

# *the* Behavior Therapist

## Contents

### Professional Issues

*James D. Herbert, Elizabeth M. Goetter, Evan M. Forman, Erica K. Yuen, Breann M. Erford, Joseph J. Milillo, and Stephanie P. Goldstein*

Crossing the Line: Interstate Delivery of Remote Psychological Services • 145

### Clinical Forum

*Abigail A. Goldsmith, Kendall C. Wilkins, and Sonya B. Norman*

When Having One Disorder Is the Exception, Not the Norm: Psychological Comorbidity in Veterans • 153

### Public Health Issues

*Adam S. Weissman*

Feeling Powerless? 11 Tips to Help Parents and Kids Cope With Stress and Worry in the Aftermath of Natural Disasters: STOP AND COPE • 158

### At ABCT

Voluntary Contributors • 159

Call for Award Nominations • 160

Call for Continuing Education Sessions • 162

Nominations for ABCT Officers • 163

New Benefit for ABCT Members • *back page*

### Professional Issues

## Crossing the Line: Interstate Delivery of Remote Psychological Services

*James D. Herbert, Drexel University*

*Elizabeth M. Goetter, Drexel University, University of California, San Diego, and VA San Diego Healthcare System*

*Evan M. Forman, Drexel University*

*Erica K. Yuen, Drexel University, Medical University of South Carolina, Ralph H. Johnson Veterans Affairs Medical Center*

*Breann M. Erford, Joseph J. Milillo, and Stephanie P. Goldstein, Drexel University*

The past decade has witnessed a dramatic increase in interest in evidence-based practice in applied psychology and related fields. Given its historical grounding in science, it is not surprising that behavior therapy has emerged at the forefront of this movement. Despite the widespread need for efficacious and cost-effective treatments and the development and scientific validation of interventions for a range of conditions, many of those who could benefit from such services do not receive them (Kohn, Saxena, Levav, & Saraceno, 2004; Wang, Berglund, & Kessler, 2000).

There are a number of reasons for the gap between the development of scientifically sound, evidence-based practices, the availability of such services, and the ability of those in need to access

[continued on p. 147]

*tBT is now  
ON-LINE*

*2005–present*

 <http://www.abct.org>

[ABCT Members Only](#)

[the Behavior Therapist](#)



them. Among these barriers are problems associated with dissemination, cost, stigma, and, most important, geography. Dissemination efforts have been hampered by insufficient resources, especially considering what is required to train existing providers in new treatment modalities. Even when available, the cost of services is prohibitive for some individuals. In some communities there remains a stigma associated with psychotherapy. Linguistic minorities may not have access to trained providers who speak their language. Individuals with physical or mental disabilities may be unable to travel easily to a provider's office.

### Technology and the Problem of Geography

Many of these barriers reflect a fundamental reality of contemporary mental health services: There is a geographic maldistribution of trained providers with respect to many of those in need. In Kansas, to cite just one example, the vast majority of mental health providers live in two urban areas, and 100 of the state's 105 counties are designated as mental health professional shortage areas (Nelson & Velasquez, 2011).

Indeed, approximately three-quarters of the counties nationwide have a shortage of mental health professionals (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009), and these geographic barriers are even more acute for ethnic minority populations (McCord et al., 2011). The mismatch in location between providers and patients is even more pronounced when it comes to specialist providers, such as behavior therapists specializing in the treatment of a particular condition. For example, in a review of the ABCT therapist directory, we found that only 167 out of over 2,000 therapists (8%) reported a specialization in the treatment of social anxiety disorder, and among the 8% of therapists who did report such expertise, only 1% practiced in a nonmetropolitan area (Yuen, Herbert, Forman, Goetter, Comer, & Bradley, 2012).

A promising approach to addressing this gap is through technology. Over the past few years, a growing number of health-care providers have begun exploring the use of various communication technologies to deliver services remotely. Various terms have been used to describe this approach, including *telehealth* and *e-health*, and with respect to behavioral health services in particular,

*telemental health* or *telepsychology* (Baker & Bufka, 2011). Commonly used technologies include the telephone, cell phones and other mobile devices (e.g., tablets), websites (with or without adjunctive therapist assistance), Internet-based virtual-reality platforms (e.g., Second Life), and videoconferencing programs (e.g., Skype, Google Chat, iChat, FaceTime; Yuen, Goetter, Herbert, & Forman, 2012). Through these technologies, specialist providers can offer services to patients situated at geographically distant locations. In recognition of the role that remote treatments are destined to play in the U.S. health-care system, the landmark federal Patient Protection and Affordable Care Act of 2010 features a number of provisions to promote telehealth.

Many of the advantages of such remote services are obvious. Individuals, regardless of location, can gain access to specialist providers who would otherwise remain out of reach. For example, a housebound Spanish-speaking mother suffering from panic disorder with agoraphobia in rural Iowa can be connected with a Spanish-speaking anxiety disorder expert in Philadelphia via the videoconferencing pro-



## INSTITUTE *for* BEHAVIOR THERAPY

New York City

### *Celebrating Its 40th Anniversary*

**Steven T. Fishman, Ph.D., ABPP | Barry S. Lubetkin, Ph.D., ABPP**  
***Directors and Founders***

Since 1971, our professional staff has treated over 20,000 patients with compassionate, empirically-based CBT.

Our specialty programs include: OCD, Social Anxiety Disorder, Panic Disorder, Depression, Phobias, Personality Disorders, and ADHD-Linked Disorders, and Child/Adolescent/Parenting Problems.

Our externs, interns, post-doctoral fellows and staff are from many of the area's most prestigious universities specializing in CBT, including: Columbia, Fordham, Hofstra, Rutgers, Stony Brook, St. John's, and Yeshiva Universities.

Conveniently located in the heart of Manhattan just one block from Grand Central Station. Fees are affordable, and a range of fees are offered.

**We are pleased to announce the opening of our new SOCIAL ANXIETY TREATMENT CENTER this fall. The center will be offering both individual and group therapy for this disorder.**

***For referrals and/or information, please call: (212) 692-9288***

110 East 40th St., Suite 206, New York, NY 10016

e-mail: [info@ifbt.com](mailto:info@ifbt.com) | web: [www.ifbt.com](http://www.ifbt.com)

gram Skype. Remote treatments are convenient, as patients can access services from their home, while traveling, or on breaks at work. They reduce the burden of commuting, parking, and accrued transportation costs. Remote treatments may help address the issue of stigma for some individuals because of the added confidentiality afforded by not having to sit in a quasi-public waiting room at a therapist's office. They also prevent dual relationships that can occur in rural or small town settings in which providers and patients may know each other. Furthermore, remote treatments promote high-quality services and healthy competition among practitioners by providing consumers access to a range of services beyond one's immediate physical community.

There are also a number of corresponding issues that must be addressed with these new modalities of service delivery, including concerns regarding confidentiality, the therapeutic relationship, crisis management, technological problems, and therapist competence (Van Allen & Roberts, 2011). Confidentiality can be compromised by breaches in electronic security systems (Schwartz & Lonborg, 2011). Of course, it should be remembered that traditional face-to-face communications are not necessarily at lower risk of security breaches (e.g., unauthorized physical access to protected health information), and well-configured Internet-based services can actually provide additional levels of confidentiality in some respects. Another area of concern is whether the critical therapist-patient relationship will be degraded by remote treatment formats. Although anything other than traditional, in-person, face-to-face contact will undoubtedly be less desirable for some indi-

viduals, it should not be assumed that remote treatment (e.g., via videoconferencing) negatively affects the therapeutic relationship or results in less effective treatment. Research shows that both strong therapeutic alliances and treatment results can be achieved through remote intervention (Bouchard et al., 2004). In fact, a meta-analysis found no differences in treatment effect sizes for randomized controlled trials comparing in-person and Internet-based treatment modalities (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Moreover, no research evidence to date supports the assumption that traditional face-to-face treatment is superior to comparable remotely delivered treatment (Harris & Younggren, 2011).<sup>1</sup> Nevertheless, such unsubstantiated assumptions persist, as reflected in a policy statement of the Massachusetts Board of Psychologists that raises cautions about remote practice (Massachusetts Office of Consumer Affairs and Business Regulation, 2006).

