

the Behavior Therapist

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President's Message

The Future of ABCT

Stefan G. Hofmann, *Boston University*



CBT is a growing and maturing field. As one of the premier organizations representing this dominant approach to mental health, ABCT needs to be responsive and proactive to the many current and future challenges. As the

leader in the field, we have the obligation to reevaluate on a regular basis our own leadership structure, our goals, and our mission in order to assure that we remain an active player in the ever-changing field of mental health care.

To deal with these challenges, we decided to seek the assessment of an objective and knowledgeable third-party consulting firm. After a careful screening process, we decided to work with McKinley Advisors, a well-respected consulting firm that also served the American Psychological Association and other professional organizations. We chose this firm because of the company's extensive knowledge and expertise at the intersection of business and nonprofit organizations.

McKinley interviewed some of our members, including many past presidents, and some of the central office staff. We were very satisfied with their service and pleased with the product. The advisors provided us with concrete recommendations on how to further improve our already excellent organization in order to position ourselves in the best possible situation for the future. The following article by Deb Hope and Denise Davis summarizes some of the important insights that we gained from this experience.

As you can imagine, this was a time-consuming enterprise and I want to thank everybody who participated, especially the central office staff. We all agree that it was well worth the time and money. In fact, many of us believe that it

[continued on p. 169]

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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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should be one of many such self-study exercises in years to come to help us navigate the ever-changing landscape of CBT.

...

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At ABCT

ABCT Operational Assessment Yields Important Insights

Debra Hope, *University of Nebraska–Lincoln*

Denise Davis, *Vanderbilt University*

In November 2012, the ABCT Board of Directors commissioned an in-depth study of our organization's performance. The primary objective of this "operational assessment," as it came to be known, was to evaluate ABCT's strengths and opportunities, as well as its weaknesses and threats relative to other comparable organizations and in context with our mission, vision, and values. As ABCT has continued to grow and evolve, the Board thought that it was an appropriate time to take a step back and assess the key functions of the association. The study, the first of its kind that ABCT has conducted, was designed to provide input and analysis across several key operational areas, including finance, human resources, governance, membership, and technology.

The project was guided by the Ad Hoc Operations Review Committee (the Committee), which was co-chaired by the authors and included several other current members of the Board of Directors, and informed by the work of McKinley Advisors (McKinley)¹, an independent association consulting firm headquartered in Washington, DC. McKinley consultants interviewed current and past ABCT leaders, senior staff, and others to gain insight on important questions related to ABCT's op-

erations. The firm also analyzed ABCT's performance in context with key association industry ratios and Form 990 financial data compiled from several comparable scientific and professional associations. Final recommendations from the report were presented to the ABCT Finance Committee in New York during its May 2013 meeting.

Through this project, ABCT has gained important insight into many long-standing questions about the relative health and per-

formance of our organization. Following the conclusion of the project, the Board came to consensus that an organizational review of this kind is a sound practice for an organization of ABCT's scope, and that we should conduct updates on a periodic basis with a frequency to be determined.

McKinley's findings and recommendations from the project were organized into three main categories:

- Governance, strategy, and leadership
- Internal processes, staffing, and performance
- Delivering member value

Key findings from the project include the following:

ABCT is fiscally sound, with several of its key financial ratios meeting or exceeding association-industry benchmarks for performance, a noteworthy finding given the severity of the recent recession and rela-

Key Revenue Ratios	ABCT Form 990	Form 990 Research Peer Group Average (N = 6)	Operating Ratio Report* Assns with Revenues of \$1-2 M	
			All Assns (N = 616)	IMOs** (N = 275)
Total revenue	\$1,854,379	\$2,317,295	\$1,448,039	\$1,459,134
Membership dues revenue as % of total revenue	30.3%	27%	38.5%	34.6%
Non-dues revenue as a % of total revenue	69.7%	73%	61.5%	65.4%
Conference/meeting revenue as a % of total revenue	42.6%	26.2%	24.4%	22.1%

¹The full committee was comprised of Deb Hope and Denise Davis (co-chairs), Bob Klepac, Stefan Hofmann, and Dean McKay.

* ASAE, *Operating Ratio Report*, 12th Edition, 2012; **IMOs = individual membership organizations that are the most appropriate comparable organizations for ABCT.

tively slow rebound of the global economy. Because the association's main revenue sources are diversified—membership dues, conference, and publications—we have a solid financial foundation for ABCT to continue to invest in mission-related programs and services. In fact, the consultants suggested that ABCT may be able to consider a “strategic investment fund,” which could be used to develop new programs, services, or resources that enhance member value.

The organizational structure, staffing model, and relative costs of operation are well within association-industry norms. Specifically, the location of the ABCT office in New York does not have a material impact on the cost to operate the organization. In fact, due to the association's ownership of its physical space, occupancy costs and related expenses are lower than many other scenarios. While some amount of cost reduction could be possible from moving the headquarters to another location, the Committee concluded that the disruption to the organization would greatly outweigh the benefit of any potential cost savings.

Many of the challenges faced by ABCT are common in the association community, particularly the difficulty of sustaining membership growth, developing meaningful sources of nondues revenue, and expanding public awareness of our field. McKinley encouraged ABCT to consider strategic partnerships with other organizations who support our science-based approach and offered specific guidance on how to best proceed with our dissemination efforts.

In addition to these contextual findings, the consultants provided a series of more

specific recommendations, including the following:

- Improve and enhance continuity in leadership and nurture the board/staff partnership. Strategies include developing a new “board development workshop” to engage leadership in a discussion of the role they will play in promoting strategic, generative, and fiduciary governance practices to advance the organization. The training and onboarding program should include an external perspective from outside the association on a regular basis to coincide with the terms of office for elected leaders.
- Develop and implement a clear strategy to fuel membership growth, as an expanded membership base is central to the association's future goals and objectives.
- Encourage innovation and expand technological capabilities on staff through an effort to align competencies, roles, and responsibilities for future initiatives.
- Develop a succession plan to ensure a smooth transfer of institutional knowledge from tenured leaders to future ABCT staff and volunteers.
- Add rigor to the tools and methods used for performance assessment to increase accountability and objectivity. By creating a thoughtful set of review criteria and performance metrics, the association can better understand the progress it is making toward strategic and operational goals and objectives.

Finally, one of the most important outcomes of the assessment was a decision to

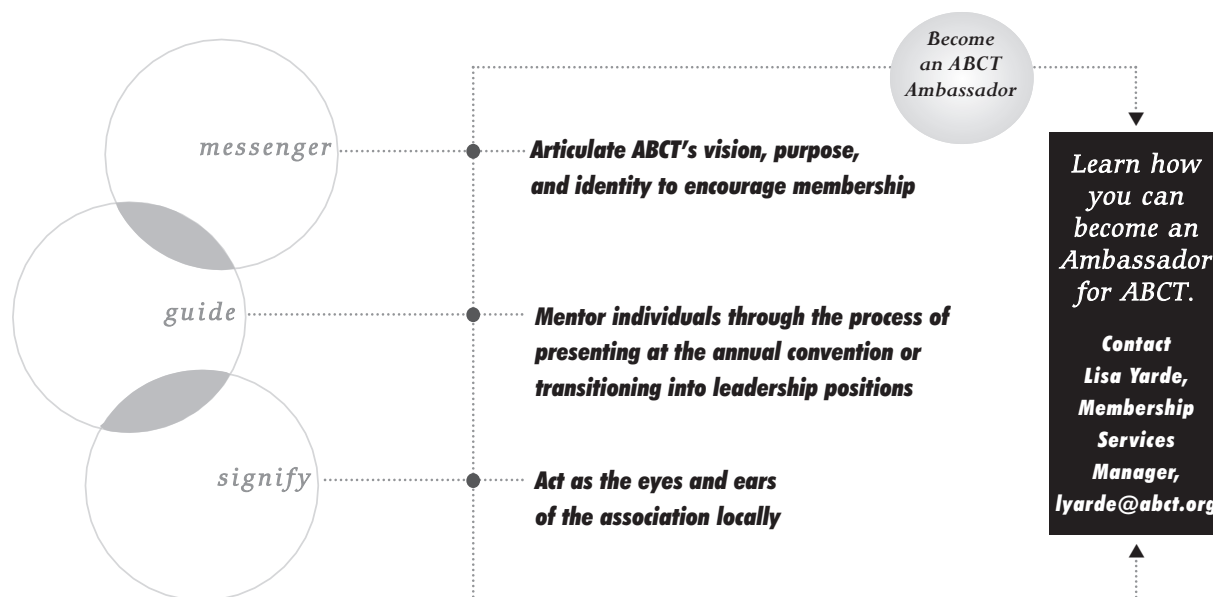
pursue a more rigorous and impactful strategic planning process, which will be informed by the comprehensive ABCT member survey that was fielded in August. We are thrilled to report that nearly 1,000 ABCT members participated in the survey, and while detailed results are not available at press time, we will share key findings of the survey, as well as the outcomes of the Board's fall strategic planning retreat, in a future issue of *IBT*. A central topic of discussion at the retreat will be how the association can continue to enhance its value to our members and the field.

We think we can safely speak for the entire Committee and Board when we say that we found the project to be extremely illuminating, valuable, and an important step in understanding where ABCT is today, and how we can most effectively lead our field in the future. The research and analysis conducted for the project was thorough, yielding a large repository of actionable data that ABCT can continue to utilize to help guide our next phase of development.

Should you have any questions about the project, its outcomes, or implications, please do not hesitate to get in touch.

