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Clinical Forum

Cognitive Therapy for Suicidal Patients: Current Status

Amy Wenzel and Shari Jager-Hyman,
University of Pennsylvania

Suicide is the 10th leading cause of death in the United States, with more than 36,000 deaths by suicide per year (Crosby, Ham, Ortega, Parks, & Gfroerer, 2011). The rate of completed suicides has increased steadily over the past decade, and the most recent statistics indicate that the rate of suicide has reached its highest level in the past 15 years (Centers for Disease Control and Prevention [CDC], 2008). Despite the enduring public health significance of suicide, only recently has attention been given to the development of efficacious treatments to prevent suicidal behavior. Traditionally, the approach to treating suicidality was to address the patient's depression (Ellis, Allen, Woodson, Frueh, & Jobes, 2009; Linehan, 2000). However, this approach is limited because (a) it assumes that all suicidal patients are depressed, which is not always the case; (b) it does not necessarily address the unique psychological mechanisms at work leading up to or during suicidal behavior; (c) it does not necessarily address other modifiable risk factors for future suicidal behavior; (d) it does not necessarily allow for patients to develop strategies that they can use during a future suicidal crisis; and (e) there is no evidence that it is efficacious, as suicidal patients are almost always excluded from randomized controlled trials (RCTs) to evaluate treatments for depression. Thus, beginning in the late 1990s, pioneering work by Aaron T. Beck and Gregory K. Brown was initiated at the University of Pennsylvania to develop a cognitive therapy protocol that specifically targeted suicidal behavior.

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[continued from p. 121]

This treatment protocol was first described in the mid-2000s (Berk, Henriques, Warman, Brown, & Beck, 2004; Henriques, Beck, & Brown, 2003) and subsequently presented in greater detail in a full-length treatment manual (Wenzel, Brown, & Beck, 2009). It was originally developed for patients who recently attempted suicide, but it can also be applied to patients who have experienced a recent episode of acute suicidal ideation that requires intervention. In this article, we view patients as being appropriate for this cognitive therapy protocol if they have experienced a recent *suicidal* crisis, which is defined as either a suicide attempt or acute suicidal ideation.

This treatment protocol's central feature is that suicidal behavior is viewed as the *primary* problem rather than as a symptom of a psychiatric disorder. As such, it can be delivered to patients with a wide range of psychiatric disorders. Similar to cognitive therapy protocols for other problems, it targets unhelpful cognitions and maladaptive behavioral patterns, and in this case, the specific cognitions and behaviors that fuel suicidal behavior are the focus of treatment. This treatment protocol also shares many other features with other cognitive therapy protocols, such as an emphasis on problem solving in the here-and-now, collaboration between the patient and therapist, and an organized session structure. It was designed to be a brief intervention (i.e., approximately 10 sessions) that can be administered in concert with other relevant treatments, such as pharmacotherapy, drug and alcohol counseling, and/or group therapy. However, because many suicidal patients present with multiple life problems and chronic emotional distress, it is not expected that patients will no longer need therapy at the end of this brief intervention. Rather, treatment moves from an *acute* phase, in which the suicide prevention protocol described in this article is delivered, to a *continuation* phase, where other psychiatric disorders, Axis II clinical presentations, and/or life problems are addressed.

The following sections describe the acute phase of treatment for suicidal patients. First, we outline the cognitive model of suicidal behavior that forms the basis of treatment. Next, we describe specific therapeutic strategies that cognitive therapists implement in their sessions with suicidal patients. We also present the primary results from the RCT designed to evaluate the efficacy of this treatment protocol. Finally, we end by highlighting new developments in the field, which center mainly on the adaptation of the cognitive therapy treatment protocol for specific populations and settings.

Theoretical Framework

According to the cognitive theory that forms the basis of this treatment (Wenzel et al., 2009), three sets of psychological processes make people vulnerable to engage in suicidal behavior. *Dispositional vulnerability factors* are long-standing psychological traits that (a) have the potential to increase life stress, (b) are associated with psychiatric disturbance (e.g., depressive symptoms), and (c) exacerbate affect dysregulation during suicidal crises. Examples of dispositional vulnerability factors include impulse aggression (Brent & Melham, 2008), problem-solving deficits (e.g., Priester & Clum, 1993; Reinecke, 2006; Schotte & Clum, 1987), an overgeneral memory style

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(Williams, Barnhoffer, Crane, & Duggan, 2006), and perfectionism (Hewitt, Flett, Sherry, & Caelian, 2006).

The second set of processes associated with suicidal behavior comprises psychological variables associated with psychiatric disturbance, as over 90% of people who engage in suicidal behavior carry one or more psychiatric diagnoses (Bertolote, Fleischmann, De Leo, & Wasserman, 2003), and nearly every psychiatric diagnosis is associated with increased suicide risk (Harris & Barraclough, 1997). These psychological processes include unhelpful cognitive and behavioral patterns indicative of psychopathology (e.g., negative triad, inactivity). It is acknowledged that the presence of these cognitive and behavioral patterns does not guarantee that a person will engage in suicidal behavior, as most people who are diagnosed with a psychiatric disorder do not engage in suicidal behavior. According to our cognitive theory, suicide risk increases as the severity of a single psychiatric diagnosis increases and with comorbidity because these clinical presentations are most likely to activate suicide-relevant schemas (e.g., hopelessness, unbearability).

The third set of psychological processes associated with suicidal behavior involves suicide-relevant cognitive processes that become salient when a suicide-relevant schema is activated. These processes include attentional biases toward suicide-relevant stimuli (e.g., Becker, Strohbach, & Rinck, 1999; Cha, Naimi, Park, Finn, & Nock, 2010; Williams & Broadbent, 1986), the inability to disengage attention from suicide-relevant stimuli, and *attentional fixation*, or a preoccupation with suicide as the only solution to one's problems. The model suggests that the threshold at which the cascade of suicide-relevant cognitive biases is activated depends on the person's history of suicidal behavior; for example, those who have made previous attempts experience these suicide-relevant cognitive processes with less provocation than those who have never made a suicide attempt (cf. Joiner & Rudd, 2000).

Strategic Therapeutic Interventions

Cognitive therapy for suicidal patients proceeds from the theoretical framework described in the previous section and is divided into three phases: (a) an early phase (Sessions 1–3), (b) an intermediate phase (Sessions 4–7), and (c) a later phase (Sessions 8–10). Interventions that occur in each of these phases are described in this section.

Early Phase

The early phase of treatment is devoted to obtaining informed consent, engaging patients in treatment, conducting a suicide risk assessment, developing a safety plan, gathering information to facilitate a cognitive case conceptualization, and developing treatment goals. Although informed consent is an important feature in the delivery of any type of psychotherapy, it deserves special attention with suicidal patients to ensure that they clearly understand the goal of treatment (i.e., to prevent future suicidal behavior), learn about other evidence-based treatment options, and formulate realistic expectations for treatment (e.g., that participating in cognitive therapy for suicide prevention does not guarantee that the patient will not engage in suicidal behavior; Rudd et al., 2009). Thus, informed consent is a first step in engaging patients in treatment, as it orients them to the treatment that will be delivered. Other ways to engage patients in treatment include instilling hope, demonstrating confidence that their problems can be addressed using this framework, and showing a willingness to talk about suicide and other difficult issues that patients are experiencing.

Of course, with any suicidal patient, a comprehensive suicide risk assessment is in order at the beginning of treatment, and continued monitoring of suicide risk is indicated. In addition to assessing for suicidal ideation, intent, and plan, therapists can also identify whether suicidal patients report other psychological features of suicidality that have been demonstrated in the empirical literature to be associated with increased suicide risk. For example, therapists can ask patients to rate their wish to live and their wish to die, with the idea that high wish-to-die ratings accompanied by low wish-to-live ratings are especially potent risk factors for eventual suicide (Brown, Steer, Henriques, & Beck, 2005). They can also ask patients who have attempted suicide about their reaction to their attempt, with the idea that patients who report regret that their attempt failed are at higher risk to eventually kill themselves than those who are glad to be alive or ambivalent (Henriques, Wenzel, Brown, & Beck, 2005). Some research suggests that suicidal ideation at patients' worst time in their lives is more predictive of suicidal behavior than current suicidal ideation (Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999); thus, therapists inquire about the characteristics of previous suicidal crises in addition to the current suicidal crisis that brought them into treatment. Other research has identified two cognitive factors that are particularly important in explaining suicidality—perceived burdensomeness to others and failed belongingness (e.g., Joiner et al., 2002; Van Orden et al., 2010)—that can be monitored on an ongoing basis and that can eventually serve as targets in treatment.

On the basis of the suicide risk assessment, therapists work with their patients to develop a *safety plan*, which is a hierarchically arranged written list of tools for dealing with a suicidal crisis (Stanley & Brown, 2011). The safety plan is not a contract that simply instructs patients not to attempt suicide; rather, it is guide for patients to consult in order to remember how not to attempt suicide. It is developed collaboratively by the patient and therapist in the first session, and it is modified in subsequent sessions on the basis of the cognitive and behavioral work that has taken place in session. Safety plans typically include six sections: (a) warning signs that a suicidal crisis is developing; (b) coping skills that patients can use on their own; (c) people with whom they can connect without talking in detail about the suicidal crisis; (d) people they can contact who can, specifically, help them manage the suicidal crisis; (e) contact information for treatment providers, hotlines, and other emergency services; and (f) a plan for the removal of lethal means. Patients are instructed to consult their plan when they notice warning signs for a suicidal crisis and to implement coping skills on their own, with the notion that they will move onto the next step on the safety plan if the previous steps do not deescalate the crisis. The development of the safety plan is perhaps the single most important activity that occurs in the early sessions of treatment, as it is the first tangible tool that patients can take home that will help them to modify suicidal behavior.