Being at a geographic distance may pose challenges in dealing with crisis situations such as domestic abuse or suicide attempts. As they would do in their home state of practice, it is important that clinicians familiarize themselves with the appropriate resources in the patient's community, as well as applicable local standards (e.g., which standards with respect to duty-to-warn/protect are operative in a given jurisdiction). Again, however, even in traditional settings, such crisis management already relies on technological tools, particularly the telephone, and telemental health settings do not preclude use of these tools. Finally, telepsychology demands that providers not only practice within their areas of competence, but also that they be competent with

respect to whatever technological tools they utilize.

In summary, the use of technological tools to deliver psychological services remotely has enormous potential for bridging the gap between evidence-based services and those in need, but also presents various challenges. These challenges are not insurmountable, and in fact, solutions are quickly emerging with the rapid evolution of this field.

### Interjurisdictional Practice

The biggest barrier to the widespread adoption of telepsychology is not technological or therapeutic, but regulatory. That is, it remains unclear what services can be legally offered across state lines within the U.S. When a psychologist consults with her patient who is located in a different state, the question arises as to where the interaction is taking place; is it the state in which the psychologist is located, the state in which the patient is located, the state in which the computer server is located, or perhaps some combination of these?<sup>2</sup> The 10th Amendment to the U.S. Constitution reserves the powers not explicitly delineated to the federal government to the states, and this includes the licensure of health-care professionals. Psychologists, physicians, social workers, counselors, and other health-care professionals are therefore licensed by the individual states. Moreover, each state has different legislative and regulatory standards, and there is no general reciprocity across states.<sup>3</sup>

In an effort to shed light on this issue with respect to the practice of psychology in particular, the American Psychological Association's Practice Organization (APAPO) recently conducted a review of the licensure laws and associated regulatory standards in all 50 states (APAPO, 2010). This review found that only 3 states



Figure 1. Response by states to request to permit residents to receive remote study treatment

<sup>1</sup>Gros, Yoder, Tuerk, Lozano, and Acierno (2011) found that videoconferencing exposure therapy for veterans with posttraumatic stress disorder, although quite effective in absolute terms, appeared to be somewhat less effective than in-person exposure therapy. However, the patients were not randomly assigned to conditions, precluding conclusions about differential effectiveness.

<sup>2</sup>The present discussion will focus on the licensure of professional psychologists, although the issues are similar for other health-care professionals, who are also licensed by the individual states.

<sup>3</sup>Licensure is likewise handled by the individual provinces in Canada.



(California, Kentucky, and Vermont) have laws specifically governing telehealth that apply to psychologists. The specific provisions of the three laws vary considerably. For example, the California statute explicitly excludes telephone and email communications, whereas Vermont makes no such exclusions. The laws also differ with respect to the specific information that is required to be disclosed to patients undergoing remote psychological services. The boards of 8 additional states (Colorado, Florida, Georgia, Massachusetts, North Carolina, Texas, Virginia, and Wisconsin) have issued opinions on telepsychology, generally specifying the issues that should be covered in obtaining informed consent (e.g., potential confidentiality risks associated with breaches in security). With respect to the delivery of psychological services across state lines, the APAPO report found that several states (e.g., Florida, Georgia, Massachusetts, North Carolina, Texas, and Wisconsin) have issued policy statements. Although the specifics vary, these policies generally require that psychologists be licensed in the state in which the recipient of services is located. Despite such explicit policies prohibiting interstate practice, the boards reported little enforcement activity to date.

Despite the comprehensiveness of the APAPO review, it remains unclear how the state licensing boards interpret the standards, especially given that the majority of states do not have telepsychology laws, and the majority of state boards have not issued explicit policy statements. The psychology licensing boards are charged with interpreting their state licensure laws, and are typically afforded considerable discretion to establish policies and procedures that govern the practice of psychology. This authority becomes especially important given that there are few explicit legislative guidelines with respect to interjurisdictional practice. In addition, many state laws treat trainees and research studies somewhat differently than routine clinical practice, which further complicates the question of when interstate practice may be allowed. Moreover, state boards tend by nature to be conservative, and licensure laws were developed in an era in which psychological services were restricted to situations in which the provider and consumer were located in the same room (Harris & Younggren, 2011).

In 2010, we launched a research project in which we sought to evaluate the effectiveness of a cognitive behavior therapy program for obsessive-compulsive disorder delivered via the teleconferencing program



thoughthelper.com is an enhanced form of CBT homework that combines the benefits of journaling & CBT with automated text analysis to help guide a cognitive restructuring process under the supervision of a therapist.

### How does it work?

- **Journaling:** web-based journal entry allows for easy free-form input, even on the go
- **Text Analysis:** journal entries are automatically color-coded to highlight cognitive distortions
- **CBT:** journal history & graphing provided for every entry to aide in evidence-based cognitive restructuring

Contact us at [www.thoughthelper.com](http://www.thoughthelper.com) to request a free trial.

Skype (Goetter, Herbert, & Forman, in preparation). Following Institutional Review Board approval, announcements for the study were posted online, and we began receiving solicitations of interest from around the country. Before proceeding, we determined that it would be prudent to seek explicit permission from each state licensing board to treat individuals within their state. Specifically, we sought clarification from each state licensing board, as a complement to information provided on websites and by the APAPO review, regarding their view of the legality of offering clinical services via telepsychology in the context of a research study.

### Method and Results

A letter was sent to the state licensing boards in 49 states, plus the District of Columbia. The letter described the study, and noted that patients from the state in question may be contacting us regarding enrolling. We requested that the board indicate whether such treatment would or would not be permitted under the board's interpretation of state statutes and related

policies. As the authors are located in Pennsylvania, we inquired of the Pennsylvania board how it would treat a request from a psychologist licensed in another state to provide telepsychology services to a Pennsylvania resident.

Over the following 3 months, 20 states responded to this initial letter. Of these, five states (Hawaii, Idaho, New Jersey, South Dakota, and Wisconsin) approved the enrollment of residents of their states in the project, and 15 states refused (Alabama, California, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Hampshire, North Carolina, Ohio, Oklahoma, South Carolina, Vermont, and Wyoming).

We then undertook a coordinated, additional 7-month effort to contact the licensing boards of the remaining 29 states and the District of Columbia. This consisted of emails, letters, and telephone calls, including several repeated attempts to reach the boards that were initially unresponsive.

Through these efforts, all but 4 states eventually responded to our requests for clarification. In addition to the 5 states that originally permitted practice within their

state, an additional 9 states and the District of Columbia granted permission for their residents to participate in the study. The final breakdown is illustrated in Figure 1. A total of 15 state boards (including the District of Columbia) granted permission to treat individuals within their state in the context of this study, whereas 31 states explicitly prohibited doing so. Despite repeated attempts using various methods, 4 states (Connecticut, Florida, Illinois, and Indiana) never replied to our request. In the case of Pennsylvania, the board referenced a 1999 memorandum that neither approved nor disapproved the practice of telepsychology, and sent an email indicating that the board did not have the authority “to issue advisory opinions or pre-approve specific conduct.” In a telephone conversation, the board administrator indicated that it was likely that the board would view a request to provide telepsychology services to someone within Pennsylvania as requiring licensure within the state (Christina Stuckey, personal communication, March 27, 2012).

The responses of the states varied considerably along a number of parameters. In some cases, an administrative staff person replied to our request, whereas in other cases the reply came from a board member or an attorney. A few states (e.g., Idaho) explicitly applauded our efforts to seek clarification on these issues and provide treatment to their residents. Others (e.g., Alaska) expressed a *laissez-faire* approach, leaving it up to the individual resident to decide whether he/she wanted to pursue treatment from a provider out of the state. Some states (e.g., North Carolina), even when ultimately deciding that they could not permit remote treatment of their residents, reached out to us to explore the possibility of some kind of exception that might permit the project to proceed. In contrast, one state sent a sharply worded letter from an attorney forbidding any involvement of the state’s residents in the project.