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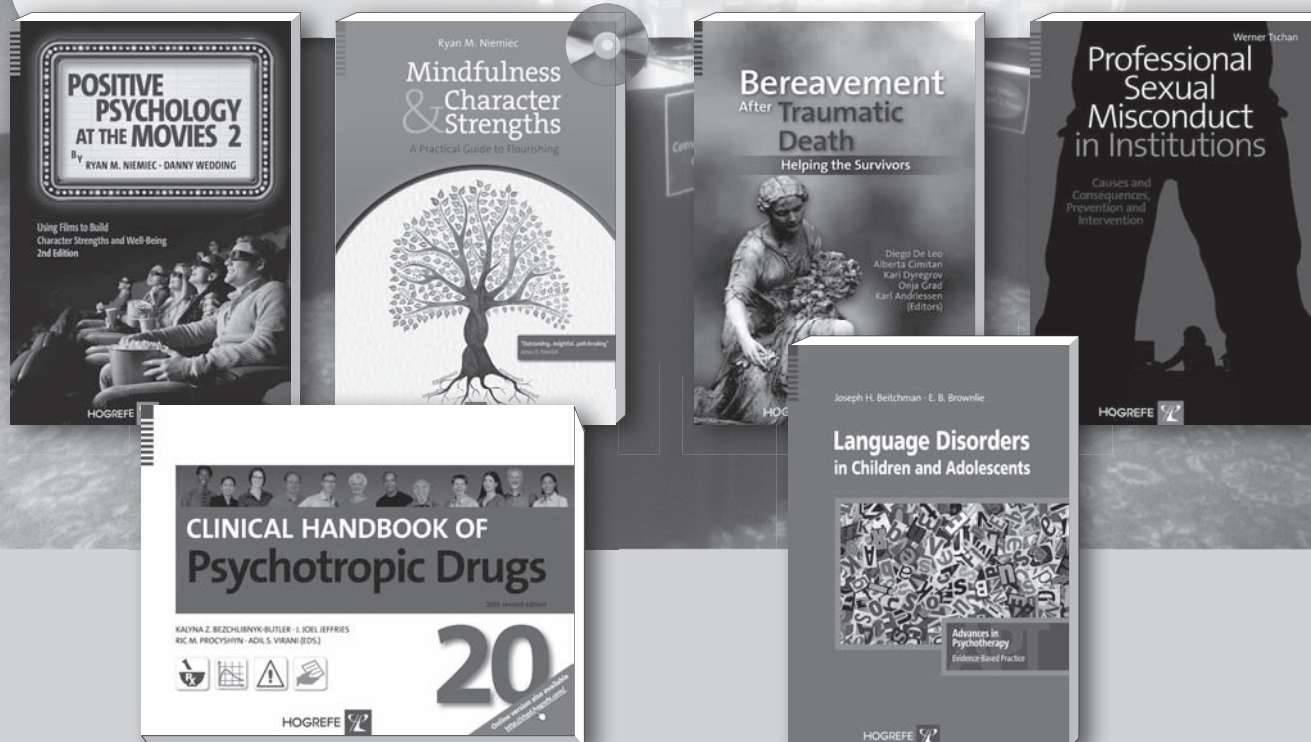
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Understanding Afghanistan and Iraq Veterans' Treatment Preferences and Perceptions of Stigma

Christina M. Gilliam, *The Institute of Living*

Melissa M. Norberg, *Macquarie University*

Christina E. Ryan, *The Institute of Living*

David F. Tolin, *The Institute of Living and Yale University School of Medicine*

The extremely stressful demands of war can lead to maladaptive symptoms in even the best-prepared military personnel. Prevalence rates for mental health disorders range as high as 20% to 42% among returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) soldiers and veterans, with posttraumatic stress disorder (PTSD) cited as one of the most common problems among this population (Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2010). Despite the efforts of the Veterans Administration to increase access to mental health treatment for OEF/OIF veterans, many OEF/OIF veterans with mental health conditions do not seek or participate in an adequate amount of treatment (Seal et al.). In fact, OEF/OIF veterans who have the greatest number and the most severe symptoms may be the least willing to seek help (Hoge et al., 2004).

Mixed findings regarding veterans' and soldiers' barriers to help seeking have caused confusion. In some studies, both stigma and negative perceptions of mental health care (e.g., beliefs that treatment is ineffective or mental health professionals are untrustworthy) were identified as barriers to help seeking (Hoge et al., 2004; Sayer et al., 2009; Stecker, Fortney, Hamilton, & Ajzen, 2007), whereas one study found an inverse relationship between negative perceptions of mental health care and help seeking (Kim, Britt, Klocko, Riviere, & Adler, 2011). Yet another study indicates that neither negative beliefs about mental health care nor perceived stigma predict help-seeking behavior (Rosen et al., 2011). Paradoxically, other studies have shown that greater perceived stigma is associated with greater interest in seeking mental health treatment (Brown et al., 2011) and

longer psychotherapy attendance (Rosen et al.). One possible reason for these mixed findings may be that previous studies on these barriers to mental health treatment assessed mental health treatments broadly; veterans or returning soldiers were questioned about their views on psychotherapy and/or pharmacologic intervention in general, without a specific definition or explanation of either of these types of treatments. In order to understand and increase acceptance of mental health treatments, it may be more informative to examine veterans' views and preferences for specific mental health treatments.

Civilians queried about their preference for PTSD treatment consistently choose psychotherapy over pharmacotherapy (Cochran, Pruitt, Fukuda, Zoellner, & Feeny, 2008; Feeny, Zoellner, & Kahana, 2009; Feeny, Zoellner, Mavissakalian, & Roy-Byrne, 2009; Roy-Byrne, Berliner, Russo, Zatzick, & Pitman, 2003; Zoellner, Feeny, & Bittinger, 2009; Zoellner, Feeny, Cochran, & Pruitt, 2003) and when queried about types of psychotherapy, they consistently choose prolonged exposure (PE) over psychodynamic therapy (Becker, Darius, & Schaumberg, 2007; Tarrier, Liversidge, & Gregg, 2006) and technology-based treatments, such as virtual reality exposure therapy (VRET; Tarrier, et al., 2006). Further, civilians often report greater credibility for their preferred treatments than their non-preferred treatments (Zoellner et al., 2009). It is yet unclear whether veterans share similar preferences for the treatment of PTSD. There is some suggestion that veterans may experience greater stigma about seeking mental health treatment due to the military culture's emphasis on emotional strength (Nash, Silva, & Litz, 2009; Vogt, 2011) as well as the added concern about how seek-

ing treatment will affect their careers (Owens, Herrera, & Whitesell, 2009; Vogt).

These civilian findings led us to examine OEF/OIF veterans' treatment preferences and factors (stigma and credibility) that may influence their preferences. We examined veterans' perceptions of PE, VRET, peer support groups (PSG), and pharmacotherapy with sertraline (SER). We chose to examine OEF/OIF veterans' preferences for PE and SER as several studies have supported their effectiveness (Boudewyns, Hyer, Woods, Harrison, & McCranie, 1990; Brady et al., 2000; Cooper & Clum, 1989; Davidson, Rothbaum, van der Kolk, Sikes, & Farfel, 2001; Keane, Fairbank, Caddell, & Zimering, 1989; Pitman et al., 1996; Tolin & Foa, 1999). We chose VRET because of the growing support for its efficacy (Gerardi, Rothbaum, Ressler, Heekin, & Rizzo, 2008; McLay, McBrien, Wiederhold, & Wiederhold, 2010; McLay et al., 2011; Reger & Gahm, 2008; Rizzo et al., 2009; Rizzo et al., 2008a; Wood et al., 2007; Wood et al., 2008) and because research has identified that a third of active-duty soldiers who are unwilling to seek face-to-face psychotherapy may be willing to seek technology-based mental health care (Wilson, 2008). We chose to examine PSG as evidence suggests that social support may serve as a protective factor against the development of PTSD (Brewin, Andrews, & Valentine, 2000; Coker et al., 2002; Pietrzak et al., 2010; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), while poor social support following a traumatic event may increase the risk of PTSD (Armenian et al., 2000; Gregurek et al., 2001; Ozer, Best, Lipsey, & Weiss, 2003). Further, peer-based interventions may allow veterans to talk to someone whom they feel can understand their problems (Stecker, et al., 2007).

Method

Participants

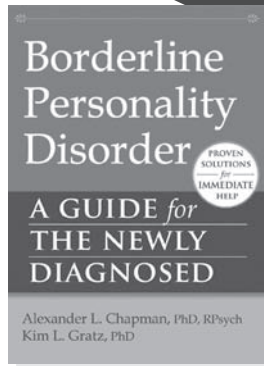
Twenty-eight OEF/OIF veterans enrolled in the study. We recruited participants via newspaper, Internet, radio advertisements, and flyers posted in the greater Hartford, CT, area. All OEF/OIF veterans were eligible for the study, regardless of mental health symptoms, treatment history, or combat exposure. Initially we tried to recruit OEF/OIF veterans with PTSD, but as we were unable to reach this group, we chose to enroll any OEF/OIF veteran. While not ideal, there is a precedent of conducting analog studies on treatment

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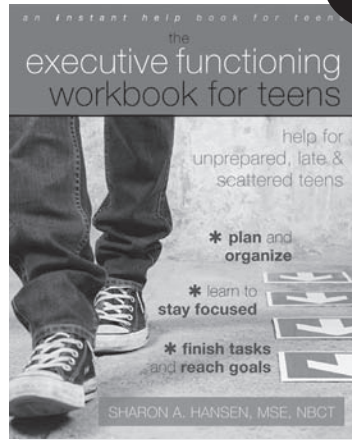
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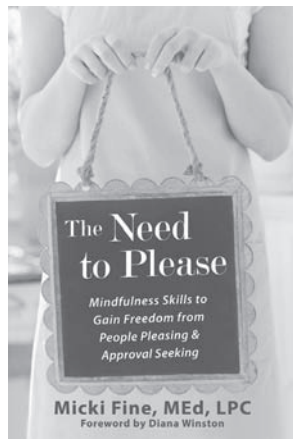
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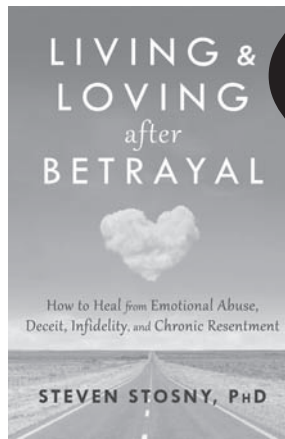
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preference for PTSD by recruiting a convenience sample regardless of trauma exposure or presence of PTSD (Becker et al., 2007; Cochran, et al., 2008; Feeny, Zoellner, & Kahana, 2009; Tarrier et al., 2006; Zoellner et al., 2003). The hospital Institutional Review Board approved this study. Demographic information is presented in Table 1. We included information about the presence of Axis I psychopathology, level of combat experience, and reports of previous mental health treatment in order to provide clinical information about the sample.

