the Behavior Therapist

Contents

Living With COVID-19: How ABCT Is Dealing With the Pandemic

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Ryerson University

IT'S MAY 4, 2020. It seems important to "date stamp" this column, since the landscape continues to change rapidly as the current pandemic runs its course. I am well aware that whatever I might say now may no longer seem as relevant in June, when this issue is released. In this column, I highlight some of the ways in which ABCT is responding to the COVID-19 crisis, and how COVID-19 is impacting ABCT.

COVID-19 is also a focus of several other articles in this issue of *the Behavior Therapist*. Michelle Paluszek and colleagues provide an overview of psychological processes related to the spread of COVID-19, how people cope with pandemics, and how we are likely to adjust to a post-COVID world. Jason Krompinger and colleagues provide suggestions for adapting exposure and response prevention for treating OCD in the age of COVID-19. Finally, Aubrey Dueweke and colleagues provide recommendations for effectively engaging children and adolescents in remotely delivered mental health services. Rounding out this issue is an original research article on promoting healthy parenting practices.

Impact of COVID-19 on ABCT

COVID-19 is impacting how ABCT does business, but it's not slowing us down. The ABCT

A B C T   P I O N E E R S   S E R I E S

GREG SIEGLE

In a discussion in which he lays out various elements that we do, or can, use to help us better address our patients' needs, Greg Siegle points to neuroscience, mindfulness, dissemination and implementation, as well as brain mechanisms, and manages to make it all visible, understandable, and come to life. Watch the interview here:

www.abct.org ABCT > FOR MEMBERS > CBT PIONEERS

INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

■ Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

■ Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

■ Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

■ Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: http://www.abct.org/Journals/?m=mJournal&fa=TBT): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Richard LeBeau, Ph.D., at **rlebeau@ucla.edu.** Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

central office is now working remotely, and the Board's June strategic planning retreat (originally scheduled as an in-person meeting in Philadelphia) will now occur virtually. Fortunately, the ABCT Board and leadership conducts much of its business remotely anyway, so for much of what we do, it's been business as usual during the pandemic.

You may be wondering what's happening with our Annual Convention. As you likely know, many organizations have had to cancel or postpone their annual meetings as a result of the pandemic. Examples include meetings of the Anxiety and Depression Association of America, American Psychological Association, American Psychiatric Association, Canadian Association of Cognitive and Behavioural Therapies, Canadian Psychological Association, International Association of Cognitive Psychotherapy, and National Association of Social Workers, to name a few. At this point in time, the ABCT convention is still planned for November. However, we are monitoring the situation closely, and will make a decision no later than the end of the summer about whether to hold our Annual Convention in Philadelphia. In case we are not able to meet in person, we are currently looking into options for holding the convention remotely. We are also investigating the possibility of a hybrid convention, with options for both in-person and remote participation. Of course, we will consider local, state, and federal guidelines regarding large gatherings and travel, as well as our members' level of comfort around meeting in person. The good news is that we received a large number of submissions, and our Program Committee is putting together an exciting meeting that will provide opportunities for continuing education, sharing cutting-edge research, and networking with colleagues. We will be in touch with more information as we have news to share about the format of our convention.

ABCT's Response to COVID-19

When the pandemic hit North America, ABCT posted a COVID-19 statement on its website, as well as links to resources on health-related information, coping with anxiety, using telehealth to provide services, and a range of other COVID-related topics. You can find these on our home page (www.abct.org/Home). The resources include websites, blogs, books, videos, podcasts, and other materials, covering a wide range of topics, such as:

- Information on the COVID-19 pandemic
- Coping with anxiety and depression in the context of COVID-19
- Best practices for telehealth
- Teaching online classes
- Parenting during COVID-19

The list of resources is updated regularly. If you have any COVID-19-related resources to suggest for the website, please feel free to send them along for consideration. Also, any suggestions for how ABCT can better serve our members or the public during this difficult time are welcome. You can reach me at mantony@ryerson.ca.

In the meantime, I hope that you and the people you care about stay well, both physically and emotionally!

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Webinar

Register Now!

www.abct.org/Conventions/?m=mConvention&fa=Webinars

JUNE 19

Helping Clients Transition to the New Normal

— Amelia Aldao, Ph.D.