Of the states that did permit their residents to obtain remote treatment, the reasons likewise varied. Even among these states, most did not permit psychologists from outside their jurisdiction to practice without limits. In some cases, exceptions to a general prohibition against interstate practice were made because the project was a research study rather than for-profit clinical services. In other cases, exceptions were made because the therapists were supervised trainees in a doctoral program, and were explicitly excluded by statute to practice limitations placed on licensed psychologists. Finally, other states permitted the

project under a temporary practice exemption, which allows psychologists licensed in another state to practice within the state for a limited number of days per calendar year.

Regarding the temporary practice exemption, it is noteworthy that although several states have such exemptions in their licensing statutes, some contain ambiguities that are open to interpretation. For example, it is sometimes unclear if an exemption of 20 days per year refers to 20 total days or 20 consecutive days, and if any contact whatsoever (e.g., scheduling an appointment) “counts” as one of these days. Although some boards were helpful in interpreting these ambiguities, other boards steadfastly and expressly refused to provide clarification of their own statutes and policies.

## Discussion

Internet-mediated and related forms of remote psychological services can greatly increase the availability of evidence-based practice, including various forms of behavior therapy. The practice of remote treatment is growing rapidly, as evidenced not only by the rapid growth of professional and scientific publications in the area, but stories in the popular media as well. The widespread availability of mobile devices, broadband Internet connectivity, and related user-friendly software applications is rapidly changing the way psychotherapy is practiced. For example, in an early paper on telepsychology published only just over a decade ago, Childress (2000) opined that it was unlikely that videoconferencing technology would ever become widely available or accepted. Yet Skype alone now has nearly 700 million users worldwide, with up to 34 million of them using the service at any given time (Rao, 2011; Russell, 2012).

### *Inconsistent Legal and Regulatory Landscape*

Unfortunately, the regulations governing the practice of remote treatment have not kept pace with these developments. State licensure laws are inconsistent with one another, and typically are silent with respect to the subject of interjurisdictional practice. The few practice guidelines that exist for remote psychological services are confusing and sometimes even contradictory with one another.

Given that the interpretation of each state’s licensure statute resides with the state’s licensing board, we attempted to clarify each state’s policies with respect to interstate delivery of remote treatment in

the context of a clinical research study by contacting the various state boards. The majority of the boards interpreted their laws such that psychological services provided to residents of their state were considered to be taking place within that state, regardless of the practitioner’s physical location. Thus, psychologists not explicitly licensed within the state were prohibited from practicing within it. The states that did permit the study to proceed did so based on a variety of rationales. In some cases a board explained a specific exception to their law that would otherwise require licensure within that state to practice within its boundaries, whereas in other cases a board simply indicated that the study could proceed but without articulating its reasoning.

Our findings illustrate the inconsistency across states with respect to the legality of the interstate practice of psychology. In discussions of remote psychological services across state lines, many authors have emphasized the importance of contacting the state licensing board in which a potential patient resides to seek guidance (APAPO, 2010; Pennsylvania State Board of Psychology, 2010). The present results reinforce the wisdom of that advice. However, it should be noted that only a minority of states promptly replied to our queries seeking clarification, and that even after several months and repeated contacts, four states never did respond. Especially given the ambiguity of the current regulatory landscape, it is incumbent upon licensing boards to respond promptly and clearly to psychologists seeking guidance on remote practice. Nevertheless, given the rate at which remote practice is growing and the anticipated increase in the number of practitioners seeking clarification, responding promptly to individual inquiries is likely to pose increasing challenges to state boards. This highlights the importance of clear and readily accessible policy statements regarding interjurisdictional practice on state board websites. As discussed above, the majority of state boards do not currently have clear policy guidelines on their websites.

Meanwhile, given that the majority of states did not permit the enrollment of their residents in our study, the most prudent course is for psychologists to assume that interstate practice is prohibited, until and unless explicitly shown to be otherwise in a given circumstance. Moreover, we do not recommend that practitioners rely on our findings to make decisions about the legality of interstate practice within any given state for two reasons. First, the present re-

sults must be interpreted in the context of a particular clinical research study. Some boards' interpretations of the legality of standard clinical practice, or even of other types of research, may differ from their interpretations of this particular study. For example, Iowa granted our request to enroll residents in the study because psychology trainees are granted an exemption despite an explicit policy statement on their website against treating Iowa residents without being licensed in the state. Second, this area is fluid and evolving rapidly, and by the time a psychologist reads this paper some states may have modified their relevant statutes, or some state boards may have issued or modified policy statements on interstate practice.

The irony of the prohibition against the interstate practice of psychology is that unlicensed coaches, psychotherapists, and other providers who face no such limitations are proliferating rapidly (Williams & Menendez, 2007). For example, a Google search of "online therapy" reveals over 27 million hits with links to service providers of varying levels of specialization, including artificial intelligence "chatbots," "eCounselors," and licensed providers of varying (and often unverifiable) professional backgrounds. Such unregulated practice is far less likely than evidence-based behavior therapy to be scientifically grounded, and precludes the public from enjoying the protections afforded by regulatory oversight. Thus, the widespread availability of these potentially unqualified providers may result in more individuals receiving lower-quality or ineffective services in lieu of treatments that work.

### **Potential Solutions**

Various professional organizations (e.g., the National Register, the American Board of Professional Psychology) are seeking to address this issue. For example, the Association of State and Provincial Psychology Boards (ASPPB) has developed an Interjurisdictional Practice Certificate, in which participating states permit psychologists holding the certificate to practice temporarily within their states; so far only five states (Georgia, Idaho, Kentucky, Mississippi, and South Carolina) participate in this program. Other programs are designed to facilitate obtaining licensure in another jurisdiction, for example by banking credentials, which is a way to centrally store evidence of professional education and achievements so that they may be easily submitted to any licensing board in the fu-

ture. These "legal fictions" may indeed facilitate the process of obtaining licensure in another state, but currently do not permit practicing on an ongoing basis within a state in which one is not explicitly licensed. Thus, as they currently stand, they do not resolve the issue.

Unless the federal government acts to supersede individual state licensure laws, the only truly comprehensive solution would be some form of national telepsychology consortium, in which states would agree on practice standards and qualifications, and the license of a practitioner within a member state would permit practice within other participating states (Harris & Younggren, 2011). Complaints could be lodged with the board in which the psychologist is licensed regardless of where the service took place. In some ways this would be analogous to the system currently in place in the Veteran's Administration (VA), in which a psychologist licensed in any state can practice anywhere within the VA system. Despite the obvious appeal of such a registry, the idea faces a number of challenges. First, in many states, participation would require legislative action to change the state licensing law. Second, states with higher licensure standards (e.g., higher required scores on the Examination for Professional Practice in Psychology) may be hesitant to recognize the licenses of states with lower standards. Nevertheless, as discussed by Harris and Younggren (2011), the profession of nursing has been at the forefront of true interstate practice, having developed a consortium program that could serve as a model for other health professions.

Despite the various challenges, it is imperative that policymakers proactively address the issue of interstate practice. The APA recently developed a Task Force on the Development of Telepsychology Guidelines for Psychologists, staffed by members of APA, ASPPB, and the APA Insurance Trust, in an effort to develop guidelines for the practice of telepsychology. Technological developments will continue, and it is inevitable that remote services will be increasingly demanded by the public and will be increasingly offered by behavioral health professionals. Psychologists are poised to assume a leadership role in resolving the issue of interjurisdictional practice, but to do so they must act quickly before the issues are inevitably resolved by the courts in ways that may be far from ideal. In addressing these issues, policymakers should take care to balance possible risks against the enormous benefits afforded by remote services,

## **Study Evidence-Based Therapies in the Pacific Northwest**

### **MASTER OF ARTS IN COUNSELING PSYCHOLOGY**

- Two-year program with late afternoon and evening classes
- Emphasis on Evidence-Based Practices in Counseling (Child and Adult) and Elective Training in Organizational Behavior and Latino Mental Health
- Meets Oregon LPC educational requirements

Faculty members are experienced in both practice and research. Their interests include: behavioral and cognitive behavioral therapy, child and adolescent psychopathology, anxiety and mood disorders, organizational behavior, program evaluation, mindfulness-based therapies, and multicultural counseling.