Measures

Axis I diagnoses were determined using the Mini-International Neuropsychiatric Interview Plus (MINI Plus; Sheehan et al.,

1997; Sheehan et al., 1998) and the Clinician-Administered PTSD Scale (Blake et al., 1995). In this study, we calculated a total score on the CAPS by summing the frequency and intensity scores across all 17 items that assess PTSD symptoms. The Credibility/Expectancy Form (ERF; Borkovec & Nau, 1972), the Self-Stigma of Seeking Help Scale (SSOSH; Vogel, Wade, & Haake, 2006), and the Social Stigma for Seeking Psychological Help Scale (SSRPH; Komiya, Good, & Sherrod, 2000) were used to assess veterans' credibility/expectancy and stigma (self and social) for seeking treatment. Wording from these original measures was modified to ask participants to respond specifically about their expectancy for the treatment of PTSD. The Combat Exposure Scale (CES; Lund, Foy,

Sipprelle, & Strachan, 1984) was used to assess the level of combat experienced during deployment.

Treatment vignettes. Four vignettes, each describing a different type of treatment for PTSD, were created specifically for this study: PSG, PE, SER, and VRET. Each treatment description contained information about the hypothesized mechanism of treatment, treatment procedures, evidence for efficacy, and potential side effects. All treatment descriptions were equivalent in length (approximately 580 words), sentence structure, reading level (9th grade), and used the term "veteran" at similar frequency. In order to ensure that each treatment description was accurate and objective, an expert (clinicians with experience in providing the type of treatment described in each vignette) who was uninvolved in the study reviewed and approved each vignette.

Table 1. Sample Description ($N = 28$)

	<i>n</i> (%)	<i>M</i> (<i>SD</i>)
Male	25(89.26)	
Age		35.15 (9.95)
Race/Ethnicity		
Hispanic	5 (17.86)	
African American	2 (7.14)	
Other/Multiracial	4 (14.29)	
Employed full time	15 (53.57)	
Married	10 (35.71)	
Branch of Service		
Army	19 (67.86)	
Marine	6 (21.43)	
Navy	1 (3.57)	
Air force	3 (10.71)	
Time since deployment		39.64 months (19.61)
Length of deployment		12.09 months (6.70)
Number of deployments		1.22 (.42)
OIF	18 (64.29)	
OEF	4 (14.29)	
OIF & OEF	2 (7.14)	
Unknown/missing data	3 (10.7)	
Axis I Diagnoses		
Alcohol Dependence	4 (14)	
Anxiety Disorder NOS	4 (14)	
Depressive Disorders	3 (11)	
PTSD	2 (7)	
Substance Abuse	2 (7)	
Agoraphobia	2 (7)	
Previous Mental Health Treatment	18 (64.3)	
Individual therapy	9 (32.14)	
Couples therapy	3 (10.71)	
Group therapy	1 (3.57)	
Medication	7 (25.00)	
More than one type	8 (28.60)	

Procedure

Research staff consisted of a licensed psychologist and postdoctoral fellows, and a bachelor-level research assistant. All research staff were experienced in administering structured diagnostic interviews and trained to administer the MINI-Plus and the CAPS. Upon providing written informed consent, participants completed the CES, followed by the MINI-Plus and CAPS. Staff then provided participants with a description of PTSD and instructions to answer the remaining questionnaires as if they themselves were experiencing PTSD. Participants then read each of the four different treatments for PTSD in a counterbalanced order. After reading each treatment description, participants completed the CEF and stigma measures in response to each treatment as if they had PTSD themselves. After reading and responding to all four of the vignettes, participants rank-ordered their preferred treatment.

Data Analyses

We conducted three repeated measures ANOVAs followed by pairwise comparisons to examine any differences in ratings of stigma (self and social) and credibility/expectancy between the four treatment descriptions. Prior to conducting the ANOVAs, Q-Q plots were inspected visually to examine normality and to check for outliers. The Q-Q plots for the variables assessing self-stigma for each treatment suggested the possibility of one outlier. We therefore ran data analyses both with and without this participant's self-stigma data.

Last, we used the Friedman rank test to assess participants' preferences for treatment, and the Wilcoxon test to compare two-paired groups following a significant Friedman's statistic.

Results

Descriptive Information

Ten (36%) met criteria for an Axis I disorder. Types of diagnoses are presented in Table 1. Those diagnosed with anxiety disorder NOS reported clinically significant symptoms consistent with PTSD, but did not meet full criteria for PTSD at the time of the study. Type of previous mental health treatment is listed in Table 1. No participant reported participating in PE or VRET. One participant endorsed participating in group therapy, but did not specify whether this group was specifically for veterans. The mean score for the CES was 18.11 ($SD = 8.67$), suggesting that this sample experienced moderate levels of combat during their deployment(s).

Stigma and Expectancy/Credibility

We conducted three repeated measures analysis of variance (ANOVAs) to examine

any differences in ratings of credibility/expectancy and stigma (self and social) between the four treatment descriptions. We found significant differences across the four treatments in ratings of credibility/expectancy, Wilks's $\Lambda = .60$, $F(3, 25) = 5.46$, $p < .01$, $\eta_p^2 = .40$, and social stigma, Wilks's $\Lambda = .49$, $F(3, 25) = 8.77$, $p < .001$, $\eta_p^2 = .51$, but not self-stigma, regardless of whether the one outlier's data were included or not (Outlier included: Wilks's $\Lambda = .86$, $F(3, 24) = .30$, $p = .82$, $\eta_p^2 = .04$; Outlier excluded: Wilks's $\Lambda = .86$, $F(3, 25) = .30$, $p = .28$, $\eta_p^2 = .14$).

Bonferroni corrected pairwise comparisons revealed that veterans rated SER significantly lower in credibility/expectancy compared to PE ($p < .05$, $d = .67$) and VRET ($p = .03$, $d = .62$). Veterans also rated SER higher in social stigma compared to PE ($p = .01$, $d = .38$), VRET ($p < .01$, $d = .61$), and PSG ($p = .02$, $d = .43$).

Due to the small sample size we lacked statistical power to examine differences in ratings of stigma and credibility between veterans with or without an Axis I disorder, or between veterans with and without a reported history of mental health treatment. Means and standard deviations of stigma

and credibility for the entire sample, as well as those of veterans with and without an Axis I disorder, and with and without a reported history of mental health treatment are presented in Table 2 for descriptive purposes.

Treatment Preference

We conducted a Friedman test to evaluate differences in rankings among VRET (median rank = 2.10), PE (median rank = 2.27), PSG (median rank = 2.48) and SER (median rank = 3.15). The test was significant, $\chi^2(3, N = 26) = 10.09$, $p > 0.02$. The Kendall coefficient of concordance was .13. We conducted follow-up pairwise comparisons using a Wilcoxon test and controlling for the Type I errors across these comparisons at the .05 level using the LSD procedure. The ranks for VRET ($p = .006$) and PE ($p = .02$) were significantly greater than the rank for SER. Analyses revealed no other significant differences in preferred ranking of treatments.

Discussion

This is one of the first studies to systematically compare OEF/OIF veterans' perceptions of different treatment modalities



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for PTSD. Results of this study suggest that veterans may prefer and believe PE and VRET to be more credible than SER. In addition, they may find SER to be more socially stigmatizing than the other three treatments (PE, VRET, or PSG). This finding is consistent with results found in civilian studies of treatment preference in which participants generally showed a bias against the use of SER (Cochran et al., 2008; Feeny, Zoellner, & Kahana, 2009; Feeny, Zoellner, Mavissakalian, et al., 2009; Roy-Byrne et al., 2003; Zoellner et al., 2009; Zoellner et al., 2003). In fact, in at least one study, receiving detailed information about SER, including treatment mechanism, strengthened participants' bias against the use of SER for PTSD treatment (Feeny, Zoellner, & Kahana, 2009). Thus, despite its evidence of efficacy, it may be beneficial to offer other treatment options besides pharmacotherapy (such as sertraline) to OEF/OIF veterans. Simply providing psychoeducation about the medication may not increase its credibility or veterans' preference for it.

No significant differences emerged in treatment preference or ratings of social stigma or credibility/expectancy between the three psychosocial treatments (PE, VRET, or PSG). Although small sample size may account for these null findings, it also is possible that veterans do not distinguish differences between psychosocial treatments. Research on the acceptability and preference for technology-based interven-

tions appear to be mixed. While there are reports that consumers find computer-assisted therapy acceptable (Gavin, Cuijpers, Craske, McEvoy, & Titov, 2010; MacGregor, Hayward, Peck, & Wilkes, 2009), there is some evidence that attrition may be higher in those participating in computer-assisted treatments compared to treatment as usual (de Graaf, Huibers, Riper, Gerhards, & Arntz, 2009; Waller & Gilbody, 2009). Undergraduate students rated technology-based treatments, including VRET, as the least preferred treatments among 14 possible treatments for PTSD (Tarrier et al., 2006) and one-fifth of patients refused computer-aided treatment for anxiety and depression when it was offered to them (Marks et al., 2003). Thus, the purported advantage of VRET as being more credible and acceptable than traditional face-to-face psychotherapy (Rizzo et al., 2008b) may not hold true.

In this study, perceptions of self-stigma for seeking treatment did not differ between the four types of treatments, suggesting that social stigma may play a more vital role in veterans' treatment seeking. However, in a recent study of veterans ($N = 490$) that included OEF/OIF veterans ($n = 248$), veterans identified both types of stigma (self and social) as barriers to care for PTSD (Ouimette et al., 2011). In this study, Ouimette et al. used a study-specific measure to assess the two types of stigma. Examination of the items shows that

Ouimette et al.'s self-stigma items assess more the emotional discomfort associated with treatment than one's self-esteem being devalued from seeking treatment. Thus, study differences may be the result of how self-stigma was measured in the two studies.