During the early phase of treatment, cognitive therapists gather a great deal of information from the patient to develop a cognitive case conceptualization. Some of the information gathered pertains to the patient's background, such as the dispositional vulnerabilities that play a role in the cognitive model of suicidal behavior described previously. However, a central goal of this information gathering is to paint a detailed picture of the situational, cognitive, emotional, and behavioral events that led up to the recent suicidal crisis that brought the patient into treatment, as well as the suicide-relevant cognitive processes that were at work during the crisis. Therapists encourage patients to "tell their story," with

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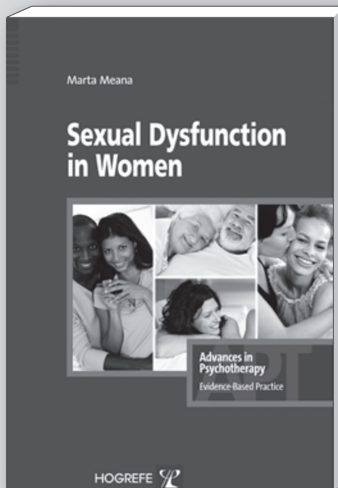

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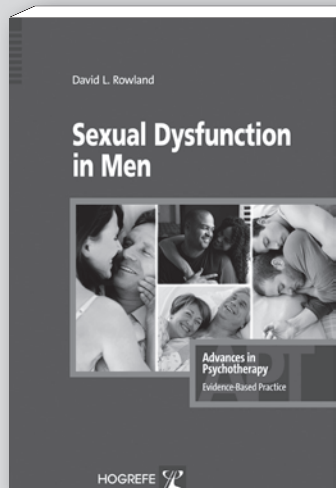

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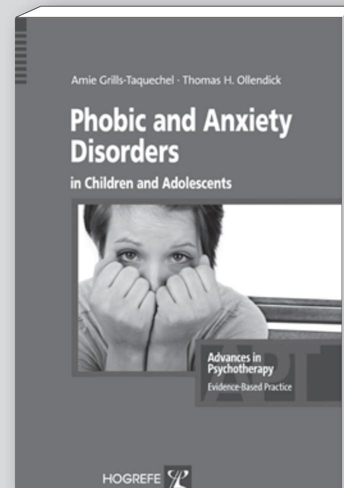

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the "story" beginning at any point in time that patients believe is relevant to understanding their suicidal crisis. As patients are describing these events, therapists take care to ask specifically about the psychological factors that contributed to the decision to make a suicide attempt (e.g., "What was running through your mind at that moment?" "When you had that thought, what did you do next?"). Therapists work with their patients to assimilate this information into a time line of events that led up to the suicidal crisis, with the goal of identifying multiple points on the time line that could serve as targets for later interventions (e.g., suicide-relevant cognitions, difficulty solving a problem).

As in most cognitive therapy protocols, a final activity that occurs in the early sessions of treatment is the development of specific and measurable treatment goals. In many instances, the development of treatment goals with suicidal patients is a daunting task, as they exhibit complex clinical presentations and report multiple life problems. Cognitive therapists who work with suicidal patients are mindful that the general goal of the acute phase of treatment is to reduce the likelihood of future suicidal behavior; thus, they use the cognitive case conceptualization that they have developed to work with their patients to identify specific goals that have the most promise in achieving this general aim. Goals pertaining to psychiatric disorders and other life problems can be developed when patients enter into the continuation phase of treatment.

Intermediate Phase

On the basis of the cognitive case conceptualization and the treatment goals, in the intermediate phase of treatment, therapists begin to apply cognitive therapy strategies to help patients acquire skills that will reduce the likelihood of future suicidal behavior. Some of these strategies take on a behavioral focus. For example, many cognitive therapists find that behavioral activation is indicated with suicidal patients in order for them to experience increased pleasure and meaning in their lives. In addition, because these patients typically receive a large number of services, cognitive therapists often work with patients to develop behavioral tools for increasing compliance with all aspects of their treatment. Other suicidal patients, such as those who are characterized by failed belongingness, have a limited or disrupted social support network. In these instances, cognitive therapists work with these patients to develop skills for strengthening their support network. At times, work on developing social support networks can take place in conjoint sessions so that the patient's close others can learn how to provide the most effective support or to solve a problem in the relationship that was related to the recent suicidal crisis. Other behavioral tools that suicidal patients develop in cognitive therapy are those that promote affective self-soothing (e.g., behaviors that engage the five senses), such as those that are incorporated into dialectical behavior therapy (DBT; Linehan, 1993). All of these behavioral strategies are aimed at increasing the likelihood that patients emerge from a crisis without harming themselves, and their successful application begins to modify beliefs that their future is hopeless, that their current life situation is intolerable, and that there is no one to whom they can turn for support.

Because cognition plays a central role in the cognitive theory of suicidal behavior, most cognitive therapists find that incorporation of cognitive strategies into treatment has the potential to deescalate suicidal crises. Thus, cognitive therapists practice *cognitive restructuring*, or the systematic process of identifying, evaluating, and modifying unhelpful cognitions, with their patients in the intermediate phase of treatment. On the basis of the cognitive case conceptualization, they target the cognitions that are most directly related to the suicidal crises. These cognitions are usually associated with beliefs that the future will not get better (i.e., hopelessness), that one's pain is intolerable (i.e., unbearability), and/or that one has no worth (i.e., worthlessness). Specific techniques that cognitive therapists use to address these cognitions include Socratic questioning (e.g., evidence for, evidence against), behavioral experiments, and future time-imaging (i.e., developing concrete mental images of the future 1, 5, and 10 years forward). The aim of cognitive restructuring is to modify suicide-relevant cognitions that are experienced during a suicidal crisis as well as unhelpful cognitions associated with psychiatric disturbance that have the potential to activate a suicide schema.

Although cognitive restructuring is often effective in modifying suicide-relevant cognitions in session, many patients report having difficulty applying these skills systematically during a suicidal crisis. This is especially true when patients are experiencing attentional fixation on suicide as the only solution to their problems. Thus, during times of agitation and emotional escala-

tion, patients need quick and easily accessed reminders of the important work that they have done in therapy. One way for patients to be reminded of their adaptive responses to suicide-relevant cognitions is to consult a *coping card*, which is a small piece of paper (e.g., index card) that contains the fruits of the cognitive restructuring work done in session. Some coping cards contain questions patients can ask themselves to get distance from their cognitions; other coping cards contain adaptive, balanced responses that the patient developed in session when evaluating a suicide-relevant thought or belief; and still other coping cards contain a list of evidence in support of hope for the future, one's ability to tolerate distress, or one's worth.

A central activity in cognitive therapy for suicidal patients is the acknowledgment and development of reasons for living, as research has shown that few reasons for living increase the risk of suicidal behavior (Jobes & Mann, 1999; Linehan, Goodstein, Nielsen, & Chiles, 1983). It is likely that few reasons for living exacerbate suicidal patients' sense of hopelessness; thus, reminders of reasons for living can decrease the potency of a suicide schema and the resulting suicide-relevant cognitive processes experienced during a suicidal crisis. Coping cards can also be used as quick and accessible reminders of reasons for living. However, at times, the words written on a coping card are not powerful enough to deter a suicidal crisis. Some patients require more tangible and vivid reminders of reasons for living. As such, the construction of an individualized Hope Kit is often a central activity in cognitive therapy for suicidal patients. The Hope Kit comprises items that serve as visual and tactile reminders of reasons for living. For example, patients often use shoe boxes to house pictures of loved ones, letters from friends, inspirational music or poems, and/or prayer cards. The Hope Kit is then kept in an easily accessible place so that patients can utilize it in times of crisis. Many patients report that the construction of the Hope Kit is the most meaningful part of their experience with cognitive therapy.

In addition to the cognitive work aimed at modifying suicide-relevant cognitions, cognitive therapists also work with suicidal patients to enhance problem-solving skills, viewing suicidal behavior, itself, as evidence of a failure to solve a problem effectively (e.g., Reinecke, 2006). The goal of problem-solving training is to improve patients' ability to cope with life stressors and engage in alternative solutions to suicidal behavior when faced with problems. Cognitive therapists systematically apply the steps to problem solving that are shared in many cognitive behavioral protocols, such as problem definition, generation of alternative solutions, decision making, and solution implementation and verification (D'Zurilla & Nezu, 2007). Solutions that prove to be successful serve as corrective learning experiences that help patients adopt a more flexible approach to problem solving and modify beliefs that their problems are unsolvable or unbearable. Thus, the acquisition of problem-solving skills addresses both a dispositional vulnerability factor that puts people at risk for suicidal behavior as well as cognitive processes that are at work during suicidal crises, as it has the potential to reduce attentional fixation.