#### **CONTACT US AT:**

Pacific University  
College of Health Professions  
Office of Admissions  
190 SE 8th Avenue, Suite 181  
Hillsboro, OR 97123  
503-352-2218  
800-933-9308  
[admissions@pacificu.edu](mailto:admissions@pacificu.edu)



**SCHOOL of  
PROFESSIONAL  
PSYCHOLOGY**



## online

### APS offering free membership to ABCT members, in honor of Alan Kazdin

Take advantage of this wonderful offer! For more details, see back page of this issue, and visit

[www.joinaps.org/?p=ABCT13&s=join](http://www.joinaps.org/?p=ABCT13&s=join)

## in-press

### The Relationship Between Baseline Drinking Status, Peer Motivational Interviewing Microskills, and Drinking Outcomes in a Brief Alcohol Intervention for Matriculating College Students: A Replication

"When students articulate no desire to change their alcohol use and related behaviors, simple reflections may only mirror these sentiments and actually impede the change process. It is important to note that these hypotheses can only be explored by coding student change talk . . ."

Tollison et al.

*Behavior Therapy*, in press

doi: 10.1016/j.beth.2012.09.002

## archive

"One of the distinguishing features of science is that it strives for maximal simplicity, parsimony, and consistency in its basic assumptions, whereas common sense is content with complexity, multiplicity, and inconsistency."

Mowrer, O. H. (1947)

"On the Dual Nature of Learning—A Reinterpretation of 'Conditioning' and 'Problem Solving'"

and to ensure that they are guided by the best available science rather than misguided assumptions and clinical lore.

## References

- American Psychological Association Practice Organization. (2010). Telehealth: Legal basics for psychologists. *Good Practice*, 41, 2–7.
- Baker, D. C., & Bufka, L. F. (2011). Preparing for the telehealth world: Navigating legal, regulatory, reimbursement, and ethical issues in an electronic age. *Professional Psychology: Research and Practice*, 42(6), 405–411.
- Barak, A., L. Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of Internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, 26(2/4), 109–160.
- Bouchard, S., Paquin, B., Payeur, R., Allard, M., Rivard, V., Fournier, T., et al. (2004). Delivering cognitive-behavior therapy for panic disorder with agoraphobia in video-conference. *Telemedicine Journal and e-Health*, 10(1), 13–24.
- Childress, C. A. (2000). Ethical issues in providing online psychotherapeutic interventions. *Journal of Medical Internet Research*, 2(1), e5. doi: 10.2196/jmir.2.1.e5
- Goetter, E. M., Herbert, J. D., & Forman, E. M. (in preparation). *Standard versus acceptance based exposure and ritual prevention for obsessive compulsive disorder via videoconference*.
- Gros, D. F., Yoder, M., Tuerk, P. W., Lozano, B. E., & Acierno, R. (2011). Exposure therapy for PTSD delivered to veterans via telehealth: Predictors of treatment completion and outcome and comparison to treatment delivered in person. *Behavior Therapy*, 42, 276–283.
- Harris, E., & Younggren, J. N. (2011). Risk management in the digital world. *Professional Psychology: Research and Practice*, 42(6), 412–418.
- Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization*, 82, 858–866.
- Massachusetts Office of Consumer Affairs and Business Regulation. (2006). *Provision of services via electronic means*. Retrieved March 18, 2012, from <http://www.mass.gov/ocabr/license/dpl-boards/py/regulations/board-policies/provision-of-services-via-electronic-means.html>
- McCord, C. E., Elliott, T. R., Wendel, M. L., Brossart, D. F., Cano, Miguel A., Gonzalez, G. E., & Burdine, J. N. (2011). Community capacity and teleconference counseling in rural Texas. *Professional Psychology: Research and Practice*, 42(6), 521–527.
- Nelson, E.-L., & Velasquez, S. E. (2011). Implementing psychological services over televideo. *Professional Psychology: Research and Practice*, 42(6), 535–542.
- Pennsylvania State Board of Psychology (2010, September). *Pennsylvania State Board of Psychology group break-out questions*, 1–2.
- Rao, L. (2011). *Skype revenue up 20 percent to \$860M in 2010; paid users up 19 percent*. Retrieved March 27, 2012, from <http://techcrunch.com/2011/03/07/skype-revenue-up-20-percent-to-860m-in-2010-paid-users-up-19-percent/>
- Russell, J. (2012). *Another week another record as Skype sees 34 million users on line at the same time*. Retrieved March 27, 2012, from <http://thenextweb.com/isider/2012/02/28/another-week-another-record-as-skype-sees-34-million-users-online-at-the-same-time/>
- Schwartz, T. J., & Lonborg, S. D. (2011). Security management in telepsychology. *Professional Psychology: Research and Practice*, 42(6), 419–425.
- Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services*, 60, 1323–1328.
- Van Allen, J., & Roberts, M. C. (2011). Critical incidents in the marriage of psychology and technology: A discussion of potential ethical issues in practice, education, and policy. *Professional Psychology: Research and Practice*, 42(6), 433–439.
- Wang, P. S., Berglund, P., & Kessler, R. C. (2000). Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine*, 15(5), 284–292.
- Williams, P., & Menendez, D. S. (2007). *Becoming a professional life coach: Lessons from the institute of professional life coach training*. New York, NY: W. W. Norton.
- Yuen, E. K., Goetter, E. M., Herbert, J. D., & Forman, E. M. (2012). Challenges and opportunities in Internet-mediated telemental health. *Professional Psychology: Research and Practice*, 43, 1–8.
- Yuen, E. K., Herbert, J. D., Forman, E. M., Goetter, E. M., Comer, R., & Bradley, J. C. (2012). *Acceptance-based behavior therapy for social anxiety disorder using an online virtual environment*. Manuscript submitted for publication.

...

**Correspondence to** James D. Herbert, Ph.D., Department of Psychology, 119 Stratton, 1341 Chestnut Street, Philadelphia, PA 19104; [james.herbert@drexel.edu](mailto:james.herbert@drexel.edu)



## When Having One Disorder Is the Exception, Not the Norm: Psychological Comorbidity in Veterans

Abigail A. Goldsmith, *Veterans Affairs San Diego Healthcare System and University of California, San Diego*

Kendall C. Wilkins, *San Diego State University/University of California San Diego Joint Doctoral Program in Clinical Psychology*

Sonya B. Norman, *Veterans Affairs San Diego Healthcare System, University of California, San Diego, and Veterans Affairs Center of Excellence for Stress and Mental Health*

Psychological injury occurs in a substantial number of returning service members and veterans. Research suggests that postcombat distress manifests in a variety of ways, ranging from post-deployment adjustment difficulties to clinical symptoms and disorders (e.g., posttraumatic stress disorder [PTSD], depression, anxiety, anger, suicidality; e.g., Bray, Bae,

Federman, & Wheelless, 2005; Harvey et al., 2011; Mansfield, Bender, Hourani, & Larson, 2011; Milliken, Auchterlonie, & Hoge, 2007; Sayer et al., 2010; Seal et al., 2009; Thomas et al., 2010). Early estimates of PTSD among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans indicate that nearly 17% of active

duty and over 24% of reserve service members screen positive for PTSD approximately 6 months after deployment (Milliken et al., 2007). These rates suggest that PTSD may be two to three times higher in our returning veterans when compared to the general population (Kessler, Chiu, Demler, & Walters, 2005; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Rates of major depressive disorder (MDD) are similarly concerning. Early estimates of MDD suggest that over 10% of active duty and 13% of reserve service members screen positive for depression approximately 6 months after deployment (Adler, Britt, Castro, McGurk, & Bliese, 2011; Milliken et al.). Even higher rates have been found in veterans presenting for VA services (e.g., 17.4%; Seal et al.). Thus, similar to PTSD, rates of MDD appear to be two to three times higher in combat veterans than in civilians (Kessler et al., 2005).

While PTSD and MDD are two of the most prevalent forms of postcombat psychopathology, veterans are also demonstrating significant problems with alcohol and substance use disorders (SUD), symptoms of other Axis I disorders (e.g., anxiety disorders other than PTSD), and suicidality and

### FREE ACCESS TO NEW WEB-BASED THERAPY

For a limited time, CBT Self-Help Therapy is offering ABCT members free access to its new website for the treatment of stress, mood disorders, and emotion dysregulation.