The results of this study should be interpreted with caution due to significant limitations of the study. First, null findings may have been due to lack of power associated with the small sample size. Veterans in this sample were also self-selected, and most did not meet criteria for PTSD or any Axis I disorder. Therefore, their perceptions of treatments for PTSD may differ from those veterans with PTSD or other mental health conditions. Although we asked veterans to respond as if they themselves were experiencing symptoms, asking people to imagine having a mental health problem, such as PTSD, is not the same as getting the opinion of those who do have mental health problems. Further, more than half (61%) of the sample reported a history of mental health treatment; thus, the results of this study may not generalize to those naïve to mental health treatment, which may be a large portion of OEF/OIF veterans. Future research is needed to examine the impact of the presence of mental health disorders and previous mental health treatment history on treatment preference and perceptions of treatment credibility and stigma. Finally, the participants' familiarity with the four

Table 2. Means and Standard Deviations for Stigma Measures ($N = 28$)

Measure	<i>M (SD)</i> Entire Sample ($N = 28$)	<i>M (SD)</i> With Axis 1 ^a ($n = 10$)	<i>M (SD)</i> Without Axis 1 ^b ($n = 18$)	<i>M (SD)</i> With Previous tx ^c ($n = 18$)	<i>M (SD)</i> Without Previous tx ^d ($n = 10$)
<i>Self-Stigma</i>					
Peer Support Group	25.29 (5.91)	26.80 (5.75)	24.44 (5.99)	25.06 (6.61)	25.70 (4.69)
Prolonged Exposure	26.29 (3.43)	26.40 (2.32)	26.22 (3.98)	25.89 (4.00)	27.00 (2.05)
Sertraline	27.04 (2.63)	26.80 (2.35)	27.17 (2.83)	26.78 (3.14)	27.50 (1.35)
Virtual Reality	27.02 (3.77)	26.87 (2.69)	27.10 (4.34)	26.32 (4.25)	28.27 (2.43)
<i>Social Stigma</i>					
Peer Support Group	5.86 (3.27)	6.30 (2.87)	5.61 (3.53)	5.61 (3.65)	6.30 (2.58)
Prolonged Exposure	5.93 (3.68)	6.50 (3.41)	5.61 (3.88)	5.72 (4.08)	6.30 (2.98)
Sertraline	7.21 (3.05)	7.30 (2.67)	7.17 (3.31)	7.11 (3.41)	7.40 (2.41)
Virtual Reality	5.39 (2.95)	5.20 (1.81)	5.50 (3.47)	5.22 (3.41)	5.70 (2.00)
<i>Credibility/Expectancy</i>					
Peer Support Group	25.46 (9.13)	23.00 (9.65)	26.83 (8.81)	26.06 (8.12)	24.40 (11.13)
Prolonged Exposure	27.54 (7.65)	23.40 (7.86)	29.83 (6.68)	27.89 (7.21)	26.90 (8.76)
Sertraline	22.36 (7.85)	21.00 (8.31)	23.11 (7.71)	22.56 (8.33)	22.00 (6.09)
Virtual Reality	27.42 (8.43)	26.00 (9.75)	28.21 (7.78)	27.04 (8.99)	28.10 (7.72)

Note. ^aParticipants who met criteria for an Axis I disorder. ^bParticipants who did not meet criteria for any Axis I disorder. ^cParticipants who reported previous mental health treatment. ^dParticipants who did not report any previous mental health treatment.

types of treatment also may have influenced participants' responses. Although the Veterans Administration has made efforts to increase availability of evidence-based psychological treatments for PTSD (e.g., prolonged exposure and cognitive processing therapy) in recent years (Department of Veterans Affairs, Veterans Health Administration, 2010; Karlin et al., 2010), the participants in this study may not have been as aware of the availability of PE at the Veterans Administration health care facilities compared to pharmacotherapy, group counseling, or general (i.e., unspecified) individual counseling. Further most VA health care facilities likely do not have the necessary equipment for providing VRET. Thus, the perceived novelty of PE and VRET compared to pharmacotherapy and group counseling may have influenced participants' responses.

Overall, the results of this study suggest that OEF/OIF veterans, like civilians, may have a preference for psychosocial treatment over pharmacotherapy, even after receiving information about SER's effectiveness. This study, along with civilian research, shows that simply educating potential clients about the availability and effectiveness of treatments may not increase its uptake. Instead, it may be more beneficial to offer multiple treatment options so that veterans may select a treatment that is consistent with their personal beliefs. In addition to interventions to reduce perceived self-stigma regarding mental health treatment, efforts to reduce treatment-stigma in loved ones and colleagues may facilitate treatment-seeking in OEF/OIF veterans given some evidence that encouragement to participate in treatment from others appears to increase treatment-seeking behaviors, despite the presence of other barriers to care (e.g., having negative beliefs about treatment; Sayer et al., 2009). Future research should examine how local policies impact treatment seeking and treatment type and how educating the friends and families of veterans affects perceived stigma and help seeking among veterans. Future studies on treatment preference and stigma for PTSD among OEF/OIF veterans need to be replicated with a sample of those diagnosed with PTSD, as we were unable to recruit such a sample.

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Clinical Forum

The Challenges in Diagnosing Narcissistic Personality Disorder: Difficult to Define, but "We Know It When We See It"

Arthur Freeman, Angela Breitmeyer, and Melissa Flint,
Midwestern University

I shall not today attempt further to define the kinds of material I understand to be embraced within that shorthand description; and perhaps I could never succeed in intelligibly doing so. But I know it when I see it... and the motion picture involved in this case is not that.

—Justice Potter Stewart, concurring opinion in *Jacobellis v. Ohio* 378 U.S. 184 (1964), regarding possible obscenity in *The Lovers*

The quote by Justice Potter Stewart (1964), "I know it when I see it," while originally in reference to the use of explicit images, could also be used to describe the common experience of clinicians when diagnosing individuals with narcissistic personality disorder (NPD). Many of us who have treated individuals with NPD, or any Axis II pathology, can resonate with the idea of "having that feeling," "having a 'gut' reaction," or simply "knowing it when we see it."

The controversy, difficulty, and reluctance of assigning Axis II diagnoses have

been well documented (Miller & Campbell, 2010; Pincus, 2011; Ronningstam, 2011). In the *Diagnostic and Statistical Manual of Mental Disorders* (2000, p. 717; DSM-IV-TR), narcissistic personality disorder is defined by the following criteria (boldface type indicates what we believe to be the operative or troubling word or phrase in each criterion):

A pervasive pattern of grandiosity (in fantasy or behavior), **need** for admiration, and **lack** of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has a grandiose sense of self-importance (e.g., **exaggerates** achievements and talents, expects to be recognized as superior **without commensurate achievements**)

(2) is **preoccupied** with fantasies of **unlimited** success, power, brilliance, beauty, or ideal love

(3) believes that he or she is "**special**" and **unique** and can only be understood

by, or should associate with, other special or high-status people (or institutions)

(4) requires **excessive** admiration

(5) has a sense of entitlement, i.e., **unreasonable expectations** of especially favorable treatment or automatic compliance with his or her expectations

(6) is interpersonally exploitative, i.e., **takes advantage** of others to achieve his or her own ends

(7) **lacks empathy**: is unwilling to recognize or identify with the feelings and needs of others

(8) is often envious of others or believes that others are envious of him or her

(9) shows **arrogant, haughty behaviors or attitudes**

In reviewing the DSM-IV-TR criteria, we know what it says, but what exactly does it mean? While aspects of defining NPD are often controversial, per DSM-IV-TR, the hallmark feature of the disorder is grandiosity.

Merriam-Webster defines grandiosity (www.merriam-webster.com) as (a) characterized by affectation of grandeur or splendor or by absurd exaggeration or (b) impressive because of uncommon largeness, scope, effect, or grandeur. According to the DSM-IV-TR, this grandiosity manifests itself in three primary ways: (a) an inflated sense of self-importance, (b) limitless fantasies, and (c) extreme behaviors. The first two aspects of self-importance and fantasy occur more internally, yet tend to be manifested externally in the individual's behavior. For instance, suppose a young woman, new to her job in the corporate world, be-

believes she is the most valuable asset to her company (inflated sense of self-importance). She firmly believes that within months, she is going to begin her “climb of the corporate ladder” and will eventually be named CEO, recognized by Fortune 500, and internationally known (limitless fantasies). Consequently, she sees herself parking in the CEO’s reserved parking space and demands that she be assigned a personal assistant for her entry-level position. However, her work has been criticized by her supervisor as being superficial and incomplete. Rather than taking the feedback and correcting her work, she makes an appointment with her supervisor’s supervisor about biased and inappropriate feedback because she views her work as excellent. Thus, her external behaviors of parking in the CEO’s reserved space and demanding a personal assistant are an outward manifestation of her internal high regard for herself.

Although grandiosity is clearly defined through Merriam-Webster, other words within the definition are somewhat vague. Below are proposed descriptors of each of these terms:

Pervasive: This implies that the behavior in part is manifested throughout the individual’s life experience (e.g., work, interpersonal relationships, family life).

Need: The pattern of seeking special treatment is not simply a desire, wish, or aspiration, but something that involves a craving.

Lack: The term “lack” seems to denote an absence of empathy rather than a limited fund of empathy; it is rarely an all-or-nothing issue.

Exaggerate: Exaggeration can involve a small embellishment, inflation, or overstatement or a powerful and unrealistic amplification.

Without commensurate achievement: The issue of what is commensurate is debatable. Who judges whether an achievement warrants special notice?

Preoccupied: A question to ask would be, is the preoccupation pervasive or transient?

Unlimited: This is an unrealistic criterion inasmuch as most narcissists do have some idea of limits and boundaries. If the individual’s view is, indeed, unlimited and that is required for the diagnosis, it would leave far fewer individuals being diagnosed with this disorder.

