Friends and colleagues—I hope that your new year is off to a terrific start. And I want to thank you for your great dedication to the field of clinical psychology. By being a member of the Society of Clinical Psychology (SCP), you are affirming your identity as a clinical psychologist. Although the field now has more professional societies than ever before—each with increasingly narrow subspecialty foci and targeted missions—SCP stands unique in its deep and mutually respectful embrace of a true integration of clinical psychological science and applied practice. SCP is one of the original divisions of the APA and remains one of the largest and most valuable resources and networks for clinicians, educators, researchers, trainees, policymakers, and the general public. I thank you for making SCP your professional home!

It’s a tremendous honor to lead SCP this year, at such a critical time for our field and for our profession. As I begin my SCP presidential term, I am truly humbled (and admittedly intimidated) by the extraordinary impacts that so many esteemed individuals have made over the years in their roles in key positions in SCP governance. For example, the field’s efforts to systematically identify evidence-based practice in psychology started in earnest in SCP in 1993, when then-president Dave Barlow launched the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (chaired by Dianne Chambless). The results of this seminal SCP task force sparked a decade of animated and productive debate in the field about how to best conceptualize indicated psychological practices—and this dialogue, in turn, paved the way for a formal definition of “evidence-based practice in psychology” that has since been adopted as official APA policy (APA Presidential Task Force on Evidence-Based Practice in Psychology, 2006).

Indeed, since our Society was founded 101 years ago(!), the field has witnessed remarkable scientific and professional advances that have so powerfully and positively improved the lives of countless individuals in need and that have firmly established clinical psychology as a sophisticated and rigorous discipline. And yet, at this time, we are faced with novel
challenges and exciting opportunities that promise to meaningfully transform the landscape of clinical psychology and the role of the clinical psychologist for years to come. Against a backdrop of unacceptable and worsening disparities in care access and quality, a shifting health care system with an uncertain future, large gaps between treatment outcomes observed in research settings versus routine community care settings, threats to the traditional role of the clinical psychologist, and the reducing prominence of psychological treatment in mental health care (e.g., Le Cook et al., 2017; Merikangas et al., 2011; Olfson & Marcus, 2010; Weissman & Cuijpers, 2017), it’s clear that innovative solutions are needed to solve today’s problems.

Most of our leading psychological treatment orientations emphasize how patients must step outside of their “comfort zones” for productive change to unfold. Whether it’s the exposure therapist having patients confront feared objects or environments, the cognitive therapist helping patients consider new and non-automatic ways of thinking, the mindfulness-based therapist having patients learn to tolerate inner experiences in nonjudgmental ways, or the psychodynamic psychotherapist helping patients examine past influences and work through unresolved conflicts to achieve difficult self-awareness—a clear transtheoretical theme is that a patient’s “comfort zone” is not fertile ground for transformation or growth.

Likewise, as a field, it’s increasingly clear that we will need to step outside of our “comfort zones” as we navigate the difficult clinical and professional challenges of our time. Kazdin and Blase (2011) noted that, despite considerable transformations in the focus of psychological interventions, the techniques used, and the evidence supporting particular intervention strategies, the field has exhibited rather minimal evolution and creativity with regard to the format and delivery of psychological intervention. Specifically, since the days of Freud’s earliest clinical work, our

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**BECOME A DIVISION 12 MENTOR**

Section 10 (Graduate Students and Early Career Psychologists) has developed a Clinical Psychology Mentorship Program. This program assists doctoral student members by pairing them with full members of the Society.

We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit [www.div12.org/mentorship](http://www.div12.org/mentorship) to become a mentor today.
field has retained a principal reliance on the traditional 1:1 patient-provider, office-based meeting. There are now clear indications that—in the context of our predominant attachment to this intervention format “comfort zone”—clinical psychology’s potential for true public health impact (i.e., the extent to which we can make meaningful changes at a population-level) is approaching a ceiling (see Kazdin & Blase, 2011). Accordingly, a guiding theme of my presidential year will be helping our field step outside of our “comfort zone”—to incorporate innovative intervention formats and novel treatment redesigns that may help us better achieve and sustain a consequential public health impact. For example, I’m gearing up to launch a Division 12 Task Force focused on Technology and Mental Health that will work to advance the roles of technology in responsible clinical practice and in promoting mental wellness in the general population. This Task Force will have 5 intersecting work groups—1) Telemental Health, focused on the use of remote technologies to provide real-time intervention (e.g., videoconferencing treatment), (2) mHealth Intervention (focused on mobile technologies, mental health apps, and asynchronous treatments), 3) Technology-Based Dissemination and Public Information; 4) Machine Learning, Artificial Intelligence, and Just-In-Time Adaptive Interventions; and 5) Social Media, Screen Time, and Mental Health. In addition, to further broaden the reach of our work beyond traditional mental health office-based settings, I will use my presidential term to advance efforts to better incorporate clinical psychological science into non-mental health settings (e.g., patient-centered medical homes, school settings, employment settings).

I certainly want to thank the most recent two presidents of SCP—Michael Otto and Gary VandenBos—both for their strong leadership, and for directly modeling how SCP presidents can use their terms to energize our Society and to pursue vital and consequential initiatives that address critical issues that confront society and our field. But perhaps most importantly, throughout my time serving in various capacities on the SCP Board, it has become clear to me that our greatest accomplishments are only achieved together—in full partnership and collaboration with an active and engaged SCP membership. I invite you all to step outside of your own “comfort zones,” make your voices heard, and even consider volunteering to serve SCP in some capacity. We are buzzing with opportunities, including education and training, a mentorship program, linking science and practice, publications, membership and recruitment, a growing webinar program, conference planning, development of special interest groups—please just reach out (jocomer@fiu.edu) if you’d like to get involved. I hope that you do – I’m looking forward to working with you!

- Jon

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One of the most consistent findings in psychiatric epidemiology is that of greater female risk for affective disorders; females are twice as likely to be diagnosed with depression (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993), and three times more likely to make a suicide attempt (Canetto & Sakinofsky, 1998). Female-biased risk for depression and suicidal behaviors emerges around the typical age of menarche, when females begin to experience hormone cycling and menstrual bleeding; female-biased risk fades in the mid-50’s, around the typical age of menopause, when hormone cycling stops (Kessler et al., 1993; Nock et al., 2008). Therefore, although the etiology of sex differences in affective risk is extremely complex (Hodes, Walker, Labonté, Nestler, & Russo, 2017; Rubinow & Schmidt, 2019), females’ greater lifetime exposure to reproductive hormone fluctuations likely plays a role. Premenstrual disorders (PMDs) such as premenstrual dysphoric disorder (PMDD) and premenstrual exacerbation (PME) of behavioral disorders are characterized by significant fluctuations in mood and behavior across the menstrual cycle, and may help to explain why sex differences in affective risk are detectable primarily during females’ reproductive years.

For too long, discussions about the role of the menstrual cycle in mood and behavior has waffled between two unhelpful extremes: (1) the argument that all females are predictably impaired each month by premenstrual changes, which is unsupported by empirical evidence (Gehlert, Song, Chang, & Hartlage, 2009), and (2) the argument that cycle effects on mood and behavior are completely culturally constructed, which is equally incorrect (Schmidt, Nieman, Danaceau, Adams, & Rubinow, 1998). Both of these positions should be replaced with a more nuanced, accurate one: most females do not experience important cyclical changes in their emotions, cognition, or behavior, and yet a minority of females (i.e., those with PMDs) do experience impairing, hormone-related changes in mood and behavior and deserve recognition, diagnosis, and treatment (Hartlage, Breaux, & Yonkers, 2014).