**Go to [www.cbt-self-help-therapy.com](http://www.cbt-self-help-therapy.com).**

**Click on “Register” & enter Discount Code ABCT#1 for free access to the entire site.**

Based on New Harbinger Publications’ best selling self-help books *The Relaxation & Stress Reduction Workbook* and *Mind & Emotions*, the site is a valuable adjunct to face-to-face therapy for your clients.

The site can:

- \* Improve client motivation and compliance.
- \* Give immediate feedback to improve skill acquisition.
- \* Allow clients to practice new skills via audio and written exercises.
- \* Allow the therapist to monitor client progress and give feedback *between* sessions.

CBT Self-Help Therapy is multi-media, with lots of video and audio content that makes it much more engaging than a traditional self-help print book. Exercises are fully interactive, so clients can enter their own personal information and save their work in a secure file. A repeatable measure of emotional distress is given three times, so that you and your clients can track their progress.

Check it out for yourself at [www.cbt-self-help-therapy.com](http://www.cbt-self-help-therapy.com).

aggression (Mansfield et al., 2011; Milliken et al., 2007; Sayer et al., 2010; Seal, Bertenthal, Miner, Sen, & Marmar, 2007; Seal et al., 2009; Thomas et al., 2010). Given the increased risk for psychological injury following deployment, the Department of Veterans Affairs (VA) has initiated rollouts to disseminate evidence-based psychotherapies for several mental health problems, including PTSD (i.e., prolonged exposure [PE], cognitive processing therapy [CPT]), and MDD (i.e., cognitive behavioral therapy, acceptance and commitment therapy). These rollouts include in-person workshops, consultation, and supervision for VA clinicians (McHugh & Barlow, 2010).

While evidence-based approaches for many forms of psychopathology common among returning veterans are effective in reducing disorder-specific symptoms, whether they address the full range of problems that affect the psychological health and quality of life in returning veterans remains an empirical question. High rates of comorbid psychopathology in combat veterans indicate that postcombat psychopathology manifests through a myriad of symptoms and disorders. In fact, studies investigating onset and prevalence of post-deployment psychopathology indicate that having comorbid posttraumatic disorders is the norm rather than the exception. Of all new OEF/OIF veterans enrolled in the VA from October 2001 to January 2008 diagnosed with mental health disorder, 29% were diagnosed with two disorders and 33% were diagnosed with three or more disorders (Seal et al., 2009).

Individuals with co-occurring posttraumatic disorders tend to fare worse than those diagnosed with a single disorder. For example, among depressed patients, concurrent PTSD is associated with a greater number of depressive episodes (Carlier, Voerman, & Gersons, 2000; Resnick, Kilpatrick, Best, & Kramer, 1992), more severe depressive symptoms (Green et al., 2006; Mollica, Caridad, & Massagli, 2007; Shalev et al., 1998), poorer treatment response (Holtzheimer, Russo, Zatzick, Bundy, & Roy-Byrne, 2005), poorer functioning, and more primary care visits (Campbell et al., 2007). Further, there is substantial shared symptomatology between PTSD, mood, and anxiety disorders (Resick & Miller, 2009; Rosen, Lilienfeld, Frueh, McHugh, & Spitzer, 2010; Rosen, Spitzer, & McHugh, 2008). Taken together, these findings suggest the need for consideration of how to most effectively and efficiently address comorbidity and the

complex array of problems with which veterans present to treatment.

In summary, comorbidity of mental health disorders among returning veterans with psychological distress is the norm, not the exception and, across a number of populations, comorbidity has a large number of negative associations. With regard to treatment, the above findings suggest three areas that require clinical and research attention: (a) the need to evaluate a broader range of outcomes for existing evidence-based treatments and potential modifications to such treatments to broaden their applicability; (b) the need to target mechanisms that underlie multiple highly prevalent disorders; and (c) the need for treatments that focus broadly on reducing psychological distress and improving functioning.

### Evaluating Existing Treatments and Potential Modifications

Evidence-based treatments for PTSD, such as PE and CPT, often lead to reductions in both PTSD and depression symptoms (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Preliminary data suggest that these treatments may also be helpful in reducing associated features of alcohol use disorders (Riggs & Foa, 2008). Further evaluation is needed to better understand if and how these treatments address the full range of psychological problems experienced by returning veterans.

Exploring and evaluating possible modifications to existing treatments to make them more broadly applicable also remains an important task. For example, the goal of one recently funded study (Amy Jak, Ph.D., PI) is to understand how CPT modified to include cognitive rehabilitation strategies compares to traditional CPT for individuals with both PTSD and traumatic brain injury (TBI). Veterans who experience TBI may present to treatment with a variety of problems (e.g., headaches, concentration difficulties, sensitivity to light, difficulties with planning, and other aspects of executive functioning) that can interfere with treatment success. The goal is to help people successfully complete and benefit from CPT.

It is important to keep in mind that not all returning veterans with mental health difficulties meet criteria for PTSD. In fact, not all veterans presenting with mental health concerns have experienced a trauma that meets *DSM-IV* Criterion A for PTSD. Thus, evaluating and modifying existing PTSD treatments is not enough to fully ad-

dress the problems with which returning veterans are presenting.

### Targeting Mechanisms Underlying Posttraumatic Psychopathology

Identifying fundamental behavioral elements that cut across multiple disorders is an outlined priority within the Strategic Plan of the National Institute of Mental Health (see Strategy 1.4; National Institute of Mental Health, 2011). Developing interventions targeting these mechanisms common to multiple disorders may be a method by which to address common comorbidities. Examples of such mechanisms within posttraumatic psychopathology include guilt, shame, anger, and avoidance. Guilt is discussed briefly here to illustrate this idea. Guilt related to a traumatic event (i.e., post-traumatic guilt) may be an important transdiagnostic treatment target for a variety of reasons. Guilt appears to be a very common posttraumatic reaction (e.g., Kubany et al., 1996) and has been identified as a factor negatively influencing postcombat transition in OEF/OIF veterans (Adler et al., 2011). Additionally, posttraumatic guilt has been implicated as a risk factor for the development and maintenance of posttraumatic psychopathology (Litz et al., 2009; Watson, Juba, Manifold, Kucala, & Anderson, 1991).

*DSM-IV-TR* has long conceptualized guilt as a contributing factor and core symptom of MDD (American Psychiatric Association, 2000). Guilt and depression show moderate to high correlations among trauma survivors (Kubany et al., 1996; Kubany & Manke, 1995; Owens, Steger, Whitesell, & Herrera, 2009), and reductions in MDD symptoms are associated with decreased posttraumatic guilt cognitions (Kubany et al., 2004; Resick et al., 2002). Guilt may also contribute to the onset and maintenance of postdeployment SUDs and suicidality. For instance, the self-medication hypothesis suggests that substance use may begin in an effort to cope with and ameliorate emotional distress, including negative affect, such as guilt (Brown & Wolfe, 1994; Khantzian, 1985). Additionally, combat-related guilt was significantly and positively associated with suicidal thoughts in a sample of Vietnam veterans (Kubany et al., 1996), and was the most significant predictor of suicide attempts in a study of Vietnam veterans with PTSD (Hendin & Haas, 1991; Hyer, McCranie, Woods, & Boudewyns, 1990).

Finally, in pilot work evaluating Trauma Informed Guilt Reduction (TRiGR), an in-

intervention designed to reduce posttraumatic guilt, changes in guilt severity and distress were significantly correlated with changes in PTSD and MDD symptoms over the course of treatment (Norman, Wilkins, Allard, Rindt, & Kusian, 2010; Norman, Wilkins, Myers, Colon, & Allard, submitted). These findings provide support for the mechanistic link between posttraumatic guilt and severity of posttraumatic psychopathology. In summary, treating mechanisms that may contribute to posttraumatic psychopathology, such as guilt, may help ameliorate symptoms of multiple disorders common among returning veterans.