11 am – 12:30 pm Eastern | 10 am – 11:30 pm Central
9 am – 10:30 am Mountain | 8 am – 9:30 am Pacific

Dr. Aldao is a Licensed Clinical Psychologist with expertise in CBT for anxiety and mood disorders. She is the Founder and Director of Together CBT, a clinic specializing in anxiety and stress in New York City. She is a Visiting Scholar at Columbia University and on the Psychiatry Faculty at Mount Sinai Hospital, where she teaches CBT to Graduate Students in Clinical Psychology and Residents in Psychiatry, respectively.

$30 for ABCT members
CE Credit: 1.5

As restrictions to physical distancing begin to lift in the coming months, we are all facing an unprecedented situation: on the one hand, we will be "going back to normal," but, on the other one, much has changed over the past few months, so we will actually living in a "new normal." This juxtaposition of familiar and new can be the source of much anxiety and distress, but it can also represent an opportunity to redefine ourselves and grow. As therapists, we have a unique opportunity to help our clients not only cope with these changes, but also thrive in the face of this new life we're about to start. In this webinar, I will discuss an emotion-focused CBT approach for helping clients manage surges in anxiety (e.g., worries about resuming in-person interactions, heightened fears of contamination, agoraphobic concerns, existential anxiety, hopelessness) and adopt a values-based approach to reenvision their lives (e.g., career, relationships, health). I will review a transdiagnostic approach, since clients might experience concerns that are not necessarily aligned with their current diagnosis (e.g., someone with social anxiety might become preoccupied with contamination). It will be highly interactive (come prepared with questions!) and we'll also tackle self-care as therapists. For a full description, including learning objectives and recommended readings, go to:

http://www.abct.org/Conventions/?m=mConvention&fa=Webinars.

From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better

Mary Jane Eimer, *Executive Director*

Frustratingly, COVID-19 is still here impacting our daily lives and immediate future. From the postings on our list serve, meetings held via Zoom, and emails received from individual members, this is clearly an innovative and resilient membership. The ever-present theme has been a "can-do attitude" to address every challenge that comes our way. The leadership, staff, and individual members have queried how do we best help the general public; how do we help our members transition from face-to-face therapy sessions to telehealth; how do we supervise students and interns; how do we teach remotely, immediately; how do we care for front-line health workers who may not have health insurance? Staff has been reading the list serve postings and contacting those of you willing to share your expertise and resources without a moment's hesitation.

Early on, the Board opted to highlight science in our efforts to reduce COVID-19's impact. They did that by emphasizing hand-washing; involving our kids in discussions, so they get to hear facts and aren't left to their own unchecked fears or imaginations; and limiting exposure, both to the virus and to media coverage of it. They also began linking to the few resources we had, such as CDC, WHO, and Health Canada. The numbers, and types, of resources have grown, and we've added topic heads—Health Information, Resources for Anxiety, Telehealth, and Coping in the Real World—as more became available. Some are links to trusted sites while others are videos developed specifically for issues impacted by the pandemic. Especially noteworthy are Kate Morrison's primer on providing telehealth and everything one needs to know to begin teaching online. And we even have some forward thinkers who are providing tips to help you return to normalcy, hopefully in the not-too-distant future. You can find this at http://www.abct.org/Information/?m=mInformation&fa=COVID19

Kate Gunthert, Membership Issues Coordinator, in cooperation with Daniella Cavenagh, Chair of our Clinical Directory and Referral Issues, undertook an initiative to get our members who were taking on new clients and transitioning to telehealth to identify themselves. We've gone from 54 to 222 members providing telehealth since mid-March. It's easy for you to add yourself to our referral list if you are licensed and take referrals. Our next move was to ask all members to post on their personal social media outlets:

> Accessibility of mental health care is particularly important in this time period. Many people need to access mental health services via telehealth. I thought I'd share a link to one of the places I look for cognitive-behavioral care providers, the Association for Behavioral and Cognitive Therapy's Find a CBT Therapist Directory: http://www.findcbt.org/FAT/. Therapists in this directory have been updating their profiles to reflect whether telehealth is an option (there is a telehealth search term on the main search page). Thank you.