With the goal of catalyzing research and clinical efforts in this area, the present paper provides an introduction to PMDs as both a critical area of clinical competence and an exciting area for further clinical research. This article begins with a primer on the menstrual cycle and what is known about PMDs, followed by an overview of research methods for studying the menstrual cycle and PMDs, followed by a research agenda highlighting critical research areas for clinical psychologists interested in engaging the field of PMDs. The article closes with recommendations for working with PMDs in clinical practice. The scope of this article is limited to the basics needed to initiate clinical practice and research work in this area. Especially interested readers can complement this primer with other in-depth epidemiological and methodological reviews (Eisenlohr-Moul et al., 2017; Hantsoo & Epperson, 2015; Owens & Eisenlohr-Moul, 2018; Schiller, Johnson, Abate, Schmidt, & Rubinow, 2016; Wei, Schiller, Schmidt, & Rubinow, 2018).

A Primer on the Menstrual Cycle and Premenstrual Disorders

The Menstrual Cycle (Figure 1). The monthly female reproductive cycle, which lasts an average of 28 days, is structured around two events: ovulation, when an egg is released from the ovary for the purposes of possible fertilization an implantation in the uterus (i.e., pregnancy), and menstrual bleeding, which is the shedding of the uterine lining and the beginning of a new cycle. These events are coordinated via hormonal feedback loops between the brain and ovaries. The prototypical human menstrual cycle can be divided roughly into two halves, bisected by ovulation. The first part of the cycle – the days from onset of menstrual bleeding to ovulation - is the follicular phase, characterized by low progesterone and increasing estradiol that peaks just prior to ovulation. The second part of the cycle – the days between ovulation and the next onset of menstrual bleeding - is the luteal phase, characterized by high levels of progesterone and a secondary peak in estradiol; because it is dictated by the lifespan of the corpus luteum (the hormone-generating shell that remains after the egg is released), the luteal phase has a standard length of 12-14 days. Estradiol and progesterone fall precipitously just prior to and during the first few days of menses (the perimenstrual days), and the cycle begins again.
Individual Differences in Menstrual Cycle Effects on Symptoms

Despite the fact that nearly all reproductive-age females experience the menstrual cycle, only a small percentage suffer from PMDs. Experimental work demonstrates prominent individual differences in neurobiological sensitivity to normal hormone changes, with normal monthly flux causing adverse mood and behavior changes only in some “hormone sensitive” females (Schmidt et al., 1998). This sensitivity likely exists on a continuum, whereby the severity of cyclical symptom change can be absent, mild, moderate, or severe (Eisenlohr-Moul et al., 2017). This work is reviewed in more detail in sections below; however, the notion of individual differences is central to the concept of PMDs and is a critical fact for undercutting the myth that all females suffer deterioration in function across the menstrual cycle. In sum, although most females do not suffer from clinically significant cyclical changes in emotional (Schwartz et al. 2012; Hengartner et al. 2017; Ben Dor et al. 2013) or cognitive (Leeners et al. 2017; Schmidt et al. 2013) symptoms across the menstrual cycle, experimental work clearly demonstrates that the subset of females with PMDs do suffer from an abnormal sensitivity to normal ovarian steroid changes (i.e., hormone sensitivity). Two commonly-recognized types of PMDs are described below.

Premenstrual Dysphoric Disorder (PMDD)

Symptoms, Prevalence, and History of PMDD. PMDD is characterized by the cyclical recurrence of distressing or impairing affective symptoms in the two weeks prior to menses onset (i.e., the luteal phase), with full remission of symptoms in the week after menstrual bleeding (see gradient representing symptom onset and offset in Figure 1). That is, in PMDD, there is a clear luteal phase confinement of symptoms. PMDD is categorized as a DSM-5 mood disorder, and although physical (e.g., cramping, swelling, bloating) and vegetative (e.g., changes in sleep or eating) symptoms can contribute to the diagnosis, at least one cyclical symptom must be emotional. The core emotional symptoms of PMDD in DSM-5 include mood swings, rejection sensitivity, anger or irritability, interpersonal conflict, depressed mood, hopelessness, feelings of worthlessness and guilt, and anxiety; at least one of these must be present for diagnosis. Additional DSM-5 symptoms include decreased interest, difficulty in concentration, lethargy or lack of energy, increased cravings or appetite, hypersomnia or insomnia, feeling overwhelmed or out of control, or physical symptoms (breast tenderness, muscle pain, bloating, weight gain). In addition to requiring at least one emotional symptom to show the cyclical pattern, the DSM-5 diagnosis requires five or more of these eleven possible symptoms to show a pattern of luteal phase confinement, a stringent cutoff intended to reduce the risk of overdiagnosis (i.e., pathologizing mild premenstrual changes). Although one can make a provisional diagnosis of PMDD based on self-report alone, a full diagnosis requires two months of daily DSM-5 symptom ratings due to the high false positive rate (Roy-Byrne, Rubinow, Hoban, & Parry, 1986).

PMDD is unique among mental disorders in that it is primarily defined not by its content, but by its time course (i.e., luteal phase confinement of symptoms).
However, observational studies do indicate that, emotionally, PMDD is characterized most commonly by irritability and mood swings, with symptoms of anxiety being the next most common, and symptoms of depression being the least common of the core emotional symptoms (Pearlstein, Yonkers, Fayyad, & Gillespie, 2005). Across patients with prospectively-diagnosed PMDD, the greatest severity of symptoms occurs between day 3–4 prior to onset of menses and 3 days after the onset of menses (Hartlage, Freels, Gotman, & Yonkers, 2012). For some, the symptoms begin following ovulation and persist through the two-week luteal phase, whereas others have symptoms only in the final week before menses. In large longitudinal studies, the point prevalence of DSM-5 PMDD is estimated around 5.5% (Epperson et al., 2012; Gehlert et al., 2009).

After previous iterations of the diagnosis (e.g., late luteal phase dysphoric disorder) were relegated to the Appendices of DSM-IIIR, DSM-IV, and DSM-IV-TR, PMDD transitioned to full diagnostic status in the DSM-5 in 2013. Originally, the proposal to include PMDD in the DSM was met with skepticism and concern about potential stigmatization or harm; however, these issues have been thoroughly investigated and generally debunked, with the overwhelming weight of the evidence indicating that acknowledgement and treatment of PMDD is appropriate (see Hartlage et al., 2014, for a data-driven rebuttal of these issues).