Because some research has found that impulsivity is associated with suicidal behavior (Mann, Waternaux, Haas, & Malone, 1999; Michaelis et al., 2004), cognitive therapists who work with suicidal patients also target this construct. Although impulsivity is most evident in a person's behavior, both behavioral and cognitive strategies can be used to reduce impulsivity. From a behavioral standpoint, patients are encouraged to use the coping strategies discussed throughout the course of treatment to help prevent impulsive suicidal behavior (e.g., consulting the safety plan, reaching out to someone in one's social support network, engaging in self-soothing activities). From a cognitive standpoint, therapists can work with patients to evaluate the commonly held idea that suicidal crises will last indefinitely. Specifically, they can conceptualize suicidal crises as having "wave-like" properties, such that they ebb and flow rather than remaining consistent. Therapists can help patients to recognize that suicidal crises will eventually pass if they are willing to postpone self-harm while "riding the wave," and they can encourage patients to conduct a behavioral experiment to "test" whether the wave will eventually recede. Therapists can also work with patients to conduct an advantages-disadvantages analysis (both short- and long-term) of acting impulsively on suicidal urges. With suicidal patients who are characterized by impulsivity, it is imperative to implement the long-term strategy of restricting means to suicide by working with patients to safeguard their environments early on in treatment to decrease the likelihood of impulsive suicidal behavior.

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Later Phase

Once it is evident that patients have acquired the skills necessary to prevent or diffuse suicidal crises, treatment shifts to the later phase, which focuses largely on reviewing and applying specific skills to prevent future suicidal crises. There are four main components to the later phase of treatment: (a) reviewing and consolidating skills acquired during the intermediate phase; (b) conducting the relapse prevention protocol, in which patients apply these skills in guided imagery exercises; (c) reviewing gains and progress towards treatment goals; and (d) determining and preparing for disposition following treatment (i.e., continuation of treatment, referring for other treatment, or termination of treatment).

The consolidation of learning, review of progress toward treatment goals, and preparation for termination are activities in which cognitive therapists would engage in the later phase of most courses of cognitive therapy. In contrast, the *relapse prevention protocol* was developed specifically for suicidal patients to demonstrate to their therapist and to themselves that they can successfully apply the skills they have acquired in treatment. It is a series of guided imagery exercises in which patients visualize and systematically describe, in the present tense, the chain of events that led to the suicidal crisis that brought them into treatment. Particular emphasis is placed on the thoughts, emotions, and behaviors that contributed to the suicidal crisis. After engaging in a guided imagery exercise in which they describe the sequence of events that led to the suicidal crisis, patients are encouraged to go through the sequence again, this time describing in detail the manner in which they would implement skills to mitigate the suicidal crisis. Subsequently (and usually in the next session), patients use guided imagery to imagine the sequence of events that could lead to a future suicidal crisis, and, again, they describe in detail the manner in which they would apply the skills they acquired in treatment. Although this protocol powerfully consolidates learning and prepares patients for future crises, some patients find it daunting. Thus, therapists are mindful of spending sufficient time in preparation for the administration of this protocol (e.g., providing a clear rationale for the exercise, obtaining patients' consent to engage in the exercise) and debriefing after the administration of this protocol (e.g., monitoring and addressing any residual suicidal ideation).

An important focus of the later phase of treatment is preparing patients for inevitable setbacks and challenges that may arise in the future, as well as focusing on identifying strategies to cope with these lapses. Some patients fall into the trap of dichotomous thinking, believing that they are "back at square one" if they experience another suicidal crisis. Thus, it is important to apply the cognitive restructuring skills acquired in the intermediate phase of treatment to help patients formulate accurate expectations about their symptoms, life problems, and unanticipated stressors following the acute phase of treatment. At the close of the later phase of treatment, therapists and patients can work collaboratively to decide whether to engage in a continuation phase of therapy, refer for other services, or taper sessions in anticipation of terminating treatment altogether.

Efficacy

In the past decade, many cognitive behavioral treatment protocols for suicidal behavior have been evaluated in RCTs (for a review, see Tarrier, Taylor, & Gooding, 2008). Overall, results from these studies support the efficacy of cognitive behavioral therapy (CBT), a term used interchangeably with cognitive therapy, for reducing suicidal ideation, suicidal behavior, and hopelessness relative to usual care. Furthermore, gains made in therapy are often maintained over time.

The specific cognitive therapy protocol described in this article was evaluated in an RCT by Brown et al. (2005). In this study, 120 patients who had attempted suicide in the 48 hours prior to admission to an emergency department were randomly assigned to receive outpatient cognitive therapy plus usual care or usual care only. The only exclusion criterion was a medical disorder that would preclude participation in outpatient psychotherapy. At baseline, 77% were diagnosed with major depressive disorder, 68% were diagnosed with a substance use disorder, and 85% were diagnosed with more than one psychiatric disorder.

Patients completed assessments at baseline and 1, 3, 6, 12, and 18 months thereafter. The main outcome variable was a repeat suicide attempt. Between the baseline and 18-month assessments, approximately 24% of patients who received cognitive therapy and 42% of patients who received usual care made at least one subsequent suicide attempt, a difference that was statistically significant (Wald $\chi^2 = 3.9$; $p = .049$). The hazard ratio was 0.51 (95% CI, 0.26 – 0.997), which indicates that patients who received cognitive therapy were approximately 50% less likely to reattempt suicide during the follow-up period than patients who received usual care. In addition, relative to patients who received usual care, patients who received cognitive therapy scored lower on the Beck Depression Inventory–Second Edition (Beck, Steer, & Brown, 1996) at the 6-, 12-, and 18-month follow-up assessments and lower on the Beck Hopelessness Scale (Beck & Steer, 1988) at the 6-month follow-up assessment.

New Developments

Since the publication of Brown et al.'s (2005) RCT, cognitive therapy for suicidal patients has been adapted for a number of different populations and settings, with many of these protocols using the term CBT. In this section, we briefly summarize recent developments in the application of CBT for suicidal adolescents and older men. We also discuss two brief, targeted interventions for suicidal patients in acute care settings: safety planning intervention and postadmission cognitive therapy.

Cognitive Behavioral Interventions for Suicidal Adolescents

According to the CDC (2008), suicide is the third leading cause of death for children and adolescents between the ages of 10 and 19, with approximately 2,000 adolescent deaths by suicide each year. Two recent studies have significantly advanced the literature on the cognitive behavioral treatment of suicidal adolescents.

In the context of a multisite study (i.e., Treatment of Adolescent Suicide Attempters [TASA]), Stanley et al. (2009) developed a manual-based psychotherapy, Cognitive Behavioral Therapy–Suicide Prevention (CBT-SP), for reducing risk for future attempts in adolescents who recently attempted suicide. Therapy consists of acute and continuation phases, both of which last approximately 12 sessions. CBT-SP is both feasible and acceptable to patients, with over 70% of patients completing at least 12 sessions, and with 100% of a subgroup of patients who were interviewed about the treatment reporting that they found it to be helpful (Stanley et al.). Although TASA was initially designed to be an RCT comparing CBT-SP, medication management, and a combination of the two, difficulties in recruitment led the investigators to modify the design to allow participants to either choose a specific treatment or be random-

ized to a treatment, and most of the participants chose to receive combination treatment. Over a 6-month period, the full sample's hazard ratios of experiencing a suicidal event (i.e., suicidal behavior, preparatory acts, or suicidal ideation) or a suicide attempt were 0.19 and 0.12, respectively, which compare favorably with hazard ratios ranging from 0.17 to 0.69 that have been reported by other research teams (Brent et al., 2009). Of course, the nonrandomized design precludes definitive conclusions regarding the efficacy of CBT-SP in treating adolescents who recently attempted suicide. However, the TASA research team has made a notable contribution to the literature by manualizing an acceptable approach to treatment for a historically difficult-to-treat population and by demonstrating that retention rates and reductions in suicidal events are comparable, if not favorable, relative to other RCTs that have evaluated treatments for severely depressed, suicidal, and/or self-harming adolescents.

Esposito-Smythers, Spirito, Kahler, Hunt, and Monti (2011) recently conducted an RCT comparing an integrated outpatient CBT intervention (I-CBT) and enhanced usual care for adolescents who recently attempted suicide and who were diagnosed with a co-occurring substance use disorder. Results of this trial indicated that groups did not differ with regard to reductions in suicidal ideation. However, relative to enhanced usual care, I-CBT was associated with significantly less global impairment and fewer suicide attempts, inpatient psychiatric hospitalizations, visits to emergency departments, and arrests. In addition, relative to those who received enhanced usual care, those who received I-CBT reported significantly fewer days in which they engaged in heavy drinking or marijuana use. Overall, I-CBT appears to be an efficacious treatment for targeting both suicidal behavior and substance-use problems in dual-diagnosed adolescents.

Cognitive Therapy for Suicidal Older Adults

Compared to other age groups, older adults are disproportionately likely to die by suicide (NIMH, 2007). Men account for approximately 85% of suicides in older adults (CDC, 2008), suggesting the need for empirically supported treatments targeting suicidal older men. Brown and his colleagues at the University of Pennsylvania (personal communication, February 21, 2012) are in the process of completing a preliminary study to assess the feasibility and accessibility of a cognitive therapy protocol adapted for this demographic. In addition, the same researchers are currently conducting a fully powered RCT examining the efficacy of this intervention with suicidal older men.