The leadership is gearing up for our triannual strategic planning retreat in early June. What better time to discuss our future than in confinement during a pandemic? Our world is growing smaller and change is coming faster. We need to address the future now so ABCT is ready in terms of resources, technology, leadership, and staffing. The Board and our coordinators will be discussing the trends they are seeing in research, academia, and practice and how this influences the services and benefits we offer you, our membership. We hired a consultant, Jeff De Cagna of Foresight First, LLC, to help us address these trends. He sent an environmental scan survey to all members of governance, including our 40 Special Interest Group leaders and members of the Task Force to Promote Equity, Access, and Inclusion. In consultation with President Antony and President-Elect Tolin, we also put together a smaller survey and sent it to nonmembers recommended by Board members and several past presidents representing different disciplines: psychology, psychiatry, and social work. This feedback will set the stage for our virtual retreat.

We are already experiencing the impact technology has on our personal and professional lives. One of the biggest challenges we are facing now is our Annual Convention—business as usual (I don't think so), totally virtual (maybe), or a hybrid (a likely choice given our partnership with the hospitality industry). Staff is looking at the alternatives and more will be shared when we have a better understanding of the alternatives available along with state and federal restrictions regarding social distancing. We are well aware of the need for members to continue to build their CVs; hone their presentation skills; network with peers in their specialty area(s); earn continuing education credits; and maintain professional friendships. We are considering multiple ways we can recognize your accomplishments while keeping you safe.

We are very pleased by the response received to our prerecorded webinars for $15 for members and nonmembers. Given that we are still in confinement, we are considering extending this promotion until August 31, and have reduced the cost of the webinar in June. Please check our website and list serve for updates.

June is also the month we begin gearing up for the November election. In this issue of *tBT*, there is an article from Patricia DiBartolo, our Leadership and Elections Committee Chair, outlining the process along with a Call for Officer Nominations. The nomination form is included in the article and available on our website under Elections. I urge you to nominate a colleague or yourself, self-nominations are welcomed, for either the 2021-2022 President-Elect; 2021-2024 Representative-at-Large and liaison to Convention and Education Issues; and the 2022-2025 Secretary-Treasurer. ABCT is a member-driven organization and your active participation in needed and appreciated.

Stay safe, everyone. Until next time!

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The Psychological Sequelae of the COVID-19 Pandemic: Psychological Processes, Current Research Ventures, and Preparing for a Postpandemic World

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Steven Taylor, *University of British Columbia*

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* contributed equally to this article

THE NOVEL CORONAVIRUS disease, known as COVID-19, arose in Wuhan, China in December of 2019. As of May 4, 2020, the virus has infected over 3.4 million people and led to over 239,000 deaths globally (World Health Organization, 2020a), and the numbers continue to rise exponentially. The World Health Organization declared COVID-19 a pandemic on March 11, 2020. In response to the COVID-19 pandemic, governments have imposed unprecedented changes, such as closures of all nonessential business and mandated self-isolation. Health officials have also recommended social distancing, avoidance of crowded areas, and increased hygiene practices in attempt to reduce the spread of COVID-19 (World Health Organization, 2020b). The magnitude of the situation is further highlighted by the unabating news and media revolving around COVID-19.

As a consequence of the threat of infection, life has become characterized by financial uncertainty, fear, stress, and other substantial lifestyle changes (e.g., social withdrawal, isolation) that may increase risk for mental health problems. Indeed, emerging empirical evidence from China indicates that greater than 25% of the general population are currently experiencing moderate to severe levels of anxiety in response to COVID-19 (Qiu et al., 2020; Wang et al., 2020). Although the full scale of the psychological impact is not yet known, based on observations from prior pandemics (Shultz et al., 2008; Taylor, 2019a), it is anticipated to be larger than the physical impact of the COVID-19 pandemic. Efforts directed at minimizing the spread of COVID-19 and managing its psychological sequelae are timely and critical.

While much remains unknown about responses to COVID-19, existing research on past global outbreaks (e.g., SARS, Ebola, swine flu), which is reviewed in detail by Taylor (2019a), may be relevant and informative in this regard. Empirical evidence from previous pandemics indicates that psychological factors play an instrumental role in infectious disease mitigation, social disorder, and vulnerability to mental health problems associated with pandemics (Taylor, 2019a). Investigating psychological factors influencing behavioral and emotional responses to COVID-19 is, therefore, key to reducing the impact of COVID-19.

The current paper is structured to provide an overview of the potential influence of media broadcasting, psychological mechanisms involved in disease avoidance, and psychological traits potentially implicated in responses to COVID-19. These factors are discussed in greater detail by Taylor (2019a). We then describe current psychological research on COVID-19 and our ongoing research program aimed at addressing gaps in understanding of psychological processes and traits that influence behaviors and emotional distress related to COVID-19. To conclude, a discussion of expectations for the postpandemic period and implications for the delivery of CBT is provided.