**Biological Mechanisms of PMDD.** A pervasive misconception about PMDD is that is it caused by abnormal hormone levels, hormone metabolism, or hormone “imbalance.” In fact, those with PMDD cannot be differentiated from controls by their peripheral hormone levels or patterns across the menstrual cycle (Schmidt, Purdy, Moore, Paul, & Rubinow, 1994) or hormone metabolism (Nguyen et al., 2017); put simply, their reproductive hormone function across the cycle is normal. However, a number of studies have demonstrated that most patients with prospectively-diagnosed PMDD show an abnormal behavioral response to normal hormone changes. In several key experiments, Schmidt et al. have demonstrated that inducing a reversible menopause (using GnRH analogue injections) eliminates symptoms of PMDD, whereas addback of either estradiol or progesterone causes a resurgence of symptoms (Schmidt, Nieman, Danaceau, Adams, & Rubinow, 1998). Critically, these symptoms of hormone addback subside after 2-3 weeks of stable hormone addback, suggesting that PMDD is caused not by an abnormal sensitivity to elevated levels of hormones, but rather by an abnormal sensitivity to the normal cyclical changes in hormones that occur each month following ovulation (Schmidt et al., 2017).

The exact mechanism (or, more likely, mechanisms) of this abnormal sensitivity to post-ovulatory hormone surges in PMDD is unknown, and the search to uncover critical pathways is ongoing (reviewed in Hantsoo & Epperson, 2015). Several lines of investigation are focused on altered luteal phase serotonergic function in PMDD (Roca et al., 2002), altered function of the GABA-A receptor and its response to GABAAergic progesterone metabolites (MacKenzie & Maguire, 2014; Martinez et al., 2016), and, most recently, altered cellular gene expression relevant to hormone processing (Dubey et al., 2017). Seven expert, up-to-date reviews are available for those who wish to read further about the state of the knowledge in this small but growing area (Schiller et al., 2016; Wei et al., 2018). However, for the purposes of this primer, the critical point is that PMDD is caused by an abnormal neurobiological sensitivity to normal hormone changes across the menstrual cycle, and not abnormal or disordered reproductive hormones or function.

**Evidence-Based Medical Treatment of PMDD.** At present, evidence-based treatment of PMDD is primarily medical. Nevertheless, clinical psychologists should be aware of the primary empirically-supported treatments for PMDs.

Based on a number of positive randomized controlled trials, **selective serotonin reuptake inhibitors (SSRIs)** are the first line treatment for PMDD (Casper & Yonkers, 2019; Meir Steiner et al., 2006). About 60% of prospectively-diagnosed PMDD patients respond to SSRIs (Halbreich, 2008). Notably, SSRIs work rapidly in PMDD, beating placebo after just 24 hours (Steinberg, Cardoso, Martinez, Rubinow, & Schmidt, 2012); therefore, they are equally effective when used only in the luteal phase (vs. all month long) (Meir Steiner et al., 2006).

If SSRIs are not effective, treatment moves toward suppressing hormone flux by preventing ovulation. The least invasive method of ovulation suppression is **combined oral contraceptives (COCs)** taken on a 24–4 (24 active pills, 4 inactive pills) or continuous schedule (i.e., with a shortened or eliminated hormone-free interval). Two large RCTs demonstrate a benefit of a drospirenone-containing oral contraceptive when used on a 24-4 schedule (Lopez, Kaptein, & Helmerhorst, 2012). Clinical trials using continuous COCs with levonorgestrel, another progestin, demonstrate more mixed effects (Ellen W Freeman et al., 2012).

Some individuals with PMDD develop chronic mood symptoms on COCs or do not experience relief (Gingnell et al., 2013); in this case, other cycle suppression treatments can be pursued. Monthly injections of **GnRH analogues** (e.g., leuprolide acetate), which are used routinely by gynecologists to treat endometriosis and other gynecological complaints, can be used to temporarily shut down hormone production by the ovaries, causing a month-long reversible menopause. A meta-analysis of RCTs reported consistent beneficial
effects of GnRH analogues in PMDD (Wyatt, Dimmock, Ismail, Jones, & O’Brien, 2004). However, in order to maintain bone and heart health while also preventing endometrial cancer, addback of both estradiol and progesterone is necessary while taking GnRH analogues. In the first month of this hormone addback (on top of the GnRH analogue), there is a temporary resurgence of PMDD symptoms; however, this subsides after a month of stable addback (Schmidt et al., 2017).

If the GnRH analogue plus hormone addback (often called a “menopause trial”) is an effective treatment, and the patient elects for it, a total hysterectomy with bilateral oophorectomy (removal of the uterus and both ovaries) is indicated to remove all hormone flux and initiate surgical menopause; longitudinal studies indicate that this surgical procedure is effective for most patients with PMDD who have experienced remission on GnRH analogues (Cronje, 2004). Of note, bilateral oophorectomy is the critical element of this treatment—if either ovary remains, ovulation (and, therefore, PMDD) still occurs. Removal of the uterus is also recommended, since it eliminates the need for post-surgical progesterone treatment, and unopposed estradiol addback can be used to manage menopausal symptoms and maintain bone and heart health.

Psychosocial Mechanisms in PMDD. A small number of studies have examined psychological factors associated with prospectively-diagnosed PMDD and severity of symptom expression. Compared with controls, patients with PMDD show higher trait levels of brooding rumination (Craner, Sigmon, Martinson, & McGillicuddy, 2014), and higher brooding rumination among patients with PMDD prolonged residual symptoms in the early follicular phase (Dawson et al., 2018). Patients with PMDD also report higher trait levels of avoidant or impulsive behaviors than controls (Craner et al., 2014; Petersen et al., 2016). In response to a negative affect induction, patients with PMDD report more self-focused attention, a trait associated with rumination and poor emotion regulation, than controls (Craner, Sigmon, & Martinson, 2015). Another study found that patients with PMDD showed within-person increases in self-focused attention during the premenstrual week that partially mediated degree of premenstrual mood changes (Craner, Sigmon, & Young, 2016). Finally, another found that cyclical changes in anhedonia and difficulty concentrating were the DSM-5 PMDD symptoms most strongly associated with cyclical impairment (Schmalenberger, Eisenlohr-Moul, Surana, Rubinow, & Girdler, 2017).

A larger number of studies have also examined the role of psychosocial stress in premenstrual symptoms. Although some studies using cross-sectional methods to diagnose PMDD (a method known to produce an unacceptable percentage of false positives) have observed greater prevalence of trauma exposure in PMDD vs. controls (Pilver, Levy, Libby, & Desai, 2011), more rigorous studies in which PMDD was prospectively-diagnosed did not find an increased exposure to trauma in individuals with this condition (Segebladh et al., 2011). However, another study in a sample of patients with prospectively-diagnosed PMDD found that the strength of the daily link between progesterone levels and symptoms was stronger in patients with histories of trauma exposure, suggesting a possible influence of trauma on the severity (rather than the occurrence) of luteal phase symptoms in PMDD (Eisenlohr-Moul et al., 2016). In addition to historical trauma exposure, current stress may increase risk for PMDD symptoms. A prospective study following medical students who were or were not beginning a stressful shift-based clinical assignment found greater increases in premenstrual mood deterioration among patients in the high stress condition (Namavar Jahromi, Pakmehr, & Hagh-Shenas, 2011). In another study, cycles preceded by higher-than-usual perceived stress showed greater premenstrual mood deterioration (Gollenberg et al., 2010). More work is needed to explore the biological and psychological mechanisms by which stress may cause increases in PMDD symptoms.