Special and unique: One can make the case that we are all special and unique,

and that specialness defines the issue of diversity.

Excessive: A question to ask would be, Is the excess also pervasive or more attached to specific issues, persons, opportunities, and settings?

Unreasonable expectations: What may be deemed as unreasonable by one person may not be seen by others as unreasonable.

Takes advantage of others: What is not specified is how, when, why, and where the manipulation or misuse occurs. What is the cost to the individual that is being mistreated?

Lacks empathy: Here, again, the issue is not a total lack of empathy but a misuse of the empathic process or limited empathy.

Arrogant, haughty behaviors or attitudes: For the observer of specific behaviors, any lack of humility may be viewed as arrogant and inappropriate.

In addition to the terms contained within the diagnostic criteria, the clinical literature on NPD is largely abstract, theoretical, and general (Ashmun, 2004). Thus, what we propose is viewing NPD through a lens on three fronts. First, we need to establish that there are several subcategories of NPD which will be identified and explicated. For the purposes of this article, we are proposing ten distinct narcissistic subtypes, as originally proposed by Freeman and Fox (2012): positive self-esteem; healthy; group; helpful; real; compensated; oblivious; ruthless; hypervigilant; and helpless. Thus, our approach would be categorical—however, we view the different subtypes on a continuum of severity and “normal.” While two proposed subtypes (i.e., positive self-esteem and healthy narcissism) would not be considered pathological per se, these classifications serve as “anchor points” to conceptualize the full spectrum of narcissism, from a “normal” baseline through severe pathology. Second, there is a need to identify the unique manifestation as a primarily internalizing disorder, primarily externalizing disorder, or combined type (Krueger, McGue, & Iacono, 2001). Thus, our approach would be dimensional. Finally, each subtype would receive a severity rating from 1 to 4 based upon the level of functional impairment. Thus, our approach would be hierarchical. All of these factors combined—i.e., the categories, dimensions, and hierarchy—would yield a more specific

diagnosis and lead the clinician to be able to do specific treatment planning.

In order to fully capture the broad expanse of possible human experience with regard to the narcissistic spectrum (ranging from “normal” behaviors to those considered to be more pathological), we suggest dividing behaviors into 10 subclassifications noted above. Depending on the situation-specific cultural implications, some of these behaviors and subclassifications might be viewed as normal cultural experiences of some diverse groups; however, for others, these behaviors might be seen as clearly different from the cultural expectations of the predominant culture in their area. Taking that into account, these classifications focus on the phenomenological experience of that person and those around him/her. This will allow us to view narcissism through these different lenses. It also warrants that we conceptualize and treatment plan based on the levels of severity, which require specific therapeutic approaches (Freeman & Fox, 2012), which be discussed in the next *IBT* article on this topic. The subtypes can be defined as follows:

Subtype 1: “Positive Self-Esteem”

When looking at the full continuum of any issue, we must include what some may suggest is “normal” or “expected.” For example, if one were to hear Michael Phelps declare that he was the most decorated Olympian of all time, not only would he be reciting fact, he would be expected to show a great deal of pride in the accomplishment at hand. When there is evidence that the assertion is correct, we call this positive or “healthy” self-esteem, rather than labeling it negative in any way. Therefore, it anchors the least deviant or “normal” end of the spectrum. Typical automatic thoughts for this subtype are: “I am proud of my accomplishments,” “I have achieved great things,” “I am pleased with what I have done,” and “Hard work and practice pay off.”

Case Example

Jason is a 30-year-old male who was asked to give a college commencement speech at his alma mater, Stanford University. Jason takes great pride in his accomplishment of earning his Ph.D. at Stanford at age 24. He is not waving a flag or bragging that he went to a better school than others—he is stating, matter of fact, what he has earned. The key word is that he has earned his degree through effort, dedication, and hard work.

Subtype 2: "Healthy" Narcissism

Certainly there are people who have gifts and/or outstanding attributes. While they are "special" in this sense, they do not appear to have a need or desire to flaunt this to others. They may give to charities that are close to them, but they do not go on prime-time television to do so. As mentioned in Freeman and Fox (2012), an example of such a person is Bill Gates. Despite his fortune, he remains fairly quiet and humble in the public eye (to date). Typical automatic thoughts for this subtype are: "My accomplishments set me apart from others," "I have achieved at a higher level than most my age," and "I recognize that I work hard and do great work." Typical automatic thoughts for this subtype are: "I am proud of myself," "It is not necessary to shout out my accomplishments but I would be proud to discuss them," or "There is no need for false humility."

Case Example

Margaret is a 47-year-old retired Air Force officer. She received a military honor in which she was awarded a medal and a lapel pin. Every day, she wears her lapel pin "proudly, but not loudly." Everyone who comes in contact with her will see her pin, but she will not go out of her way to make a point of announcing her honor.

Subtype 3: "Group" Narcissism

The "specialness" of these individuals was bestowed upon them because of their membership in an organization or group. With the definition of a group being quite open, this could refer to a gang, family system, school, social club, work organization, or even religious group. If the group were to no longer exist, the elevated status would also disperse. For example, if one was invited into a specific club based on living in a certain gated community, "outsiders" would be unwelcome because they might be considered to be of "lesser" status. If a member was to move from that community, their membership would also be void. Typical automatic thoughts of this subtype are: "Others wish they could be me," "I am a member of a powerful group," and "People should feel special to associate with me."

Case Example

Timothy is a 16-year-old teenager who recently joined a powerful local gang. As a gang member, he saw himself as more special than nongang members and deserving of prestige and status. He also recognized the benefits and "safety" of this gang out-

weighed the disadvantages and were worth the risk. One day, he forgot to wear the signature red and black colors of his gang and did not receive the typical recognition he had come to expect. After that day, he was sure to remember to wear the gang's colors, as that offered him a sense of protection and prestige.

Subtype 4: "Helpful" Narcissism

Persons with characteristics of helpful narcissism are often unaware that their guiding and correcting of others is perceived to be negative. This person feels free to correct family, peers, colleagues and even strangers without invitation. Their "offer" of help, even when overtly rejected, is continued despite pleas from those involved for the "help" to stop. In other words, their perception is that they are "on a mission" to help others, whether called upon or not. Thus, their personal identity is based on how helpful they are to others, which can only be defined internally. One example of such behavior may occur within the bounds of an adult child's marriage. The "helpful" parent might comment on the child rearing or housekeeping skills of the adult child. Despite requests to cease such behavior, the parent continues, interjecting their ideas, perhaps going as far as moving items in the home and/or changing household rules with regard to the children. Typical automatic thoughts of this subtype are: "If people listened to me, they would get things done right," "Others would be lost without me," "I play an important role in ensuring that things run smoothly," or, "If I really wanted your opinion I would tell you what that opinion should be."

Case Example

Helen, a 69-year-old female, lives across town from her son and his wife and three children. She comes to their home almost daily, lets herself in with her key, might come at very early hours, helps herself to their home, insisting that she is the expert in all things, especially child rearing and homemaking. This, of course, causes a great deal of turmoil within the family. One example of her "helpfulness" included a tutorial on the only way to appropriately vacuum a living room in the most aesthetic way.

Subtype 5: "Real" Narcissism

The superiority asserted by those who have characteristics of "real" narcissism requires that they be constantly justified by others and validated to maintain their perceived elite status. They are quite open about the unique attributes that they (and

often only they) can bring to the situation for which others around them should be thankful. Typical automatic thoughts for this subtype are: "I am superior to others," "My accomplishments well exceed those of everyone else," and "People should be honored to be in my presence."

Case Example

Jennifer is a 31-year-old woman who presents to therapy at the request of her employer as a contingency of her professional development plan. She is quite angry about this plan and declares several times that she "doesn't need to be here." She identifies that she has been falsely accused of being "verbally aggressive" and "overbearing" towards lateral peers and managers alike. She feels that they lack appreciation for all she brings to the table and wonders what will happen when the "whole place falls apart when she leaves over this [explicative]" because "without [her], nothing will get done!"

Subtype 6: "Compensated" Narcissism

This person creates a superhero façade to cover up for perceived failures. As described decades ago by Horney (1937), this individual feels the need to inflate him- or herself to appear competent while demeaning and degrading others. Typical automatic thoughts for this subtype are: "Other people are so incompetent," "I am truly powerful," and "Others should recognize my superiority."

Case Example

Tom is a 40-year-old male who, in describing his family-of-origin experience, identified himself as the "runt of the litter," the "dummy," the "loser," and the "failure of the family." Tom is a community college dropout; his siblings have completed medical, law, and doctorate degrees. In Tom's description of others at work, he declared himself to be "superman" and consistently degraded others, labeling them "incompetent" and "stupid." It appears that Tom raises himself above others, not through performance but by standing upon their backs.

Subtype 7: "Oblivious" Narcissism

Quite literally, these individuals are oblivious to their impact on others. They are often so offensive that they are excluded from events or groups, only to complain that they have no idea why they have been excluded. They may not intentionally set out to offend, but they do—repeatedly. With no awareness that "the foot has been inserted into the mouth" yet again, they

move forward through life with a path of devastation in their wake. Typical automatic thoughts for this subtype are: "People cannot handle the truth," "I wish people would just realize their incompetence," and "I cannot understand why someone would not want to be with me."

Case Example

Sarah is pleased and proud of what she describes as her caustic wit and her ability to "cut to the chase" and call a "spade a spade." She is often at a loss to explain why she has few friends, fewer dates, and, at age 37, has never had a relationship that lasted more than 3 months. When asked to explain this state of affairs, she states, "People just don't like to hear it like it really is."

Subtype 8: "Hypervigilant" Narcissism

Individuals who struggle with the hypervigilant subtype may often be seen as paranoid. They are constantly on guard for whomever might be the next assailant on their integrity. They tend to be "on guard 24/7" and easily provoked to counterattack when presented with the most nonthreatening of discourse. Typical automatic thoughts for this subtype are: "Why are people always out to get me?" "I wish others would not be so hostile towards me," and "What is it with people these days?"