The Role of Media

People are being inundated with information related to COVID-19 through news and social media outlets. Indeed, the World Health Organization (2020c) has described the current state of the COVID-19 pandemic as a "massive infodemic." Mass media, through the use of emotionally charged language and images, can have a profound influence in exaggerating the perceived dangers associated with infectious disease (Kilgo et al., 2018: Muzzati, 2005). Consequently, the media may then exacerbate individual inclinations towards fear or indifference. While it is important that the public remain informed about the pandemic (e.g., current government regulations, public health recommendations and actions), prolonged media exposure can also lead to "media fatigue," in which individuals become desensitized to the media and potentially disregard important information (Collinson et al., 2015). Further compounding the issue is the abundance of misinformation that may cause increased anxiety as people may not know which sources of information are reliable (Taylor, 2019a).

Government communication through the media during a pandemic is a powerful source of influence (Devakumar et al., 2020). On the one hand, transparent and clear messaging can relieve anxiety and uncertainty by providing the public with accurate and up-to-date information on the state of the pandemic (Eaton & Kalichman, 2020; Taylor 2019a). On the other hand, the use of xenophobic language, inconsistent information, and suggestion of government conspiracies has the potential to give rise to public fear and division. It is of the utmost importance that governments carefully construct messages in coordination with other officials to deliver an effective, cohesive message to the public on COVID-19 (Kapiri & Ross, 2020).

Behavioral Immune System

Due to the microscopic nature of viral pathogens, an individual's biological immune system is only reactive to infection and insufficient to prevent infection (Duncan & Schaller, 2009; Taylor, 2019a). As such, the behavioral immune system (BIS) has evolved to mobilize in response to the threat of infection. The BIS is a complex system involved in detecting and responding to perceived indicators of the presence of an infectious disease (e.g., someone coughing or sneezing; Ackerman et al., 2018; Schaller & Park, 2011). The BIS further elicits emotional reactions (e.g., disgust, fear, anxiety) to facilitate behavioral avoidance of virus-relevant cues and pre-

Essential Resources for Your Practice

vent contact with potential pathogens (Schaller & Park).

The cues detected by the BIS are only sometimes indicative of infection (Schaller & Park, 2011). To ensure protection, the BIS tends to generate false-positive errors in that it may incorrectly perceive a cue to indicate infection when it is not present. Further, there are individual differences in the sensitivity of the BIS (Duncan & Schaller, 2009; Duncan et al., 2009). Some individuals may be especially sensitive or attentive to the presence of cues that may suggest pathogens and such cues elicit a more intense reaction. Individuals with higher levels of perceived vulnerability to infection and disgust sensitivity reflect this phenomenon.

Disgust Sensitivity

Disgust sensitivity—the extent to which an individual experiences emotional distress and repulsion from disgust-inducing stimuli—is proposed to be an indicator of a sensitive BIS (Goetz et al., 2013; Taylor, 2019a). Disgust may be elicited through taste, sight, or smell (Terrizzi et al., 2010). Sick or unhygienic people, bodily content, and dirty environments are examples of proposed universal disgust-inducing stimuli (Curtis et al., 2011). Individuals with heightened disgust sensitivity tend to react more intensely to disgust-inducing stimuli. A similar reaction may be elicited by stimuli that resemble, or come into contact with, disgust-inducing stimuli (Curtis et al.; Oaten et al., 2009; Rozin et al., 2008). Disgust sensitivity has been found to be involved in the development and maintenance of certain phobias (e.g., spider phobia, blood-injection-injury phobia; Olatunji, 2006; Olatunji et al., 2006) as well as contamination-based obsessive-compulsive disorder (Olatunji et al., 2005).