Psychotherapy for PMDD. Several RCTs have examined the impact of time-limited cognitive behavioral therapy (mean of 6 sessions) on symptoms of PMDD, and generally find a small-to-medium effect sizes for benefit relative to waitlist control (reviewed in Kleinstäuber, Witthöft, & Hiller, 2012)). However, a recent meta-analysis demonstrated no effect of CBT (vs. control) on PMDD symptom severity, instead finding only a significant reduction in impairment (Kleinstäuber et al., 2012). Unfortunately, several of the studies did not conduct prospective diagnosis of PMDD and did not rule out comorbid conditions, calling into question the nature of their samples; further, the total number of patients studied in these trials was only N=173. Therefore, larger trials with more rigorous inclusion criteria are needed before a firm conclusion about the efficacy of CBT in PMDD can be made.

On the other hand, very little evidence is available regarding the emotional, cognitive, and behavioral mechanisms of PMDD, and therefore CBT protocols targeting any unique mechanisms that may exist in PMDD have yet to be developed or tested. The limited existing evidence regarding the psychopathology of PMDD indicate roles for rumination, avoidant or impulse emotion-driven behaviors, and anger or interpersonal conflict as drivers of PMDD symptom severity (Pearlstein et al., 2005). Therefore, treatments that focus on development of concrete behavioral skills for use in responding to an array of negative emotions such as dialectical behavior therapy (DBT; Linehan, 2014) or the unified protocol (UP; Barlow et al., 2011) could, in theory, be more effective than generic CBT for reducing symptoms and impairment in PMDD. Finally,
it should be noted that PMDD can be accompanied by cyclical suicidality; in such cases, DBT would seem to be a rational treatment approach for reducing suicide risk (Linehan et al., 2006).

**Premenstrual Exacerbation (PME) of Underlying Disorders**

**Symptoms, Prevalence, and History of PME.** Premenstrual exacerbation (PME) of an underlying disorder occurs when chronic symptoms of an existing psychiatric disorder are significantly worsened before or during menses. As noted above, PMDD is characterized by a luteal phase confinement of symptoms, whereas in PME symptoms are chronic but worsen around the onset of menses. PME has been documented to occur in a wide variety of medical diagnoses (Pinkerton, Guico-Pabia, & Taylor, 2010). In general, the course of PME is less well-defined than PMDD, but generally follows similar pattern in which symptoms peak in the late luteal phase and show improvement in the mid-to-late follicular phase (see gradient in Figure 1). In addition to a pattern of worsened symptoms prior to menses, there is also some evidence that addictive disorders can also show a primary or secondary worsening around ovulation, when surging estradiol increases reward sensitivity (e.g., Martel, Eisenlohr-Moul, & Roberts, 2017).

So far, prevalence estimates are only possible for PME of depressive disorders, highlighting the critical need for additional work in this area. In a large prospective study of females with depressive disorders in the community, around 60% these individuals demonstrate significant (≥ 1 person-standard-deviation of that symptom) PME of at least one symptom across two menstrual cycles (Hartlage, Brandenburg, & Kravitz, 2004), indicating that PME is a common phenomenon in depressive disorders that may complicate the course of treatment in females. The fact that PME of depression is common may suggest that it plays a role in female-biased depression risk, since PME may serve to initiate or maintain depressive episodes (Kiesner, 2017).

Unfortunately, epidemiological data is lacking to estimate the prevalence of PME in any other mental disorder. Many small (N<50) longitudinal studies have observed main effects of the cycle on symptom severity in various mental disorders, suggesting the likelihood that females diagnosed with those disorders are similarly at risk for (though not necessarily suffering from) PME. These disorders include bulimia nervosa (Edler, Lipson, & Keel, 2007), borderline personality disorder (Eisenlohr-Moul, DeWall, Girdler, & Segerstrom, 2015; Eisenlohr-Moul et al., 2018), obsessive-compulsive disorder (Vulink, Denys, Bus, & Westenberg, 2006), bipolar disorder (Dias et al., 2011; Teatero, Mazmanian, & Sharma, 2014), schizophrenia (Seeman, 2012), substance abuse (Martel et al., 2017), and post-traumatic stress disorder (Nilni et al., 2015). Of note, a longitudinal study in bipolar disorder demonstrated that patients with PME of bipolar (vs. those females with bipolar without PME) suffered a more severe and chronic course of illness (Dias et al., 2011). In addition, a large number of studies have indicated an increased risk of suicide attempt and death around the onset of menses (Saunders & Hawton, 2006). Despite these main effects, it is not likely that all patients with these disorders suffer from PME; rather, similar to what was observed in PME of depression, risk for PME probably varies on a spectrum within the larger diagnostic group and may serve to exacerbate or prolong symptoms for some female patients. In sum, it seems likely that PME is present in many—but not all—cases of female psychopathology.

Despite years of research studies demonstrating the occurrence of PME in various disorders, PME is not yet acknowledged as an official diagnostic specifier in the DSM-5 or in any other diagnostic classification system. However, one could imagine a future iteration of the DSM in which “with perimenstrual exacerbation” can be specified in order to indicate the presence of this complicating factor that may require specific adjunctive treatment. The most relevant precedent for such a specifier would be the option to specify “with peripartum onset” in the DSM-5 diagnosis of mood disorders (APA, 2013). However, for the moment, PME is not generally acknowledged or assessed in clinical practice, despite evidence for its existence.

**Biological Mechanisms and Treatment of PME.** Although one might expect that the biological causes of PME are the same as that of PMDD, several recent clinical trials have demonstrated that, at least in patients with PME of depression, many PMDD-specific treatments are not effective, calling into question the notion of a globally shared PMDD and PME pathophysiology. Drospirenone-containing COCs were recently evaluated as an adjunct to SSRI for patients with PME of depression, and failed to beat placebo (Peters, Freeman, Kim, Cohen, & Joffe, 2017). Further, randomized controlled trials have demonstrated that GnRH analogues are not more effective than placebo for patients with PME of depression (Freeman, Sondheimer, & Rickels, 1997; Freeman, Sondheimer, Rickels, & Albert, 1993). Finally, secondary analyses of a subsample of patients with PME of ongoing disorders in an evaluation of isocallopregnanolone, a GABA-A allopregnanolone antagonist currently in development, found a strong benefit relative to placebo for PMDD but no benefit for patients with PME of an ongoing disorder (Bixo et al., 2017). This could indicate that PMDD is characterized by altered GABAAR function, whereas PME of some disorders (e.g., depression) is not. No trials have examined the effect of SSRI or CBT on PME of depression or any other disorder, and these remain the first-line treatments of choice for individuals with depression with or without PME. In
Comorbidity and Overlap Between PMDD and PME.

It is important to recognize that neither PMDD nor PME are monolithic groups, and it is likely that some patients with PME are suffering from similar hormone sensitivities to those with prototypical PMDD and will therefore respond to similar treatments focused on reducing the negative effects of fluctuating hormones (see PMDD section above). While it is often the case that an individual has PMDD, PME, or neither, it is also possible to have both PMDD and PME (Hartlage & Gehlert, 2001). As an example, it is possible to have PME of depression (chronic depression with worsening before and during menses) and also have a PMDD pattern (i.e., luteal phase confinement) of five other symptoms—usually physical symptoms, mood swings, anger/irritability, rejection sensitivity, and anxiety symptoms that ONLY appear between ovulation and menses. In sum, more work is needed to understand who is sensitive to what kind of hormone changes, and how this can be diagnosed and treated most efficiently.

