DSM-5 (American Psychiatric Association, 2013, p. 20) allows the *possibility* that the problem may reflect a biological process, but this is not a necessary component of the definition. In practice, proponents of the definitional argument also play fast and loose—using the term illness to mean *organic* illness ("just like diabetes") in general communication, but falling back on the definitional meaning when pressed for evidence.

To be sure, there are individual psychiatrists who have been less enthusiastic towards, and even opposed to, the medical model. Peter Breggin and the late Thomas Szasz come to mind. In the last 10 years or so, more have joined their ranks—for example, Daniel Carlat, Sandra Steingard, and John "Mickey" Nardo. In the U.K., a group of psychiatrists known as the Critical Psychiatry Network has convincingly debunked the notion that psychiatric conditions are illnesses (Bracken et al., 2012). In their conclusions they state unambiguously: "Psychiatry is not neurology; it is not a medicine of the brain." As outspoken as some of these psychiatric dissenters have been, they do not significantly detract from psychiatry's general acceptance and endorsement of the medical model.

Brain Pathology

Over the past 40 years or so, various attempts have been made to prove that the conditions listed in DSM are brain illnesses. These proofs usually involve showing that the activity in question is associated with a characteristic neural pathology, and therefore the activity is an illness. Most of the attempts have foundered under scrutiny. For instance, the brain damage theory of "schizophrenia" lost credibility when it was demonstrated that the characteristic damage was actually caused by neuroleptics (Ho et al., 2011). Similarly, the dopamine theory of schizophrenia and the various chemical theories of depression have all fallen by the wayside (Valenstein, 1998). Apart from those DSM entries that are clearly ascribed to the effects of a substance or a general medical condition, no psychiatric diagnosis has been reliably linked to a clearly defined biological pathology. In April 2013, just weeks before the publication of DSM-5, Thomas Insel, M.D., Director of NIMH, shocked his psychiatrist colleagues by stating: "While DSM has been described as a 'Bible' for the field, it is at best a dictionary, creating a set of labels and defining each" (Insel, 2013). When confronted with these deficiencies in their conceptual framework, some psychiatrists, as mentioned earlier, fall back on the definitional argument. Others, however, contend that, since the brain controls and modulates activities of thinking, feeling, and behaving, if these are suboptimal in any way, then there must be some fault in the brain (Novella, 2007). But even if characteristic neural correlates were accurately and reliably identified, this will never be the full story.

Consider the case of violent behavior. Let's say person X punches person Y in the face, and the question arises: Why did X punch Y? An explanation might be offered along the following lines. The muscles in X's arm contracted and rapidly released; this activity was caused by the coordinated firing of various neurons in the presence of adequate concentrations of electrolytes in the blood stream. This neuronal activity was initiated by chemical activity in the synapses which in turn was influenced by sensory input signals, etc.

This kind of account, if developed in detail, might easily run to several million words, could be 100% true, and would indeed constitute an *explanation* of the act of punching. Behaviors, thoughts, and feelings are underpinned and driven by corresponding physiological activity. This is true whether the behavior is functional or dysfunctional, productive or counterproductive, helpful or unhelpful. *The fact that a behavior can be explained in physiological terms does not make the behavior an illness. All* behavior can be explained in physiological terms. One could, for instance, conduct a physiological analysis (similar to the one above) for the activity of riding a bicycle. This would not prove that bike-riding is an illness. Nor would it be the full story or even the main story.

Another way of explaining the punching incident, for instance, might go like this. X was raised in a rough environment in which violent retaliation was routinely reinforced as the appropriate response to any kind of physical challenge. At an early age he acquired the habit of responding violently when he felt threatened. This habit had not been extinguished, and was still strong at the time of the incident. Y was speaking loudly and aggressively and had begun to assault X, so X knocked him down and punched him in the face. I suggest that while both explanations could be true and valid, the behavioral account has more usefulness and relevance for people working in the human service field, and indeed for people generally who are trying to understand human behavior, feelings, conflict, and so on.

A complication in this area is the fact that neural malfunctions can and do occur, and sometimes these malfunctions can cause psychological/behavioral problems. A number of such conditions are known, and the underlying biological malfunctions have been identified with various degrees of precision. For instance, in late-stage syphilis, when the germ starts to attack the brain, the individual often becomes insane. But, and this is the critical point, the vast majority of behavior that meets the APA's criteria for a mental illness is not associated with known biological *pathology*.

Another complication stems from the fact that people can *learn*. We can acquire new skills and behaviors, and it is obvious that these acquisitions are dependent upon, and are maintained by, underlying neurological changes. If I visit a place where I've never been before, and afterwards I can accurately recall details of the site, it is clear that something inside my brain has changed. Similarly, newly acquired skills and habits, whether they are functional or otherwise, are a direct reflection of neural changes.

Suppose I have, for instance, an extreme fear of social gatherings. This is an acquired fear, and it is likely that I have acquired it through social conditioning or any number of adverse events. But regardless of the psychological and sociological factors that created the fear, there is something in my brain that corresponds to, and indeed *causes*, physiologically, this particular fear response.

Getting rid of this fear is generally not difficult. I could design a program of systematically increasing exposure; I could ask a psychologist or a socially gifted friend to help me; or I could join a self-help group. Assuming that the retraining is successful, then the neural underlay will also be removed, or disabled, or modified in some way.

Psychiatry's approach, however, is to get rid of the fear by directly targeting the neurological basis. The methods they use include drugs, electric shock, magnetic pulses—and they apply this approach not just to fears, but to virtually all the problems that are brought to their attention.

Let's consider another example: painful memories. Suppose I have truly horrendous memories of a particular school I attended as a child, and that these memories are vivid and distressing. And let us accept, for the sake of argument, that the neurological trace of this building and all its horrors is confined to one tiny spot in my brain. A highly skilled neurosurgeon might conceivably be able to go in with a tiny electrode

and burn out the offending tissue, and I would never be troubled by this memory again.

I'm not suggesting that anything of this sort is, or ever will be, possible (if for no other reason than that the bad memories are probably *not* confined to one tiny neural location). But this is the essential reasoning behind the brain illness theory: that painful memories, "crazy" thoughts, bouts of depression, counterproductive habits, are all best understood in terms of their neural underpinnings, which have to be removed, damped down, rebalanced, adjusted, burned out, or whatever, even though they are not *in themselves* pathological, with regards to genesis, functioning, or structure. Horrendous memories are actually adaptive. They remind us to avoid situations that have high adverse potential, and their intrusive and distressing qualities diminish naturally (i.e., the fear response is extinguished) through repeated narration in a socially supportive context (i.e., through exposure with response prevention).

Tampering with the brain in a misguided attempt to get rid of unhappy thoughts, counterproductive habits, or unrealistic ideas is like trying to delete something from a computer by scratching the on/off traces from the hard drive with a needle! It might actually work, but the potential for collateral damage is high, and, more importantly, there are better ways to achieve the objective.

Which takes us back to the fundamental question: If a person's thoughts, feelings, or behaviors are causing him distress, should his neural underpinnings be considered an illness, even though there is no actual neural pathology? And it is immediately clear that this is not something that admits of proof; rather it is a matter of semantics. Psychiatrists choose to call all significant human problems illnesses. They cling to this position even though their attempts to identify actual pathology have been consistently unsuccessful. They simply state it to be so. If the neural entities are causing distress or pain or disability, then by definition, they are illnesses. Psychiatrists use this "conclusion" to justify the administration of drugs. But the fact that the "conclusion" is entailed in their definitional decision is seldom, if ever, acknowledged. Nor is it routinely acknowledged that this is not the usual sense of the term "illness."

Damage Done by the Medical Model

In general medicine, the medical model is not only valid and helpful, it is the essential underpinning to effective treatment. In *psychiatry*, however, the reliance on the medical model is not only spurious and unhelpful, but also *harmful*. Despite the similarity in name, diagnoses in general medicine are radically different from psychiatric diagnoses. In general medicine, the diagnoses, provided they are correct, *are* indeed the proximate causes of the presenting problems. In psychiatry, this is emphatically not the case.

Consider the following hypothetical conversation:

FAMILY MEMBER: Why is my mother so depressed and inactive?

PSYCHIATRIST: Because she has a mental illness called major depression.

FAMILY MEMBER: How do you know she has this illness?

PSYCHIATRIST: Because she is so depressed and inactive.

The mental illness explanation is spurious. The only evidence for the diagnosis is the very problem that it purports to explain. There is no explanatory pathology "behind" the symptoms—nothing to break the circularity that is evident in the above conversation.

By contrast, consider a very different kind of conversation that might occur in general medicine:

FAMILY MEMBER: Why is my son coughing all the time and spitting up nasty-looking phlegm?

PHYSICIAN: Because he has an illness called pneumonia. It's an infection of the lung.

FAMILY MEMBER: How do you know he has pneumonia?

PHYSICIAN: Because of his X-rays and the lab results from the cultures we took. You can see them yourself.

In the latter example, the pneumonia *is the cause of the symptoms*. That's what the word "diagnosis" means in general medicine. In psychiatry, however, even though the "diagnosis" has no explanatory value, it is routinely presented to clients as if it did. Because of this, it effectively terminates any attempt to identify *valid* causes. The primary agenda in an initial interview is the "uncovering" of the diagnosis, a facile sorting activity, which consists essentially of selecting the "best fit" for the client's self-report from the DSM catalog. Once this has been done, the etiology question is considered solved, and it is rare to find in psychiatry even cursory attempts to explore or identify genuine causes of the presenting problems. Indeed, the paradigm of the 15-minute "med check" effectively militates against any such exploration (Carlat, 2010).

Within this context, the problem, say depression, is conceptualized as a primary illness, rather than the ordinary, and incidentally adaptive, human response to a major loss or to chronic poverty, or to victimization, or to a life of personal or occupational drudgery. The notion that one can help people come through a period of depression, or indeed long-standing, enduring depression, without addressing these kinds of issues flies in the face of a hundred years of psychological theorizing and practice, not to mention thousands of years of ordinary human common sense. Yet it is an inherent implication of the psychiatric medical model, and has become the norm in psychiatric pharmacotherapy. The "logic" is that the pills correct the depression, so there's no need to explore these other factors, which at most are considered tangential.

The notion that pills can treat problems of depression or anxiety, or overexcitement, or inattention is precisely the same marketing philosophy promoted by street-drug vendors: something to ease the pain and difficulties of life. The chemicals do provide a temporary relief from distressing feelings, and customers in both arenas usually express themselves satisfied with the product. But by any humanistic reckoning, the resulting drug-induced state, with its multiple adverse effects, is a poor substitute for quality of life, as any recovered addict can attest.

Besides stifling genuine exploration, the psychiatric medical model is inherently *disempowering*. Prior to the pharmacotherapy era, clients who sought help even from psychiatrists were given the message that they could overcome their problems with effort and with help. Psychiatry's message today is that clients are broken or damaged, and must take pills or ECT or TMS, etc., if they hope to improve their lot. Often they are encouraged to take the pills for life. A recent study demonstrated that credible (though actually spurious) chemical imbalance feedback given to individuals with a history of depression "... failed to reduce self-blame [and] elicited worse prognostic pessimism..." (Kemp et al., 2014). In addition, the application of the diagnostic label provides subtle encouragement to people to act in accordance with the "requirements" of the label. (What can you expect of me? I'm a schizophrenic.) Labels also generate within others the notion that the labeled individual is fundamentally different and can be expected to function in characteristically

suboptimal ways. These kinds of expectations often have the effect of eliciting and reinforcing the behaviors in question.

It is widely claimed by psychiatrists that this process of medicalizing the presenting problem helps reduce the stigma attached to "mental illness," but in fact the reverse is the case. Efforts to destigmatize "mental illness" by promoting the biogenetic model have been largely counterproductive (Angermeyer et al., 2011).

Alongside, and possibly eclipsing, these shortcomings of the psychiatric medical model is the fact that the drugs are neither as efficacious nor as safe as psychiatry has claimed.

Antidepressants, touted for decades as successful treatment for depression, have been consistently shown to be only marginally better than placebos (Kirsch, 2010). Claims for the efficacy of these products have been based almost entirely on industry-sponsored, short-term trials, in which the primary outcome measure has been client self-report. In addition, evidence is accumulating that chronic depression is frequently an adverse effect of long-term ingestion of antidepressants at high dosages (El-Mallakh, Gao, & Jeannie Roberts, 2011). There is also growing credible concern that SSRIs are causally related to suicidal and violent behavior. In May 1990, the FDA required Eli Lilly, the manufacturer of Prozac, to add "suicidal ideation" and "violent behaviors" to its label. Other manufacturers of these products have issued similar statements.

The adverse effects of neuroleptics, including dyskinesia and akathisia, have been known for years. There is also growing evidence, as mentioned earlier, that the reductions in brain volume, formerly attributed confidently by psychiatrists to the progressive effects of schizophrenia, are in fact an adverse effect of the neuroleptic drugs. There is also evidence that individuals who take these products over an extended period fare more poorly than those who are tapered off (Harrow, Jobe, & Faull, 2012; Wunderink et al., 2013).

The Behavioral Tradition

Psychology is a science. It draws its conclusions from detailed and meticulous observations and routinely subjects these conclusions to ongoing scrutiny and revision. During the first half of the 20th century, psychology identified and codified, with a good measure of success, the general principles of behavior acquisition. Concepts such as stimulus, response, reinforcement, and generalization were developed, defined, and organized into a conceptual framework that not only helped us to understand counterproductive behavior, but also to develop successful intervention strategies. For behavioral psychology, counterproductive behavior was acquired in accordance with the same general principles as "ordinary" behavior, and there was no place for the concept of illness in explaining the genesis or maintenance of these problems.

These strategies, collectively known as behavior therapy, entailed: the precise definition and measurement of the presenting problem; the creative adaptation of behavioral principles to the amelioration of the problem; and routine follow-up assessment. Behavior therapy, although very successful in practice, was, and still is, widely criticized as being simplistic, mechanical, and manipulative. The reality is quite different. Although the general principles underlying behavior therapy are relatively straightforward, the application of these principles to the specific problems of specific individuals requires a very high level of empathic, interpersonal engagement, and an ability to identify the often subtle and elusive factors that are maintaining the problem behavior. The behavior therapist has to be able to work effectively and cooperatively with clients and with front-line staff, and is routinely involved in questions of ethics, civil rights, and human dignity. Behaviorism is indeed a science, but the successful application of behavioral principles to human problems is an advanced, multifaceted interpersonal skill.

By about 1975, behavior therapy had demonstrated its effectiveness in a wide range of problems encountered in the mental health field. In less than a half hour of browsing through the old journal stacks at my local university, I found the following studies.