Empirical evidence implicating disgust sensitivity in pandemic-related reactions has been emerging. Disgust sensitivity has been found to predict greater fear of infectiou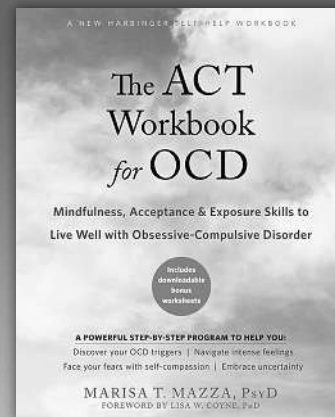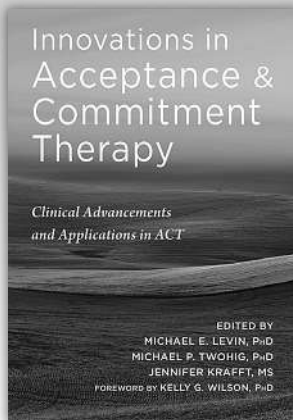s disease (e.g., Ebola; Blakey et al., 2015; Brand et al., 2013; Wheaton et al., 2012). A recent study also suggests that disgust sensitivity may interact with the physical consequences factor of anxiety sensitivity (AS; referred to below) to predict greater concern of infection from an infectious disease (McKay et al., in press). Disgust sensitivity may be a relevant trait to consider for differentiating who may be at risk for greater COVID-19-related anxiety or fear.

Perceived Vulnerability to Disease

Perceived vulnerability to disease (PVD) refers to the individual's belief of how likely they would be to contract an infectious disease (Taylor, 2019a). The BIS is particularly sensitive in individuals with high PVD. An individual with high PVD is more likely to perceive a disease as a threat and have an anxious emotional and behavioral reaction. For this reason, it is believed that those with elevated PVD are likely to experience high levels of emotional distress during a pandemic (Taylor). The trait may also partly account for the drive to avoid groups who are perceived to be likely infected with COVID-19.

As infectious diseases are often transmitted through social contact, theorists propose that the BIS evolved to influence attitudes and social interactions in attempt to avoid infection (Schaller & Park, 2011). This influence may come in the form of xenophobia (i.e., prejudice towards foreigners; Schaller & Park). When threatened by an outbreak, individuals who are highly motivated to avoid infection may exhibit xenophobia due to the belief foreigners are sources of infection. Studies indicate that individuals with elevated PVD are most likely to endorse negative attitudes towards foreigners and avoid contact with foreigners (e.g., Aarøe et al., 2017; Duncan et al., 2009; Faulkner et al., 2004).

The avoidance, stigmatization, and blame of out-groups (i.e., groups one does not belong to) is not an uncommon reaction to the threat of an infectious disease (Makhanova et al., 2015; Taylor, 2019a). Evidence of xenophobia was observed during SARS and the Bubonic Plague (Cohn, 2010; Washer, 2004). Xenophobia directed at individuals of Chinese ancestry is being reported during the COVID-19 pandemic (e.g., Aguilera, 2020). Discrimination may not only hinder joint efforts to mitigate the spread of infectious disease, but also create undue distress for out-groups (Taylor). Marginalized groups may already find themselves vulnerable during the COVID-19 pandemic for a number of reasons. For example, members of marginalized groups may be less likely to seek out or afford health care services, may lack financial resources to effectively self-isolate as per recommendations, or may be more likely to have preexisting chronic health conditions that increase risk of COVID-19-related complications (Eaton & Kalichman, 2020; Hutchins et al., 2009; Smith & Judd, 2020; Yancy, 2020). The pandemic may further drive social, financial, and

health care disparities experienced by marginalized groups, putting them at even greater risk of physical and mental health problems (Eaton & Kalichman; Yancy). The implementation of comprehensive interventions directed at addressing COVID-19-related fear, xenophobia, and socioeconomic inequalities are needed to bolster the protection of vulnerable groups during the COVID-19 pandemic.

Psychological Traits

To slow the spread of infection, communities will have to work collectively in accordance with public health recommendations. Health officials are currently encouraging social distancing and proper hygiene behaviors (e.g., handwashing) and will likely recommend all eligible individuals receive a COVID-19 vaccine when they become available (World Health Organization, 2020b); however, not everyone will be willing to engage in such behaviors. Some individuals may magnify infection risk by engaging in maladaptive behaviors (e.g., failing to wash hands, maintain social distancing, or receive a vaccine). Other individuals might react to COVID-19 with moderate fear, motivating them to adhere to recommendations, while others may experience intense and debilitating fear. Below we address individual difference factors that may influence anxiety and stress responses and their possible downstream effects on adaptive or maladaptive COVID-19-related behaviors.