Research Priorities for Improving Understanding and Treatment of PMDs

Clinical psychologists have unique areas of methodological competencies, especially differential diagnosis and assessment, that may make them highly suited to contributing to research on PMDs. Further, given the increasing focus on research and biology in training programs, many clinical psychologists have additional areas of expertise, such as affective neuroscience or psychoneuroendocrinology, that can be readily used to contribute to research on PMDs. Below is a primer on measurement of the menstrual cycle, after which several key research areas are highlighted with particular attention to the ways in which clinical psychologists can contribute to research in PMDs.

How to measure the menstrual cycle in longitudinal studies

Using cycle counting methods to establish menstrual cycle day (and categorical menstrual phase) is an inexpensive and powerful way to understand or covary the effects of the cycle on a repeated outcome of interest in a longitudinal study. In order to generate both cycle day and cycle phase variables for use in models, three dates are needed: the date of the observation, the date of the prior menses onset, and the date of the subsequent menses onset (see Figure 1 for counting visuals). Backward-counting from the day before menses onset (day -1) to day -15 is recommended for delineating the luteal phase and its sub-phases; forward-counting from the day of menses onset (day 1) to day 10 is recommended for delineating the follicular phase. (Of note, without backward count, cycle day and phasing is highly inaccurate and untrustworthy, since the length of the follicular phase is variable both between and within people). This results in a “cycle day” variable that can be used to graph the impact of the entire cycle from ovulation to the next mid-follicular phase; it can also be further categorically coded into a within-person cycle phase variable (e.g., Edler et al., 2007). For more information about the many options for coding menstrual cycle phases from this cycle day variable in order to test hypotheses about the impact of the cycle on an outcome of interest, see our recent methodological paper on this topic (Schmalenberger & Eisenlohr-Moul, 2019). Additional biological measures, such as urine luteinizing hormone testing, basal body temperature, or hormone measures can be used to validate and correct cycle phasing decisions; however, when both backward and forward counting are possible for a given observation, this is a reliable and valid method of measuring the impact of the menstrual cycle in research studies.

How to study PMDs

Simply put, studying PMDs requires repeated measures in order to carry out meaningful hypothesis tests about cyclical symptom changes. Given that retrospective measures of PMDD (and PME) lack specificity, single-time-point self-report measures of PMD symptoms are not acceptable for publication or citation as evidence of such symptoms. In order to conclude that a female has cyclical mood change or a PMD, symptoms must at least be measured at weekly (and preferably daily) intervals.

Our laboratory has developed a standardized scoring system for making the diagnosis of PMDs called the Carolina Premenstrual Assessment Scoring System (C-PASS; Eisenlohr-Moul et al., 2017). A worksheet with detailed instructions, an excel macro, and a SAS macro are available in the resources section for facilitating use of the C-PASS system (see Resources section below). The details of this scoring system can be found in the validation paper (Eisenlohr-Moul et al., 2017); in brief, for symptom to meet C-PASS criteria for the PMDD pattern in a given cycle, it
must meet four different requirements: relative symptom elevation: percent symptom elevation during premenstrual phase relative to postmenstrual phase >=30% (percent change calculations are explained in the linked worksheet above); absolute clearance: postmenstrual week maximum <=3; absolute severity: premenstrual week maximum >=4; and duration: at least two premenstrual week days >=4). The cycle-level diagnoses of PMDD are made by counting the number of DSM-5 symptoms meeting criteria on all four dimensions in a given cycle (must be >=5) and noting if a core emotional symptom meets criteria (number of core symptoms >=1). Next, the C-PASS makes the diagnosis of PMDD at the person level by counting the number of cycles meeting diagnostic criteria for PMDD (cycles meeting criteria >=2). The diagnostic procedure for PME is exactly the same, with one exception: the requirement for absolute clearance is omitted from the process. The C-PASS scoring system (Eisenlohr-Moul et al., 2017), including the excel and SAS macro, can be used in research either to diagnose individuals categorically (e.g., individual A meets criteria for PMDD across two cycles of daily ratings, whereas individual B does not) and measure symptom cyclicity dimensionally (e.g., individual A showed an average of 45% premenstrual elevation of depression across two cycles; individual B showed an average of 28% premenstrual elevation of depression across two cycles). In addition to these methods, which use daily ratings to create between-person variables, daily symptoms can also be modeled directly as repeated outcomes in multilevel models, using coded menstrual cycle variables (Schmalenberger & Eisenlohr-Moul, 2019) as categorical or continuous predictors (e.g., as in (Dawson et al., 2018; Eisenlohr-Moul et al., 2018).

If one simply wishes to exclude potential participants who might have a PMD, retrospective questionnaires such as the Premenstrual Symptoms Screening Tool (PSSST) can be used (Steiner et al., 2003), since is has good sensitivity (but inadequate specificity for clinical diagnosis). Although use of this type of retrospective questionnaire will also exclude many individuals who do not actually have PMDs (e.g., false positives), you will also likely eliminate nearly all individuals with PMDs (Eisenlohr-Moul et al., 2017).

Critical Research Areas in PMDs

Improving Assessment of PMDs. There are many unanswered research questions in the field of PMDs related to assessment, an area in which clinical psychologists are well-trained. As noted above, problems of poor specificity for retrospective PMD assessment have led to the DSM-5 requirement that PMDD can only be diagnosed using two months of daily symptom ratings. This is extremely burdensome, and it is possible that new measurement developments could reduce this burden for patients and providers and improve detection of PMDs. Improvement of this process could take many forms, including identification of other retrospective self-report questions about PMD symptoms that provide greater power for prediction of a prospective diagnosis based on daily ratings, use of passive tracking of behavior or physiology, or integration of informant retrospective report of PMD symptoms as more specific diagnostic indicators.

An additional area in desperate need of effort is the estimation of prevalence of PME in DSM-5 disorders other than depression; given the requirement of prospective daily confirmation, this will necessitate the use of large representative samples followed across several cycles (e.g., Hartlage et al., 2004). A better understanding of the scope of PME across each DSM-5 disorder is necessary to underscore the public health relevance of PME in different disorders. Given the heterogeneity of PMDs, more work is needed to identify whether there are subtypes of PMDs with respect to time course across the cycle or symptom type. This work may be useful for predicting differential responses to treatments. For example, it could be the case that PME of certain anxiety disorders show more in common with PMDD (in terms of cyclical course or content) than does PME of depression, which could have important implications for treatment of PMEs. We also need information about the impact of PME on resistance to standard treatments in various disorders, as it may be the case that PME of some disorders is more detrimental to female outcomes than PME of others (e.g., Dias et al., 2011).