### Transdiagnostic Treatments to Address Distress and Functioning

Another approach to treating the multiple forms of psychopathology found in returning veterans is the use of treatments designed to be transdiagnostic (e.g., using techniques that may universally act to reduce distress). Acceptance and Commitment Therapy (ACT) is an example of an intervention that has empirical support for the treatment of depression, and is currently being evaluated for the treatment of multiple other disorders, including PTSD, substance use, and eating disorders. An ongoing multisite randomized clinical trial (Lang et al., 2011) is under way to evaluate ACT in the treatment of multiple forms of distress for returning veterans. Participants can meet criteria for a number of Axis I disorders, including PTSD, depression, and/or TBI, but they do not need to have any specific disorder. This study will shed light on whether a single treatment can be helpful to address the multiple ways in which distress presents itself in the OEF/OIF/OND population.

Given the complex, overlapping clinical presentation of veterans following deployment, future studies should consider outcomes focused on improved functioning, rather than solely assessing symptom reduction (Kaplan, 2003). A focus on functional outcomes across mental health disorders is especially important because reported rates of functional problems in a number of domains—including social, family, school, work, and community—are even more prevalent than mental health diagnoses among OEF/OIF/OND veterans (e.g., over 25% report functional difficulties in at least one domain; Sayer et al., 2010). Further, PTSD and depression contribute uniquely to low mental-health-related quality of life in OEF/OIF veterans

(Pittman et al., 2012), and having co-occurring PTSD and depression is associated with an even lower health-related quality of life than is found in those with either disorder alone (Erbes, Westermeyer, Engdahl, & Johnsen, 2007).

The clinical needs of returning military service members postdeployment are multifaceted, with higher rates of PTSD and MDD than civilians, and a myriad of associated symptoms and co-occurring disorders. Effective treatments exist for disorders common to returning veterans. However, the complex presentations of returning veterans suggest that further evaluation of existing and novel treatments is needed. Such an evaluation includes a consideration of transdiagnostic approaches to clinical care with a focus on the following: evaluating a broader range of outcomes for existing treatments, targeting mechanisms that may underlie co-occurring disorders, and broadly focusing treatments to reduce distress and improve functioning. Such efforts will allow us to continue to help this new cohort of veterans transition successfully to civilian life.

### References

- Adler, A. B., Britt, T. W., Castro, C. A., McGurk, D., & Bliese, P. D. (2011). Effect of transition home from combat on risk-taking and health-related behaviors. *Journal of Traumatic Stress, 24*(4), 381-389.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR). Washington, DC: Author.
- Bray, R. M., Bae, K. H., Federman, E. B., & Wheelless, S. C. (2005). Regional differences in alcohol use among US military personnel. *Journal of Studies on Alcohol, 66*(2), 229-238.
- Brown, P. J., & Wolfe, J. (1994). Substance abuse and post-traumatic stress disorder comorbidity. *Drug and Alcohol Dependence, 35*(1), 51-59.
- Campbell, D. G., Felker, B. L., Liu, C. F., Yano, E. M., Kirchner, J. A. E., Chan, D., et al. (2007). Prevalence of depression-PTSD comorbidity: Implications for clinical practice guidelines and primary care-based interventions. *Journal of General Internal Medicine, 22*(6), 711-718.
- Carlier, I. V. E., Voerman, B. E., & Gersons, B. P. R. (2000). Intrusive traumatic recollections and comorbid posttraumatic stress disorder in depressed patients. *Psychosomatic Medicine, 62*(1), 26-32.
- Erbes, C., Westermeyer, J., Engdahl, B., & Johnsen, E. (2007). Post-traumatic stress disorder and service utilization in a sample of service members from Iraq and Afghanistan. *Military Medicine, 172*(4), 359-363.
- Green, B. L., Krupnick, J. L., Chung, J., Siddique, J., Krause, E. D., Revicki, D., et al. (2006). Impact of PTSD comorbidity on one-year outcomes in a depression trial. *Journal of Clinical Psychology, 62*(7), 815-835.
- Harvey, S. B., Hatch, S. L., Jones, M., Hull, L., Jones, N., Greenberg, N., et al. (2011). Coming home: Social Functioning and the mental health of UK reservists on return from deployment to Iraq or Afghanistan. *Annals of Epidemiology, 21*, 666-672.
- Hendin, H., & Haas, A. P. (1991). Suicide and guilt as manifestations of PTSD in Vietnam combat veterans. *The American Journal of Psychiatry, 148*(5), 586-591.
- Holtzheimer, P. E., Russo, J., Zatzick, D., Bundy, C., & Roy-Byrne, P. P. (2005). The impact of comorbid posttraumatic stress disorder on short-term clinical outcome in hospitalized patients with depression. *American Journal of Psychiatry, 162*(5), 970-976.
- Hyer, L., McCranie, E. W., Woods, M. G., & Boudewyns, P. A. (1990). Suicidal behavior among chronic Vietnam theatre veterans with PTSD. *Journal of Clinical Psychology, 46*(6), 713-721.
- Kaplan, R. M. (2003). The significance of quality of life in health care. *Quality of Life Research, 12*, 3-16.
- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617.
- Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048.
- Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142*(11), 1259.
- Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment, 8*(4), 428.
- Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., et al. (2004). Cognitive trauma therapy for battered women with PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology, 72*(1), 3.
- Kubany, E. S., & Manke, F. P. (1995). Cognitive therapy for trauma-related guilt: Conceptual bases and treatment outlines. *Cognitive and Behavioral Practice, 2*(1), 27-61.
- Lang, A. J., Schnurr, P. P., Jain, S., Raman, R., Walser, R., Bolton, E., et al. (2011). Evaluating transdiagnostic treatment for distress and impairment in veterans: A multisite randomized controlled trial of Acceptance and Commitment Therapy. *Contemporary Clinical Trials, 33*(1), 116-123.
- Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., et al. (2009). Moral in-



- jury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 29(8), 695-706.
- Mansfield, A. J., Bender, R. H., Hourani, L. L., & Larson, G. E. (2011). Suicidal or self-harming ideation in military personnel transitioning to civilian life. *Suicide and Life-Threatening Behavior*, 41(4), 392-405.
- McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: a review of current efforts. *American Psychologist*, 65(2), 73.
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association*, 298(18), 2141.
- Mollica, R. F., Caridad, K. R., & Massagli, M. P. (2007). Longitudinal study of posttraumatic stress disorder, depression, and changes in traumatic memories over time in Bosnian refugees. *The Journal of Nervous and Mental Disease*, 195(7), 572.
- National Institute of Mental Health. (2011). *The National Institute of Mental Health Strategic Plan*. Retrieved from <http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml>
- Norman, S. B., Wilkins, K. C., Allard, C. B., Rindt, S., & Kusian, J. (2010, November). *Adjunctive guilt treatment for OEF/OIF service members with PTSD*. Paper presented at the Annual Convention of the Association for Behavioral and Cognitive Therapies, San Francisco.
- Norman, S. B., Wilkins, K. C., Myers, U. S., Colon, C., & Allard, C. B. (submitted). *A pilot study of trauma informed guilt reduction (TRiGR) Therapy with OEF/OIF/OND Veterans*.
- Owens, G. P., Steger, M. F., Whitesell, A. A., & Herrera, C. J. (2009). Posttraumatic stress disorder, guilt, depression, and meaning in life among military veterans. *Journal of Traumatic Stress*, 22(6), 654-657.
- Pittman, J. O. E., Goldsmith, A. A., Lemmer, J. A., Kilmer, M. T., & Baker, D. G. (2012). Posttraumatic stress disorder, depression, and health related quality of life in OEF/OIF Veterans. *Quality of Life Research*, 21, 99-103.
- Resick, P. A., & Miller, M. W. (2009). Posttraumatic stress disorder: Anxiety or traumatic stress disorder? *Journal of Traumatic Stress*, 22(5), 384-390.
- Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, 70(4), 867.
- Resnick, H. S., Kilpatrick, D. G., Best, C. L., & Kramer, T. L. (1992). Vulnerability-stress factors in development of posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 180(7), 424-430.
- Riggs, D. S., & Foa, E. B. (2008). Treatment for co-morbid posttraumatic stress disorder and substance use disorders. In S. H. Stewart & P. J. Conrod (Eds.), *Anxiety and substance use disorders* (pp. 119-137). New York: Springer.
- Rosen, G. M., Lilienfeld, S. O., Frueh, B. C., McHugh, P. R., & Spitzer, R. L. (2010). Reflections on PTSD's future in DSM-IV. *The British Journal of Psychiatry*, 197(5), 343-344.
- Rosen, G. M., Spitzer, R. L., & McHugh, P. R. (2008). Problems with the post-traumatic stress disorder diagnosis and its future in DSM-IV. *The British Journal of Psychiatry*, 192(1), 3-4.
- Sayer, N., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services*, 61(6), 589-597.
- Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103 788 US veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs Facilities. *Archives of Internal Medicine*, 167(5), 476.
- Seal, K. H., Metzler, T. J., Gima, K. S., Bertenthal, D., Maguen, S., & Marmar, C. R. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans using Department of Veterans Affairs health care, 2002-2008. *American Journal of Public Health*, 99(9), 1651.
- Shalev, A. Y., Freedman, S., Peri, T., Brandes, D., Sahar, T., Orr, S. P., et al. (1998). Prospective study of posttraumatic stress disorder and depression following trauma. *American Journal of Psychiatry*, 155(5), 630.
- Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry*, 67(6), 614.
- Watson, C. G., Juba, M. P., Manifold, V., Kucala, T., & Anderson, P. E. D. (1991). The PTSD interview: Rationale, description, reliability, and concurrent validity of a DSM-III based technique. *Journal of Clinical Psychology*, 47(2), 179-188.