Unrealistic Optimism Bias

Unrealistic optimism bias is the tendency to have overly positive beliefs about one's future (Taylor & Brown, 1988). People who have an unrealistic optimism bias tend to believe that positive events are more likely to happen to them than to others and, as such, underestimate the dangers of disease and other potential threats (Weinstein, 1980). During the SARS outbreak, those with unrealistic optimism bias believed themselves to be less likely to contract the infection than others (Ji et al., 2004). Individuals with unrealistic optimism bias may pose a serious societal threat during pandemics as they are unlikely to practice proper preventative health behaviors, such as proper handwashing and vaccination (Taylor, 2019a).

Unwillingness to vaccinate, even in a minority of individuals, can have sizeable repercussions on the public (World Health Organization, 2020d). Efforts to eradicate the disease through vaccine distribution

may be diminished. Contention arising from opposing views on vaccine acceptability (e.g., potential use of "vaccination certificates" to allow travel) could also incite societal discord and strife. In addition to unrealistic optimism bias, other psychological traits (discussed further below) may influence vaccine hesitancy. For example, individuals with high intolerance of uncertainty (IU) or health anxiety could be concerned about the potential unknown side effects of a vaccine and, thus, be unwilling to receive it (Petrie et al., 2004; Taylor, 2019a).

Health Anxiety

The tendency to become distressed by illness-related stimuli (e.g., fever, coughing) is known as health anxiety (Abramowitz & Braddock, 2011; Asmundson & Taylor, 2020a; Taylor & Asmundson, 2004). Both high and low levels of health anxiety are associated with maladaptive behaviors. Those with low health anxiety are unlikely to engage in recommended hygiene behaviors and are especially vulnerable to unrealistic optimism bias (Gilles et al., 2011). Previous studies of prior epidemics indicate that individuals with low health anxiety are least likely to adhere to social distancing and to wash their hands as per recommendations (Goodwin et al., 2009; Jones & Salathe, 2009; Rubin et al., 2009; Williams et al., 2015; Wong & Sam, 2011). On the other hand, those with elevated heath anxiety tend to worry excessively about their health and can overestimate the degree of threat posed by an illness (Hedman et al., 2016; Taylor & Asmundson, 2004; Wheaton et al., 2010), including COVID-19.

People with high health anxiety are likely to overuse health care services and experience high levels of impairment when experiencing a perceived threat (Bobevski, et al., 2016; Eilenberg et al., 2015; Sunderland et al., 2013). They are often hypervigilant towards their bodily sensations and more likely to interpret those symptoms as dangerous (Tyrer & Tyrer, 2018). Due to the widespread media coverage of COVID-19, people may begin paying closer attention to bodily sensations that they would have previously ignored. Self-isolation may also worsen health anxiety, as environments with low external stimuli may facilitate awareness of internal stimuli (Taylor & Asmundson, 2004).

Anxiety Sensitivity

Conceptually similar to health anxiety, AS is the fear of anxiety or arousal-related reactions (e.g., rapid heartbeat, shortness of breath) based in the belief that these reactions are harmful or bring about negative consequences (e.g., death; Reiss & McNally, 1985; Taylor, 2019b). Health anxiety and AS share an overarching fear of bodily changes or sensations and misinterpretation of these changes or sensations as dangerous (Taylor, 2019a). When an individual with heightened AS experiences normal bodily sensations (e.g., when anxious), anxiety and the acquired fear response to these sensations are magnified (Taylor et al., 2007). AS is purported to increase risk for a range of disorders, including anxiety-related disorders (Bernstein et al., 2005; Schmidt et al., 2006; Tull et al., 2009). Elevated AS, particularly relating to concern of physical consequences (e.g., heart attack), may also increase risk for pandemic-related anxiety and certain behavioral patterns (Blakey et al., 2015; Taylor, 2019a). The physical consequences factor of AS has also been shown to mediate the relationship between obsessive-

compulsive symptoms (e.g., checking, washing) and fear of swine flu (Brand et al., 2013). Further research is necessary to elucidate the potential role of AS in COVID-19-related anxiety and disease-mitigating behaviors.