Identifying Key Psychological Mechanisms of PMDs. As noted above, only a handful of studies have examined the psychological mechanisms (e.g., rumination, self-focused attention, emotion-related impulsivity) of cyclical symptom expression in PMDD; and virtually no attention has been paid to psychological mechanisms of cyclical symptom exacerbation in PME of other disorders. Many potential avenues in this area remain untapped. For example, in order to intervene early in the luteal process of PMDD symptom expression, it will be critical to understand which symptoms appear first, and which symptoms may be central to driving expression of the rest. Network analysis studies of premenstrual symptoms, as well as longitudinal changes in network structure across the cycle, could help to clarify the core processes that might be targeted by psychotherapies. Additionally, nearly all studies of PMDs have used self-reported symptoms, whereas directly observed behavior in PMDs remains unstudied. This is a critical area for laboratory studies in experimental psychopathology research. Finally, given the evidence that interpersonal symptoms such as anger/irritability, rejection sensitivity, and interpersonal conflict are among the most common and impairing symptoms in PMDD (Pearlstein et al., 2005), laboratory studies focused on behavioral analysis of dyadic interactions are also warranted to...
clarify how PMD symptoms may change interpersonal interactions, and whether interpersonal skills training or partner-supported therapies may be rational treatment avenues.

CBT interventions for PMDD have failed to show significant effects of symptom severity in a recent meta-analysis (Kleinstäuber et al., 2012). Perhaps this is unsurprising, given that so little is understood about the cognitive and behavioral mechanisms of PMDs. Before developing and testing further psychotherapeutic interventions for PMDs, more information may be needed about the time course of symptom expression in the luteal phase, and therefore how specific cognitive and behavioral processes might be modified to reduce symptom escalation. Existing studies in PMDD have implicated emotion dysregulation, impulsivity, rejection sensitivity, interpersonal conflict, and cognitive problems in the expression of PMDD; it seems warranted to examine these processes further in laboratory settings, and to evaluate which skills might mitigate luteal (vs. follicular) emotional and physiological reactivity in the moment for those with prospectively-diagnosed PMDD. Once key mediators and promising skills have been identified, rational treatments can be constructed and evaluated in clinical trials.

Clarifying Biological Underpinnings of PMDs. The pathophysiology of PMDs (mostly PMDD) is a small but rigorous area of neurobiological research, historically carried out primarily by a few psychiatrists and behavioral scientists without clinical training (Wei et al., 2018). Increasingly, clinical psychologists receive basic training in the neurobiological bases of mood, cognition, and behavior, and often receive advanced training in affective neuroscience, psychoneuroendocrinology, and other areas relevant to the study of PMDs. Accordingly, many clinical psychologists have specific skills (e.g., in randomized controlled trials, peripheral endocrine and immune measures, and imaging methods such as fMRI, EEG, or PET) that can be readily applied to generating knowledge about the biological underpinnings of PMDs. Of particular note, researchers have yet to uncover the fundamental causes of abnormal hormone sensitivity in PMDs. Studies using mechanistic trials to uncover the brain mechanisms of evidence-based (or novel) treatments represent one key area that could lead to a clearer understanding of the pathophysiology of PMDs. Thoughtfully-designed observational studies are also needed to uncover possible neurobiological PMD subtypes of change across the cycle, which may help to identify more granular, useful treatment targets in PMDs, or help to predict responses to existing treatments.

The biological underpinnings of PME in females with depression is a critically understudied area. Around 60% of females with a depressive disorder experience clinically significant worsening of at least one symptom (Hartlage et al., 2004), and it has recently become clear that the pathophysiology of PME in females with depressive disorders is unique from that of PMDD (reviewed above). Therefore, a fresh set of clinical trials, experimental laboratory studies, and longitudinal analyses are needed to understand the pathophysiology of this condition. Studies are also needed to understand whether PME of other disorders, such as borderline personality disorder, are also underpinned by a unique pathophysiology, or whether they share important biological underpinnings with PMDD. Suppressed metabolism of hormones to GABAergic metabolites in females with depression (Agis-Balboa, Guidotti, & Pinna, 2014) and PSTD (Pineles et al., 2018) may lead to a greater sensitivity to perimenstrual hormone withdrawal in some individuals, and a preliminary trial in our laboratory provides initial support for this hypothesis (Eisenlohr-Moul et al., 2018). It will be critical to replicate and probe the mechanisms of such effects using diverse methodologies.

Finally, there is currently no longitudinal evidence about how PMDs develop and interact with psychopathology during critical developmental periods, although a theory has recently been proposed (Kiesner, 2017). Longitudinal work is sorely needed in this area and could uncover interactive roles of genetics and particular environmental stressors in the onset of PMDs. Further, this work may help us to understand whether and how cyclical mood changes and chronic psychopathology mutually reinforce and perpetuate one another over time. This work may ultimately lead to detection and treatment of PMDs at critical time points that could prevent a long-term impact of PMDs on female-biased risk.

Clinical Applications

Psychotherapy Patients as a Group at Risk for PMDs

The majority of patients seeking psychotherapy are females of reproductive age (Vessey & Howard, 1993), who either have a monthly menstrual cycle or are taking hormonal medications that can cause hormone fluctuations (Willis, Kuehl, Spiekerman, & Sulak, 2006). These facts alone are sufficient to recommend that all psychotherapists receive some rudimentary training in the menstrual cycle and PMDs; however, clinical psychology and other psychotherapy training programs do not yet provide training in the menstrual cycle or PMDs. There have been good reasons for caution around these issues in the past, such as a concern about stigmatizing or disempowering females and a lack of empirical knowledge about the scope of PMDs (Hartlage et al., 2014); however, given the strong experimental evidence for individual differences in hormone sensitivity that has accumulated over the past 30 years (Wei et al., 2018), the time is right for psychotherapists and clinical scientists to receive basic
training in and contribute more regularly to the field of PMDs.

Clinical psychologists (both non-prescribing and those with prescribing privileges) can and should take an active role in the assessment, treatment planning, and management of PMDs. Many psychologists may feel that biological processes such as the menstrual cycle are beyond their scope of practice or area of expertise. However, a basic knowledge of the menstrual cycle and PMDs can be conceptualized as similar to knowing how sleep, diet, exercise, caffeine intake, or alcohol use affect mood in some individuals. Although clinical health psychologists and others with a biological bent may engage more intensively in the PMD treatment process, all clinical psychologists can quickly gain a basic understanding of the menstrual cycle and PMDs.

Recommendations for Assessment, Referral, and Treatment of PMDs

The basic clinical tasks for a psychologist in this area can be summarized as (1) assessment and diagnosis of PMDs using daily ratings across two cycles, (2) referral to a prescriber with an awareness of evidence-based guidelines for PMD treatment, (3) helping the patient monitor progress using daily ratings, and (4) using psychotherapies to reduce PMD-related impairment and treat comorbidities. The first step, assessment and diagnosis, is appropriate for all females with concerns about premenstrual symptoms who are naturally-cycling (i.e., those who are not pregnant, breastfeeding, or using the contraceptive pill, patch, or ring—each of which prevent ovulation and the natural cycle). Assessment begins by having the patient track their symptoms daily across at least two menstrual cycles, preferably using the Daily Record of Severity of Problems (DRSP; Endicott, Harrison, & Nee, 2006), which measures all DSM-5 PMDD symptoms. Next, graphs are inspected to determine whether symptoms are confined to the luteal phase (PMDD), an exacerbation of a chronic disorder (PME), a mixture of both (e.g., chronic depression with PME as well as >=5 other symptoms confined to the luteal phase, i.e., PMDD), or none of the above. Tools such as Prementrics App and the C-PASS scoring system, which can streamline collection and diagnosis of daily ratings, are linked in a Resources section below. Referral to a competent prescriber comes next. Starting with a reproductive psychiatry specialist is ideal, but not always possible; in the absence of an expert, most prescribing providers with access to evidence-based treatment guidelines (linked in the resources section) can carry out first-line treatments and eventually refer to a gynecologist if a GnRH analogue trial or oophorectomy with hysterectomy is desired. Finally, as the patient engages in medical management of their symptoms, the psychologist can help the patient to continue tracking their symptoms and any side effects of treatment using the same method used for diagnosis; this allows an objective evaluation of how treatments are impacting symptoms and empowers the patient to communicate clearly with their prescribing provider. Although CBT is not yet evidence-based for reduction of symptoms in PMDD, it is effective for reducing impairment and may be required for treatment of comorbid conditions (Kleinstäuber et al., 2012).