Brief Cognitive Behavioral Intervention in Acute Care Settings

The standard of care for suicidal patients seen at emergency departments is to assess for risk of suicide and refer accordingly to appropriate level of care. However, despite the best efforts of emergency department staff, a significant portion of suicidal patients do not engage in treatment following emergency evaluation for a suicidal crisis (e.g., O'Brien, Holton, Hurren, & Watt, 1987). In response to this observation, Stanley and Brown (2011) designed a single-session, stand-alone brief intervention for emergency and acute care settings, known as the safety planning intervention (SPI). That is, they have developed the safety planning procedure from the protocol described in this article into a brief intervention unto itself. The aim is for patients to have a completed safety plan when they leave the emergency department so that some measure has been taken to reduce future suicidal behavior even if they do not have a single follow-up visit with a mental health professional. The efficacy of SPI is currently being evaluated in a national Department of Veteran Affairs clinical demonstration project, as well as in an urban emergency department (Stanley & Brown, 2011).

Of course, patients determined to be at imminent risk for suicide by emergency staff are commonly admitted to inpatient units. However, there is a paucity of RCTs that have examined whether inpatient hospitalizations are actually effective in preventing future suicide attempts. In response to this concern, Ghahramanlou-Holloway, Cox, and Greene (2011) have adapted the cognitive therapy protocol described in this article into a targeted treatment for inpatients admitted due to a recent suicide attempt (i.e., postadmission cognitive therapy [PACT]). PACT consists of approximately six 60- to 90-minute individual sessions, preferably administered over the course of 3 consecutive days. This research team is in the process of pilot testing this treatment to assess the feasibility of its implementation in inpatient settings. Pending the results of this feasibility study, future RCTs will be conducted to determine the efficacy of this treatment.

Conclusion

The past decade has witnessed tremendous strides in the evidence-based treatment of suicidal patients, and the current decade promises to make significant advances in the adaptation of the evidence-based treatment to specific populations and settings. Cognitive therapy clearly reduces the frequency of repeat suicidal behavior in adult attempters relative to the care that these patients would typically receive. Mounting evidence suggests that it has great promise in reducing suicidal ideation and behavior in suicidal adolescents. The task for cognitive behavioral therapists in this organization is to disseminate this treatment so that suicidal individuals can get the targeted care that they need following a suicidal crisis.

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SIG Spotlight

Women's Issues in Behavior Therapy SIG

Lindsay S. Ham, ***University of Arkansas***

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Mission of the SIG: The Women's Issues in Behavior Therapy SIG is open to all ABCT members who are interested in women's issues. We are committed to increasing women's participation in all levels of conference activity and in ABCT governance, to increasing knowledge and awareness of women's health and mental health issues, and to providing opportunities for women of ABCT to network with each other.

In line with our mission, the Women's SIG continues to be open to, support, and be committed to increasing women's involvement in ABCT as well as to disseminating knowledge related to women's issues. We remain an active SIG that has been a home to many of the trailblazing women in ABCT as well as future leaders. Two exemplars are J. Gayle Beck, Ph.D., and Debra A. Hope, Ph.D., both of whom have been active in our SIG and have served as President of ABCT. In 2006, SIG Leader Giao Tran, Ph.D., organized a dinner to honor past female presidents of ABCT. Those in attendance included Linda Carter Sobell, Ph.D. (1993-1994), Antoinette M. Zeiss, Ph.D. (1996-1997), Marsha M. Linehan, Ph.D. (2000-2001), Jacqueline B. Persons, Ph.D. (2002-2003), Patricia A. Resick, Ph.D. (2003-2004), J. Gayle Beck, Ph.D. (2004-2005), and Anne Marie Albano, Ph.D. (2006-2007). Historically, we have also held less formal activities such as SIG dinners, cocktail hours, and breakfasts to provide opportunities for SIG members to network with one another. Below we describe activities, awards, and ways to become involved in the Women's SIG this year. For more details regarding the SIG, these activities, and submission instructions, please see the Women's SIG website, https://sites.google.com/site/abctwsig/.

ABCT SIG Poster Exposition (Due September 5, 2012)

Each year our group takes part in the SIG Poster Exposition, an opportunity for the Women's SIG to encourage students and new members to get involved with ABCT and women's issues.

SIG Student Poster Exposition Best Student Poster Award

Graduate or undergraduate student female members whose posters are accepted for presentation at the SIG poster exposition may be considered for this award. The winner selected by the Poster Committee is awarded a certificate and a $100 prize, in addition to being recognized at the annual Women's SIG meeting. In 2011, Katelyn Anderson of the University of Maryland was awarded the Best Student Poster Award for her poster entitled "Gender Specific Relationship Between Distress Tolerance and HPA Axis Response to Stress Among Adolescents."

New Investigator Award and Student Researcher Award (Due November 1, 2012)

These awards are given based on a sole or first author paper or conference talk that was published, accepted, or presented in the previous year. Priority is given to submissions that focus on research relevant to women's issues. Junior professional women who are no more than 5 years post-Ph.D. or other terminal degree may be considered for the New Investigator Award. Each of the winners selected by the Awards Committee is given a certificate of achievement and a monetary prize of $100, and is recognized at the SIG meeting. This year's winner of the New Investigator Award is Dr. Danielle MacDonald of Ryerson University for her paper entitled "Impossible Bodies, Invisible Battles: Feminist Perspectives on the Psychological Research on Treatment of Eating Disorders in Queer Women" (doi:10.1080/10538720.2011.611100). The winner of the Student Researcher Award was Jennifer Milliken of the University of Wisconsin, Milwaukee, for her poster "Assessment of Emotional Response to Risk of Sexual Assault."

SIG Leadership and Committees

Another way to get involved in the Women's SIG is to join one of our committees or pursue a leadership position. We encourage SIG members, including students, post-docs, early career, mid-career, and late-career to become involved. Students in particular can get involved in governance by becoming a student representative as well as in joining student-eligible committees. Of the 14 members of the Women's SIG current leadership and support team, 7 are students.

In addition to supporting research on women's issues, the Women's SIG is com-

Table 1. **Women's Participation in AABT/ABCT in 1998 and 2008**

Type of Event	Percentage of Female Participation in 1998†	Percentage of Female Participation in 2008††	Direction of Change
Workshop (leader)	45.2	36.4	–8.8
Institute (leader)	41.7	37.5	–4.2
Symposium Chair	45.5	51.6	+6.1
Symposium Discussant	22.1	30.6	+8.5
Symposium Paper First Author	45.5	54.4	+8.9
Clinical Roundtable Moderator	20	37.5	+17.5
Clinical Roundtable Panelist	33.3	46.3	+13
Master Clinician Seminar (leader)	22.2	28.6	+6.4
Poster Session First Author	59.8	70.4	+10.6
Panel Discussion Moderator	60	63.2	+3.2
Panel Discussion Participant	49.2	40	–9.2
Program Committee Member	34.9	60.9	+26

†Data compiled by RaeAnn Anderson, M.S. ††Data compiled by Sandra Sigmon, Ph.D.

mitted to advancing the careers of women in psychological science. Data gathered from the 1998 AABT and 2008 ABCT conference programs illustrate the areas where there is still room for improvement. Table 1 shows the percentage of women involved in various conference activities, spanning from poster presenters to program committees and workshop leaders, at each time point. In addition, the change in the proportion of women involved in each role across the 10-year period is presented. Women are particularly underrepresented in some of the most valued or prestigious activities that require years of professional experience, such as master clinician seminars and institute leaders. However, as of 2008, women are particularly well represented in first authorship of posters, symposium participants, and in Program Committee involvement. Women's participation continues to grow in these areas, although women's participation is not increasing in positions that require the most years of experience and/or prestige. A goal of our SIG is to advance the careers of those both groups of women, current experts, and new professionals.

We hope you will join us for our annual SIG meeting at ABCT in November, and begin or continue your involvement in the Women's SIG. To join or to renew your annual membership (Full member: $16; Student member: $8), you may use PayPal online or send payment to the Treasurer, Dr. Jillian Shipherd (https://sites.google.com/site/abctwsig/home/membership for information about both options).

Women's Issues in Behavior Therapy Special Interest Group:

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Professional Issues

Ethical Issues in Disaster Response: Doing No Harm, Doing Some Good

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Advances in communication provide greater and more rapid knowledge of disasters around the globe than ever before available. Regardless of where they occur—whether New York City in 2001 or Haiti in 2010—the usual response is a great mobilization of human and other resources to the affected area. However, given that societies and individuals affected by disasters are in a position of acute and often extreme vulnerability, and responses to disasters may have many different motivations and take different forms, it is important that disaster responses should be conducted ethically as well as efficiently. In what follows, we examine the question of what makes the conduct of disaster response ethical.

Although people may be genuinely motivated to help in disasters—including trained disaster relief workers and mental health professionals, and untrained citizens with a desire to relieve the suffering of others—without proper preparation, including ethics, there is a risk that their response may be guided by seemingly less-than-ethical considerations, such as the type of disaster. For example, disaster helpers appear to be more willing to help in a natural disaster than a complex one (i.e., a disaster of human design, such as terrorism and genocide). From their survey of more than 6,000 health care workers in New York City, Iserson and his colleagues (2008) found that the willingness to work ranged from a high of 84% during a mass casualty incident to a low of 48% during a SARS outbreak. In addition, they found that 83% of physicians and nurses said they would help after a natural disaster, 67% after an explosion, 59% after a chemical incident, 56% after a biological incident or contagious epidemic, and 52% after a radiological event.[1]

As reported by Iserson et al. (2008), reasons to help include (a) adherence to a professional codes of ethics, (b) personal religious values that reinforced the professional ethical codes, and (c) thinking that choosing not to work would impose an unfair burden on coworkers. Reasons to limit or avoid help included the high risk to self and, concomitant with that, the risk to the helper's family should anything happen to the helper. The variability in responses leads to the question, *What does it mean to be ethical?*

Ethics and Ethical Behavior

"Ethical," as a general concept, refers to value judgments concerning right and wrong, or good and bad, in human conduct (Zalta, 2008). Behavior is ethical to the extent it reflects accepted principles or a moral code guiding the practice of a particular profession—which is not to imply that this is always a self-conscious or intellectual process, but is often the result of good habits that are barely noticed and hardly scrutinized.