Patterson and Teigen (1973) used operant conditioning to teach a psychotic client to provide factual answers to biographical questions, where previously her responses had been delusional. Walker and Buckley (1968) used a shaping program to teach attending behavior to a bright 9-year-old boy who, prior to the behavioral intervention, had been extremely disruptive in class. Ullmann, Krasner, and Edinger (1964) used simple social reinforcement ("mmhhmm"s, smiles, nods, etc.) to teach long-term hospitalized psychotic clients to give common (i.e., "normal") associations to stimulus words. McLaughlin and Nay (1975) used response cost to reduce, to the point of virtual elimination, the frequency of hair pulling in a 17-year-old girl who had been assigned a "diagnosis" of trichotillomania.

Even during the 1960s, behavior therapy was a thriving and successful field, generally considered to be on a par with, or even superior to, drug treatment in efficacy and safety. Since about 1970, however, it has declined both in popularity and perceived helpfulness relative to drug therapy, which has become increasingly accepted not only in professional circles, but within society generally. This change was not evidence driven. Drug therapy was backed by pharmaceutical money and has become a multibillion dollar global industry. Behavior therapy, in contrast, has no financial backers.

Discussion

Psychologists who seek prescriptive authority claim that their practices will not degenerate into the pill-for-every-problem approach that dominates psychiatry today. But it is generally forgotten that in the 1960s and early '70s, psychiatrists were saying the same thing. It has been estimated that prescriptive authority will enable a psychologist to almost double his/her earnings (Grohol, 2010). This is a powerful behavioral determinant.

Psychiatry wholeheartedly embraced the pill-for-every-problem practice not because it had any validity, but because it was, and is, abundantly reinforced. It proved to be a slippery slope, however, and has seduced psychiatry into a wide range of questionable activities. In recent years we have seen the corrupt relationships with pharma, the fraudulent research, the ghost-writing scandals, the prescribing of neuroleptic drugs to infants for temper tantrums, and so on. Psychiatrists were drawn into these activities, not because of some putative moral deficiency, but because these activities are systematically reinforced by a pharma industry that is willing to distribute largesse to anyone who will help them sell drugs. It is naïve to imagine that psychologists are somehow immune to these kinds of powerful reinforcers (Bradshaw, 2014).

In retrospect it is easy to see that the great error of psychology's youth was in forging an overly close, and, in fact, dependent alliance with psychiatry. It is also easy to see why this happened. The mental hospitals provided a ready-made work environment, together with instant credibility and respectability. But the cost has been high. Psychologists were expected to adopt, and conform to, the medical model. The behavioral model and behavioral expertise were

systematically marginalized. The general perception today is that psychologists and psychiatrists are pretty much the same, except that psychologists can't prescribe drugs. If the prescribing authority movement continues to gain ground, even that distinction will vanish.

The drive for prescribing authority is simply the latest chapter in psychology's ongoing effort to obtain parity with psychiatry *in psychiatry's playing field*, when, in fact, time and energy would have been better spent in developing our own arena, underpinned by our own, more empowering, and less damaging, conceptual model.

Behaviorally inspired psychologists have always been uncomfortable in the psychiatry-dominated milieu. Most of us stifled our objections or, to use the late George Albee's phrase, held our noses (Albee, 2005), and did the best we could. Perhaps the drive for prescriptive authority, endorsed as it is by the American Psychological Association, will be the final straw, and will stimulate those psychologists who yearn for conceptual validity, ethical integrity, and safe, effective interventions to break away from mainstream mental health and to establish their own therapeutic milieu and their own professional identity as behavioral consultants.

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Prescriptive Authority for Psychologists: A Survey of the ABCT Membership

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The American Psychological Association (APA) has advocated prescriptive authority for psychologists (RxP) as a matter of policy since 1996. Well-funded lobbying efforts have won specially trained psychologists the legal right to prescribe in New Mexico, Louisiana, Illinois, and the territory of Guam. Although APA-affiliated proponents contend the current status of RxP "… makes the question of whether we should prescribe medications moot" (Bray et al., 2014, p. 137), concerns about its scientific legitimacy and potentially harmful consequences remain unresolved (Hickey, 2014; Ransom, 2014; Tumlin & Klepac, 2014). Owing to the intensely political nature of RxP, debate on this issue has often been discouraged (Tumlin & Klepac), and the APA has been criticized for aggressively promoting RxP without encouraging adequate deliberation and informed consent from its membership (Society for a Science of Clinical Psychology [SSCP] Task Force statement on prescribing privileges, 2001). Although RxP has been the "law of the land" for two decades, its strong potential to shape the future of professional psychology necessitates ongoing, open, and critical analysis. The purpose of the present study, and this special issue of *the Behavior Therapist*, is to contribute to that analysis.

Scholarly dialogue surrounding RxP should be informed by an accurate and up-to-date assessment of how professionals currently perceive the relevant issues. Although a large number of surveys have assessed professionals' attitudes toward RxP (see Walters, 2001, for a meta-analytic review), this literature is limited by several factors. First, many surveys were conducted more than a decade ago. Important developments have occurred in the intervening years, including: (a) a long succession of RxP legislative failures (Robiner, Tumlin, & Tompkins, 2013), (b) an RxP bill recently passed in Illinois whose intensive training requirements and practice restrictions may severely curtail future legislative efforts (Moran, 2014; Tumlin & Klepac, 2014), (c) growing concerns regarding the validity of biomedical approaches to mental health problems (Deacon, 2013; Hickey, 2014) and the effects of psychotropic medications (Kirsch, 2010; Whitaker, 2010), and (d) backlash against the APA (including multiple class-action lawsuits) following the revelation that the "practice assessment" practitioners had been required to pay, which helped fund RxP lobbying efforts, was not mandatory. There is also evidence suggesting that support for RxP has decreased over time among psychology interns and training directors (Fagan et al., 2004), but as with most RxP surveys, this finding has become dated. These developments highlight the importance of obtaining an up-to-date assessment of professionals' attitudes toward RxP.

A second limitation of existing survey research concerns the nature of questions asked of respondents. Previously published surveys have often failed to include questions addressing concerns about RxP (e.g., Fagan et al., 2007), adequately specify key questions, by (for example) assessing support for RxP among "properly trained" psychologists without specifying what constitutes proper training (Walters, 2001), and/or assess the full range of concerns about RxP highlighted by its opponents (e.g., Grandin & Blackmore, 2006). To date, arguably no investigation has surveyed professionals' attitudes toward a comprehensive range of adequately specified questions reflecting the major positions of both proponents and opponents of RxP.

Third, attitudes toward RxP among ABCT members have not been assessed. The RxP movement was initiated by practice-oriented psychologists within the APA (Tumlin & Klepac, 2014), and most RxP opinion surveys have recruited practice-oriented samples (Walters, 2001). Given ABCT's strong scientific values, combined with longstanding opposition to RxP among science-oriented clinical psychologists (SSCP, 2001), it is possible that less support exists for RxP among ABCT members than among psychologists in general. ABCT members are involved in shaping the direction of professional psychology with regard to training, science, and practice. Given the potential future impact of RxP on each of these domains, it is important to obtain an up-to-date and thorough assessment of where the membership stands on RxP.

The present study was conducted to obtain a comprehensive assessment of ABCT members' attitudes toward RxP. Members were surveyed regarding specific positions/claims advanced by both proponents (e.g., Bray et al., 2014) and opponents (e.g., Tumlin & Klepac, 2014) of RxP. Participants were also surveyed regarding their endorsement of the biomedical model, as well as their support for ABCT developing an official policy regarding RxP. Although this study was primarily exploratory in nature, two hypotheses were tested: (a) consistent with previous research (Walters, 2001), students would report more favorable attitudes toward RxP than professionals, and (b) support for the biomedical model would be significantly, positively associated with support for RxP.

Method

Participants and Procedure

In April of 2014, an email invitation to participate in the present study was sent to all professional and student members of ABCT (N = 4,795). The web-based survey was initiated by 1,222 individuals, 976 of whom completed all survey items and comprised the final sample (20.4% response rate). Demographic characteristics of the sample are presented in Table 1. This study was approved by the University of Wyoming institutional review board.

Measure

The survey was constructed for the present study and contained three sections. The first section assessed demographic characteristics and background information. The second section asked participants to rate their agreement with each of 36 statements regarding RxP and/or the biomedical model. Responses were provided on a 5-point scale (0 = *Disagree strongly*, 1 = *Disagree*, 2 = *Unsure*, 3 = *Agree*, and 4 = *Agree strongly*). Survey items were constructed by the author, and reviewed by numerous colleagues, based on a thorough review of the RxP literature, including the accompanying articles in this special issue of *the Behavior Therapist*. These items were intended to assess attitudes toward a full range of positions adopted by RxP advocates and opponents, including those related to training and regulation standards, client care, and the effects of RxP on professional psychology. Six items were also constructed to assess support for the biomedical model, which posits that mental health

Table 1. Demographic Characteristics of the Sample ($N = 976$)

Characteristic	*M*	*SD*
Age	40.81	13.62
Years of Professional Practice	12.87	12.15
	N	%
Gender		
Female	566	58.0
Male	410	42.0
Ethnicity		
Caucasian	858	87.9
Hispanic/Latino/a	41	4.2
Asian American/Pacific Islander	28	2.9
Other	28	2.9
African American/Black	21	2.2
Highest Degree		
Ph.D.	608	62.3
Masters	210	21.5
Bachelors	66	6.8
Psy.D.	44	4.5
Other	36	3.7
M.D.	12	1.2
Field of Highest Degree		
Clinical Psychology	834	85.5
Other	65	6.7
Counseling Psychology	35	3.6
School Psychology	20	2.0
Psychiatry	12	1.2
Counseling	10	1.0
Primary Professional Activity		
Student	234	24.0
University Teaching, Research, & Service	196	20.1
Private Practice	179	18.3
Institution-Based Practice	137	14.0
University Research	72	7.4
Other	64	6.5
Research Institution	46	4.7
University Teaching	31	3.2
University Service	17	1.7
Theoretical Orientations that Guide Work		
Behavioral	884	90.6
Cognitive	834	85.5
Biological/Behavioral Neuroscience	231	23.7
Family/Systems	182	18.6
Eclectic/Integrative	172	17.6
Experiential/Humanistic	110	11.3
Psychodynamic/Psychoanalytic	80	8.2
Other	61	6.3

problems are brain diseases caused by biological abnormalities and emphasizes biological treatment (Hickey, 2014). The third section contained items assessing overall support for RxP and support for ABCT developing an official policy related to RxP. A copy of the survey is available upon request from the author.

Results

Item-Level Responses

Table 2 presents descriptive statistics for the 36 items in the second section of the survey. Although mean responses to many survey items approximated the midpoint of the 5-point response scale, "Unsure" was the modal response to only 3 of 36 items. The distribution of responses to many items included a substantial percentage of respondents who expressed either agreement or disagreement. To illustrate, responses to item 1 ("Psychologists should expand their scope of licensed clinical practice to include the administration and clinical management of psychotropic medications") were as follows: "Disagree strongly" = 26.7% ($n = 268$), "Disagree" = 22.1% ($n = 216$), "Unsure" = 16.8% ($n = 164$), "Agree" = 19.0% ($n = 178$), and "Agree strongly" = 15.5% ($n = 150$).

ABCT members reported somewhat more disagreement than agreement with expanding psychologists' practice to include RxP and the notion that RxP represents the natural evolution of psychology. Respondents evidenced unfavorable views, on average, of RxP training that occurs in psychology schools, particularly when delivered in an online format. More unfavorable than favorable views were also evident regarding psychologists' ability to resist economic incentives that favor prescribing over psychotherapy, the likelihood of prescribing psychologists relocating to rural settings to treat underserved clients, and the appropriateness of generalizing findings of the Department of Defense study of prescribing psychologists. These somewhat unfavorable ratings did not appear to reflect negative attitudes toward psychotropic medications per se, as participants held slightly more favorable than unfavorable views of the safety and efficacy of psychotropic medication and the notion that the ability to prescribe would allow psychologists to be more helpful to their clients.

Respondents evidenced favorable attitudes toward more rigorous RxP training than that obtained by prescribing psychologists (Ransom, 2014), such as traditional medical training, prerequisite undergraduate coursework in the biological and physical sciences, and broad biomedical training and experience. Respondents were also significantly more likely to endorse regulation of prescribing psychologists by a state or provincial board of medicine than board of psychology, $t(975) = 10.92, p < .001, d = .35$. ABCT members evidenced particularly favorable views of collaborating with medical colleagues and obtaining additional training to facilitate such collaboration, and tended to prefer collaboration to RxP. The vast majority of respondents (89.2%; $n = 873$) either agreed or agreed strongly that RxP advocates should produce empirical evidence in support of the

RxP model prior to additional efforts to seek prescriptive authority. Participants were more likely to agree than disagree that RxP produces negative consequences for professional psychology, such as expanding the profession beyond its scope of competence, detracting from its focus and philosophy, devaluing the value of psychotherapy, and detracting from efforts to disseminate empirically supported psychological treatments. Lastly, respondents tended to agree that the funding and resources devoted to RxP would be better allocated to other causes relevant to professional psychology.

The final two survey questions assessed overall support for RxP and attitudes toward ABCT developing an official stance on the issue. Responses to the item, "To what extent do you support prescriptive authority for psychologists?" were as follows:

- "I strongly oppose prescriptive authority for psychologists": 32.1% (n = 313)
- "I somewhat oppose prescriptive authority for psychologists": 20.2% (n = 197)
- "I neither oppose nor support prescriptive authority for psychologists": 10.0% (n = 98)
- "I somewhat support prescriptive authority for psychologists": 21.0% (n = 205)
- "I strongly support prescriptive authority for psychologists": 16.7 (n = 163)

The final survey item asked respondents, "Should ABCT develop an official policy regarding prescriptive authority for psychologists?" Responses were as follows:

- "ABCT should develop an official policy advocating prescriptive authority for psychologists": 24.1% (n = 235)
- "ABCT should develop an official policy opposing prescriptive authority for psychologists": 31.6% (n = 308)
- "ABCT should remain neutral regarding prescriptive authority for psychologists": 44.4% (n = 433)

Demographic Characteristics as Predictors of Attitudes Toward RxP

The 36 items from the second section of the survey were subjected to a principal components analysis. The purpose of this analysis was to reduce survey items into composite scores to facilitate analysis of support for RxP and the biomedical model as a function of demographic characteristics. Factors were rotated using an oblique (Oblimin) transformation. The first six eigenvalues were 14.16, 3.36, 2.01, 1.30, 1.18, and 0.95. Analysis of the scree plot supported a clearly interpretable three-factor solution that explained 54.2% of the variance in survey items. Factor loadings derived from the pattern matrix are presented in Table 2.