Intolerance of Uncertainty

IU is another trait factor that may have important consequences for COVID-19-related coping. IU refers to the individual's ability to handle missing information and feelings of uncertainty that may accompany it (Carleton, 2016). People with high IU prefer predictability in their lives and can feel paralyzed with indecision when faced with an unexpected situation (Birrell et al., 2011). High IU has been found to contribute to a variety of mental health conditions and to be linked to the development of excessive worry (Gentes & Ruscio, 2011; Rosser, 2018; Shihata et al., 2016). Individuals with elevated IU may perceive COVID-19 as a particularly distressing time given its many unpredictable situations and unknowns, including, but not limited to, contracting the virus, perceiving who is infected, what could be carrying the virus, how to protect oneself or loved ones, as well as potential job loss (Taylor, 2019a). Additionally, high IU has been associated with health-related checking and reassurance seeking (Dugas & Robichaud, 2007). Similar to health anxiety (Asmundson & Taylor, 2020a, 2020b), the need for confirmation that one is free of infection may motivate those with higher IU to contact medical services even with relatively benign symptoms and consequently overburden the health care system. There is potential that the news media may further fuel uncertainty, especially given that there is still much to learn about COVID-19.

Current Findings and Ongoing Research

At present, limited research has been published on the psychological factors involved in the COVID-19 pandemic. Cross-sectional population studies from China suggest substantial anxiety and depression during the initial stage of the COVID-19 pandemic (Qiu et al., 2020; Wang et al., 2020). One study on college students in China indicated that 25% of the students were experiencing mild to severe levels of general anxiety and that those who knew someone infected with COVID-19 were particularly distressed (Cao et al., 2020). Health care workers also appear to be especially at risk of poorer mental health outcomes. Significantly high rates of mild to severe symptoms of depression (50%), anxiety (45%), and insomnia (34%) were reported in one study (Lai et al., 2020). Another study indicated that front-line health care workers in China are more at risk than nonclinical staff to experience general fear and symptoms of anxiety and depression (Lu et al., 2020). Studies directed at understanding psychological factors are still ongoing as the COVID-19 pandemic continues to unfold; for example, the Montreal Behavioural Medicine Centre is conducting the International COVID-19 Awareness and Responses Evaluation, a longitudinal online study. While there are a number of research groups working to understand the psychological impacts of COVID-19, the evidence to date is limited by focus on general measures of anxiety or narrow conceptualizations of COVID-19-related fears. The breadth of COVID-19-related distress may prove to be quite expansive.

Our own international research team is conducting a large-scale population representative study in Canada and the United States using online survey methodology across three time points (baseline, 1 month, and 3 months) to examine various psychological traits and COVID-19-related distress. Data from the first wave, comprising 6,854 respondents, has been used in the development and initial validation of the COVID Stress Scales (CSS; Taylor et al., 2020), comprising 36 items on five scales assessing COVID danger and contamination fears, COVID fears about economic consequences, COVID xenophobia, COVID compulsive checking, and COVID traumatic stress symptoms. The CSS offer promise as tools for better understanding the psychopathology associated with COVID-19 and for identifying people in need of mental health services due to the COVID-19 pandemic in particular and future pandemics in general. We are also developing an online self-assessment platform that, based on feedback from CSS self-assessment, individuals will be offered tailored resources to help them better cope with pandemic-related distress. Future waves of our data collection will give a clearer indication of the mental health landscape as the pandemic evolves over time and will help inform efforts to combat COVID-19 as well as anticipated fallouts in the postpandemic era.

Preparing for the Postpandemic Era

There are numerous ways in which life may change as a result of the COVID-19 pandemic, and there are currently many uncertainties. It is not clear, for example, whether COVID-19 will disappear from the population, as did SARS, or whether COVID-19 will become a seasonal infection, analogous to seasonal influenza. But we can be fairly certain that the current pandemic will eventually end. There are various subtle ways in which the lives of many people will be changed by the pandemic. These are discussed in detail by Taylor and Asmundson (2020). In the remainder of the present article, we focus on the implications for mental health practitioners.