Ethical standards may be viewed two ways. First, they may be viewed as relative, as adjusting with changes in a community's standards; hence, ethical decisions are neither categorically "right" nor "wrong," but exist on a continuum from clearly ethical to clearly unethical. From this perspective, ethical standards are a product of the culture, which means they may change over time, and be interpreted differently by different members of the culture. Of course, this position is problematic; for example, ethnic cleansing may be deemed acceptable simply because a culture accepts it as normative (Etkin & David, 2007).

[1] Differential willingness to help also can be found among disaster donors. News media, governments, UN agencies, NGOs, and the private and public sectors respond more generously to natural disasters than to complex ones, such as war and internal conflicts, because natural disasters can occur suddenly anywhere in the world, so everyone is vulnerable, and because with a natural disaster cause and blame cannot be attributed to people, although the outcomes may be (Spiegel, 2005, p. 1917). Christie, Asrat, Jiwani, Maddix, and Montaner (2007) observed that international funding in response to a natural disaster (the 2004 tsunami) far exceeded that for a complex disaster (the HIV/AIDS epidemic in developing countries), despite the latter being responsible for 14 times more deaths during the same year.

Second, ethical standards may be viewed as universal or objective principles that supersede cultural and individual differences. For example, Dunfee and Strudler (2000) suggested two principles—to respect the dignity of all human beings and to respect human autonomy—and the Code of Conduct for the International Red Cross and Red Crescent Movement (International Committee of the Red Cross, 1994) offers a third: human suffering must be alleviated whenever it is found. However, arguing for universal or objective principles is as controversial as ethical relativism: it is unlikely that there are trans-cultural ways of understanding concepts such as dignity, and a claim to a "universal" or "objective" principle may merely be the application of unexamined ethnocentrism.

Ultimately, disaster helpers pick and choose from among a variety of possibilities of what principles will guide their own actions and will serve as the criteria for judging their own behavior. From their survey of physician and nurse disaster helpers, Iserson et al. (2008) concluded:

> The decision to stay or leave will ultimately depend on individuals' risk assessment and their value systems. Professional ethical statements about expected conduct establish important professional expectations and norms, but each individual will interpret and apply them according to his or her own situation and values. (p. 351)

Schemas for Guiding Ethical Decision Making

Useful resources exist for guiding ethical decision making, for addressing the question: How can we minimize harm while doing some good? To help answer this question, we focus on three very different, albeit not necessarily conflicting, perspectives. First, we examine practical, situational concerns that may influence a disaster helper's ethical decision making. Second, we consider the potential role of the code of ethics of a disaster helper's professional organization in her or his ethical decision making. And third, we evaluate how three different value systems interact and balance to create ethical principles and, from them, ethical behavior.

Situational Concerns

This first schema, a practical one, underscores four considerations of the disaster situation that impact the judgment regarding whether something a disaster helper does is ethical or not. The first is the *means or methods* used to enact the practice or behavior, such as whether the disaster helper uses Psychological First Aid or some other crisis intervention. This consideration includes attention to whether what is done is evidence based or not, that is, the extent to which the helper can justify what she or he does as the "right" intervention.

The second consideration concerns the *ends or goals* of the behavior, what the helper hopes to accomplish with what he or she is doing. Is the goal to help the survivor feel safe and secure, to ventilate and validate his or her experience, and predict and prepare for the future—three goals of crisis intervention (Young, 1998)? This would mean that appropriate behavior may include helping a family leave its damaged home or obtaining medical assistance, helping them feel safe and secure, encouraging them to talk about their important concerns and validating what they say, aiding them in setting small, achievable daily goals and exploring options for rehabilitation, and helping them predict and prepare for the postdisaster period (Rosenfeld, Caye, Lahad, & Gurwitch, 2010).

The third consideration focuses on the *motives or intentions* of the disaster helper enacting the behavior, his or her personal reasons for doing what he or she is doing. Personal motivation may include tangible rewards, such as receiving pay, or intangible rewards, such as the pleasure derived from helping others. Motives differ from goals; for example, while deriving pleasure from helping others may be the motivator, this could be expressed in pursuing different goals, such as "to reunite the survivor with her family" or "to focus the survivor on achieving daily tasks, such as eating and drinking."

The fourth consideration, the *consequences or effects* of the behavior in question, has three subcomponents. The first is the consequences for the disaster survivors, which includes assessing the goals of nonmaleficence and beneficence—"balancing the risks of doing nothing and doing harm" (Reitman, 2006, p. 115)—and balancing "survivors' abilities, resources and strengths and the need for support and assistance" (United Nations, 1997, p. 85).

The second subcomponent is the consequences for the disaster helper. For example, Levy (2008), reflecting on his work as a Red Cross disaster helper for victims of Hurricane Katrina, noted how he became reacquainted with the power of reflective listening, learned about the greatly expanded role therapy plays in a disaster situation compared to usual circumstances, and recognized how he took for granted community services, such as garbage collection, phone service, and the school system.

Table 1. **Website Addresses of Professional Organizations' Codes of Ethics**
American Academy of Psychiatry and Law: Ethical Guidelines (2005) http://www.aapl.org/pdf/ETHICSGDLNS.pdf
American Medical Association: Principles of Medical Ethics (2001) http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml
American Nurses Association (2001) http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses
American Psychiatric Association: Psychiatry Ethics (2001) http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards.aspx
American Psychological Association: Ethical Principles of Psychologists (2010) http://www.apa.org/ethics/code/index.aspx
Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief (1994) http://www.ifrc.org/Docs/pubs/disasters/code-conduct/code-english.pdf
Ethical and Religious Directives for Catholic Health Care Services (2001) http://www.usccb.org/bishops/directives.shtml
Ethical Standards for School Counselors (2004) http://www.schoolcounselor.org/files/ethical%20standards.pdf
National Association of Social Workers: Code of Ethics (2008) http://www.socialworkers.org/pubs/code/code.asp

The third subcomponent considers the consequences for the larger social community. For example, the United Nation's (1997) publication, *Disaster Management Training Programme, Trainer's Guide*, highlights the positive effects disaster relief work may have on how the "international community conceives of its rights and obligations to protect affected people" (p. 37). On the other hand, inappropriate assistance may undermine local initiatives and delay "recovery of the normal economic systems within the community" (p. 104), or fail to plan for sustaining positive interventions (Rennie & Behets, 2006).

Professional Organizations' Codes of Ethics

The second schema useful for guiding a disaster helper's ethical decision making focuses on professional organizations' codes of ethics, written to steer the behavior of members of the organization. A professional organization develops a code of ethics to allow it to create a coherent set of policies and procedures, present an agreed upon and ethical base for action, and help guide the various elements in disaster planning and implementation. Unfortunately, as Grimaldi (2007) points out, "the code of ethics for most healthcare professions is somewhat ambiguous" (p. 163). Table 1 presents the website addresses of a variety of professional organizations' codes of ethics.

American Psychological Association. The American Psychological Association offers 10 ethical standards, 3 of which may be used directly to guide the behavior of disaster helpers (American Psychological Association Ethical Principles of Psychologists, 2010). For example, Standard 2: Competence, indicates that "psychologists provide services . . . with populations and in areas only within the boundaries of their competence," and

> "in emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied [i.e., denying services is worse than providing what might well be inadequate services]. The services are discontinued as soon as the emergency has ended or appropriate services are available."

Standard 3: Human Relations, indicates that "psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law," and "take reasonable steps to avoid harming their clients/patients . . . and to minimize harm where it is foreseeable and unavoidable." Finally, Standard 4: Privacy and Confidentiality, states that "psychologists have a primary obligation and take reasonable precautions to protect confidential information." The remaining ethical standards address issues associated with advertising, record keeping, education, research, assessment, and therapy (which focuses primarily on avoiding unethical relationships with clients).

International Federation of Red Cross and Red Crescent Societies. The International Federation of Red Cross and Red Crescent Societies provides the most specific list of disaster-related ethical standards (Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations [NGOs] in Disaster Relief, 1994), which is not surprising given its exclusive focus. The standards relate to ethical behaviors both for disaster helpers interacting with individual survivors/clients, and for interacting with communities:

> *Code of Conduct No. 1*. The Humanitarian imperative comes first.
>
> The right to receive humanitarian assistance, and to offer it, is a fundamental humanitarian principle which should be enjoyed by all citizens of all countries . . . .
>
> *Code of Conduct No. 2. Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone*.
>
> Wherever possible, we will base the provision of relief aid upon a thorough assessment of the needs of the disaster victims and the local capacities already in place to meet those needs. . . . Human suffering must be alleviated whenever it is found; life is as precious in one part of a country as another. Thus, our provision of aid will reflect the degree of suffering it seeks to alleviate.