Factor one accounted for 39.3% of item variance and assessed support for RxP. Fourteen items assessing support for pro-RxP positions had salient ($\geq$ .40) positive loadings on this factor, whereas 12 items assessing anti-RxP positions had salient negative loadings. Notably, pro-RxP and anti-RxP items did not form separate factors but rather combined to form a single factor, indicating that support for one position tended to occur at the expense of the other. The second factor explained 9.3% of the item variance and was comprised of six items with salient loadings, each of which assessed support for the biomedical model. Factor three assessed support for collaboration with prescribers. This factor explained 5.6% of item variance and consisted of three items with salient loadings. The first two factors were considered adequately stable based on the recommendations of Guadagnoli and Velicer (1988), and factor scores were calculated to assess support for RxP and support for the biomedical model. Because factor three did not include four or more items with factor loadings above .60, it was not included in subsequent analyses.

As hypothesized, support for RxP was significantly albeit modestly correlated with support for the biomedical model, $r(976) = .19, p < .001$. Age was negatively correlated with support for RxP, $r(976) = -.13, p < .001$, and support for the biomedical model, $r(976) = -.24$, $p < .001$. Similarly, the duration of professional practice was negatively correlated with endorsement of RxP, $r(976) = -.11, p < .001$, and the biomedical model, $r(976) = -.25, p < .001$. Support for RxP and the biomedical model was compared across three groups: students, private practitioners, and individuals involved in university teaching, research, and service (subsequently referred to as "academics"). A one-way ANOVA comparing group differences in RxP support factor scores was significant, $F(2, 606) = 20.30$, $p < .001$, $\eta_p^2 = .06$. Tukey HSD tests revealed marginally greater support for RxP among students than private practitioners, $p = .08$, $d = .21$. Students evidenced substantially more support for RxP than academics, $p < .001$, $d = .65$. Private practitioners also supported RxP to a significantly greater extent than academics, $p < .001$, $d = .38$. Between-group differences were also examined with respect to the item, "To what extent do you support prescriptive authority for psychologists?" A chi-square test revealed significant differences in response frequencies (see Table 3), χ^2 (8) = 72.20, $p < .001$, Cramer's V = .24. The majority of students (55.6%) somewhat supported or strongly supported RxP, whereas most private practitioners (53.1%) and academics (66.9%) somewhat opposed or strongly opposed RxP. Lastly, a one-way ANOVA examining group differences in biomedical model support factor scores was significant, $F(2, 606) = 12.05, p < .001$, $\eta_p^2 = .04$. Tukey HSD tests revealed significantly greater support for the biomedical model among students than private practitioners ($p = .02$, $d = .26$) and academics ($p < .001, d = .49$), who did not differ significantly from each other ($p = .11$, $d = .20$).

Discussion

The present study was conducted to assess attitudes toward RxP and related issues among the membership of ABCT. The findings indicate considerable diversity of opinion among ABCT members. Many respondents endorsed support for RxP, particularly students and members of younger age and with less experience. Overall, however, ABCT members tended to oppose RxP, support rigorous medical training and experience for psychologists who prescribe, express concern about the negative effects of RxP on professional psychology, and prefer collaboration with medically trained prescribers to RxP. ABCT members also tended to agree that RxP proponents should produce objective, empirical evidence for the safety and efficacy of existing training models prior to seeking prescriptive authority in more states. Lastly, although more members supported ABCT formally opposing than supporting RxP, a plurality of members preferred the organization to remain neutral with regard to RxP.

As hypothesized, student members reported significantly more favorable attitudes toward RxP than professionals. Whereas a slight majority of students supported RxP, a slight majority of private practitioners and two-thirds of academics opposed RxP. Fagan et al. (2004) speculated that psychologists at the beginning of their careers may support RxP as a means of promoting economic survival, whereas mid-career psychologists are more entrenched in their career paths and prefer the status quo to investing their resources in completing new and unfamiliar training. An alternative interpretation for the present findings involves two possibilities: (a) RxP is

Table 2. Descriptive Statistics and Factor Loadings for Survey Items

Item	*M*	*SD*	*Factor 1: RxP*	*Factor 2: Biomedical Model*	*Factor 3: Collaboration*
1. Psychologists should expand their scope of licensed clinical practice to include the administration and clinical management of psychotropic medications.	1.72	1.43	**.77**	.14	.29
2. Extending the practice of psychology to include prescriptive authority is the natural evolution of psychology.	1.54	1.40	**.73**	.16	.28
3. It would enhance the healthcare system if psychologists obtained prescriptive authority through training programs run by psychology schools.	1.85	1.45	**.73**	.11	.32
4. If prescriptive authority for psychologists were legal where I live, I would be interested in obtaining APA-approved training in clinical psychopharmacology to be able to prescribe.	1.74	1.58	**.64**	.15	.35
5. The ability to prescribe psychotropic medications would allow psychologists to be more helpful to their clients.	2.16	1.40	**.67**	.18	.32
6. Prescribing psychologists are necessary to meet an urgent need to increase client access to prescribers of psychotropic medications.	1.76	1.39	**.66**	.23	.24
7. Psychologists who obtain prescriptive authority will be able to successfully resist economic incentives that favor prescribing medications over providing psychotherapy.	1.53	1.30	**.61**	.20	.19
8. Psychologists who obtain prescriptive authority are likely to relocate their practices to rural settings in order to improve access to psychotropic medications among underserved clients.	0.98	0.98	**.49**	.14	.19
9. It would enhance the healthcare system if more psychologists learned enough about psychotropic medications to effectively collaborate with medical colleagues in prescribing medications for their clients.	3.18	1.08	.18	-.10	**.72**
10. I would be interested in obtaining additional training in clinical psychopharmacology to enhance my collaborations with prescribers.	2.79	1.24	.17	.00	**.73**
11. The ability to effectively collaborate with prescribers in other disciplines would allow psychologists to be more helpful to their clients.	3.22	0.91	.07	-.08	**.76**
12. Rather than seek prescriptive authority, psychology should encourage collaboration with medical colleagues who already prescribe.	2.79	1.18	**-.82**	-.04	.07
13. It would enhance the healthcare system if more psychologists obtained the traditional medical training to prescribe medications, such as that of physicians, advanced-practice nurses, or physician assistants.	1.86	1.32	.23	.22	.39
14. Rather than seek prescriptive authority, psychology should encourage psychologists who are interested in prescribing to obtain traditional medical training, such as that of physicians, advanced-practice nurses, or physician assistants.	2.20	1.29	**-.74**	-.01	.03
15. Psychologists who prescribe medication should be trained in programs run by psychology schools.	1.55	1.23	**.66**	-.09	.23

(Table 2, continued)

16. Mental health problems are brain diseases.	1.70	1.11	-.03	**.83**	-.13
17. Mental health problems are caused by biological abnormalities (e.g., chemical imbalances, faulty brain circuits).	1.85	1.04	-.03	**.84**	-.07
18. Psychotropic medications work by correcting the biological abnormalities (e.g., chemical imbalances, faulty brain circuits) that cause mental health problems.	2.01	1.09	.02	**.77**	.01
19. Generally speaking, psychotropic medications are safe and effective in the treatment of mental health problems.	2.20	0.96	.06	**.65**	.00
20. Generally speaking, psychotropic medications alone are more effective than psychotherapy alone for mental health problems.	0.64	0.69	.01	**.52**	-.15
21. Generally speaking, the combination of psychotropic medication(s) and psychotherapy is more effective than psychotherapy alone for mental health problems.	2.36	1.10	.07	**.55**	.12
22. If psychologists prescribe, their prescribing practice should be regulated by a state or provincial board of medicine.	2.95	1.10	**-.49**	.28	.18
23. If psychologists prescribe, their prescribing practice should be regulated by a state or provincial board of psychology.	2.29	1.35	**.47**	-.06	.19
24. Online training programs run by psychology schools provide enough medical education to allow psychologists to prescribe psychotropic medications competently and independently.	0.69	0.96	**.59**	-.07	.05
25. Psychologists who prescribe should complete the same undergraduate prerequisites (e.g., biology, chemistry, organic chemistry, algebra, physics) as other prescribers as recommended by the APA Ad Hoc Task Force on Psychopharmacology (Smyer et al., 1993; Professional Psychology: Research & Practice).	2.74	1.12	**-.65**	.09	.27
26. Because psychotropic medications interact with other medications, prescribers need to have broad awareness of medical conditions and the entire range of medications and treatments (e.g., dialysis) that may affect the impact of psychotropic medication	3.54	0.65	**-.61**	.13	.29
27. Psychologists learning to prescribe medication independently should have experience in medical settings with clients who have a variety of biomedical and psychiatric conditions.	3.22	0.84	**-.60**	.11	.29
28. In addition to standard coursework on the biological basis of behavior, graduate training in psychology should include courses designed to prepare psychologists to prescribe medications.	1.94	1.38	**.51**	.17	.38
29. Psychologists have been allowed to prescribe medications in two states for more than 10 years based on a special program of abbreviated training. Before seeking prescriptive authority in more states, advocates should develop objective, empirical evidence confirming that this model is safe and effective.	3.37	0.86	**-.58**	-.01	.36
30. It is appropriate to generalize the findings of the Department of Defense study, which trained 10 psychologists and included extensive on-site training (i.e., 1 year of didactics; 1 year of clinical practicum that included a 6-month inpatient rotation), to the APA training model that is less intensive and has less clearly defined experience requirements (e.g., no inpatient psychiatric requirement).	1.30	1.12	**.55**	-.06	.13
31. I would feel comfortable referring a client for psychotropic medication to a prescribing psychologist whose biomedical education equaled 30 semester hours of online courses from a	1.08	1.15	**.66**	-.04	.11

(Table 2, continued)

psychology school and whose clinical practicum was supervised by a psychologist.					
32. Adding medication management would push psychology beyond the proper bounds of its scope of competence.	2.23	1.31	**-.75**	-.12	-.09
33. Adding medication management would detract from psychology's focus and philosophy.	2.35	1.37	**-.67**	-.26	-.15
34. By emphasizing increased access to medication as a high priority for improving the nation's healthcare system, advocates of prescriptive authority for psychologists are de-emphasizing the value of psychotherapy.	2.38	1.32	**-.63**	-.33	-.05
35. By emphasizing increased access to medication as a high priority for improving the nation's healthcare system, advocates of prescriptive authority for psychologists are detracting from efforts to disseminate empirically supported psychological treatments.	2.38	1.36	**-.65**	-.32	-.07
36. The funding and resources devoted to the prescriptive authority agenda would be better allocated to other causes (e.g., lobbying for research funding through NIH, clinical practice guidelines, address the predoctoral internship supply and demand imbalance).	2.75	1.25	**-.74**	-.21	-.06

Note. Factor loadings ≥ |.40| are listed in boldface type.

aggressively marketed to graduate students by the APA (Bray et al., 2014) as part of a broad, politically motivated campaign that discourages debate (Tumlin & Klepac, 2014), and (b) professional psychologists, particularly ABCT members with strong scientific values, may have acquired a particularly informed, critical, and data-driven opinion of the issue. This interpretation is consistent with survey research indicating majority-level opposition to RxP among directors of clinical training (Evans & Murphy, 1997) and clinical diplomats of the American Board of Professional Psychology (Plante, Boccaccini, & Anderson, 1998), in contrast to broader support for RxP among professional psychologists in general (Sammons, Gorny, Zinner, & Allen, 2000). Taken together, ABCT members' attitudes toward RxP appear more consistent with the critical positions articulated by Ransom (2014) and Tumlin and Klepac (2014) than the supportive position advocated by Bray and colleagues (2014).

The hypothesis that support for RxP would be significantly, positively associated with support for the biomedical model was also supported, although the magnitude of this association was small. As with RxP, support for the biomedical model was greatest among students and younger respondents with less professional experience, and lowest among academics. Hickey (2014) noted that an underappreciated aspect of RxP is its implicit endorsement of the biomedical model. The practice of prescribing psychotropic drugs assumes that mental health problems are caused by biological abnormalities and that medications correct these abnormalities. Both of these assumptions are scientifically questionable and highly controversial (Deacon, 2013; Whitaker, 2010). An important yet rarely discussed issue in the RxP debate concerns the compatibility of the biomedical model with traditional psychological approaches to understanding and treating mental health problems. Bray and colleagues (p. 137) contend that "the fixation on behavior and psychosocial issues by some psychologists is dated and does not fit with current scientific evidence about the integral biopsychosocial nature of human beings…" However, an emphasis on behavior and psychosocial issues is the foundation of cognitive-behavioral therapy, which is characterized by theoretical assumptions (e.g., "abnormal" behavior is acquired via the same learning principles as "normal behavior"; Hickey, 2014) that are inconsistent with those of the biomedical model. The

Table 3. Support for RxP Among Students, Private Practitioners, and Academics

Response to "To what extent do you support prescriptive authority for psychologists?"	Students	Private Practitioners	Academics
	n (%)	*n* (%)	*n* (%)
Strongly oppose	31 (13.2)	65 (36.3)	85 (43.4)
Somewhat oppose	41 (17.5)	30 (16.8)	46 (23.5)
Neither oppose nor support	32 (13.7)	12 (6.7)	18 (9.2)
Somewhat support	76 (32.5)	35 (19.6)	26 (13.3)
Strongly support	54 (23.1)	37 (20.7)	21 (10.7)

observation that humans are influenced by biopsychosocial factors does not, by itself, indicate that psychologists should adopt biological theories and treatments. Mental health problems may be studied at different levels of analysis (e.g., molecular genetics, cognition), and different levels of analysis are useful for different purposes (Kendler, 2005, 2012). Hickey's (2014) description of a neuronal vs. environmental explanation for an individual's violent behavior underscores the importance of determining which level of analysis is most useful and relevant for a professional seeking to understand and modify this behavior. The fact that a psychological phenomenon can be understood at the biological level (or any other level, for that matter) does not necessarily mean it should be.

These are dynamic times in the field of professional psychology. Advocates for RxP recently won the legal right to prescribe psychotropic medications in a third state (Illinois), but the bill is so severely restrictive (e.g., requiring extensive undergraduate prerequisite science courses and medical training comparable to that of a physician assistant, with severe restrictions on the types of patients who can be seen and drugs that can be prescribed) that it may forestall, if not eliminate, further legislative successes if it becomes the model for RxP bills elsewhere. The APA continues to vigorously pursue RxP despite the opposition of many critics within the field whose position may be increasingly difficult to ignore as a result of the Illinois RxP bill and a growing public debate regarding the validity and consequences of biomedical approaches to mental health problems. Findings from the present study indicate that the membership of ABCT, despite representing a clear diversity of opinions, tends not to support RxP, harbors concerns about the adequacy of existing training models and the effects of RxP on the profession, prefers collaboration with prescribers to RxP, and would rather see the resources devoted to RxP allocated to other causes. It is hoped that these findings will inform ongoing scholarly debate regarding the pros and cons of RxP.