Case Example

Patty, a 19-year-old woman, was expecting a phone call from her friend at 7:00 P.M. At 7:20, Patty's friend called her, explaining that she was stuck in traffic. Patty stated that she "didn't want to hear any more excuses" and exclaimed, "How dare you forget about our phone call!"

Subtype 9: "Ruthless" Narcissism

This type of narcissism describes the person who actually gains satisfaction or enjoyment from being party to the humiliation of others. They may bully, insult, tease, point out flaws in others, and gain satisfaction in embarrassing others publicly. At times, they may even find this humorous and attempt to have others join in on the "fun" against an identified victim. They appear to lack empathy. Typical automatic thoughts for this subtype are: "It does not matter what other people think of me," "I do not care about the feelings of others," and "People better get out of my way."

Case Example

Eddie is a 42-year-old man who was attending his weekly poker night. One of his friends brought along his brother-in-law, who came from a small farming town.

Within minutes of his arrival, Eddie offered up a toast, followed by a joke that was derogatory toward farmers, insinuating that they were "stupid" and "backwards." Despite others' obvious discomfort, Eddie continued to make offensive remarks, stating, "Wait 'til you hear this one, guys . . ." Several of the men left the poker table, clearly offended, while Eddie continued to verbally badger the guest.

Subtype 10: "Helpless" Narcissism

In clinical practice, these clients are often (mis)diagnosed as having refractory anxiety or refractory depression. The "win" in therapy for this client involves not allowing him- or herself to be helped. The unconscious mantra, "neither therapist nor modality, nor hospital nor medication, can help," defines what may be a rather long and complicated history. If they are refused care, or feel as if they are about to be rejected, they may beg you to help them because you might be "the one" who can finally break through. Typical automatic thoughts for this subtype are: "I cannot be helped," "My problems are far too great," and "I wish I could find someone who truly understands how bad things really are for me."

Case Example

Carol, a 52-year-old woman, sought the help of a renowned psychologist as a last resort after countless therapy experiences with the most highly regarded doctors. As a college graduate and daughter of an accomplished surgeon, she had the best opportunities afforded to her. Despite this, she is unemployed, lives at home, and her mother is her only friend. She has no dating history and her life consists of walking the dog and watching television with her mother. Her mother caters to her every whim and requires no remuneration in return. "You're my only hope, doctor! Do you think you can help me?"

In addition to the 10 proposed subtypes, we suggest a further classification system, typically used when diagnosing children (i.e., internalizing versus externalizing disorders). This distinction originated from research on the manifestation of psychopathology in children suggestive of a two-factor structure (Achenbach & Edelbrock, 1984). Within the context of NPD, there are internalizing components related to negative cognitions and externalizing components related to a lack of behavioral constraint. Common to both internalizing and externalizing disorders is emotional distress,

which is directed inward when individuals have appropriate levels of impulse control, and directed outward when such distress is accompanied by a lack of impulse control (Krueger & Tackett, 2003).

Perhaps the most logical emphasis should be on the individual's tangible, identifiable, external behaviors. For example, if we assign each of the 9 criteria for NPD as either internal, external, or both, it would appear then that the majority of the criteria are external: (4) requires excessive admiration; (6) is interpersonally exploitative; (7) lacks empathy; and (9) shows arrogant, haughty behaviors or attitudes. Three of the criteria would be internal: (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love; (3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people; and (8) is often envious of others or believes that others are envious of him or her. Two of the criteria would be both internal and external: (1) has a grandiose sense of self-importance, exaggerating achievements and expecting to be recognized as superior; and (5) has a sense of entitlement, i.e., unreasonable expectations or automatic compliance.

Depending on the combination and permutation of criteria within clients, we can describe various subcategories of NPD. For instance, if a client possessed all five of the external criteria, then that would be one type of narcissism. Likewise, if a client possessed all of the internal criteria, then that would be a second type of narcissism. Finally, if a client possessed a combination of internal and external criteria, then that would be a third type of narcissism (i.e., combined). Furthermore, narcissistic patterns may be a result of a diathesis-stress model. Individuals may have a genetic predisposition towards narcissistic behavior. It is, however, in our view, the experiences in one's family of origin and subsequent environmental reinforcement that will then dictate how the possible predisposition is actualized. Finally, in discussing narcissism as an externalizing behavioral pattern, particularly one that is learned, there is the possibility that such a pattern can be unlearned, which offers some hope in the treatment of individuals with NPD. For clarity, it might be helpful to consider a very condensed version of the DSM-IV-TR criteria in Table 1:

In addition to an emphasis on the external behaviors of narcissism, another proposed

approach to the multidimensional issue of narcissism is to explicitly describe the sub-categories of the disorder and the relative severity that each category holds. The per-

to successfully maintain relationships, employment, or fulfill important obligations.

Although this multifaceted system might present challenges at first, in the end it will yield a more specific criteria set, a more comprehensive diagnostic system, and better treatment planning. To illustrate this point, we conclude with one final case example.

Ferdinand, a 43-year-old married man, seeks therapy in an attempt to have the therapist “help his family learn to mind [him] better.” He reports a history of unfulfilling interpersonal relationships beginning in late adolescence (at home and in the workplace) and several extramarital affairs. He spends every spare moment in the gym, working out (excessively?) to maintain his “Mr. Universe” physique. Furthermore, he reports that his wife is getting “a little flabby” and that she should “hit the gym” to work on her “trouble areas.” He reports that his children (Ben, aged 14, and Olivia, aged 17) want “nothing to do with him.” His wife works at a full-time job, with a part-time job evenings and weekends, which Ferdinand feels limits her “availability” to cook, clean, and do her “wifely duties.” Over the past weekend, he reports that he confronted her about her lack of “attention” to his needs, stating, “You should consider yourself lucky to have a husband like me! There is nobody as special as me who would put up with someone as drab as you!” When she failed to respond with dotting admiration, he made sure to inform her that “ALL the girls in the gym tell me how buff I am. THEY appreciate me!”

Ferdinand holds a midmanagement position at a local bank and is angry over being “passed by” for several promotions. He has recently been reprimanded by his supervisor for delegating tasks to his peers, acting as if he is their supervisor when he is not. Despite these reprimands, he continues to delegate to his peers, stating that it is in the “company’s best interests.” He reports being “baffled” that he is continually not invited to special events, parties, and outside activities with his coworkers because he is sure he would be the “life of the party.”

In considering this case example, we will apply our system of classification illustrating the use of subtype, subcategory, and severity. According to the DSM-IV-TR criteria, Ferdinand clearly demonstrates the hallmark criteria of a pervasive pattern of grandiosity, need for admiration, and lack of empathy (beginning by early adulthood and present in a variety of contexts), in addition to: (1) a grandiose sense of self-im-

portance, (2) a preoccupation with fantasies of unlimited beauty, or ideal love, (4) requiring excessive admiration, (5) a grandiose sense of entitlement, (7) lacking empathy, and (9) showing arrogant, haughty behaviors or attitudes. Based on the specific symptom presentation, he meets the established criteria for the DSM-IV-TR diagnosis of NPD.

To further classify using our comprehensive diagnostic system, Ferdinand demonstrates a complete lack of awareness about his impact on others, i.e., the Oblivious subtype. He is offensive to others and consequently is not included in parties, activities, and plans; however, he displays no awareness as to why he is excluded. For example, we have information that his children have little interaction with him, presumably because of this type of behavior, and that his coworkers would rather not see him outside of the office. Ferdinand may not intend to be intentionally hurtful towards others, but that is often how he comes across. For example, telling his wife to go to the gym is likely cruel in his present communication style.

In addition to applying the subtype classification, we also propose to use a subcategory classification of internal, external, and combined. In Table 2, you will note that he has the following combined criteria of self-importance and entitlement; the following internal criterion of fantasies; and the following external criteria of admiration, lack of empathy, and arrogance. Thus, it is evident that Ferdinand’s narcissism manifests itself more externally than internally.

The last step would be applying the severity index. When applying the severity criteria, it is clear that Ferdinand has frequent problems as a result of his narcissism. Persons who fall into the frequent severity category display behavior that often causes problems for the individual. For example, this individual’s sense of entitlement may result in problems with the law and interpersonal relationships (e.g., disciplinary ac-

Table 1

1	self-importance	C
2	fantasies	I
3	special/ unique	I
4	admiration	E
5	entitlement	C
6	exploitative	E
7	lacks empathy	E
8	envious	I
9	arrogance	E

Note. C = combined; I = internalizing;
E = externalizing.

son demonstrating symptoms on the mild side of the continuum within any one subtype may be only mildly problematic to those around him/her. However, as we move towards the more severe side of the spectrum, the pattern of behavior becomes more and more detrimental, not only for the individual (although they may beg to differ), but for the persons in both their work and social/ familial spheres.

Finally, a proposed severity index would offer finer graduations and more operational definitions of narcissistic behaviors. Essentially, this index would involve a 4-point scale, ranging from mild to severe (similar to how other disorders, such as major depressive disorder, are coded in the DSM-IV-TR). Below is the proposed severity index:

1. *Noticeable*: Behavior is noticeable, but does not interfere with functioning. Such individuals would be perceived as “annoying.” An example would be bragging about one’s accomplishments.

2. *Occasional*: Behavior occasionally causes problems for the individual. In this instance, narcissism may intersect with other Axis II (Cluster B) pathology. For instance, one’s partner may perceive the individual as selfish and contemplate ending the relationship with the individual.

3. *Frequent*: Behavior frequently causes problems for the individual. For example, this individual’s sense of entitlement may result in problems with the law and interpersonal relationships, e.g., disciplinary actions at work.

4. *Severe*: Behavior is severe and debilitating, significantly impairing one’s functioning. This individual would not be able

Table 2

1	self-importance	C	✓
2	fantasies	I	✓
3	special/ unique	I	
4	admiration	E	✓
5	entitlement	C	✓
6	exploitative	E	
7	lacks empathy	E	✓
8	envious	I	
9	arrogance	E	✓

Note. C = combined; I = internalizing;
E = externalizing.

tions at work). Thus, with Ferdinand's overall clinical presentation, he would be diagnosed with NPD, oblivious subtype, primarily externalizing, frequent severity.