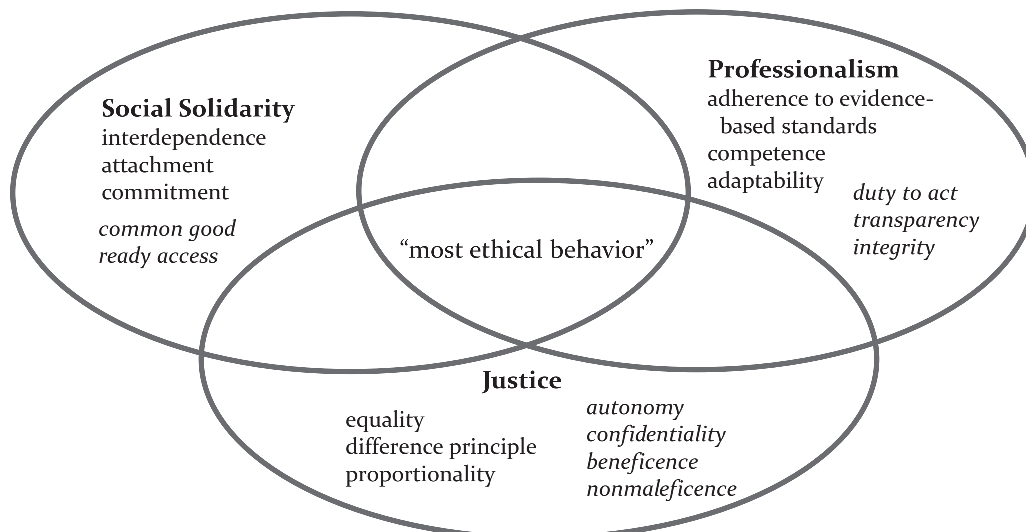

Fig. 1. Model of the relationship of three values to ethical behavior. Adapted from Tuohey (2007).

Code of Conduct No. 6. We shall attempt to build disaster response on local capacities.

All people and communities—even in disaster—possess capacities as well as vulnerabilities. Where possible, we will strengthen these capacities by employing local staff, purchasing local materials and trading with local companies. Where possible, we will work through local NGHAs as partners in planning and implementation, and cooperate with local government structures where appropriate.

The remaining parts of the code are: Code 3, "Aid will not be used to further a particular political or religious standpoint"; Code 4, "We shall endeavour not to act as instruments of government foreign policy"; Code 5, "We shall respect culture and custom"; Code 7, "Ways shall be found to involve programme beneficiaries in the management of relief aid"; Code 8, "Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs"; Code 9, "We hold ourselves accountable to both those we seek to assist and those from whom we accept resources"; and Code 10, "In our information, publicity and advertising activities, we shall recognise disaster victims as dignified humans, not hopeless objects."

The two codes of ethics detailed here, from the American Psychological Association (APA) and the International Federation of Red Cross and Red Crescent Societies (IFRCRCS), as well as others from organizations listed in Table 1, have many similarities (see Grimaldi, 2007, for an analysis of the codes of ethics from the American Medical Association and the American Nurses Association). For example, all of them insist that disaster helpers only provide services within their range of competency (although the APA allows for exceptions), and that conversations with disaster survivors be kept confidential. All state that mental health practitioners have the ethical obligation to *first do no harm*.

Although the codes have similarities, each differs, reflecting the particular interests of the organization. For example, the APA code offers much more guidance in areas given little attention by other codes, such as ethical conduct associated with record keeping, advertising, and carrying out research. The IFRCRCS code is most different from the others, relating each standard of ethical conduct specifically to the disaster situation, something handled briefly, if at all, by other codes. Regardless of problems with operationalizing principles and directives, a disaster helper's professional organizational association provides her or him with guidelines—albeit often vague—for how to avoid harm while doing some good, for behaving ethically when serving as a helper.

Value Systems, Ethical Principles, and Ethical Virtues[2]

A third schema useful for guiding a disaster helper's ethical decision making in a disaster context takes a different approach than the other two, acknowledging that the various elements that make up ethical behavior are in a dynamic balance, a balance that is constantly shifting, depending on the changing circumstances a disaster helper may encounter. The three values, as described by Tuohey (2007), are *social solidarity, professionalism*, and *justice*. Figure 1, adapted from Tuohey, depicts the three values, some of the characteristics of each, and their overlapping structure.

Social solidarity, according to Tuohey (2007, p. 23), is a "value that refers to the bonds that unify a community, as well as to the structures, such as schools and organizations, that support and maintain those bonds." Three characteristics of social solidarity (listed in Figure 1) are *interdependence*, both with and among others; *attachment*, having to do with interest in others and their concerns; and *commitment*, including support for the social structures that make social life possible. Two ethical principles derived from these characteristics are *common good*, the conditions such as health care, housing, and food, that each person and groups of persons need to live a full and productive life, and *ready access* to public services, so as to be able to receive health care and basic necessities such as food and shelter, with relative ease, or at least without bureaucratic obstacles.

A disaster helper for whom social solidarity is a highly important value will fervently believe that it is important for members of a community to be interdependent, that they should have an interest in each other and each other's concerns, and that it is important to work hard to support people's ready access to public services, so as to be able to receive health care and basic necessities such as food and shelter, with relative ease.

Professionalism "refers to the importance of maintaining the competence, performance measures, and social contribution of groups, organizations, and professions upon which society depends" (Tuohey, 2007, p. 24). Included in this category are disaster helpers, as well as others who need to maintain a high level of professionalism to ensure mitigation of a disaster's impact, such as a community's police, firefighters, carpenters, electricians, and sanitation engineers. "The value of professionalism, which means more than 'being a professional,' refers to the importance of maintaining the competence, performance measures, and social contribution of groups, organizations, and professions upon which society depends" (p. 24).

Three characteristics of professionalism (listed in Figure 1) are *adherence to evidence-based standards*, which means that a disaster helper's actions are supported by evidence for their usefulness and are accepted by the professional community; *competence*, including both knowledge and skills (Everly, Hamilton, Tyiska, & Ellers, 2008, argue that specialized training in disaster mental health services is *requisite* to working as a disaster helper); and *adaptability*, the ability to adjust competencies, standards, and practices to the particular disaster circumstances. Three ethical principles derived from these characteristics are the *duty to act*, the obligation to perform one's professional duties without inducement; *transparency*, being open regarding one's actions; and *integrity*, the need to act with honesty, reliability, and fairness, and being willing to be held accountable to explain one's actions.

A disaster helper for whom professionalism is a highly important value will strive to adhere to evidence- or experience-based standards that are verifiable or accepted by her or his professional community, will work hard to ensure that she or he has both the knowledge and skill necessary to behave competently, and will consider it important to be adaptive, adjusting competencies, standards, and practice to the challenges of the particular disaster.

Finally, the value of *justice* relates to the "fundamental commitment that individuals have toward one another" (Tuohey, 2007, p. 24) to behave in ways that make social life possible. This commitment makes social solidarity possible, and energizes professional decision making. Unless members of a community behave in ways that ensure that "right relationships" exist between and among individuals and groups, the quality of social life is greatly reduced. In Figure 1, three characteristics of justice are depicted:

[2] The term "ethical virtues," rather than the more common "ethical behavior," is being used here partly because virtues encompass both outward behavior and intention, and also because they link what we say here with an ethical theory (or field of theories) called virtue ethics (Crisp, 2010; Zachar, 2006).

equality, the avoidance of bias; the *difference principle*, which guides helpers to show some preference to the most vulnerable members of society; and *proportionality*, which makes salient consideration of the tensions that can arise between the liberty of the individual, the needs of society, and the standards of a profession. Four ethical principles are linked to these three characteristics: *autonomy*, respect for the individual and her or his claims and aspirations; *confidentiality*, the protection of an individual's privacy; *beneficence*, the obligation to provide for the good of others; and *nonmaleficence*, the obligation not to harm self or others.

A disaster helper for whom justice is a highly important value will strive to treat people equally, without bias, while simultaneously giving preferential treatment to society's most vulnerable members. In addition, this disaster helper will endeavor to ensure confidentiality and to protect each individual's privacy.

Problems within the three values. While all the characteristics drawn from the three values and their associated principles may be judged as important, each has its own special problems. For example, the first characteristic of professionalism, adherence to evidence-based standards, is often a sticking point because it raises a question disaster helpers are usually reluctant to pose: What evidence is there that what I do has benefit—and if there is an absence of evidence that what I do is beneficial, should I use it? Lohr, Devilly, Lilienfeld, and Olatunji (2006) argued that to use anything but well-supported therapies is inherently unethical (although defining "well-supported" is notoriously difficult). From their review of the evidence available for a wide range of interventions, they concluded that "there appears to be substantial evidence to consider CBT as an efficacious treatment for trauma-related disorders" (p. 31); in addition, evidence is ambiguous or not compelling for many interventions, such as Traumatic Incident Reduction, and evidence of harm is available for some, such as Critical Incident Stress Debriefing. Are disaster helpers, therefore, limited to Psychological First Aid for crisis intervention, and to CBT for post-crisis intervention, because other therapeutic approaches have little evidence for their efficacy?