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CALL *for* WEB EDITOR

ABCT is seeking a Web editor to assist in updating material in, and developing policies for, its Web site. The position is funded with an honorarium. The role principally involves helping to develop content for the Web site and reviewing the site and navigational structure to ensure it remains best suited to our audiences. Technological knowledge is less essential, and the web editor is not expected to post to the site or otherwise take on the function of a web master. The following mission statement and strategy statement detail information on the proposed aims, activities, and audiences of this new Web site effort.

Web Page Mission Statement

The Web page serves a central function as the public face of ABCT.
As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT as a professional activity and serving as a resource and information source for matters related to CBT.

Informational and resource activities are directed toward three conceptual groups:

- ***Members***—with emphasis on providing an interface for many of the administrative functions of the organization, including conference information, dues, public listing of therapists, etc.
- ***Nonmember Professionals***—to advertise the comparative efficacy, diversity of styles, and methods of cognitive-behavior therapy, with additional information on training opportunities, available syllabi, and new findings in the scientific literature.
- ***Consumers***—to provide information and treatment resources on disorders and their treatment, with emphasis on the style, "feel," and efficacy of cognitive-behavior therapy, as well as information on additional issues that consumers confront in treatment (e.g., combined treatments, relapse prevention, etc.).

Web Page Strategy Statement

One of the broader changes in the architecture of the Web page is that our content will now come up on searches. Accordingly, we need to plan content that will bring professionals and consumers to our site.
The Web editor will need to liaise with associate editors, periodical editors, committees, and SIGs for content.
Such content includes:

- Diagnosis-specific information pages (e.g., information on depression and its treatment)
- Efficacy information (comparative, combination treatment issues)
- The "feel" of cognitive-behavioral treatment
- CBT, BT, DBT, RET . . . what is in a name?
- Recent research findings
- Position statements—regarding issues in the field (to clarify what our organization stands for)
- Speakers bureau
- Links to publications
- Helping media find the right person to discuss a topic
- CBT curricula
- Featured therapist of the month
- Research funding available
- Learning opportunities

ABCT's Web site is now a mature site, having undergone several structural revisions. Now, we are looking for a member to help us maximize our own Web's outreach potential and grow it while maintaining structural integrity. In addition, candidates can apprentice with our current Web master, learning the interface among Web editor, Web master, and central office.

HOW *to* APPLY

ABCT members interested in applying for this position should contact David Teisler, Director of Communications, ABCT, at teisler@abct.org. The deadline for applications is **September 15, 2014.**

Welcome From the Program Chair | L. Kevin Chapman, *Private Practice*

I hope to see you in Philadelphia for ABCT's 48th annual meeting! I am extremely thankful for President Dean McKay and the ABCT Board for inviting me and subsequently approving and supporting me as Program Chair. Serving as Program Chair has provided me with a unique perspective into the complexities involved in synthesizing various components to create a dynamic program. We received close to 2,000 submissions that were subject to a rigorous peer review, which included a record number of peer reviewers this year.

The theme of this year's meeting is "Enhancing CBT by Drawing Strength from Multiple Disciplines." Grounded in empiricism at its inception, CBTs have continued to be the cornerstone of the contemporary practice of psychology. The evolution of CBT has included the infusion of findings from diverse empirical backgrounds that have created systematic approaches to alleviate mental illness. This year, we further explore our diverse roots by synthesizing these multiple influences into one conference, focusing on presentations that highlight newer technological insights in addition to theoretical perspectives from the behavioral and social sciences that enhance the effectiveness of CBT.

We are delighted to have David Clark from the University of Oxford open this year's convention with his invited address "Developing and Disseminating Effective Psychological Therapies for Anxiety Disorders: Science, Economics & Politics," illustrating the interplay between theoretical and experimental development within CBT that has facilitated dissemination to the general public. Next, Liz Phelps from NYU will deliver her invited address "Mechanisms of Fear Control" and ultimately describe innovative ways to achieve more lasting fear reduction.

Lauren Alloy from Temple University will present "Reward Hypersensitivity in the Onset and Course of Bipolar Spectrum Disorders" and will address why the paradox of bipolar spectrum disorders is associated both with high achievement and marked impairment. Next, Tom Ollendick from Virginia Polytechnic Institute will present "Treatment of Phobic and Anxiety Disorders in Children and Adolescents: Where To From Here?" This discussion will focus on moderators and mediators of change in interventions for youth with anxiety disorders. Finally, in his Presidential Address, Dean McKay will present "Embracing the Repulsive: The Case for Disgust as a Functionally Central Emotional State in the Theory, Practice, and Dissemination of Cognitive-Behavioral Therapy." Also, don't miss "A Conversation With Aaron T. Beck and Judith Beck." Drs. Beck will take their seats for an informal and interactive armchair conversation.

It has been a distinct honor to serve as Program Chair. There are so many colleagues who have made this event possible. First, I would like to extend a special thanks to the members of the 2014 Program Review Committee for their expertise, diligence, and flexibility. This year's program would not have been possible without your efforts. Second, the chairs of the Convention and Education Planning Committee did a truly exceptional job with this year's program: David Atkins (AMASS), Jeff Goodie (CIT), Lauren Weinstock (Institutes), Sarah Kertz (Master Clinician Seminars), and Barbara Kamholz (Workshops). An extra special thanks to Jeff Goodie who also served as the Coordinator of Convention and Education Issues as well as Sabine Wilhelm, Mauren Whittal, and James Herbert, our Representatives-at-Large.

Finally, words cannot express how thankful I am for two people in particular. My exceptional Assistant Program Chair and graduate student, Ryan DeLapp, has been a cornerstone throughout this process. His diligence, support, and flexibility have not gone unnoticed. Last and definitely not least, I would like to thank Mary Ellen Brown, Director of Education and Meeting Services. Her support and wisdom of our organization have undoubtedly facilitated this process in its entirety. Thank you, Mary Ellen and Ryan.

Best wishes to you all and please have a most enjoyable convention!

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About the Itinerary Planner

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2014 convention in Philadelphia. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner.

The Itinerary Planner is accessible on ABCT's website at www.abct.org/conv2014. To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can ***search*** by session type, or you can ***browse*** by day. (Keep in mind, the ABCT convention program book will only be mailed to those who preregister by **October 20**. Programs will be distributed on-site to all other registrants.) After reviewing this special Convention 2014 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

www.abct.org/conv2014

Clinical Intervention Trainings

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

A Day of Mindful Practice to Enhance Your Clinical Practice

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

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

| *special event* |

Attendee Orientation to the ABCT Convention

Friday, 8:00 – 9:00 A.M. | Grand Ballroom D

To maximize your ABCT convention experience, join us first thing Friday morning!*

Enjoy a cup of coffee and get your personal blueprint to the Convention. Whether you are a first-time convention attendee or just want to refresh your memory on how to navigate the Convention, ***all are welcome***. Learn how to take full advantage of networking opportunities, how to make the Convention program book your personal road map, and how to utilize the online convention itinerary planner.

*With Jon Grayson, *Membership Committee Chair;* Danielle Maack, *Student Membership Committee Chair*; David DiLillo, *Membership Issues Coordinator;* Hilary Vidair, *ABCT Ambassadors Chair;* Mary Jane Eimer, *Executive Director of ABCT*.

THURSDAY | 8:30 a.m. – 5:00 p.m.
CLINICAL INTERVENTION TRAINING 2

Contemporary Problem-Solving Therapy: A Transdiagnostic and Evidence-Based Psychotherapy

Christine Maguth Nezu, Drexel University
Arthur M. Nezu, Drexel University

Problem-Solving Therapy (PST) is an evidence-based system of psychotherapy that is based on research demonstrating the mediating and moderating role of social problem solving (SPS) regarding stress and psychopathology. SPS is the process whereby people direct their coping efforts at altering the problematic nature of stressful events, their negative reactions to such occurrences (i.e., emotional dysregulation), or both. If one's problem-solving attempts are unsuccessful or ineffective, significant negative emotional reactions are likely to occur. Stressful events may be experienced as a single traumatic episode, chronic stressors or problems, or high sensitivity to life stressors associated with early negative life experiences. The overarching treatment goals of PST are to foster adoption of emotion-regulation skills and adaptive problem-solving attitudes and behaviors as a means of effectively minimizing the negative effects of stressful events. More specifically, PST is geared to increase optimism, improve emotional regulation, increase resilience, and foster successful coping with ongoing stressors. Several meta-analytic reviews of the PST outcome literature strongly support its efficacy for the treatment of a wide range of emotional disorders across ages and clinical populations. This clinical training incorporates recent updates to PST based on advances in understanding the neurobiological substrates of the relationship among emotional, cognitive, and behavioral pathways of learning that are incorporated in this approach. This includes the role of nonconscious conditioned emotional reactivity and information processing. Therapy targets include the mindful attunement to one's inner experience, as well as specific emotional, cognitive, and behavioral skill development. This transdiagnostic approach has a strong evidence base regarding successful treatment for multiple clinical populations. Training materials will be provided and clinical training is designed to be experiential using role-plays and clinical demonstrations.

Institutes

TICKETED

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

THURSDAY

—full day—

INSTITUTE 1
8:30 a.m.

Radically Open Dialectical Behavior Therapy (RO-DBT): For Disorders of Overcontrol
Thomas. R. Lynch, *University of Southampton*

INSTITUTE 2
8:30 a.m.

Motivational Interviewing: Skill Building and Updates
Daniel W. McNeil, *West Virginia University*
Trevor A. Hart, *Ryerson University*
Emily M. Selby-Nelson, *Cabin Creek Health Systems*

—5-hour—

INSTITUTE 3
1:00 p.m.

Psychotherapy for the Interrupted Life: An Evidence-Based Treatment for Adult Survivors of Childhood Abuse
Tamar Gordon, *Ferkauf Graduate School*
Christie Jackson, *New York Harbor Healthcare System*
Susan Trachtenberg Paula, *Jewish Board of Family and Children's Service*

INSTITUTE 4
1:00 p.m.

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

INSTITUTE 5
1:00 p.m.

Interpersonal Psychotherapy–Adolescent Skills Training: A Group Depression Prevention Program
Jami Young, *Rutgers University*
Laura Mufson, *Columbia University Medical Center, College of Physicians and Surgeons*
Christie Schueler, *Rutgers University*

INSTITUTE 6
1:00 p.m.

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

INSTITUTE 7
1:00 p.m.

Neurocognitive and Translational Interventions
Greg Siegle, *University of Pittsburgh*
Kristen Ellard, *MGH/Harvard Medical School*

INSTITUTE 8
1:00 p.m.

The Compassionate Use of Exposure Strategies in Acceptance and Commitment Therapy
John P. Forsyth, *University at Albany, SUNY*

INSTITUTE 9
1:00 p.m.

Helping Clients Quiet Their Mind and Get to Sleep: A Client-Centered Approach to Cognitive Behavioral Therapy for Insomnia
Colleen E. Carney, *Ryerson University*

AMASS

Advanced Methodology and Statistics Seminars

TICKETED

A special series of offerings for applied researchers, presented by nationally renowned research scientists.

AMASS 1
Introduction to Hierarchical Linear Models for Longitudinal Data
Robert Gallop, *West Chester University*

AMASS 2
Mplus Bootcamp: An Introduction Covering Basic to Intermediate Functions
Abby Lynn Braitman, *Old Dominion University*

Mini Workshops

NO TICKET REQUIRED

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

MINI WORKSHOP 1

Alliance-Focused Training: Strategies for Identifying, Addressing, and Repairing Ruptures in the Therapeutic Alliance

Jeremy D. Safran, *New School for Social Research, Beth Israel Medical Center*
J. Christopher Muran, *Derner Institute of Advanced Psychological Studies, Adelphi University*
Catherine Eubanks-Carter, *Ferkauf Graduate School of Psychology, Yeshiva University*

MINI WORKSHOP 2

DBT for Adolescents With Bipolar Disorder

Tina Goldstein, Nina Hotkowski, Rachael Fersch-Podrat, *University of Pittsburgh Medical Center*

MINI WORKSHOP 3

Awareness and Connection in Ethnically and Racially Diverse Therapist-Client Dyads

Monnica Williams, *Center for Mental Health Disparities*
Chad T. Wetterneck, *Rogers Memorial Hospital*

MINI WORKSHOP 4

Going Digital: Building eHealth and mHealth Interventions

Jennifer Duffecy, Mark Begale, Stephen M. Schuller, David C. Mohr, *Northwestern University*

MINI WORKSHOP 5

Three Levels of Family Involvement in the Treatment of Children With Anxiety Disorders

Deborah Roth Ledley and Lynne Siqueland, *Children's and Adult Center for OCD and Anxiety*

MINI WORKSHOP 6

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

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

MINI WORKSHOP 7

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

Cory F. Newman, *University of Pennsylvania*

MINI WORKSHOP 8

Beyond Preaching to the Choir: Practical Approaches to Training Psychiatry Residents in Cognitive-Behavioral Therapies

Barbara W. Kamholz, Gabrielle I. Liverant, Justin M. Hill, *VA Boston Healthcare System and Boston University School of Medicine*

MINI WORKSHOP 9

Taking Exposure and Response Prevention from the Treatment Manual to Your Patients: A Guide to Application for All Mental Health Disciplines

Patrick B. McGrath, *Alexian Brothers Behavioral Health Hospital*

MINI WORKSHOP 10

Using Structured Therapeutic Games to Enhance Empirically Based CBT Treatment for Child Sexual Abuse

Craig Springer and Justin Misurell, *Children's Hospital of New Jersey, Newark Beth Israel Medical Center*

MINI WORKSHOP 11

Recovery-Oriented Cognitive Therapy: An Evidence-Based Program for Individuals With Schizophrenia, in and Out of the Hospital

Paul Grant, Aaron Brinen, Aaron T. Beck, *Perelman School of Medicine, University of Pennsylvania*

MINI WORKSHOP 12

CBT With Children and Adolescents in School Settings

Torrey A. Creed, *Aaron T. Beck Psychopathology Research Center, University of Pennsylvania*

MINI WORKSHOP 13

Values Work in Acceptance-Based Behavioral Therapy: Helping Clients Reclaim Their Lives

Susan M. Orsillo, *Suffolk University*
Lizabeth Roemer, *University of Massachusetts at Boston*

MINI WORKSHOP 14

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

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

MINI WORKSHOP 15

From Self-Criticism to Self-Compassion: Enhancing CBT for Anxiety and Mood Disorders

Ricks Warren, *University of Michigan*

MINI WORKSHOP 16

The Safety Planning Intervention for Reducing Suicide Risk

Gregory K. Brown, Kelly L. Green, Barbara Stanley, *University of Pennsylvania Perelman School of Medicine*

MINI WORKSHOP 17

Conceptualizing and Assessing Spirituality in Cognitive Behavioral Therapy

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

Master Clinician Seminars

TICKETED

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

MASTER CLINICIAN SEMINAR 1
Cognitive Behavior Therapy for Jealousy
Robert L. Leahy, *American Institute for Cognitive Therapy*

MASTER CLINICIAN SEMINAR 2
Integrating CBT Strategies Into Ongoing Clinical Practice
Michael W. Otto, *Boston University*

MASTER CLINICIAN SEMINAR 3
Acceptance and Change in Couple Therapy: Integrative Behavioral Couple Therapy
Andrew Christensen, *UCLA*

MASTER CLINICIAN SEMINAR 4
Cognitive Therapy for Social Anxiety Disorder
David M. Clark, *University of Oxford*

MASTER CLINICIAN SEMINAR 5
Perspective Taking and Compassion in Modern CBT
Steven C. Hayes, *University of Nevada*

MASTER CLINICIAN SEMINAR 6
Comprehensive CBT for OCD to Maximize Gains
Lata K. McGinn, *Yeshiva University, Albert Einstein College of Medicine*

MASTER CLINICIAN SEMINAR 7
When Anxiety Traps Emerging Adults and Thier Parents: Developmentally Informed CBT for the "Failure to Launch"
Anne Marie Albano, *Columbia University Center for Anxiety and Related Disorders*

Presidential & Invited Addresses

Presidential Address

SATURDAY | 5:00 – 6:30 p.m.