As shown in the example above, our system provides a much richer diagnostic picture of an individual presenting with this disorder. Using subtypes, it allows a clinician to further categorize the unique manifestation of NPD for an individual. Using dimensions, it allows a clinician to determine whether the symptoms are primarily internalizing, externalizing, or both. Using a severity index, it allows a clinician to assess the level of functional impairment. Thus, our approach could be considered categorical, dimensional, and hierarchical. Although not currently substantiated empirically, a potential future direction would be to implement clinical trials in which therapists utilized this diagnostic system in comparison to more traditional means of diagnostic assessment.

The DSM-IV-TR criteria provide a framework for additional classification, categorization, and severity criteria. Such a comprehensive system allows the clinician to direct care that would be specific to a client's unique symptom manifestation and constellation. We are able to more adequately and accurately address the unique symptoms of clients with NPD. Now, we

not only "... know it when we see it" but we can now say..."*We know it when we see it, so we can help to modify it!*"

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Past Presidents Series

Perspectives From Past Presidents: Foundations of Behaviorism and Studying Behavior Change

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This brief article is the first in a four-part series that provides recommendations on relevant literature and resources from expert researchers and clinicians: past presidents of the Association for Behavioral and Cognitive Therapies (ABCT). Past presidents were surveyed for their perspectives on research articles, theoretical articles, books, websites, and self-help books they would recommend to members of ABCT and to readers of *the Behavior Therapist*. This provided an opportunity to connect readers to the expertise of some of the leaders in our field. After an examination of the responses, it seemed most

informative to organize their recommendations based on content rather than medium. The following suggestions are foundational texts and resources in the field and science of behaviorism and the study of behavior change, beginning with broad historical texts and followed by more specific applications.

Science and Human Behavior (Skinner, 1953) is a classic text that provides a close examination of human behavior and demonstrates ways such behavior can be changed and controlled through experimental science. Dr. Thomas Ollendick, president of ABCT from 1994–1995,

stated that this book laid "the foundation for behavior therapy and cognitive behavior therapy." This text, cited over 9,200 times, provided an overview of behaviorism, including reflexes, operant behavior, discrimination, and punishment. It then argued that this science, which had until this point been used primarily with animals, can be employed to influence and control human behavior, and introduced the role of self-control, groups of people, and broader agencies in the maintenance of this control. Dr. Ollendick also recommended another foundational text in Bandura's (1977) *Social Learning Theory*. This book, cited over 22,000 times, explored the behavioral aspects of social learning theory while emphasizing cognitions and the role of the individual.

Dr. Philip Kendall, president from 1989–1990, recommended a text focused on understanding aggressive behavior through behavioral principles. *Frustration and Aggression* (Dollard, Doob, Miller, Mowrer, & Sears, 1939) explored the assumption that "aggression is always a consequence of frustration" (p. 1). Chapters focus on the role of aggression in socializa-

tion, adolescence, criminality, and democracy, along with more dated references to fascism, Marxism, and communism. Dr. Kendall recommended this early text as a “great theoretical document, infused with research-based information.”

A text that extends the theoretical principles of behaviorism to applications of behavior change was recommended by Dr. David Barlow, president from 1978–1979. Bandura’s (1969) *Principles of Behavior Modification* provided a specific emphasis on the vicarious, symbolic, and self-regulatory processes involved in social learning and their role in increasing and decreasing behaviors. This text focused on the basic principles of behavior modification, but extended the field through an examination of conditions under which these principles could be utilized for self-enhancement.

Some of the most commonly used behavior modification programs have been based on applied behavior analysis (ABA). Dr. Michel Hersen, president from 1979–1980, recommended an article by Baer, Wolf, and Risley (1968) that examined various dimensions of ABA. This manuscript cited over 2,300 times, described the primary components of ABA and included an additional focus on appropriate procedural descriptions of effective techniques, the practical importance of these skills, and the generalizability of skills learned through ABA.

Dr. Ollendick recommended another text (co-authored by another ABCT past president, Gerald Davison) that demonstrated the use of behavioral principles in clinical practice. Goldfried and Davison’s (1976) *Clinical Behavior Therapy* approached behavior therapy as an emphasis within clinical work that was closely tied to basic psychological research and social psychological theory. Specific therapeutic techniques included behavioral assessment,

relaxation training, behavior rehearsal, cognitive relabeling, and problem solving. Goldfried and Davison emphasized the importance of cognitive processes to behavior change, clearly outlining the cognitive behavioral therapy the field is familiar with today.

Applications of behavior change in clinical practice have also led to examinations of therapeutic outcomes. Dr. Anne Marie Albano, president of ABCT from 2007–2008, recommended an article (authored by past president Alan Kazdin) that provided a conceptualization of behavior change, focusing on response covariation instead of symptom substitution. Kazdin (1982) argued that behavioral responses are related, and treatment of one behavior may result in changes in other behaviors. The article proposed a new conceptual framework with which to explore behavior change in the context of psychotherapy. Dr. Albano recommended this text to aid in understanding how “theories are developed and ideas are vetted via the empirical literature.”

Dr. Debra Hope, president from 2010–2011, and Dr. Barlow recommended another text that focused on the examination of behavior change and behaviorism. Sidman’s (1960) *Tactics of Scientific Research: Evaluating Experimental Data in Psychology* has been instrumental in the evaluation of behavior analysis and behavior therapy. Dr. Barlow explained that this text focused on within-subject research design, identifying the “philosophy and theory of how to focus on the individual in psychological research.” The research methodology outlined in Sidman’s text provided the basis for many of the studies that have supported behaviorism and behavior therapy and will continue to influence the study of behavior change.

These books and articles on the foundations of behaviorism and behavior change have set the stage for the empirical and clinical

work that is currently being done within ABCT. Past presidents have provided their expert recommendations of these seminal texts for the continued education of professionals, educators, students, and readers of *the Behavior Therapist*. Future articles in this series will include additional recommendations from Drs. J. Gayle Beck, Steven Hollon, Rosemary Nelson-Gray, and Jacqueline Persons, and will address themes such as assessment and evidence-based practice and data analysis and research design.

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Classified

FELLOWSHIPS IN ADVANCED COGNITIVE THERAPY WITH AARON T. BECK, M.D. The Aaron T. Beck Psychopathology Research Center in the Perelman School of Medicine at the University of Pennsylvania is seeking applicants for two types of Postdoctoral Fellowship positions: (1) Ruth L. Kirschstein National Research Service Postdoctoral Fellowship Award from the National Institute of Mental Health and (2) Aaron T. Beck Endowed Fellowship (see www.aaronbeckcenter.org). Fellows will have the opportunity to participate in cutting-edge CT projects that include research or training in collaboration with Dr. Aaron T. Beck and core faculty, Drs. Greg

Brown, Torrey Creed, and Paul Grant. Successful candidates may focus on (1) schizophrenia, (2) implementation and dissemination of CT, or (3) suicide prevention. Populations may include children, adults and older adults. Applicants should have earned a Ph.D., Psy.D., or equivalent in psychology or related field and had previous training in CT, severe mental illness, or dissemination/implementation. We especially encourage bilingual candidates to apply.

Please email curriculum vita, cover letter, and two letters of recommendation to Aaron T. Beck, M.D.: abeck@mail.med.upenn.edu. *The University of Pennsylvania is an Equal Opportunity/Affirmative Action Employer*. Applications will be accepted until November 30, 2013.

ADVERTISING in tBT

Classified ads are only \$4.00 per line. For a free price estimate, attach the text of your ad in the form of a Word document and email Stephanie Schwartz at sschwartz@abct. For information on display ads, deadlines, and rates, contact S. Schwartz at the email above or visit our website at www.abct.org and click on ADVERTISE.

Call

for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shireen L. Rizvi, Ph.D., of Rutgers University, is pleased to announce the 2014 awards program, to be presented at the 48th Annual Convention in Philadelphia. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include David H. Barlow, G. Alan Marlatt, Antonette M. Zeiss, Alan E. Kazdin, and Thomas H. Ollendick. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2014**

Mid-Career Innovator

This year we are introducing a new award category. Eligible candidates for the Mid-Career Innovator Award are members of ABCT in good standing who are at the associate professor level or equivalent mid-career level, and who have made significant innovative contributions to clinical practice or research on cognitive and/or behavioral modalities. The 2014 Mid-Career Innovator Award will be given in honor of Alan Marlatt. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Mid-Career Innovator" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2014**

Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Previous recipients of this award are Richard Heimberg, G. Terence Wilson, Richard J. McNally, and Mitchell J. Prinstein. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Mentor" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2014**

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, and Mark S. Bauer. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com.

com. Include “Distinguished Friend to BT” in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2014**

Student Dissertation Awards

- *Virginia A. Roswell Student Dissertation Award* (\$1,000)
- *Leonard Krasner Student Dissertation Award* (\$1,000)
- *John R. Z. Abela Student Dissertation Award* (\$500)

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: (a) candidates must be student members of ABCT; (b) topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined; (c) the dissertation must have been successfully proposed; and (d) the dissertation must not have been defended prior to November 2013. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents. Self-nominations are accepted or a student's dissertation mentor may complete the nomination. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include candidate's last name and “Student Dissertation Award” in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2014**

Student Travel Award

This award is designed to recognize excellence among our student presenters and to aid in allaying some of the significant travel costs associated with presenting at the convention. Accompanying this honor will be a monetary award (\$500) to be used to facilitate travel to the ABCT convention. Eligibility requirements for this award specify that nominees must be (a) speaking at the 2014 convention as a symposium presenter (i.e., first author on a symposium talk), panel participant, or moderator; (b) student members of ABCT in good standing; (c) currently enrolled as a student, including individuals on predoctoral internships in the 2014–2015 year but excluding postbaccalaureates. Information about the nomination form and application will be available following announcement of conference acceptances.