Summary and Conclusion

Premenstrual disorders (PMDs) such as premenstrual dysphoric disorder (PMDD) and premenstrual exacerbation (PME) of underlying conditions represent an important public health problem with bearing on the female-biased risk of affective disorders and suicidal behaviors. Furthermore, although the majority of psychotherapy patients and psychological research subjects are females of reproductive age who are at high risk of cyclical mood changes, clinical psychologists do not usually receive basic training or engage in this area. Very reasonable concerns about perpetuating stereotypes about female fragility or the empirical status of PMDs may have prevented psychologist training and engagement in PMDs in the past. However, the current evidence unequivocally supports the acknowledgement, clinical engagement, and research study of PMDs by clinical psychologists, and the application of psychologist expertise to these understudied and undertreated conditions will undoubtedly enrich the field.

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Resources

Assessment of PMDs:
- C-PASS Scoring System for diagnosing and quantifying PMDs symptom-by-symptom in complex clinical cases or research studies: https://www.med.unc.edu/psych/wmd/resources/clinicians-researchers/

Treatment of PMDs:
- Evidence-Based Treatment Guidelines: https://www.uptodate.com/contents/treatment-of-premenstrual-syndrome-and-premenstrual-dysphoric-disorder

International Association for Premenstrual Disorders:
- www.iapmd.org
  - Evidence-based educational content for patients, providers, and caregivers
  - Free peer-support services for patients
  - Provider directory

Premenstrual Disorders (continued)
SCP Member Spotlight on Dr. Robert Woody

Dr. Robert (Bob) Woody is a distinguished member of SCP whose career represents the integration of psychology, law, and ethics with an interest in multicultural and diversity issues, as well as the role of psychology in advancing public health. Dr. Woody’s career exemplifies the integration of science and practice, and he has been an active member and leader in SCP and APA. We had the opportunity to learn more about Dr. Woody through our Q&A correspondence. Read on to learn more!

Where did you complete your training?

Following an undergraduate degree in music education from Western Michigan University, I received a Master’s degree in counseling from Michigan State University, a Specialist in Education degree in school psychology from Western Michigan University, and a Doctor of Philosophy degree from the College of Education at Michigan State University. I completed a postdoctoral fellowship in clinical psychology at the University of London Institute of Psychiatry (Maudsley Hospital) and completed two years of postdoctoral training in group psychotherapy at the Washington School of Psychiatry. In 1975, I earned a Doctor of Science degree in health services research and administration (community mental health) from the Graduate School of Public Health at the University of Pittsburgh. This was followed by completion of a Juris Doctor degree from the Creighton University School of Law in 1981. I also earned a Certificate of Graduation from the Basic Police Academy at the Pat Thomas Law Enforcement Center (a state-sponsored training program in Tallahassee, FL) in 2004.

What is your current position/occupation?

For forty-four years, I have been a tenured professor at the University of Nebraska at Omaha where I have served as Dean for Graduate Studies and Research and on many administrative committees, including President of the Faculty Senate. I am currently teaching graduate courses in Ethics & Law for Psychologists and Administration of Psychological Services, as well as Social Psychology and Forensic Psychology on the undergraduate level. I have taught courses in the history of psychology, clinical psychology, psychological assessment, therapeutic interventions, and community mental health.

I maintain a part-time independent law practice as a consulting attorney, emphasizing health care, education, employment, and business law with an emphasis on consultation and supervision to mental health practitioners on preventing and resolving disputes with service users (e.g., licensing complaints). I have constructed codes of ethics, drafted and dealt with regulatory laws, and participated in administrative law proceedings. I also practice as a part-time consulting psychologist for selected clinical and forensic cases with an emphasis on ethics, standards, legal, family, and marital problems. In the community, I have, for years, served on the Douglas County (NE) Planning Commission, and a Member of the Douglas County (NE) Board of Adjustment.

I have published 38 books/monographs and over 200 articles (many of which were for publications of state psychological associations) with an emphasis on integrating ethics and law including: Woody, R. H. (2013). Legal self-defense for mental health practitioners: Quality care and risk management strategies. New York: Springer Publishing. For more information about my career and professional activities, please visit BobWoodyHelpsPsychology.com.

How long have you been a member of SCP?

I have been a member of The Society of Clinical Psychology (Division 12) for several decades, including serving on the Board of Directors as Treasurer and serving on numerous Division Committees.

Please describe any roles you have with APA or other national, state, or local organizations.

Since joining APA in 1966, I have been on many APA committees and boards including the APA Council of Representatives (four terms), the APA Ethics Committee, Board of Directors for Clinical (Division 12) and Independent Practice (Division 42), and countless other committees in various divisions. These activities have led to my being an APA Fellow. I have earned Diplomates in Clinical and Forensic Psychology, ABPP; Psychological Assessment, ABAP; and other documentation of my professional qualifications. I have been admitted to the Florida, Michigan, and Nebraska Bars.

For several decades, I was active with the Florida
Psychological Association as President-Elect, 2000; President, 2001; Past President, 2002, Board of Directors 2000-2008; Education and the Conference Planning Committees, 2001-2013 (Chair, 2006-2013); Elections and Awards Committee, 2002; and President, Division of Forensic Psychology, 2002-2005.

I have been honored to receive awards from the Florida Psychological Association including Outstanding Professional Service (1989), Award for Outstanding Lifetime Achievements and Contributions (2010), 2008 Psychologist of the Year, and an Award for Outstanding Service to the Board of Directors (2008). I have received the Excellence in Service Award from the University of Nebraska at Omaha (2014) and an Award for Outstanding Dedication to Families and the Practice of Marriage and Family Therapy from the Nebraska Association of Marriage and Family Therapy (2005). I was also President of Basic Recruit Class #281 at the Pat Thomas Law Enforcement Center (2004) and received an Award of Distinction from the Florida Department of Law Enforcement Bureau of Professional Development On-Line Training Development Team (2010).

What do you see as an important direction for the field of Psychology?

It seems apparent that health care will continue to be a driving force for modern clinical psychology, especially pharmaceuticals and primary care. Given my background in public health, I am committed to promoting both community and governmental objectives. Psychologists should become competent in influencing macro systems, such as criminal incarceration. To achieve standing in the health care operations that are advanced by governmental entities, professional associations such as APA should give priority and advocacy to the role of psychology in and competency for health care services.

What are your hobbies?