DEAN MCKAY
Fordham University
Embracing the Repulsive: The Case for Disgust as a Functionally Central Emotional State in the Theory, Practice, and Dissemination of Cognitive-Behavioral Therapy

Invited Addresses

FRIDAY | 11:00 – 12:00 p.m.

DAVID M. CLARK
University of Oxford
Developing and Disseminating Effective Psychological Therapies for Anxiety Disorders: Science, Economics, and Politics

FRIDAY | 12:30 – 1:30 p.m.

ELIZABETH A. PHELPS
New York University
Mechanisms of Fear Control

SATURDAY | 12:00 – 1:0 p.m.

LAUREN B. ALLOY
Temple University
Reward Hypersensitivity in the Onset and Course of Bipolar Spectrum Disorders

SATURDAY | 2:00 – 3:00 p.m.

THOMAS H. OLLENDICK
Virginia Polytechnic Institute & State University
Treatment of Phobic and Anxiety Disorders in Children and Adolescents: Where to From Here?

SATURDAY | 4:00 – 5:00 p.m.

AARON T. BECK & JUDITH BECK
Beck Institute for Cognitive Behavioral Therapy
A Conversation with Aaron T. Beck and Judith Beck

Workshops

NO TICKET REQUIRED

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

WORKSHOP 1

Implementing Trauma-Focused Cognitive Behavioral Therapy in a Group Format

Esther Deblinger and Elisabeth Pollio, *Rowan University School of Osteopathic Medicine*

WORKSHOP 2

Interoceptive Exposure for Anxiety Sensitivity: Principles, Practice, and Maximizing Inhibitory Learning

Brett Deacon and Joshua J. Kemp, *University of Wyoming*

WORKSHOP 3

Emotion Regulation Therapy: A New Approach for Chronic Anxiety and Recurring Depression

Douglas S. Mennin, *Hunter College*
David M. Fresco, *Kent State University*

WORKSHOP 4

Preparing for the Role of Behavioral Health Consultant and Translating CBT Principles to Integrated Primary Care

Risa B. Weisberg and Cara H. Fuchs, *Brown University*

WORKSHOP 5

Intensive CBT for Youth With OCD

Jamie A. Micco and Noah C. Berman, *Massachusetts General Hospital*

WORKSHOP 6

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Core Treatment Strategies and Recent Developments

Matthew W. Gallagher, *National Center for PTSD*
Shannon Sauer-Zavala, *Boston University*
James F. Boswell, *University at Albany, SUNY*
Todd J. Farchione, *Boston University*

WORKSHOP 7

When Life Gives You Lemons . . . Use Strengths-Based CBT's Four-Step Model to Build Resilience

Christine A. Padesky and Kathleen A. Mooney, *Center for Cognitive Therapy*

WORKSHOP 8

Targeting Transdiagnostic Mechanisms: A Practical Road Map to Case Formulation and Treatment Planning

Rochelle I. Frank, *University of California, Berkeley*
Joan Davidson, *San Francisco Bay Area Center for Cognitive Therapy*

WORKSHOP 9

How to Do Research in Your Private Practice

Jacqueline B. Persons, *Cognitive Behavior Therapy and Science Center, and University of California at Berkeley*

WORKSHOP 10

Teaching and Supervising Cognitive Behavioral Therapy: Delivering Effective Multidisciplinary Training

Donna M. Sudak, *Drexel University College of Medicine*
Leslie Sokol, *Beck Institute for Cognitive Therapy and Research*
Robert Reiser, *Palo Alto University*
R. Trent Codd, III, *Cognitive-Behavioral Therapy Center of WNC, P.A.*

WORKSHOP 11

Acceptance and Commitment Therapy: Using Mindfulness, Compassion, and Values in the Treatment of Trauma

Robyn D. Walser, *VAPA*

WORKSHOP 12

Cognitive Behavioral Social Skills Training: An Introduction and Overview

Eric Granholm, *University of California, San Diego*
Jason Holden, *Veterans Medical Research Foundation*

WORKSHOP 13

Adjunctive Mobile Technologies for Cognitive Behavioral Therapies

Frederick Muench, *Columbia University College of Physicians and Surgeons*
Ryan Hansen, *Ohio State University*
Matthew Price, *University of Vermont*

General Sessions

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

Clinical Round Tables

New Directions in CBT With Youth: Oh, the Places You'll Go!
Chair: Robert Friedberg
Panelists: Elizabeth Laugeson, Eduardo Bunge, David Bak, Micaela Thordarson, Marisa Keller

Is There CBT in Heaven? Addressing Spirituality in the Context of CBT
Chairs: David Rosmarin and Jeremy Cummings
Panelists: William Hathaway, Dean McKay, Michelle Pearce, Harold Robb

Unify to Simplify: Transdiagnostic Approaches to Research and Treatment
Chair: Simon Rego
Panelists: David Barlow, Christopher Fairburn, Brian Chu

Overcoming Obstacles to Doing Research in a Private Practice Setting
Chair: Jacqueline Persons
Panelists: Polina Eidelman, Janie Hong, Travis Osborne, Cannon Thomas, Jason Luoma

Training Clinicians in the Practice of CBT With Young Patients
Chairs: Robert Friedberg and Micaela Thordarson
Panelists: Aude Henin, John Piacentini, Michael Southam-Gerow, Thomas Ollendick

Treating Patients Suffering From Insomnia and Chronic Pain
Chair: Robert Meyers
Panelists: Michael Perlis, Donn Posner

Barriers to Assessment and Evidence-Based Behavioral Interventions: Examination of the Phenomenology of Autism Spectrum Disorders and of Comorbid Disorders in Youth
Chair: Danielle Ung
Panelists: Jeffrey Wood, Denis Sukhodolsky, Ovsanna Leyfer, Amy Drahota, Chelsea Ale, Alexandra Gibson

Evidence-Based Training in Couple Therapy in the U.S. Veteran's Administration
Chair: Andrew Christensen
Panelists: Shirley Glynn, Steffany Fredman, Candice Monson, Timothy O'Farrell

Mindfulness Training for Highly Stressed and Distressed People With OCD, Anxiety, Trauma-, and Stressor-Related Disorders: Adaptations for the Challenges
Chair: Christine Molnar
Panelists: Michael Baime, Donald Marks, Jennifer Block-Lerner, Jonah Cohen, Lynne Siqueland

Enhancing CBT: Innovative Behavioral Treatments for Bipolar Disorder
Chair: Lauren Weinstock
Panelists: Louisa Sylvia, David Miklowitz, Thilo Deckersbach, Tina Goldstein, Kristen Ellard,

You Know What They Say . . . The Truth About Popular CBT Beliefs!
Chair: Simon Rego
Panelists: Michelle Craske, Thomas Ollendick, Adam Radomsky, Barbara Rothbaum

The Perils of Popularity: Challenges and Best Practices in the Delivery of Mindfulness-Based Interventions
Chairs: Donald Marks and Frank Gardner
Panelists: Dennis Tirch, Steven Hickman, Chris Molnar, Donald McCown

Addressing Functional Impairments in ADHD: Assessment and Treatment Across the Life Span
Chairs: Richard Gallagher, Joshua Langberg
Panelists: Steven Evans, Arthur Anastopoulos, Mary Solanto

New Directions in CBT for Anger and Aggression
Chair: Denis Sukhodolsky
Panelists: Stephanie Smith, Howard Kassinove, Michael Toohey

Panel Discussions

Next-Generation CBT for Psychosis: Incorporating Mindfulness and Acceptance Into Treatment
Brandon Gaudiano, *Moderator*
Panelists: Paul Grant, Steven Hayes, Kim Mueser, Roger Vilardaga

Taking Care of Business: A Real-World Discussion About Owning and Operating a CBT Clinical Practice
David Rosmarin, *Moderator*
Regine Galanti, *Moderator*
Panelists: Thröstur Björgvinsson, R. Trent Codd, Michael Maher, Lisa Napolitano, Dena Rabinowitz

Enhancing the Maintenance of Child Treatment Outcomes: What Strategies Help and What Studies Are Needed?
David Kolko, *Moderator*
Panelists: John Lochman, Thomas Dishion, Sheila Eyberg

Current Controversies in How to Implement Exposure Therapy
Jonathan Abramowitz, *Moderator*
Panelists: Joanna Arch, Brett Deacon, Adam Radomsky, Stephen Whiteside, Maureen Whittal

Addressing Controversies in Empirically Supported Treatments: New Standards on the Horizon?
Dean McKay, *Moderator*
Panelists: David Tolin, David Klonsky, Marvin Goldfried, Bethany Teachman, Evan Forman

Toward a Personalized Mental Health Science: How Genetics, Statistics, and Adaptive Treatment Algorithms Can Help to Better Measure and Assist Individual Patients
Aaron Fisher, *Moderator*
Panelists: Christopher Beevers, Robert DeRubeis, Peter Molenaar, Scott Compton

Plugging the Leaky Pipeline: Mentoring Women in Clinical Psychology
Laura E. Sockol, Moderator
Panelists: Dianne Chambless, Joanne Davila, Richard Heimberg, Lata McGinn, Sabine Wilhelm, Antonette Zeiss

Recent Theoretical and Empirical Developments in the Effective Use of Time-Out
Camilo Ortiz,Kristin Kunkle, *Moderator*s
Panelists: Cheryl McNeil, David Reitman, Scott Jensen, William Warzak, Stacy Shaw

Integrating Neurofeedback With CBT for PTSD
Kate Nooner, *Moderator*
Panelists: Carmen Russoniello, Carmen McLean, Ruth Lanius, Laurence Hirshberg, Celeste DeBease

Enhancing the Teaching of CBT: A Multidisciplinary Perspective
Panelists: Kerstin Blomquist, Jamie Bodenlos, Christopher Lootens, Markowitz Sarah

Developing a Career in LGBT Clinical Research: How to Address Barriers and Identify Unique Training Opportunities
Michael Newcomb, *Moderator*
Panelists: David Pantalone, Debra Kaysen, Conall O'Cleirigh, Trevor Hart, Tyson Reuter

Working With Families of Suicidal Adolescents: Empirically Based Clinical Strategies
Michele Berk, *Moderator*
Panelists: Jennifer Hughes, Alec Miller, Guy Diamond, Tina Goldstein, Molly Adrian

Addressing Peer Victimization Across Settings: Perspectives From Diverse Disciplines
Eric Storch, Annette La Greca, Timothy Cavell, Brian Chu, Alyssa Johns

For Clinicians, by Clinicians: Secrets to a Successful CBT Private Practice
Daniel Hoffman, *Moderator*
Panelists: Andrea Macari, Daniel Hoffman, Mary Alvord, Joshua Magee

DBT for Adolescents: From the Trenches to Training and Implementation
Lorie Ritschel, *Moderator*
Panelists: Laurence Katz, Jill Rathus, Alec Miller, Anthony DuBose

The Multidisciplinary Past and Future of Evidence-Based Treatments for Serious Mental Illnesses
Jerome Yoman, Mary Sullivan, Kim Mueser, Alex Kopelowicz

Protecting the Practice of CBT
E. Katia Moritz, *Moderator*
Panelists: Jonathan Hoffman, James Herbert, Mitchell Schare

Recent Research on Relationship Education: Controversies and Implications for Social Policy
Galena Rhoades, *Moderator*
Panelists: Richard Heyman, Scott Stanley, Kristina Gordon

Intensive Data: Bringing Intensive Longitudinal Data and Ambulatory Assessment to Clinical Research and Practice
Lance Rappaport, *Moderator*
Panelists: Jean-Philippe Laurenceau, David Atkins, Aidan Wright, Nicholas Jacobson

Beyond Categories: A Conversation About Transdiagnostic Psychological Interventions
Peter Meidlinger, *Moderator*
Panelists: Debra Hope, Michelle Craske, Steven Hayes, Bruce Chorpita, Shannon Sauer-Zavala, Alexander Talkovsky

Integration of Recovery Into Services Across Settings for People With Serious Mental Illness: How and Why?
Jason Peer, Paul Grant, Stephen Smith, Jeffery Nolting, J. Rock Johnson

Ethnoresearch and Ethnotherapy: Cultural Considerations for How We Do Psychology
Ana Bridges, Janie Hong, Monnica Williams, Brittany Hall-Clark, Joaquin Borrego, Bianca Villalobos

Forty Years Back Inform 10 (Maybe More) Years Forward
W. Edward Craighead, Alan Kazdin, David Barlow, G. Terence Wilson

Interdisciplinary Collaboration in Intensive Behavioral and Social-Learning-Oriented Psychiatric Rehabilitation Programs: Alternative Approaches
William Spaulding, *Moderator*
Panelists: Richard Hunter, Jason Vogler, Jennifer Snyder, Amanda Collins-Messman, Robert Johnson