Although "evidence-based standards" often is defined in terms of the evidence available for a particular intervention, alternative perspectives exist. In an attempt to move away from reviewing particular interventions and, instead, uncovering what characteristics useful interventions share, Hobfoll and his colleagues (2007), who formed a worldwide panel of experts on the study and treatment of disaster survivors, came to agreement on intervention principles, not specific intervention approaches. They argued that interventions are useful to the extent that they promote five outcomes: (a) a sense of safety (people who can maintain a relative sense of safety fare better; for example, they have a lower risk of developing PTSD, and this is true even when threat continues); (b) calming (extremely high levels of emotionality, especially if prolonged, can lead to a variety of problems, such as panic attacks, that foreshadow even greater problems in the months to follow, such as depression); (c) a sense of self-efficacy and community efficacy (it is important for people to feel that their actions and beliefs, and being a member of a competent community, will lead to positive outcomes; otherwise, an attitude of "can't do" stymies effective responses); (d) a sense of connectedness (social support and attachment to loved ones and social groups combats stress and trauma by providing a variety of means of coping, such as help with problem solving, emotional understanding and acceptance, and normalization of feelings); and (e) a sense of hope (people who remain optimistic are more likely to have favorable outcomes after a disaster—hope counters the feeling that the world is shattered and broken, a feeling that leads to despair). These five principles of effective interventions, the authors argued, "apply to all levels of intervention, from those focusing on the individual to those that are broadly community based" (p. 300). Of course, Hobfoll and his colleagues may merely be sidestepping the issue of determining if an intervention is useful by changing the question from, "Is X intervention efficacious?" to "Does X intervention promote the five outcomes?" To claim that interventions are useful to the extent that they promote these five outcomes, one may ask the same old question: How do you know they promote those outcomes (i.e., where is your evidence)?

Problems balancing the three values. Besides the problems and tensions *within* each of the three values, such as the example of selecting the best intervention to use, there are tensions *among* the three values. Given the disaster situation—for example, widespread destruction of property, sudden occurrence, large numbers of people affected, suffering that cannot be alleviated without assistance (see Rosenfeld et al., 2010, for a discussion of the defining elements of a disaster)—a disaster helper is compelled to make choices, and those choices have an ethical dimension. For example, what happens when a disaster helper is confronted with a situation in which a community shows signs of being corrosive (i.e., people are split into factions that work against each other—see Erikson, 1994), has damages that require a wide variety of helper skills, and which has diverse populations hit equally by the disaster? A disaster helper (a) who holds social solidarity as highly important and believes it essential for members of a community to be interdependent, and (b) who holds professionalism also as important and wants to ensure that she or he has all the skills necessary to behave competently, and (c) who holds justice as highly important and wants to treat people equally and without bias while also giving preferential treatment to the community's most vulnerable members, will need to decide what to do first, and this decision will reflect the helper's attempt to balance the three values—at this moment, in this instance. How the values are balanced will reflect the helper's "ethical hierarchy," her or his ordering of the "good choices" in this situation.

In the end, the "most ethical behavior" balances the three values: social solidarity, professionalism, and justice. The balance is dynamic, that is, the three values often are in tension with one another—a tension that is to be expected—and the balance depends on the characteristics of the disaster, the helper, the code of ethics of her or his professional organization, and the social and cultural context within which the helper works.

Figure 1 makes the relationship among the three values clearer. Note that the center of the figure has the words "most ethical behavior" in quote marks, a change from Tuohey's (2007) model. What is important to realize is that different people may agree in broad terms about what constitutes ethical behavior, but when it comes to looking at a specific example they may disagree; also, the balance among the three values may be different for different people (e.g., some may think that the value of social solidarity is more important than professionalism when assessing the ethical dimension of behavior).

Situational Concerns, Professional Codes of Ethics, and the Values of Social Solidarity, Professionalism, and Justice: What Constitutes (Un)ethical Behavior?

When assessing whether a disaster helper is behaving ethically, few would argue against the importance of taking into account the situational constraints of a dis-

aster situation, the ethical code of her or his professional organization, and the characteristics and principles of the values of social solidarity, professionalism, and justice. An individual disaster helper's ethical behavior, however, like other kinds of behavior, is some combination of being reflective and impulsive: whatever the behavior, it reflects who the person is—training, experience, understanding of the disaster situation, ethical concerns and considerations—what the situation demands—the extent of damage, the immediacy of medical and technological needs, the predictable dangers in the developing situation, the availability of resources—and the likely outcomes given different courses of action. Judgment will need to find some common ground between the loose standards of ethical relativism and the strict bases of ethical universality.

As people adapt to different situations they make judgments about which of their ethical principles—whether considering practical situational concerns, their professional organization's code of ethics, or the weighting of values associated with social solidarity, professionalism, and justice—are more important than others *in this instance*. In the end, what anyone does is the result of a balancing act, of pitting one "good reason" against another "good reason." Therefore, in the final analysis, people (almost) always behave ethically—at least from their own perspective—all an observer needs to know is which ethical principles are guiding them. "Ethical lapses," Marcia Angell, Editor-in-Chief of the *New England Journal of Medicine* from 1988–2000, reminds us, "are almost never cases of bad people, doing bad things, for no good reason. More often they are good people, doing bad things, for good reasons" (quoted in Sodeke, 2005).

For each disaster helper, the "final test" of one's ethics is not memorization of the code of ethics of one's professional organization, or whether the individual understands how the characteristics of various values lead to particular ethical principles, which in turn require specific behaviors. Rather, the final test is how the helper balances the variety of ethical principles and concerns that are of importance to her or him in response to what is confronted in the field. Each helper should consider the following questions as she or he comes to understand what constitutes ethical behavior:

- Which principles are most important to the helper?
- Under what circumstances does the helper's hierarchy of ethical principles change? How does the helper balance the myriad of ethical principles and concerns?
- Has the helper ever behaved in a way that, upon reflection, struck her or him as unethical? What motivated the helper's behavior in the first place? What will the helper do next time?

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Lighter Side

Our Fifteen Minutes of Fame

Elizabeth Moore, ***Institute of Living***

As we were all taught in high school, occupations are most broadly divided into two main categories: those that work well as a reality television show, and those that do not. Those that do include jobs such as cake decorator, antique appraiser, housewife in an exciting city, and living in New Jersey (yes, this counts as a job). Those that do not include being an accountant, brick layer, and living in any state but New Jersey. I had always assumed that being a psychologist fell into the latter category. What drama-seeking American would want to watch the logical redirection of maladaptive thoughts? Or a series of 1-minute hyperventilation interoceptives? Our job is to reduce the role of excessive emotion and redirect to logical objective evaluation. And this flies in the face of everything reality television thrives on. But we could only be safe for so long. Over the past few years, television has discovered and embraced disorders such as hoarding and obsessive-compulsive disorder, dragging psychologists into the spotlight.

For those of you who may someday find yourselves on television and who, like me, were absent the day this was covered in graduate school, I will share some invaluable tips.

1. Do not expect anyone to help with your hair, makeup, or wardrobe. Sadly, being on reality TV means looking like a real psychologist.

2. Turn off your microphone when you are using the bathroom (unless you would like to have an intimate relationship with the sound guys).

3. If, during a decluttering shoot, you are chased by bees, raccoons, or scorpions, don't be a hero. Being judged as a wimp by the viewing audience is better than a trip to the ER.

4. Do not expect television people to make you look prettier using special effects. I've asked and they won't.

5. Be prepared to be mentioned on websites and blogs. Some of the comments will be appropriate and kind and some will be nice but creepy. One woman blogged about wanting to put on an adult diaper, buy some chloroform and duct tape, and drive to Hartford to pay a visit to one of my colleagues. And, of course, some will be less than nice, like the user who expressed a desire to "slap the 'smart glasses' off [my] face."

6. Don't be surprised when you hear from your fifth-grade boyfriend, barely remembered junior high classmates, and the aunt who apparently only faked her own death. Holidays with family will involve nonstop talk of your television appearances. "Right, right, you just had triplets and bought a house, but tell me all about the fight you had with that professional organizer . . ."

7. On a related note, be aware that you will become pigeonholed as an expert in whatever people saw you doing on TV. And that this could affect your practice and "real" life. So if you are averse to treating any particular population, it may not be wise to embrace an opportunity for national recognition related to that population. For example, avoid participating in shoots focused on decluttering if you're the type who's fantasized about starting a philanthropic organization called "Doctors Without Hoarders."

8. Brace yourself for the post-airing e-mails. About two-thirds will be people asking for help for themselves, relatives, and friends. The other third will be from people commenting on your physical appearance and/or wanting to start some type of romantic involvement. I'm no expert on human behavior, but these kinds of people make fantastic relationship prospects. Oh, no wait—I am and they don't.

Above all, however, we must maintain our priorities as professionals and keep the people we help our number-one priority. One of my patients saw me on TV and mentioned to her teenage daughter that I was her psychologist. Her daughter asked, "Does that mean she's extra good or extra bad?" This is a fair and insightful question. The interests of television and the interests of a responsible mental health provider often seem incompatible. Our professional integrity and ethical standards should not change with context. We owe it to our patients, our profession, and ourselves to always remain on the "extra good" side.

. . .