Correspondence to Abigail A. Goldsmith, VA San Diego Healthcare System, 3350 La Jolla Village Drive (MC 116B), San Diego, CA, 92161; email: [agoldsmith@ucsd.edu](mailto:agoldsmith@ucsd.edu)

# graduate Mentorship directory

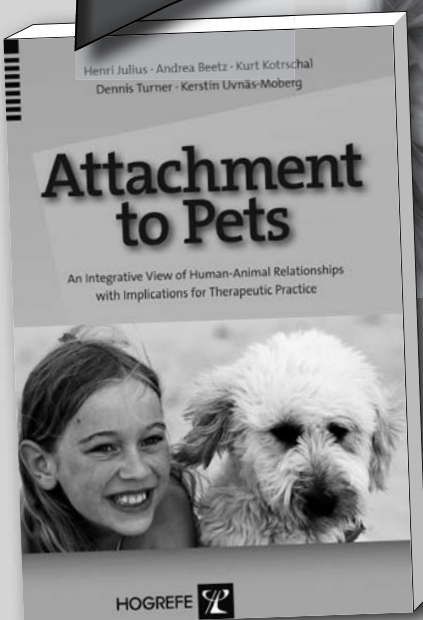
<http://www.abct.org/Mentorship>

*"Every student deserves to be treated as a potential genius." — Anton Ehrenzweig*

*The history of psychology, and especially the history of the cognitive and behavioral therapies, is one of lineage and relationships, where professionals trace their lineage back three or four generations. This directory is not intended as an exhaustive list of graduate programs; rather, it is a list of ABCT members affiliated with programs in which they are potentially available to serve as a mentor. ABCT's Mentorship Directory connects exceptional students with the best mentors that psychology has to offer. Promote your lab, and allow your next student to find you by name, interest, location, or program.*

## Pet Therapy and Animal-Assisted Therapy

New!



Henri Julius, Andrea Beetz, Kurt Kotrschal,  
Dennis Turner, & Kerstin Uvnäs-Moberg

### Attachment to Pets

An Integrative View of Human-Animal  
Relationships with Implications for  
Therapeutic Practice

2013, xiv + 192 pp. with Forewords by  
Judith Solomon and Sir Patrick Bateson  
ISBN 978-0-88937-442-3, US \$49.00

***"A comprehensive, scientific foundation for human-animal therapy." (Judith Solomon)***

In recent years, the ancient symbiosis between humans and their pets has entered a new phase, marked by the burgeoning clinical specialty of human-animal therapy. This approach uses the relationship between humans and their (mainly) mammalian pets to support the growth of emotion regulation, social skills, and mental health in children, adolescents, and adults.

But how are humans and animals able to develop close bonds at all? What makes it possible for animals to have a therapeutic effect on humans? And how can we best use this understanding in animal-assisted therapy?

In this unique book, a team of expert biologists and psychologists integrate and combine sophisticated biological and psychological knowledge to answer these questions. Together they have created a comprehensive, scientific foundation for human-animal therapy, a foundation that will facilitate the development, implementation, and evaluation of effective new interventions.

See sample pages at [www.hogrefe.com](http://www.hogrefe.com)

#### Recent praise:

*"The authors accomplish a long-awaited merging of evolutionary, biophysiological, and psychological processes likely to occur in human-animal interaction in an intellectually stimulating and practically applicable narrative. This book is useful for students, scientists, and practitioners, and will be essential to guide advancement of the field of human-animal interaction."*

Rebecca Johnson, PhD, RN, FAAN, President, International Association of Human-Animal Interaction Organizations, Professor & Director, Research Center for Human-Animal Interaction, MU College of Veterinary Medicine, Columbia, MO

*"This much-needed integrative book explains how the relationship between animals and therapists/clients can effectively be used to provide animal-assisted interventions with positive outcomes. It also presents a valuable scholarly framework that advances the endeavors of the International Society for Animal-Assisted Therapy."*

Lynette Hart, PhD, School of Veterinary Medicine, University of California, Davis, CA

Order online at [www.hogrefe.com](http://www.hogrefe.com) or call toll-free (800) 228-3749 (US only)

HOGREFE



Hogrefe Publishing · 30 Amberwood Parkway · Ashland, OH 44805  
Tel: (800) 228 3749 · Fax: (419) 281 6883  
E-Mail: [customerservice@hogrefe.com](mailto:customerservice@hogrefe.com)

# Feeling Powerless? 11 Tips to Help Parents and Kids Cope With Stress and Worry in the Aftermath of Natural Disasters: STOP AND COPE

Adam S. Weissman, *Founder and Executive Director, Child & Family Cognitive Behavioral Psychology, PLLC, and Columbia University*

**EDITOR'S NOTE:** *As mental health professionals, we are often contacted by the media and concerned families during times of crisis to offer some guidance on coping. What follows is a summary of some cognitive and behavioral coping strategies that could serve as a reference to provide guidance for families when disasters like Hurricane Sandy occur.*

One of the hardest parts of a devastating natural disaster like Sandy is feeling out of control. Uncertainty is the root of anxiety; it's human nature. We naturally feel anxious and unbalanced in the face of uncertainty, whether it's the current economic climate or not being able to reach a loved one in the aftermath of a hurricane.

The key to mental equilibrium is acceptance of the things we can't control and slowing down our thoughts and emotions by problem solving and weighing the evidence for and against our worried thoughts. While it is possible that a call to a friend or relative that goes straight to voicemail may mean that he/she is in serious danger, we also know that laptop and smart phone batteries don't last very long in situations of massive power outages. So what's more likely—that our loved ones are in serious duress? or that they simply can't access their email, Facebook, and the like for a period of time until their power comes back on?

During a period of uncertainty, it is important that we all take care of ourselves, and each other. The coping tips below are a good place to start.

## 1. Shift Your Focus

When you're feeling tense or stressed out, you may get the urge to mentally replay your worries over and over in your mind. Shift your focus to something more positive. Remind yourself of something that makes you feel good. This can be a place you find relaxing and peaceful (e.g., a favorite beach or park) or maybe for your

kids, a place where they have had fun recently (e.g., an amusement park or baseball game).

## 2. Take Deep Breaths

You can also shift your focus to your body. Find a quiet, comfortable place to sit or lie down, and concentrate on your bodily sensations and on your breath. Take long, deep breaths from your diaphragm; try inhaling slowly through your nose for 5 seconds, and then exhaling through your mouth for 7. Exhaling longer than you inhale deepens your breathing, which helps calm your nervous system. To enhance your mindful breathing, you can say a mantra as you focus on your breath (e.g., "one . . . relax; two . . . relax"; "breathe in calm, breathe out stress")

## 3. Open the Door and Get Some Fresh Air

If you've been cooped up for days, of course you're feeling on edge! Go outside, maybe take a short walk (if it's safe where you are), and get some fresh air. Most important, get back into your routine as soon as possible. Don't let your stress or fear derail you from getting back on track with the things that you enjoy and the things that are important and fulfilling in your life.