Emotional Dysfunction in BPD: Translating Insights From Recent Laboratory Research Into Clinical Practice
Caitlin Fang, *Moderator*
Panelists: M. Zachary Rosenthal, Kim Gratz, Nathaniel Herr

Suicide Prevention: Targeted Evidence-Based Training Across Disciplines
Andre Ivanoff, Anthony DuBose, Marsha Linehan, Sara Landes

Expanding the Depth and Scope of Contemporary Behavior Therapy: Interdisciplinary Conversations on Meaningful Clinical Outcomes
Timothy Ritzert, *Moderator*
Panelists: Joanna Arch, John Forsyth,

David Fresco, Todd Kashdan, Robert Leahy

Sleep and Psychopathology: Bidirectional Impacts Across the Life Span
Michelle Capozzoli, *Moderator*
Panelists: Colleen Carney, Erin Cassidy-Eagle, Subhajit Chakravorty, Jodi Mindell, Michael Perlis

Symposia

A Tale of Sciences: Adapting Evidence-Based Treatments to the Specific Needs of Children
Dikla Eckshtain, Chair
Joel Sherrill, Discussant

Adapting ACT Techniques to Treat Intimate Partner Violence
Erika Lawrence, Chair
Daniel O'Leary, Discussant

Adding Physical Activity to Your Clinical Practice: Models, Methods, and Mechanisms
M. Alexandra Kredlow, Chair
Kristin Szuhany, Chair
Michael Otto, Discussant

Advancement and Enhancement of Parent-Child Interaction Therapy: Novel Applications and Implementation Across Contexts and Disciplines
Christopher Campbell, Chair
Robin Gurwitch, Chair
Cheryl McNeil, Discussant

Advances in Trauma Research in Lesbian, Gay, Bisexual, and Transgender Populations
Brian Feinstein, Chair
Michael Newcomb, Chair
Patricia Resick, Discussant

Advancing Dissemination-Implementation Science and Practice: Predictors, Mediators, and Outcomes Relevant to Community Contexts
Mei Yi Ng, Chair
Alyssa Ward, Chair
Cara Lewis, Discussant

Advancing Goals of Personalized Medicine in Mental Health: How Outcome Research and Moderators Can Inform Treatment Selection
Robert DeRubeis, Chair
Zachary Cohen, Chair
Michelle Craske, Discussant

Anger and Aggression in BPD: Using Multidisciplinary Approaches to Explore Predictors, Functions, and Outcomes
Jessica Peters, Chair
Kim Gratz, Discussant

Anger Rumination and Self-Perceptions in Externalizing Behaviors
Bradley White, Chair
Raymond Tafrate, Discussant

Assessing and Modifying Anxiety-Disorder-Related Attention and Interpretive Biases in Adults
Akanksha Srivastav, Chair
Jonathan Huppert, Discussant

Behavior Analysis and Pharmacotherapy in the Treatment of ADHD: Synergy of Effects
Michael Manos, Chair
William Pelham, Chair
Leonard Bickman, Discussant

Behavioral Research in Tourette Syndrome: Standing on the Shoulders of Neuroscience, Psychiatry, and Neurology
Emily Ricketts, Chair
Douglas Woods, Discussant

Beyond Psychology: Expanding the Reach of the Treatment Evidence Base for Youth
Sarah Kate Bearman, Chair
Kimberly Hoagwood, Discussant

Biosignatures of Affective Psychopathology: Insights From Psychophysiological Measures of Emotional Processing
Emmanuel Garcia, Chair
Samantha Berthod, Chair
Tracy Dennis, Discussant

Brief Cognitive Behavioral Interventions to Reduce Suicide Attempts in Military Personnel
Craig Bryan, Chair
Gregory Brown, Discussant

Brief Interventions for at-Risk and Distressed Couples
Brian Doss, Chair
Scott Stanley, Discussant

Brief Mindfulness- and Acceptance-Based Interventions: When a Little Goes a Long Way
James Marchman, Chair
Kirk Strosahl, Discussant

Broadening Scope of Couple Research Beyond the Dyad: Examining Impact of External Influences on Relationship Processes and Outcomes
Aleja Parsons, Chair
Ronald Rogge, Discussant

Can Environment Trigger a Personality Disorder? New Evidence and Clinical Lessons From Stress Research
Randy Auerbach, Chair
Christopher Conway, Chair
Carla Sharp, Discussant

Cognitive Bias Modification: Advancing Clinical Science and Practice
Shari Steinman, Chair
Lauren Hallion, Chair
David Tolin, Discussant

Community-Based Interventions for Hoarding Disorder
Christiana Bratiotis, Chair
Gail Steketee, Discussant

Comorbidity of ADHD and Unipolar Depression: Patterns of Co-Occurrence, Psychosocial Explanations, and Structural Neuroimaging Findings
Michael Meinzer, Chair
Jeremy Pettit, Chair
Andrea Chronis-Tuscano, Discussant

Couples and the Emotional Cycles of Military Deployment
Steven Sayers, Chair
Scott Stanley, Discussant

Cross-Cultural Psychology and Couples Relationships
W. Kim Halford, Chair
Brian Baucom, Discussant

Cultural Considerations in the Treatment of Ethnic-Minority Adolescents

at Risk for Suicidal Behavior
Colleen Jacobson, Chair
Regina Miranda, Chair
Elizabeth Jeglic, Discussant

Developing and Disseminating Contingency Management Interventions for Behavior Change
Jeremiah Weinstock, Chair
Carla Rash, Chair
Alan Budney, Discussant

Developments in Understanding Hoarding Disorder: A Focus on Phenomenology, Risk, and Treatment
Kiara Timpano, Chair
Randy Frost, Discussant

Dissemination and Implementation of CBT for Youth Anxiety
Rinad Beidas, Chair
Marc Atkins, Discussant

Do Safety Behaviors Facilitate or Hinder Fear Reduction? Evidence From the Lab to the Clinic
HanJoo Lee, Chair
Michael Telch, Discussant

Does Cognitive Therapy Improve the Outcomes of Patients With Recurrent Depression?
Robin Jarrett, Chair
Michael Thase, Chair
W. Edward Craighead, Discussant

Drawing on the Strengths of Experimental Cognitive Paradigms to Understand and Modify Anxiety-Related Attentional Biases to Threat
Andrea Nelson, Chair
Bethany Teachman, Discussant

Dysregulation of Specific Emotions in Psychopathology: Novel Findings From Multimethod Transdiagnostic Studies
Andrada Neacsiu, Chair
Bunmi Olatunji, Discussant

Emerging Trends and Novel Directions in Dissemination and Implementation Science
Alex Dopp, Chair
Kaitlin Gallo, Chair
Shannon Wiltsey Stirman, Discussant

Emory PReDICT Study: Initial Presentation
W. Edward Craighead, Chair
Steven Hollon, Discussant

Emotion Regulation Across Obsessive-Compulsive Spectrum Disorders
Melissa Norberg, Chair
Jessica Grisham, Chair
Sabine Wilhelm, Discussant

Enhancing Assessment and Treatment for Perpetrators of Intimate Partner Violence
Galina Portnoy, Chair
Robin Barry, Discussant

Enhancing Evidence-Based Practice Dissemination and Implementation Through the Theory of Planned Behavior
Cara Lewis, Chair
Brad Nakamura, Discussant

Evidence-Based Assessment Strategies for Improving Clinical Diagnosis
Andrew Freeman, Chair
Thomas Ollendick, Discussant

Evidence-Based Interventions to Support Healthy Same-Sex Romantic and Sexual Relationships
Sarah Whitton, Chair
Steven Safren, Discussant

Examining the Underlying Neurobiology and Phenomenology of Repetitive Behaviors
Sarah Morris, Chair
Robert Simons, Discussant

Expanding Our Understanding of Obsessive-Compulsive-Related Disorders Through the Study of Emotions Beyond Anxiety
Hilary Weingarden, Chair
Sabine Wilhelm, Discussant

Expanding the Focus in SAD: A Deep Dive Into Completely Novel Approaches for Conceptualization and Treatment
John Richey, Chair
Stefan Hofmann, Discussant

Exploring the Boundaries of Training: Novel Approaches to Expanding the Impact of Evidence-Based Practice Trainings
Julie Harrison, Chair
Sonja Schoenwald, Discussant

Families Under Stress: Processes of Coping as Novel Targets of Intervention
Bruce Compas, Chair
Steven Hollon, Discussant

Fear Learning and Extinction: Integrating Evidence From Multiple Perspectives to Enhance Knowledge and Treatment Outcomes for Anxiety Disorders: Session I
Allison Waters, Chair
Michelle Craske, Discussant

Fear Learning and Extinction: Integrating Evidence From Multiple Perspectives to Enhance Knowledge and Treatment Outcomes for Anxiety Disorders: Session II
Allison Waters, Chair
Michelle Craske, Discussant

First Look at Results From the Pittsburgh Child Anxiety Treatment Study
Jennifer Silk, Chair
Patricia Tan, Chair
Deborah Beidel, Discussant

Furthering Treatment Integrity Measurement Science: Exploring Challenges and Implications for Dissemination and Implementation
Cassidy Arnold, Chair
Bryce McLeod, Discussant

Genetic and Neuroendocrine Markers of Stress Reactivity: Tracking Risk for Depression and Anxiety Disorders
Lisa Starr, Chair
Suzanne Vrshek-Schallhorn, Chair
Michelle Craske, Discussant

Health Disparities for Diverse Populations: Exploring Treatment Outcomes and Cultural Considerations for Treatment Engagement
Ana Bridges, Chair
Bianca Villalobos, Chair
Steven Lopez, Discussant

Identifying Predictors of Treatment Outcome in Behavioral Activation
Rachel Hershenberg, Chair
Steven Hollon, Discussant

Implementing and Testing Evidence-Based Practices in Routine Clinical Settings: Outcomes in Three Partial Hospital Programs
Kristy Dalrymple, Chair
Kelly Koerner, Discussant

Individuals With Substance Use Disorders Involved With the Criminal Justice System: Implications for Treatment
Mandy Owens, Chair
Frank Gardner, Discussant

Innovations in the Treatment of OCD in Youth: From Mechanisms to Management
Lara Farrell, Chair

Innovative Mindfulness- and Acceptance-Based Interventions for College Student Mental Health
Zella Moore, Chair
Raymond DiGiuseppe, Discussant

Innovative Treatment Approaches for Working with Children and Adolescents with Selective Mutism
Brittany Roslin, Chair
Steven Kurtz, Chair
Jami Furr, Discussant

Innovative Uses of Technology to Enhance Intervention in the Domains of Binge Eating, Obesity, and Physical Activity
Meghan Butryn, Chair
David Sarwer, Discussant

Innovative Ways to Enhance Treatment for Youth Mood Disorders: Using What We Know to Guide What We Do
Dikla Eckshtain, Chair
Anthony Spirito, Discussant

In-Session Processes of Change During PTSD Treatment: Fear Reduction, Cognitive Processes, and Distress Tolerance
Stephanie Keller, Chair
Adele Hayes, Discussant

Intimate Partner Violence Assessment and Treatment in Military Populations
Adam LaMotte, Chair
Richard Heyman, Discussant

Leveraging Social and Personality Psychology Concepts to Advance Clinical Science
R. Kathryn McHugh, Chair

Malleability of Attention Bias in Depression: From Interactive Cognitive Biases to Cognitive Training
Jonas Everaert, Chair
Ernst Koster, Chair
Nicholas Turk-Browne, Discussant

Marrying the Laboratory and Daily Life: Ambulatory Physiological Responses to Relationship Conflict as It Occurs in Everyday Life
Brian Baucom, Chair
Matthew Goodwin, Discussant

Maximizing the Effects of Attention Bias Modification for Anxiety: How and for Whom
Jennie Kuckertz, Chair
Yair Bar-Haim, Discussant

Measuring and Predicting Suicidal Behavior: New Directions and Innovative Methods
Mitch Prinstein, Chair
Anthony Spirito, Discussant

Measuring Implementation of Multiple Evidence-Based Interventions in Large Mental Health Service Systems
Lauren Brookman-Frazee, Chair
Arthur Evans, Discussant

Mechanisms of Change in SAD Treatment
Lance Hawley, Chair
Karen Rowa, Discussant

Meditations on Meditation: Mechanisms of Change in Mindfulness-Based Interventions
Michael Moore, Chair
David Fresco, Discussant

Mobilizing Technology to Enhance CBT: Using Smartphone Delivery Systems for Assessment, Intervention, and Prevention
Mariann Weierich, Chair
Robert Leahy, Discussant

Moderators, Mediators, and Predictors of Psychosocial Treatment Response Among Children and Youth With ADHD
Jenelle Nissley-Tsiopinis, Chair
Thomas Power, Chair
Howard Abikoff, Discussant

Modifications and Alternatives to Existing Behavioral Therapies for Tourette Syndrome and Tic Disorders
Tabatha Blount, Chair
Douglas Woods, Discussant

Multimethod Examination of Mechanisms Underlying Women's Intimate Partner Aggression
Nicole Weiss, Chair
Lauren Sippel, Chair
Jennifer Langhinrichsen-Rohling, Discussant

Multimodal Technology-Enhanced Treatments for Substance Use
Joseph De Leo, Chair
Kathleen Carroll, Discussant

Neural and Genetic Mechanisms Underlying Adolescent Psychopathology
Randy Auerbach, Chair
Joanna Chango, Chair
Thomas Olino, Discussant

New Advances in Cognitive Therapy for Schizophrenia
Paul Grant, Chair
Larry Davidson, Discussant

New Advances in the Incorporation of Psychophysiological Data to Enhance the Assessment and Treatment of Youth
Christine Cooper-Vince, Chair
Danielle Cornacchio, Chair
Paulo Graziano, Discussant

New Directions in Human Disgust Conditioning Research: Implications for the Etiology and Treatment of Anxiety-Related Disorders
Thomas Armstrong, Chair
Michelle Craske, Discussant

New Directions in Implicit Associations Research in Psychopathology
Alexandra Werntz, Chair
Ernst Koster, Discussant

New Directions in Information Processing and Psychopathology
Kiara Timpano, Chair
Bethany Teachman, Discussant

New Directions in Research on Scrupulosity
Ryan Jacoby, Chair
Jonathan Abramowitz, Discussant

New Directions in the Multidisciplinary Study of PTSD: An Examination of Novel and Understudied Risk and Resiliency Factors
Michael McDermott, Chair
Danielle Maack, Discussant

New Extensions of Cognitive Bias Modification for Youth Anxiety
Jennie Kuckertz, Chair
John Piacentini, Discussant

New Focus in Suicide Research: What Distinguishes Suicide Ideators, Suicide Attempters, and Suicide Decedents?
Alexis May, Chair
David Klonsky, Discussant