Correspondence to Elizabeth Moore, Ph.D., Institute of Living, 200 Retreat Ave., Hartford, CT 06106; elmoore@harthosp.org

Post an event on ABCT's

CE Calendar

http://www.abct.org

Professionals, Educations, Students

CE Calendar

Full Members

Janet Gruber Arnold
Anthony D. Bandele
Joseph Christopher Bedosky
Michelle Belmont
Dessa Bergen-Cico
Elson M. Bihm
Andrea Bradford
Peter Britton
Kamila Maria Cass
Marge Coffey
Kenneth Conner
Joseph P. DeCola
Sherry Kaye Desselle
Betty L. Everett
Donald Fleck
Lisa M. Fucito
Les Adam Gellis
Kelly Lynn Gilrain
Kristin Guarino
Meredith Gunlicks-Stoessel
Laura Hernandez-Guzman
Amy Hoch
Sharon Kirkpatrick
Emily Klass
Ruth Marion Knapp
Michele M. Koschin
Larry J. Lantinga
Dianne Lavin
Jonathan Lerner
Melissa Chase Levesque
Erica MacGregor
Walter J. Matweychuk
Robert W. McLellarn
Katherine Ann Mehler
Karla Klein Murdock
L. Laura Ochoa
Luz Esther Rivera
Katherine Ryan
Kristen Scarlett
Michael Scherer
Lenette Gimple Snyder
Virginia Ellen St. John
Sara Schloss Stave
Margaret Harper Swartz
Lance P. Swenson
Gary Talbott
Angela Tzelepis
Amanda Uliaszek
Polina L. Umylny

New Professionals

Shandra M. Brown Levey
Sarah Buchanan
Eric R. Clausell
Desiree Gallagher
Renay Gartner
Michael Roy

Postbaccalaureates

Erin M. Altenburger
Emily Bernstein
Laura Burnham Bragdon
Elle Brennan
Todd Brown
Taylor Adele Burke
Danielle Cornacchio
Natalie Deleon
Jessica Nina Galang
Pamlyn K. Hill
Natalie Marie Holbrook
Jeremy MacLaren Kelly
Michael S. Kljuchnikov
Morganne A. Kraines
Haeyeon Lee
Kelly M. MacKenzie
Carmen Martinez
Katherine McMorran
Sarah Elisabeth Perzow
Alejandra Piquer Martinez
Megan E. Renna
Lillian Reuman
Ilyana Romanovsky
Zachary Rosenberg
Leah Shesler
Tyler J. Smith
Hannah Snyder
Jessica Yumiko Suzuki
Sara Troupe
Anne Cathryn Wilson
Ivori Alexandria Zvorsky

Students

Yemisi Temitope Abiona
Caroline Francoise Acra
Anita Marie Alexander
Jennifer Allen
Angela Almeida
Jennifer Altman
Lisa Marie Anderson
Caroline Axelrod
Jennifer Lee Bakalar
Tom Barry
Michele Bechor
William Wesley Benson
John Best
Hayden Bottoms
Erin Lashley Brannan
Tiffany Marie Bruder
Erica Van Buckner
Samantha Busa
Derrecka Myschele Butler
Stephanie Caldas
Alison Carlis
Brad Carmichael
Amanda Carson-Wong
Charissa Chamorro
Amanda Rose Chassuel
Caitlin Conner
Amanda Cooney
Lauren Courtright
Dev Crasta
Sara Beth Danitz
Candrick C. DarkaShade
Laura Dewey
Minh-Chau Do
Alison Dockery Ervin
Sapna D. Doshi
Anita Elderkin
Alyssa L. Faro
Betsy E. Feinberg
Leah Feinberg
Jamie Fialkoff
Robyn L Fielder
Robin Hertzbach Fierstein
John Fleming
John Stephen Gaffney
Andrew Joseph Gentile
Benjamin Glueck
Dana Richardson Grip
Brittany Nicole Hall-Clark
Herschel Harden, III
Lauren E. Harrison
Tyler Anne Hassenfeldt
Sarah Elizabeth Hayes
Zohal Heidari
Angela V. Hill
Aspasia Paraskevi Hotzoglou
Mackenzie Leigh Hughes
Natalie E. Hundt
Cornelia Iucha
Stephanie M. Jarvi
Kathryn Jeter
Krishnapriya Josyula
Monica Karsai
Matthew Keough
Sangsun Kim
Ashley M. Kuhn
Margaret Lafontant
Aaron Jeffrey Landau
Kristen Leishman
Agnes Lenda
Ashley N. Linden
Brit Lizabeth Lippman
Nathaniel Joseph Lombardi
Lorenzo Lorenzo-Luaces Valencia
Viliyana E. Maleva
Larissa Aine Maley
Steve Mazza
James McAbee
Julie McCarthy
David Lee McCluskey, Jr.
Rebecca Carol McDermott
Daniel Millstein
Kirk Mochrie
Jillian Kathleen Murphy
Jennifer Nehme
Jacqueline Nesi
Kristin Newman
Shala Nicely
Patricia J. Osborne
Hanna Owens
Lisa Paliotta
Stephanie Grace Park
Brendt P. Parrish
Emily J. Paull
Michelle Pelcovitz
Elizabeth Persons Raffanello
Andra Raisa Petca
Rachel Alyssa Petts
Maribel Plasencia
Donetta Donetta
Quinones Quinones
Annie Rabinovitch
Jenni Rafacz
Lisset Ramirez
Michelle Elizabeth Roley
Bryn Elizabeth Schiele
Robyn Schneiderman
Samantha Rose Schulman
Katharine Seagly
Candice Nicole Selwyn
Sarah Setchell
Dan Sharir
Megan Simon
Kelsey Camden Smith
Linda Spiro
Anne Steel
Aliza Tova Stein
Minhdan Thuy Ta
Sean Tams
Terry V. Timmons
Heather Rose Trachta
Jamie Travis
Nevelyn N. Trumpeter
Tyler Tulloch
Tabitha Anne Van De Ven
Jamie Stewart Van Leuven
William Michael Vanderlind
Cixin Wang
Joanna Lynn Watson
Inga Drofn Wessman
Amy White
Denise Monet White
Michael Andrew Widroff
Lindsey Wiernik
Margaret Wilson
Julie Woosley
Jeffrey Alan Worthington
Monica S. Wu
Igor Yakovenko
Melissa Jean Zielinski

Call *for*

Continuing Education Sessions

47th Annual Convention | November 21–24, 2013
Nashville

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.

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.

Risa Weisberg, *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.

L. Kevin Chapman, *Master Clinician Seminar Committee Chair*
masterclinicianseminars@abct.org

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the continuing education session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at **www.abct.org**.

Submission deadline: February 1, 2013

Nominations for ABCT Officers: Get in on Choosing the Leaders

Raymond DiGiuseppe, ***Chair, Leadership and Elections Committee***

We are approaching the nominations period for ABCT's elected leadership positions. Profession al 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 2013-2014, then as President from 2014-2015, and then as Past President from 2015-2016.

Each representative serves as a liaison to one of the branches of the association. The representative position up for 2013 election will serve as the liaison to the Academic and Professional Issues Coordinator. The Coordinator works with a diverse and broad set of committees such as the Academic Training Committee, that oversees our Mentor Directory, our CBT Medical Education Directory, and coordinates our listing of syllabi. Other committees reporting to the Coordinator are Affiliations and Specializations, Awards and Recognition, International Associates, and Research Facilitation. 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 you 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 (2013–2014)

____

____

REPRESENTATIVE-AT-LARGE (2013–2016)

____

____

NAME (printed)

____

SIGNATURE (required)

____

2013 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, 2013, 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 Raymond DiGiuseppe, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.

19th Annual Awards & Recognition

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 2013 awards program. 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 Albert Ellis, Leonard Krasner, Steven C. Hayes, David H. Barlow, G. Alan Marlatt, Antonette M. Zeiss, and Alan E. Kazdin. Please complete the online nomination form 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.

Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Past recipients of this award include Alan E. Kazdin in 1998, David H. Barlow in 2001, Terence M. Keane in 2004, Thomas Borkovec in 2007, and Steven D. Hollon in 2010. Please complete the online nomination form at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Research" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Research, 305 Seventh Ave., New York, NY 10001.

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include the Clinical Psychology Program at SUNY Binghamton, The May Institute, the Program in Combined Clinical and School Psychology at Hofstra University, the Doctoral Program in Clinical Psychology at SUNY Albany, and Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology. Please complete the online nomination form at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Training Program" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

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.

[*continued on next page*]

{Student Dissertation Awards, continued}

Eligibility requirements for these awards are as follows: (1) Candidates must be student members of ABCT, (2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, (3) The dissertation must have been successfully proposed, and (4) The dissertation must not have been defended prior to November 2012. 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 online nomination form 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.

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 Jon Kabat-Zinn, Nora Volkow, John Allen, Anne Fletcher, Jack Gorman, Art Dykstra, Michael Davis, Paul Ekman, The Honorable Erik K. Shinseki, and Michael Gelder. Please complete the online nomination form at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.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.

NOMINATIONS FOR THE OUTSTANDING SERVICE AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

Outstanding Service to ABCT

Please complete the online nomination form 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.

President's New Researcher Award

ABCT's 2012–2013 President, Stefan G. Hofmann, Ph.D., invites submissions for the 35th 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 Stefan G. Hofmann, Ph.D., Robert Klepac, Ph.D., and Dean McKay, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 5, 2013, 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 5, 2013**.

Nominate online: www.abct.org

Deadline for nominations:
March 1, 2013

the Behavior Therapist
Association for Behavioral and Cognitive Therapies
305 Seventh Avenue, 16th floor
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212-647-1890 | www.abct.org
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http://www.abct.org/conv2012/