Family members have been known to joke, “What other people might consider a hobby, you turn into a job.” From my undergraduate major in music education, my passion remains instrumental music (mainly brass and fretted instruments). Although I no longer perform publicly, I practice music every day—to say the least, music is therapeutic. Incidentally, one of my sons is living my musical life for me—he is a Distinguished Professor of Music Education at our Nebraska Lincoln campus.

What led to your interest in clinical psychology and/or area of interest?

My first professional employment was teaching music in a public school. I realized that many of the youngsters needed positive interventions, usually with the family, for emotional and behavioral issues. In taking graduate classes, I became increasingly intrigued by interventions for pathology. In my PhD program at Michigan State, I was fortunate to have training with, among others, Burt Karon and Norm Abeles. As the years passed, I was blessed with other excellent clinical experiences, such as postdoctoral training at the Maudsley Hospital in London (with Monte B. Shapiro and others), which was followed by the unique group psychotherapy training program at the Washington School of Psychiatry (with Morris B. Parloff and others)—behaviorism to psychoanalytic!

Congratulations to Division 12 Section 4 Rep Kalyani Gopal, who is receiving a Congressional Award for her work with female victims of violent crimes and domestic violence, and for her professional mentoring of women!

She will be receiving this award in Chicago on International Women’s Day.
Diversity Spotlight

Randy Salekin, Ph.D.
University of Alabama

I thought I would use this Diversity Spotlight piece to provide a brief introduction of myself for those who may not already know me. My name is Randy Salekin and I am a new board member for the division as well as a Professor at the University of Alabama. I have been a long time member of Div. 12 and have enjoyed being part of the society. Over the years, I have seen numerous ways in which my colleagues, students, and membership have continued to work diligently together on important issues, including diversity. This effort is part of an overarching goal to advance the common interests of our broader society. As a new board member, I am happy to serve as Chair of the Diversity committee and I would like to share with you the committee’s plans for the up-coming year. Fortunately, I am following former committee chair, Kim Penberthy, who provided a terrific framework. Much of her (and her committees) work, is reflected in the events for the up-coming year. Many of the committee members are continuing on and include Elizabeth Yeater, Tahirah Abdullah, Priscilla Lui, Sheehan Fisher, and Michelle Schultz, with student representatives Fanny Ng and Amanda Sanchez. There are four main outlets/events that I elaborate on below.

Diversity Spotlight

Thankfully, we have space devoted to issues of diversity in the Clinical Psychologist. As chair of this committee, I plan to continue working alongside committee members to provide relevant pieces in the “Diversity Spotlight.” We hope to deal with timely and pertinent issues. In a previous issue, Dr. Yeater wrote about sexual violence against women and what psychologists can do to help clients who have been victimized. In the last issue, Dr. Yeater reflected on the broader issue of cultural climate and the need for those in positions of power to “step up to the challenge of setting a cultural context that does not condone sexual violence against women.” The Diversity Spotlight will continue to seek and select thoughtful pieces that reflect current issues pertaining to diversity.

The Diversity Blog

This February, we will be launching a second year of “the diversity blog”, a forum where committee members will publish posts discussing important diversity issues. I will begin by introducing the committee and the purposes of the blog to get the conversation started. Our hope is to discuss a variety of topics, initiated by committee members, and to have a minimum of four blogs posted per year. This blog is intended to provide another avenue/opportunity for open discourse among our members.

Student Awards

The Diversity Committee will continue to offer a divisional Student Award to recognize student excellence among those who have diverse backgrounds. Three awards have been issued thus far. The first was awarded at the APA convention in August 2017 and two were awarded (2 students tied for first) in August 2018. The winner of the 2019 award will soon be announced and will receive his/her award in August, 2019 at our convention in Chicago. We are very open to giving two awards in subsequent years if there is a tie in a given year.

Webinar

In 2019, the diversity committee plans to continue offering webinars throughout the calendar year. Scheduled for the next webinar is Dr. Julie Williams. The title of her webinar is “Disability in the Diversity Dialogue in Psychology.” Keep your eyes open for an announcement of the specific date for this webinar where you can earn CE credits.

The Convention Social Hour

The APA convention will be upon us in August. This year, as in the past, we will host a social hour (co-sponsored by Division 6) in the Division 12 Hospitality Suite. The student award will be given at the Division’s Award Ceremony, and the awardee will have an opportunity to discuss or give a presentation on some of their research at the social hour in the Hospitality Suite. The social hour offers an opportunity to gather and talk as well as recognize student awardees.

Stay Involved

In closing, our aim is to offer opportunities for discourse, education (training), networking, and awards. We want to increase visibility and involvement in the diversity committee, so please consider taking part. If you have ideas about a topic that you would like to share with the broader group please contact us. Oh, and if you are at APA in August and see any of the committee members, please come up and say hello. We look forward to hearing from you and meeting you. We are excited to get started.
Did you know that by 2030, 20% of your clients are likely to be over age 65? And that 24% of the current U.S. population was born during the Baby Boom of 1946 to 1964? Providing services to older adults can be a joyful, rewarding, and intellectually stimulating experience.

The Society of Clinical Geropsychology (SCG) began in 1994 as Section 2 of the American Psychological Association’s Division of Clinical Psychology. Our vision is to foster the mental health and wellness of older adults through science, practice, education, and advocacy, and to advance the field of professional geropsychology. We are excited to be celebrating our 25th year!

Our purpose is to promote the general objectives of the American Psychological Association and the Division of Clinical Psychology (Division 12); to support and to encourage the evolution and development of the subspecialty of clinical geropsychology in both its scientific and professional aspects; to increase scientific understanding of the mental health of older adults; to promote the development of models for the delivery of psychological services to older adults, as well as other ways of enhancing the welfare and mental health of older adults; to foster collaboration and the sharing of information among clinical geropsychologists; and to increase the quality and availability of training opportunities in clinical geropsychology.

Some of the recent and ongoing activities of SCG are as follows:

- Our group continues to develop training opportunities for psychologists who work with older adults and wish to improve their expertise in the area. Some of our members have developed a Geropsychology Peer Consultation Group to assist members who wish to obtain consultation in their work.

- Our new President, Dr. Nancy Pachana, trained in the United States and now works at the University of Queensland in Australia. One of her goals as President is to forge relationships with international clinical psychology groups to increase our international presence and to provide assistance on an international level to psychologists who serve older adults.

- Our Past-President, Dr. Doug Lane, developed a group of SCG members who will serve as liaisons with other APA divisions. These liaisons will raise awareness of our Society and inform other divisions and sections of our availability for consultation and collaboration.

- Our Society provided feedback related to older adults to the APA on its proposed guidelines for treatment of depression.

- We recently created a Gerodiversity Award to recognize accomplishments in this area, and the award is open to students and professionals from ANY Division of APA.

The Society of Clinical Geropsychology (SCG) welcomes new members and we invite you to open our website (geropsychology.org) for information on how to become a member! The need for psychologists who work with older adults will continue to grow in the coming years; you can be part of this exciting opportunity to serve a complex and ever-interesting clinical population.

To learn more about the Society of Clinical Psychology, visit our web page:

www.div12.org
The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Div 12 of the APA). Its purpose is to communicate timely and thought provoking information in the domain of clinical psychology to the Division members. Also included is material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. In addition, The Clinical Psychologist includes archival material and official notices from the Divisions and its Sections to the members.

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5 Case Vignette; Further Reading; References  
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