New Treatment Developments in Comorbid Anxiety and Autism Spectrum Disorders
Alessandro De Nadai, Chair
Matthew Lerner, Discussant

Nonsuicidal Self-Injury: Recent Developments of This New Research Diagnosis
Tina In-Albon, Chair
E David Klonsky, Discussant

Novel Analytic Methods to Clinical Psychology
Nicholas Jacobson, Chair
Lance Rappaport, Chair
Robert Gallop, Discussant

Novel and Innovative Applications of Evidence-Based Treatments for Emotional Disorders in Adolescent Patients
Anu Asnaani, Chair
Jonathan Comer, Discussant

Novel Applications of DBT Skills Training
Nicholas Salsman, Chair
Marsha Linehan, Discussant

Novel Mechanisms Linking Anxiety and Substance Abuse
Joshua Magee, Chair
Michael Otto, Discussant

Novel Methods of Assessment and Treatment Delivery for Youth OCD
Andrea Nave, Chair
Jonathan Comer, Discussant

Novel Treatments for Difficult-to-Treat Anorexia Nervosa
Angelina Yiu, Chair
Kalina Eneva, Chair
C. Alix Timko, Discussant

Parent Engagement in Evidence-Based Interventions for Children: What Is It, Why Does It Matter, and How Can We Measure It?
Aubrey Carpenter, Chair
Alice Carter, Discussant

Parent-Youth Interactions and Links With Youth Psychopathology: Improving Multimethod and Multi-Informant Approaches to Assessment
Sarah Thomas, Chair
Deborah Drabick, Discussant

Pediatric Bipolar Disorder: From Risk to Prevention
Rachel Freed, Chair
Aude Henin, Chair
David Miklowitz, Discussant

Peer Victimization and Depression During Adolescence: Understanding Pathways to Vulnerability
Liza Rubenstein, Chair
Mitchell Prinstein, Discussant

Personalizing Treatment: Predictors of Treatment Utilization and Response in Bipolar Disorder
Louisa Sylvia & Thilo Deckersbach, Chair
Tina Goldstein, Discussant

Positive Emotion and Reward Dysregulation Across Psychopathology: Multimethod Approaches and Implications for Treatment
Lauren Fussner, Chair
Thomas Olino, Discussant

Prospection and Psychopathology: Integrating Cognitive, Social, and Clinical Science
Christine Cha, Chair
Donald Robinaugh, Chair
Richard McNally, Discussant

Psychological Adjustment Among Area Youth After the Boston Marathon Bombing and Subsequent Manhunt
Aubrey Carpenter, Chair
Jonathan Comer, Chair
Annette La Greca, Discussant

Psychophysiological Biomarkers of Anxiety
Jenna Suway, Chair
Nader Amir, Discussant

Reaching Families in the Treatment of OCD
Johanna Thompson-Hollands, Chair
Keith Renshaw, Discussant

Recent Advances in Understanding and Treating OCD: Mechanisms of Change and Novel Treatment Targets
Kiara Timpano, Chair
Gail Steketee, Discussant

Recent Contextual Behavioral Research Targeting Psychological Inflexibility
Michael Twohig, Chair
Akihiko Masuda, Discussant

Reciprocal Impact of Stress and Depression: Taking a Closer Look at Stress Type, Stress Domain, and Stress Reactivity
Josephine Shih, Chair
Constance Hammen, Discussant

Reexamining Implicit Cognition in Psychopathology: The Role of Associative and Propositional Processes
Rudi De Raedt, Chair
Bethany Teachman, Discussant

Relationship Interventions for Underrepresented Couples
Hannah Williamson, Chair
Justin Lavner, Discussant

Response to Trauma and PTSD in the Context of Romantic Couples
Keith Renshaw, Chair
Donald Baucom, Discussant

Safety Planning for Suicidal Patients: Empirical Support and Future Directions
Kevin Crowley, Chair
Barbara Stanley, Discussant

Seasonal Affective Disorder: Treatment and Integrative Psychological, Physiological, and Environmental Mechanisms
Kathryn Roecklein, Chair
Sandra Sigmon, Discussant

Seeking Sensations: Innovative Advancements for Utilizing Interoceptive Exposure to Target Anxiety Sensitivity
Laura Dixon, Chair
Brett Deacon, Discussant

"Siri, Rate My Therapist": Interdisciplinary Research on Scaling Up the Evaluation of Psychotherapy
David Atkins, Chair
Zac Imel, Chair
Steven Hollon, Discussant

Social and Emotional Functioning in Youth With Anxiety
Anna Jones, Chair
Eric Storch, Discussant

Social Anxiety and Substance Use Comorbidity: New and Extended Findings
Ashley Howell, Chair
Norman Schmidt, Discussant

Social Cognition in Schizophrenia: We Know It's Important; Do We Know What It Is?
Shannon Couture, Chair
Will Spaulding, Discussant

Stress and Coping on Both Sides of the Law: Mindfulness-Based Interventions With Criminal Justice and Law Enforcement Populations
Sarah Bowen, Chair
Katie Witkiewitz, Chair
Raymond Chip Tafrate, Discussant

Suicidal Belief System Among Military Personnel and Veterans
Craig Bryan, Chair
Tracy Clemans, Discussant

Tailoring Assessment and Intervention for ADHD in Higher Education Through Translational and Clinical Science
Laura Knouse, Chair
Steven Safren, Discussant

Tele-CBT: Efficacy, Predictors, and Challenges When Using the Internet to Deliver CBT
Gretchen Diefenbach, Chair
James Herbert, Discussant

The Hopelessness Theory Turns 25: Current Status and Future Directions
Evan Kleiman, Chair
Lauren Alloy, Discussant

Treatment Development for Children and Adolescents with ADHD and Behavior Disorders: Promoting Engagement, Integrity, and Successful Outcomes
George DuPaul, Chair
Thomas Power, Discussant

Treatment Factors in Childhood Anxiety and OCD
Robert Selles, Chair
Phillip Kendall, Discussant

Treatment of PTSD in Persons With Serious Mental Illness: Research on Cognitive Restructuring, Prolonged Exposure, and Eye Movement
Kim Mueser, Chair
Patricia Resick, Discussant

Treatment-Resistant OCD: Which Pharmacological and Cognitive-Behavioral Augmentation Strategies Work, and for Which Patients?
Laurie Zandberg, Chair
H. Blair Simpson, Discussant

Understanding the Effect of Gender in Emotional Disorders
Grant Shulman, Chair
Debra Hope, Chair
Dianne Chambless, Discussant

Understanding the Importance of Provider Knowledge and Attitudes in the Implementation of Evidence-Based Practices
Kelsie Okamura, Chair
Rachel Haine-Schlagel, Chair
Kristin Hawley, Discussant

Understanding the Role of Disgust in Anxiety and OC Spectrum Disorders: A Transdiagnostic Approach
Hana Zickgraf, Chair
Martin Franklin, Discussant

Understanding the Use of and Engagement With Behavioral Intervention Technologies for Mental Health
Stephen Schueller, Chair
David Mohr, Discussant

Using Social Psychology Tools to Better Understand Social Anxiety Processes
Michelle Lim, Chair
Katya Fernandez, Chair
Eva Gilboa-Schechtman, Discussant

Utilizing Technology to Advance Treatment for the Range of Direct and Indirect Self-Injurious Behaviors
Kate Bentley, Chair
Matthew Nock, Discussant

Variability in Relationships Across Time and Contexts: Clinical Influences from Social and Quantitative Psychology
Kayla Knopp, Chair
Ximena Arriaga, Discussant

Victim Intoxication During Sexual Trauma: Clarifying Key Questions
Anna Jaffe, Chair
Dean Kilpatrick, Discussant

What Do You Expect? The Structure and Malleability of Expectancies for Change and Their Impact on Treatment Motivation
Kari Eddington, Chair
Timothy Strauman, Discussant

You're Making Me Anxious: Development, Validation, and Creative Implementation of Social Evaluation Stimuli
Bethany Neczypor, Chair
Eva Gilboa-Schechtman, Discussant

Special Interest Group Meetings

Attendance at an ABCT Special Interest Group meeting is a wonderful networking opportunity. The SIGs focus on a diverse range of topics, including treatment approaches, specific disorders, or unique populations.

Addictive Behaviors
Friday, 2:15 – 3:15, Room 309/310

African Americans in Behavior Therapy
Friday, 12:00 - 1:00 PM, Room 410

Aging Behavior and Cognitive Therapy
Saturday, 3:15 – 4:15 PM, Room 410

Anxiety Disorders
Saturday, 1:30 – 2:30 PM, Room 308

Asian American Issues in Behavior Therapy and Research
Friday, 2:30 – 3:30 PM, Room 410

Attention-Deficit/Hyperactivity Disorder
Saturday, 9:00 – 10:00 AM,
Franklin Hall 10

Autism Spectrum and Developmental Disorders
Saturday, 9:45 – 10:45 AM, Room 308

Behavioral Medicine and Integrated Primary Care
Saturday, 1:00 – 2:00 PM, Room 309

Behavior Analysis
Saturday, 12:45 – 1:45 PM, Room 301

Behavioral Sleep Medicine
Friday, 2:30 – 3:30 PM, Room 301

Bipolar Disorders
Friday, 10:15 – 11:15 AM, Room 308

Child and Adolescent Anxiety
Saturday, 1:00 – 2:00 PM,
Franklin Hall 9

Child and Adolescent Depression
Friday, 4:00 – 5:00 PM, Room 309/310

Child Maltreatment and Interpersonal Violence
Friday, 11:00 – 12:00 PM,
Room 309/310

Child and School-Related Issues
Friday, 11:15 – 12:15 PM, Room 308

Clinical Psychology at Liberal Arts Colleges
Friday, 12:30 – 1:30 PM, Room 308

Clinical Research Methods and Statistics
Saturday, 2:15 – 3:15 PM, Room 309

Cognitive Therapy
Friday, 10:30 – 11:30 AM, Room 410

Couples Research and Treatment
Saturday, 11:00 – 12:00 PM,
Franklin Hall 10

Dissemination and Implementation Science
Saturday, 2:15 – 3:15 PM,
Franklin Hall 10

Forensic Psychology
Friday, 11:00 – 12:00 PM, Room 301

Functional Analytic Psychotherapy
Friday, 3:45 – 4:45 PM, Room 301

Hispanic Issues in Behavior Therapy
Friday, 1:15 – 2:15 PM, Room 410

Men's Mental and Physical Health
Saturday, 9:45 – 10:45 PM, Room 410

Military Psychology
Friday, 3:00 – 4:00 PM, Room 308

Mindfulness and Acceptance
Friday, 4:00 – 5:00 PM, Room 308

Native American Issues in Behavior Therapy and Research
Saturday, 12:30 – 1:30 PM, Room 410

Neurocognitive Therapies/ Tranlational Research
Saturday, 9:30 – 10:30 AM, Room 301

Obesity and Eating Disorders
Saturday, 10:00 – 11:00 AM, Room 310

Parenting and Families
Saturday, 3:15 – 4:15 PM, Room 301

Schizophrenia and Severe Mental Illness
Saturday, 2:00 – 3:00 PM, Room 301

Spiritual and Religious Issues
Friday, 1:45 – 2:45 PM, Room 308

Student
Saturday, 11:15 – 12:15 PM, Room 310

Study of Lesbian, Gay, Bisexual, and Transgender
Friday, 1:15 – 2:15 PM, Room 301

Suicide and Self-Injury
Saturday, 2:30 – 3:30 PM, Room 308

Technology and Behavior Change
Saturday, 11:00 – 12:00 PM, Room 308

TIC and Impulse Control Disorders
Friday, 12:15 – 1:15 PM, Room 301

Trauma and PTSD
Saturday, 11:00 – 12:00 PM, Room 410

Women's Issues in Behavior Therapy
Friday, 3:45 – 4:45 PM, Room 410

Registration & Hotel

Preregister on-line at www.abct.org or, to pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the preregistration deadline of October 20, 2014. Between October 20 and October 27 registrations will be accepted at the on-site rates and no registrations will be processed after October 27.

Please note new policy: Convention Program Books will be distributed on-site. Only those who choose to pay the postage and handling fee of $10 will be mailed a book.

To receive discounted member registration fees, members must renew for 2015 before completing their registration process.

Preconvention Activities

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

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

Any preconvention activities (Clinical Intervention Training Sessions, Institutes and AMASS) that have open spots will be on sale at the on-site Preconvention Registration window on the 4th floor of the Philadelphia Marriott on Thursday: 7:30 a.m. to 1:00 p.m.

General Registration

To streamline registration, badges and tickets will be mailed to those who preregister. At the hotel you can pick up the program book, addendum, additional information, and ribbons at counters on the 4th floor. **BRING YOUR BADGE, TICKETS, AND CONFIRMATION FORM WITH YOU TO THE MEETING**.

On-site registration AND materials pickup will be open:

- Thursday: 11:00 a.m. - 8:00 p.m.
- Friday: 7:30 a.m. - 3:00 p.m.
- Saturday: 8:00 a.m. - 3:00 p.m.
- Sunday: 8:00 a.m. - 11:30 a.m.

The general registration fee entitles the registrant to attend all events on November 21-23 except for ticketed sessions. Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. Email confirmations will be sent within one week for faxed and mailed registrations. If you do not receive an email confirmation in the time specified, please call the central office: (212) 647-1890 or email Tonya at tchilders@abct.org.

You must wear your badge at all times to be admitted to the general sessions and the exhibits. If you lose your badge there will be a $10 charge for the replacement.

All presenters (except for the first two presenters of ticketed CE sessions) must pay the general registration fee. Ticketed session leaders will receive information as to their registration procedure from the ABCT Central Office.

Admission to all ticketed sessions is by ticket only. Preregistration is strongly advised as tickets are sold on a first-come, first-served basis.

Please note: **NO PURCHASE ORDERS WILL BE ACCEPTED.**

Registering On-Line

The quickest method is to register on-line at www.abct.org. Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members' discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew. To get member rates at this conference, your ABCT dues must be paid through October 31, 2015. The ABCT member year is November 1 - October 31.

Registering On-Site

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

Registering by Fax

You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please DO NOT send a follow-up hard copy. This will likely cause double payment. For preregistration rates, please register BEFORE the deadline date of October 20.

Registering by Mail

All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, New York, NY 10001. For preregistration rates, forms must be postmarked by the deadline date: October 20

Forms postmarked between October 21 and October 27 will be processed at on-site rates. Forms postmarked October 28 or later will not be processed and will be mailed back to the sender. There will be no exceptions.