■ **Nomination deadline: August 1, 2014**

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Nominations for the following award are solicited from members of the ABCT governance.

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include “Outstanding Service” in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2014**

President's New Researcher Award

ABCT's 2013–2014 President, Dean McKay, Ph.D., invites submissions for the 36th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. Submissions must include the nominee's current curriculum vita and one exemplary paper. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or post-residency); and (b) have been published in the last two years or currently be in press. Submissions will be judged by a review committee consisting of Dean McKay, Ph.D., Stefan G. Hofmann, Ph.D., and Jonathan D. Abramowitz, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 4, 2014, and must include four copies of both the paper and the author's vita and supporting letters if the latter are included. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

■ **Submission deadline: August 4, 2014**

NOMINATE ONLINE:
www.abct.org

call

for

Continuing Education Sessions

Please send a 250-word abstract and a CV for each presenter.

For submission requirements and information on the CE session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at www.abct.org.

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

Workshops and Mini Workshops

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

Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention.

Please limit to no more than FOUR presenters.

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

Barbara Kamholz, Workshop Committee Chair
workshops@abct.org

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.

Please limit to no more than FOUR presenters.

Lauren Weinstock, Institute Committee Chair
institutes@abct.org

Master Clinician Seminars

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

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

DEADLINE

for Submission : February 1, 2014

Nominations for ABCT Officers: Get in on Choosing the Leaders

Christopher Martell, *Chair, Leadership and Elections Committee*

We are approaching the nominations period for ABCT's elected leadership positions. Professional organizations are as strong as their members' participation. ABCT belongs to all of us and the selection of leaders represents the single most important task that members accomplish. Please take ownership of your association and participate in the leadership selection process. Make this the year you guide your professional home and make a contribution by running for office or take an active role in selecting our leaders. If you ask members who have previously served in a leadership role in ABCT why they participated, they all share similar reasons for participating in the leadership: they wanted to make a difference, and they did. Will you or someone you know run for office? In addition to the inherent satisfaction achieved from contributing to ABCT, you have the opportunity to develop new friendships while reconnecting with old ones.

This coming year we need nominations for two elected positions: President-Elect

and Representative-at-Large. Those members who receive the most nominations will appear on the ballot. In April, members in good standing vote for the candidates of their choice to serve for 3 years. The President-Elect serves in that function from 2014-2015, then as President from 2015-2016, and then as Past President from 2016-2017.

Each representative serves as a liaison to one of the branches of the association. The representative position up for 2014 election will serve as the liaison to the Membership Issues Coordinator. The Coordinator works with a wide variety of committees devoted to membership and membership services. These include the Membership Committee; Committee on Student Members; Leadership and Elections; List Serve; the Clinical Directory and Referral Issues, which just revamped our on-line referral network, Find a CBT Therapist; Social Networking Media Committee, responsible for our Facebook page; and our ever-growing Special Interest Groups Committee. This representative

serves a crucial role working with the Coordinator to ensure these committees have clear job descriptions that are in keeping with the ABCT mission statement and keep the Board updated on their activities throughout the year. All full members in good standing are eligible to be nominated, and there is no limit to the number of members you can nominate for any of the positions.

Electioneering starts at the Annual Convention. So if you are interested in running for office, or if you have a candidate in mind, start the campaign now with the nominations and go to the Annual Convention and start making your case to the electorate.

How to Nominate: Three Ways

- ➔ Mail the form to the ABCT office (address below)
- ➔ Fill out the nomination form by hand and fax it to the office at 212-647-1865
- ➔ Fill out the nomination form by hand and then scan the form as a PDF file and email the PDF as an attachment to our committee: membership@abct.org.

The nomination form with your original signature is required, regardless of how you get it to us.

Good governance requires participation of the membership. ABCT needs your participation to insure good governance and to continue to thrive as an organization. ■

NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals:

PRESIDENT-ELECT (2014-2015)

REPRESENTATIVE-AT-LARGE (2014-2017)

NAME (printed)

SIGNATURE (required)

2014 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2014, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send this nomination form to Christopher Martell, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.

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.

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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

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



Upcoming Webinars

Friday, September 20, 2013
11:00 a.m. EST

Jeffrey E. Barnett, Psy.D., ABPP

Ethical, Legal, and Clinical
Considerations in Behavioral
Telehealth

Friday, December 13, 2013
11:00 a.m. EST

Alec Miller, Psy.D.

DBT With Adolescents: Research
and Clinical Developments

Thursday, February 6, 2013
11:00 a.m. EST

Jonathan Abramowitz, Ph.D.

Exposure Therapy for OCD
Symptom Dimensions

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BEHAVIOR THERAPY Volume 44, #3, Sept. 2013

Taylor et al. Epidemiology of Insomnia in College Students: Relationship With Mental Health, Quality of Life, and Substance Use Difficulties

Capron et al. Distress Tolerance and Anxiety Sensitivity Cognitive Concerns: Testing the Incremental Contributions of Affect Dysregulation Constructs on Suicidal Ideation and Suicide Attempt

Ammerman et al. A Clinical Trial of In-Home CBT for Depressed Mothers in Home Visitation

Desrosiers, Klemanski, & Nolen-Hoeksema. Mapping Mindfulness Facets Onto Dimensions of Anxiety and Depression

Martinelli, Cavanagh, & Dudley. The Impact of Rumination on State Paranoid Ideation in a Nonclinical Sample

Abramowitz et al. Treating OCD in Intimate Relationships: A Pilot Study of Couple-Based Cognitive-Behavior Therapy

Levy et al. Characteristics of Individuals Seeking Treatment for Obsessive-Compulsive Disorder

Boswell et al. Anxiety Sensitivity and Interoceptive Exposure: A Transdiagnostic Construct and Change Strategy

Oser et al. Differential Associations Between Perceived and Objective Measurement of Distress Tolerance in Relation to Antiretroviral Treatment Adherence and Response Among HIV-Positive Individuals

Ortiz & Del Vecchio. Cultural Diversity: Do We Need a New Wake-Up Call for Parent Training?

Bardeen, Fergus, & Orcutt. Experiential Avoidance as a Moderator of the Relationship Between Anxiety Sensitivity and Perceived Stress

Levinson, Langer, & Rodebaugh. Reactivity to Exclusion Prospectively Predicts Social Anxiety Symptoms in Young Adults

Hawkins & Cogle. Effects of Interpretation Training on Hostile Attribution Bias and Reactivity to Interpersonal Insult

Choi et al. Depression in Homebound Older Adults: Problem-Solving Therapy and Personal and Social Resourcefulness

Krieger et al. Self-Compassion in Depression: Associations With Depressive Symptoms, Rumination, and Avoidance in Depressed Outpatients

Feldner et al. Initial Evaluation of an Integrated Treatment for Comorbid PTSD and Smoking Using a Nonconcurrent, Multiple-Baseline Design

Zaki et al. Emotion Differentiation as a Protective Factor Against Nonsuicidal Self-Injury in Borderline Personality Disorder

COGNITIVE AND BEHAVIORAL PRACTICE Volume 20, #3, August 2013

COGNITIVE-BEHAVIORAL CASE CONFERENCE

Robichaud. A Clinical Case of Generalized Anxiety Disorder

CONTAINS VIDEO | *Robichaud.* Cognitive Behavior Therapy Targeting Intolerance of Uncertainty: Application to a Clinical Case of Generalized Anxiety Disorder

CONTAINS VIDEO | *Hayes-Skelton et al.* An Acceptance-Based Behavioral Therapy for Individuals With Generalized Anxiety Disorder

CONTAINS VIDEO | *Fresco et al.* Emotion Regulation Therapy for Generalized Anxiety Disorder

Hjemdal et al. Metacognitive Therapy for Generalized Anxiety Disorder: Nature, Evidence and an Individual Case Illustration

FEATURED ARTICLE WITH ACCOMPANYING COMMENTARIES

TARGET ARTICLE | *Koons et al.* Negotiating for Improved Reimbursement for Dialectical Behavior Therapy: A Successful Project

COMMENTARY | *Rizvi.* When Insurance Companies and Clinicians Pay Attention to Data, Everybody Wins: A Commentary on Koons, O'Rourke, Carter, and Erhardt

COMMENTARY | *Wisniewski & Altman.* Commentary on Koons et al.'s "Negotiating for Improved Reimbursement for Dialectical Behavior Therapy: A Successful Project"

COMMENTARY | *Jacobo et al.* "Stay in the Game": Collecting Data on Symptom Improvement in Naturalistic Settings in Order to Increase Reimbursement Rates

REGULAR ARTICLES

Bagner et al. Home-Based Preventive Parenting Intervention for at-Risk Infants and Their Families: An Open Trial

Spuij et al. Cognitive-Behavioral Therapy for Prolonged Grief in Children: Feasibility and Multiple Baseline Study

Calzada, Basil, & Fernandez. What Latina Mothers Think of Evidence-Based Parenting Practices: A Qualitative Study of Treatment Acceptability

McIlvain, Walter, & Chard. Using Cognitive Processing Therapy-Cognitive in a Residential Treatment Setting With an OEF/OIF Veteran With PTSD and a History of Severe Traumatic Brain Injury: A Case Study

BOOK REVIEW

Hofmann, S. G. (2012). *An Introduction to Modern CBT: Psychological Solutions to Mental Health Problems*
Reviewed by Kristalyn Salters-Pedneault

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 Anjali P. Arora
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 Gregory Baron
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in-press article

A Case Study Illustrating Therapist-Assisted Internet Cognitive Behavior Therapy for Depression

“Also readily apparent in the client-therapist email exchanges is that the therapist was not able to use the typical visual cues to convey her reactions, such as eye contact, body language, or facial expressions. In some instances, however, keyboard techniques were used to enhance communication to make the emails look and feel more like an in-person encounter (e.g., quotes, italics, bold text).”

Pugh et al.

Cognitive and Behavioral Practice
in press, accepted

doi:10.1016/j.cbpra.2013.08.002

archive

“... part of the universe is enclosed within the organism’s own skin.”

B. F. Skinner, 1953

Science and Human Behavior

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