## 4. Play a Game or Do Something Fun With Your Family

School closings can provide a unique opportunity for family bonding time. How often are we stuck at home, perhaps with no cell phone? TV? Facebook? Spend time together as a family, talking, playing board games, building that fort in the living room the kids have been asking about for weeks! Watching a funny movie together if you do have power. When we're doing something fun, smiling and laughing, it's pretty hard to feel anxious. Find the silver lining and turn this stressful event into a fun and posi-

tive family bonding experience that the kids will remember forever.

## 5. Anxious Thought Busters

When we're feeling stressed out, we have anxious, exaggerated thoughts; we tend to overestimate the likelihood of something bad happening and underestimate our own abilities to cope. Give yourself (and your kids) a pep talk. Identify your anxious thoughts and come up with more positive, realistic coping thoughts (e.g., "I have been in worse situations than this before and have been able to manage just fine"; "What would I tell a friend?"; "I can rely on my friends and family if I need help"; "The power will be back on soon").

## 6. New Adventures

Sometimes we can get stuck in our daily routine and not take the time to stop and think about our overall stress level, how we are balancing our lives, and perhaps scheduling some time for fun. Think of this "down" time as an opportunity to break free from your weekly routine. Start planning some dates for your next family vacation or perhaps a romantic weekend getaway!

## 7. Draw or Write

Writing down your anxious thoughts can help relieve some of the stress caused by repetitive worry, especially at night before bed when rumination tends to rear its ugly head and disrupt sleep. Write down your anxious thoughts or fears on a piece of paper, put the paper aside, and revisit your list in a few hours. Your worried thoughts may not seem so bad in the morning. Coach your kids to write down their worries, as well, or express themselves through drawing.

## 8. Close Your Eyes and Imagine Your Peaceful Place

Create your own utopia in your mind and go through each sensory experience—what you see, hear, smell, feel, and taste. Perhaps make a special soothing playlist for your iPod and play some relaxing music in the background.

## 9. Open Up to a Parent or Friend

Share your feelings and don't be afraid to ask for help. Encourage your kids to talk about their feelings, as well, and to ask questions if they are feeling scared. Help each other and your neighbors.



## 10. Problem Solve

Write down (or say out loud) the steps you are prepared to take to manage stressful situations that may arise (e.g., power outage, road block, running low on food, no public transportation, property damage). We are generally better problem-solvers than we give ourselves credit for, especially when we are feeling stressed out. Slow down your thoughts and emotions by following the 5 STEPS below:

- Say the problem
- Think of solutions
- Examine each solution (pros and cons)
- Pick a solution
- See if it worked

## 11. Exercise

You haven't made it out to the gym in days, so you probably have some pent-up energy. Take a break, walk up and down a few flights of stairs, do some pushups or situps at home, or sign up for that Zumba or kickboxing class you've been dying to try. No matter what's going on in your life, exercise will often make you feel better. Try it out, and rate your stress level before and after on a scale of 0 to 10!

...

**Correspondence to** Adam Weissman,  
Ph.D., Child/Adolescent Treatment Center  
(CAT-C), Institute for Behavior Therapy, 110  
E. 40th St., New York, NY 10016;  
DrAdamWeissman@gmail.com

## ABCT *Slides*

We have slides showcasing ABCT, its publications, and the convention.

Giving a talk and want to  
highlight ABCT?

Grab a slide  
or two.

★

 <http://www.abct.org>

[ABCT Members Only](#) ↗

[Helpful Resources](#) ↗

[Teach CBT](#) ↗

[Slides](#) ↗

# Voluntary Contributors

*On behalf of ABCT, President Robert K. Klepac warmly thanks all who have generously supported our mission with a voluntary personal donation in 2012.*

Frank Andrasik

Jacqueline N. Cohen

Carlo C. DiClemente

George S. Greenberg

Paul E. Jansen

Thomas C. Kalin

Alan E. Kazdin

Lata K. McGinn

Dean R. McKay

Charles M. Morin

Howard M. Rombom

Douglas C. Schefft

Alyssa M. Ward

## Classified

**NRSA POSTDOCTORAL RESEARCH FELLOWSHIPS IN ADVANCED COGNITIVE THERAPY IN SCHIZOPHRENIA, SUICIDAL IDEATION, AND COMMUNITY PSYCHOLOGY WITH AARON T. BECK.** The Aaron T. Beck Psychopathology Research Center and the Center for the Treatment and Prevention of Suicide at the University of Pennsylvania Perelman School of Medicine are seeking applicants for a Ruth L. Kirschstein National Research Service Postdoctoral Fellowship (NRSA) Award from the National Institute of Mental Health (NIMH). Under the direction of Aaron T. Beck, M.D. and Gregory K. Brown, Ph.D., research fellows would have an opportunity to be involved in ground-breaking clinical and research advancements of cogni-

tive therapy for the treatment of individuals with depression, schizophrenia, and high suicide risk. Successful candidates will have the opportunity to conduct basic, effectiveness, and dissemination research studies in cognitive therapy.

Applicants who have earned an M.D., Ph.D., Psy.D., or equivalent in psychology or other related field and have had previous training in cognitive therapy of depression and or severe mental illness, are encouraged to apply. Bilingual candidates are especially encouraged to apply.

Please send a curriculum vita with a cover letter and two letters of recommendation by email to Aaron T. Beck, M.D. at [abeck@mail.med.upenn.edu](mailto:abeck@mail.med.upenn.edu).

The University of Pennsylvania is an Equal Opportunity/Affirmative Action Employer. Applications will be accepted until January 18, 2013.

# 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](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto: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](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto: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](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto: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](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto: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](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto: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](http://www.abct.org). Then e-mail the completed form and associated materials as one pdf document to [awards.abct@gmail.com](mailto: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](http://www.abct.org)**

**Deadline for nominations:  
March 1, 2013**



*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**

## 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)

---

*Good governance* requires participation of the membership in the elections. ABCT is a membership organization that runs democratically. We need your participation to continue to thrive as an organization.

**NOTE:** To be nominated for President-Elect of ABCT, it is recommended that a candidate has served on the ABCT Board of Directors in some capacity; served as a coordinator; served as a committee chair or SIG chair; served on the Finance Committee; or have made other significant contributions to the Association as determined by the Leadership and Elections Committee. Candidates for the position of President-Elect shall ensure that during his/her term as President-Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle.

This coming year we need nominations for two elected positions: President-Elect and Representative-at-Large. 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.

A thorough description of each position can be found in ABCT's bylaws: [www.abct.org/docs/Home/byLaws.pdf](http://www.abct.org/docs/Home/byLaws.pdf).

## 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.**

### Three Ways to Nominate

- ➔ Mail the form to the ABCT office (address above)
- ➔ 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](mailto:membership@abct.org).

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



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

PRSR STD  
U.S. POSTAGE  
**PAID**  
Hanover, PA  
Permit No. 4

## ▶ New Benefit for ABCT Members ...

In honor of Alan Kazdin, past president of ABCT, recipient of this year's ABCT Lifetime Achievement Award, and founding editor of a new Association journal *Clinical Psychological Science*, the Association for Psychological Science (APS) is offering free membership, including a subscription to the new journal, to all ABCT members who join APS. Free APS membership and the journal subscription will continue through December 2013.

Please consider taking advantage of this offer if you are not a member of APS. This offer is limited to ABCT members, including students, so please encourage your non-ABCT friends, colleagues, and students to join ABCT during this one-time-only "twofer" opportunity!

Simply visit APS at the link below, submit the form, and APS will take care of the rest:

**<http://www.joinaps.org/?p=ABCT13&s=join>**

*"We at APS think that APS and ABCT have much in common. For one thing, we both are dedicated to the advancement of scientific psychology and its applications. For another, we both like Alan Kazdin! And for that we should do something special . . ."*

—Alan Kraut, Executive Director, APS

||||| APS | ABCT |||||