Refund Policy

Refund requests must be in writing. Refunds will be made only until the October 20 deadline, and a $40 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 20.

Payment Policy

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

Hotel

Philadelphia Downtown Marriott
1201 Market Street
Philadelphia, PA 19107

To reserve your room go to
http://www.abct.org/conv2014
and click CONVENTION VENUE

Another ABCT Benefit: Access to the Services of ABCT's Financial Advisor, Brian McGrath

Jonathan Abramowitz, ***ABCT President-Elect,***
University of North Carolina at Chapel Hill

With **Brian McGrath,** ***Boenning & Scattergood***

If you're like me—and probably lots of us in the academic and clinical mental health fields—then you're probably not an expert when it comes to the world of finance. My wife and I, for example, joke that she could be hiding money in offshore bank accounts and I would have no idea! I actually find this somewhat surprising. After all, most of us need to have a solid background in statistics to survive graduate school. I guess the proficiency in numbers doesn't always translate from *p* values to dollar signs.

Sometime last April, I boarded a plane for New York City to attend the annual ABCT Finance Committee meeting at our Central Office. Yep, this is one of the "perks" of being President-Elect. And I have to admit that aside from visiting the ABCT Central Office for the first time and catching up with my fellow committee members, I wasn't terribly enthusiastic about it. Even my wife looked at me quizzically, as if to say, "They've put you on the Finance Committee? Really?"

But somewhere between reviewing spreadsheets and discussing financial plans for our next website software upgrade, Mr. Brian McGrath, Senior Vice President and Private Wealth Manager at Boenning & Scattergood, ABCT's wealth management institution, joined us at the ABCT Central Office to discuss ABCT's investments. Brian gave us the usual rundown on how our financial portfolio is doing and what plans he has for helping ABCT earn more money. He showed us charts, graphs, and fiscal scenarios. He shared with us his knowledge of Wall Street and we had some interesting discussions about financial trends over the past century. I was very impressed with all of the data and analyses that go into managing portfolios in a strategic and tactical way while maintaining compliance within risk tolerance of the institution. I think we all came away feeling very confident that ABCT's financial portfolio is in good shape.

But we also learned about the ABCT–Boenning & Scattergood Compact—an arrangement between the two institutions that details the wealth management services, planning, products, and pricing that each ABCT member (and their household) is entitled to. In other words, you can benefit from Brian's wealth management expertise (and that of his colleagues) in the same way ABCT does. Because I thought that most members would not be aware of this opportunity (and let's face it, in this day and age, who couldn't use a little help managing their finances?), the point of this column is to tell you about Brian's background and explain the financial services you could take advantage of simply because you're an ABCT member.

Brian graduated from Millersville University in Pennsylvania and Securities Industry Institute® (SII) at The Wharton School of the University of Pennsylvania. He has more than 30 years of experience in the securities and wealth management industry, having held positions from consultant to senior managerial ranks at several leading financial institutions and investment advisory firms, such as Merrill Lynch, Wachovia, and Robert W. Baird, among others. He has served on numerous boards of directors, including Drexel University's Nesbitt School of Design and the United Cerebral Palsy Association of Philadelphia.

As a wealth manager with decades of experience in financial planning and investment management, Brian's goal is to fully comprehend the financial needs, goals, and aspirations for growing client wealth and building a roadmap in order to achieve those objectives. The process begins with a thorough complimentary consultation to ensure he understands your current financial status, personal and professional parameters, and what you would like your assets to accomplish for you and others. He may recommend a customized investment strategy; solutions that encompass one or all of the disciplines of integrated personal financial planning; or both. Whatever portfolio structure is appropriate to your risk-reward profile and agreed upon, Brian will then, for a fee, implement it with an investment process that stresses discipline and transparency.

One of the great pleasures Brian has had working on behalf of the individual and institutional clients he serves is the long-standing relationships developed and maintained over the years and the continual introductions to associates, family members, and households that they provide. His commitment to valued clients is to provide —or carry over—the institutional platform of fee-based advisory programs, strategic planning modalities, institutional pricing and concierge services, to all associates of the institution; thus our COMPACT. His process can be instrumental in helping the institution as well as associates and members of the institution, in achieving critical financial and life goals in a comparable way.

If Brian can help you in any way, you can contact him or his associates at 800-883-1212.

As for me, I not only survived my first Finance Committee meeting, but took away important financial lessons about ABCT's budgeting practices, financial planning, financial reporting, and accountability policies. We are extremely lucky to have such a wise Treasurer in Karen Schmaling and a dedicated and competent central office staff in New York City. And on a final personal note, I discovered a newfound appreciation for finances and plan to be a more active participant in my family's fiscal decision-making—which will certainly pay "dividends" when it comes to my marriage!

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Correspondence to Jonathan S. Abramowitz, Ph.D., University of North Carolina at Chapel Hill
jabramowitz@unc.edu

At ABCT

Secure Our Future

Karen Schmaling, *ABCT Secretary-Treasurer, Washington State University*

Development refers to growth, expansion, or "a state (of) vigorous life or action" (Oxford English Dictionary, www.oed.com). ABCT is nearing 50 years of development; we are a vigorous work in progress!

In our universities and nonprofit agencies, development is often synonymous with fund-raising. I'll address fund-raising, but I prefer the term development because it implies mindfulness of our future. Your ABCT dues support *the Behavior Therapist*, our journals *Behavior Therapy* and *Cognitive and Behavioral Practice*, our annual convention, our membership retention and recruitment activities, our governance (Board, standing committees, and task forces), our website and our list-serve, among other activities. ABCT is fiscally healthy. One reason for our fiscal health is that we are thoughtful about funding activities that are central to our core mission. The leadership of ABCT takes seriously the feedback from member surveys such as the one we did last year in August regarding what you saw as the core activities of ABCT. But what don't your dues support? There are many other activities that are aligned with our core mission that we could support, for example, focused on our student members.

Is ABCT the first professional association you joined? Did you join as a student? Think about how eye-opening ABCT conventions were as a student (AABT, for me!). Students are responsible for much more of the cost of education than ever before. ABCT awarded our first Student Travel Award for the 2013 convention, thanks to the vision and work of Denise Davis, Immediate Past Secretary-Treasurer and inaugural chair of the Development Committee. As we grow the Student Travel Award fund, we can help more students experience ABCT conventions. Or would helping fund student research be nearer and dearer to your heart? A student research award is another endowment that is being considered.

ABCT invests its funds conservatively and we are extremely pleased with our financial advisor, Brian McGrath, from Boenning & Scattergood. I encourage you to read the article in this issue by ABCT President-Elect Jonathan Abramowitz and Mr. McGrath about the financial advisory services that are available to all ABCT members as a member benefit. Currently we have four award endowments that you can add to: three support student dissertations—the John R. Z. Abela, the Leonard Krasner, and the Virginia A. Roswell awards—and the fourth supports student travel for a paper being presented at the annual convention. If you would like to discuss an idea for a new award you'd like to develop, please contact Mary Jane Eimer, ABCT's Executive Director, at mjeimer@abct.org. A new endowment can be established with $10,000 or more. Know that your donation will be stewarded well. ABCT's investments earned a 10.89% return over the past year, which is quite good, at approximately three times the rate of inflation.

How can you help?

Here are a few ideas:

1. You can make a donation anytime on ABCT's website: www.abct.org. Click on the DONATE link. (On our Donate page, please read about the impact the Student Travel Award made on last year's inaugural student travel awardee.)

2. When you renew your membership and register for the convention, you also can make a donation at the same time.

3. At the Welcoming Cocktail Party/SIG Expo at our upcoming convention in Philadelphia, you can buy ABCT a drink! When you buy a drink, look for the donation boxes near each bar. Please consider donating your change. ANYTHING and EVERYTHING helps. If every ABCT member gave just $2, that endowment would generate at least $300 a year in investment income that we could award into perpetuity!

4. You elected ABCT's leadership. Now, elect to support and add to their giving. Thus far this year, all of the current board members have donated, along with some past presidents, totaling over $6,000.

As ABCTers, we love reinforcement! Donating to ABCT is reinforced through a tax deduction, by knowing that you are contributing to student success, and contributing to the legacy of our future!

Thank you for your support, on behalf of your Development and Finance Committees!

Find a CBT Therapist

ABCT's Find a Therapist has changed! Now called ***Find a CBT Therapist****, our search engine still offers the basics of locating a therapist but has added advanced search capabilities. For example, Find a CBT Therapist enables the user to take a Symptom Checklist, review specialties, link to self-help books, and search for therapists based on insurance accepted. We urge you to sign up for the* ***Expanded Find a CBT Therapist*** *(an extra $50 per year). That way, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars.*

findCBT.org
ABCT

At ABCT

ABCT "Convention Buddy" Pilot Program

Danielle Maack, ***Student Membership Committee Chair, University of Mississippi***

Do you remember attending your first ABCT (or, in my experience, AABT) convention as a student? Were you a naturally gregarious individual or did it take you a while to feel comfortable interacting with others and really getting the most out of the convention? In an effort to welcome new first-time student attendees to the ABCT convention to help promote a positive convention experience, we are looking for participants in the new Convention Buddy program. This pilot program will match new ABCT student convention attendees ("newbie") with seasoned ABCT student attendees ("buddy") to help familiarize the newbie to the ABCT convention and navigate the meeting. So, you might ask, "What's involved in this Convention Buddy program? "It's quite simple. After the buddy/newbie match has been created (based on information from submitted interest forms), each buddy and newbie will receive each other's contact information. Prior to the convention, the buddy will be asked to connect with the newbie at least once via email or phone to arrange a meeting time and place prior to attending the Friday, November 21, ABCT awards ceremony together. Following the awards ceremony, the buddy will take the newbie to the Welcoming Cocktail Party/ SIG Expo, introduce the newbie to a few colleagues, and provide an overview on how to navigate the room. It's as simple as that! If you and your buddy decide that you want to do more together throughout the convention or end up collaborating on research, that's a bonus! Again, the overall goal is to help newbies feel comfortable and leave after having a professionally rewarding experience. This is a great opportunity to meet new people and begin volunteering with ABCT. ***Questions?*** **Please contact me at djmaack@olemiss.edu**. Interested in being a part of this exciting new program? Either fax the mail-in interest form (212-647-1865) or email the requested information to **conventionbuddy@abct.org**.

Newbie Interest Form

NAME:

AFFILIATION:

AREA OF INTEREST:

FACULTY MENTOR:

EXPECTED GRADUATION YEAR AND DEGREE:

QUESTIONS OR EXPECTATIONS OF FIRST ABCT CONVENTION:

Buddy Volunteer Form

NAME:

AFFILIATION:

AREA OF INTEREST:

FACULTY MENTOR:

EXPECTED GRADUATION YEAR AND DEGREE:

OF ABCT CONVENTIONS ATTENDED:

ABCT ONLINE CE WEBINARS

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

Watch Instantly **www.abct.org**

McNeil | **PCIT**
Parent-Child Interaction Therapy: Evidence Based Treatment for Severe Behavior Problems in Clinical Practice

Segal | **Mindfulness**
Mindfulness Meditation in Clinical Practice

Shear | **Grief**
Getting Grief Back on Track: Introduction to Complicated Grief and Its Treatment

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

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

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

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

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

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

Barnett | **Ethics**
Ethical, Legal, and Clinical Considerations in Behavioral Telehealth

Miller | **DBT**
DBT With Adolescents: Research and Clinical Developments

Abramowitz | **Exposure for OCD**
Exposure Therapy for OCD Symptom Dimensions

We also have numerous podcasts and webcasts on our website.

http://www.abct.org

Get Information

Videos & Webcasts

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

Call *for* Editors

Call for Candidates for Editor of

Cognitive and Behavioral Practice

Candidates are sought for Editor-Elect of *Cognitive and Behavioral Practice*, Volumes 24–27. The official term for the Editor is January 1, 2017, to December 31, 2020, but the Editor-Elect should be prepared to begin handling manuscripts approximately 12 to 18 months prior.

Candidates should send a letter of intent and a copy of their CV to Anne Marie Albano, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008, or via email to teisler@abct.org

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Communications, will provide you with more details on the selection process as well as duties and responsibilities of the Editor. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647.1890.

Letters of intent MUST BE RECEIVED BY September 15, 2014. Vision letters will be required by October 1, 2014.

now

ABCT

online

ANNUAL CONVENTION

Enjoy the preregistration discount: register by Oct. 20!

http://www.abct.org/conv2014

in-press

What Does the Acceptance and Action Questionnaire (AAQ-II) Really Measure?

". . . a central part of the problem . . . is that one tries to capture a dynamic and shifting psychological process with a static and global self-report measure"

Wolgast
Behavior Therapy
doi: 10.1016/j.beth.2014.07.002

archive

"Parents must not only have certain ways of guiding by prohibition and permission, they must also be able to represent to the child a deep, almost somatic conviction that there is meaning in what they are doing."

Erik H. Erikson
Childhood and Society (1950)

the Behavior Therapist
Association for Behavioral and Cognitive Therapies
305 Seventh Avenue, 16th floor
New York, NY 10001-6008
212-647-1890 | www.abct.org
ADDRESS SERVICE REQUESTED

AWARDS & RECOGNITION

Congratulations to ABCT's 2014 Award Winners

Career/Lifetime Achievement

- *Lauren B. Alloy, Ph.D.*
  Temple University
- *Lyn Y. Abramson, Ph.D.*
  University of Wisconsin, Madison

Outstanding Mentor

- *Bethany Teachman, Ph.D.*
  University of Virginia

Mid-Career Innovator
Given in 2014 in honor of G. Alan Marlatt, Ph.D.

- *Carla Kmett Danielson, Ph.D.*
  Medical University of South Carolina

Distinguished Friend to Behavior Therapy

- *Vikram Patel, FMedSci*
  Professor of International Health
  London School of Hygiene & Tropical Medicine

President's New Researcher

- *Michael D. Anestis, Ph.D.*
  University of Southern Mississippi

Outstanding Service to ABCT

- *Mary Jane Eimer, CAE*
  Association for Behavioral and Cognitive Therapies
- *Michael Petronko, Ph.D., ABPP*
  Rutgers University, Graduate School of Applied and Professional Psychology

Virginia A. Roswell Student Dissertation Award

- *Anahi Collado, M.S.,* University of Maryland, College Park

Leonard Krasner Student Dissertation Award

- *Samantha Moshier, M.A.,* Boston University

John R. Z. Abela Dissertation Award

- *Mei Yi Ng, A.M.,* Harvard University

Jellinek Memorial Award

- *Linda C. Sobell, Ph.D., ABPP,* Nova Southeastern University

ABCT **Awards & Recognition** **Shireen L. Rizvi, Ph.D., Chair**