Although the staggering infectious impact of COVID-19 may soon subside, clinicians will be faced with the challenge of managing the anticipated pervasive surge of mental health concerns. Early evidence from China at the onset of the pandemic suggests an increase in general mental health problems, including anxiety and depression (Qiu et al., 2020; Wang et al., 2020). Stressors related to COVID-19 (e.g., quarantine, unemployment, financial hardship, marital strain, isolation, social withdrawal, death of loved ones) will likely initiate or exacerbate mental health problems (Brooks et al., 2020; Shultz et al., 2015; Taylor, 2019a). Some individuals infected with COVID-19 may suffer persistent psychological distress, as was found with SARS (Hong et al., 2009). Among front-line health care workers, there may be profound distress from burnout due to an excessive workload and moral injuries during the pandemic (Williamson et al., 2020). Further, front-line health care workers may be at an elevated risk for experiencing traumatic stress symptoms related to exposure to illness and death (Shultz et al., 2015; Taylor, 2017), as was the case with SARS (Naushad et al., 2019; Wu et al., 2009). As governments ease restrictions, stressors will involve readjusting lifestyles, coping with the potential threat of another wave of COVID-19, and residual anxiety in the absence of an illness threat. While some may attempt to resume their previous lifestyle, others (e.g., those who are introverted, health-anxious) may remain in seclusion to shelter from the world, similar to agoraphobia or hikikomori (i.e., social withdrawal lasting greater than 6 months; Teo, 2010). At present, the current mental health care structure is ill-prepared to deal with the need for psychological services

brought upon by COVID-19. There is an urgent need for available, quality mental health services tailored for the distress, lifestyle changes, and needs of the current and postpandemic society.

Telehealth, also referred to as telemedicine, and online psychotherapy are well-poised to respond to the growing demand for services that are accessible from home. Videoconferencing psychotherapy may be an efficacious alternative to face-to-face therapy (Berryhill et al., 2019). Likewise, there is strong empirical evidence to support therapist-guided and unguided internet-delivered CBT for general mental health issues as well as a range of mental disorders (Andersson, 2016; Andrews et al., 2018; Hadjistavropoulos et al., 2016; Karyotaki et al., 2017). There is anticipation that COVID-19 may serve as the catalyst for the widespread acceptance and provision of online- or telehealth-delivered psychotherapy (Wind et al., 2020). However, it is very likely that currently online programs will require tailoring to address the mental health impacts specific to COVID-19, at least in the most severely impacted. For example, it may be necessary to provide mental health services in a stepped- or blended-care approach whereby those with minor issues receive an online or app-delivered COVID-19-specific health information intervention, those with moderate issues receive a similarly focused and delivered self-managed intervention, and the most severely impacted are treated with a similarly focused intervention that also includes individual coaching via telephone or text. Such interventions for COVID-19-specific distress are currently in the development and testing stages.

Conclusion

The COVID-19 pandemic is anticipated to have a pervasive impact on the actions and well-being of society as a consequence of a combination of substantial, widespread individual and societal changes, media exposure, and preexisting psychological traits and mechanisms. Research is needed to not only assess the extent of this concern, but also to inform recommendations that ensure appropriate treatment. Fortunately, this research is under way in various countries. Clinicians are urged to adapt and reform current practice in line with evidence-based, accessible clinical practice. Government officials and health care practitioners should make efforts to prepare for the unknown and potentially long-standing imprint of COVID-19 on the mental health and well-being of the current generation.

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Adapting Exposure and Response Prevention in the Age of COVID-19

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THE COVID-19 PANDEMIC has affected most people on the planet. This article was written to address how it has specifically affected the clinical decision making of those who treat individuals with obsessive-compulsive disorder (OCD). OCD is characterized by recurrent, persistent, and distressing thoughts, images, or urges (i.e., obsessions) which drive maladaptive behaviors that are carried out as a means of eliminating that distress (i.e., compulsions, or rituals). While the compulsions provide short-term relief, they simply reinforce the obsessions and create a situation wherein the patient is robbed of opportunities to confront their fears and come to rely on the compulsions to navigate their world. The gold-standard approach to treatment, exposure and response prevention (ERP), involves patients confronting their fears repeatedly while resisting engaging in compulsions. A simple example is a patient deliberately coming into contact with everyday items they deem "contaminated" and resisting efforts to wash their hands or otherwise remove the contaminant. Given the new reality that we all traverse, it may be necessary for clinicians to make adjustments to the ERP approach in particular circumstances.

This article, written by psychologists who specialize in treating those with OCD, will review key principles to bear in mind when clinicians are considering modifying their approach to exposure therapy amidst this public health crisis. We will review considerations on both the exposure and prevention fronts, helping patients distinguish between following guidelines and carrying out compulsions, targeting core psychological processes, leveraging the unique advantages of telehealth, and bearing in mind the effect of the pandemic on clinicians themselves. These recommendations emerge as a result of extensive clinical experiences with the heterogeneity and, importantly, *adaptability* of OCD, as observed both before and during the pandemic. We would emphasize that while these principles are empirically supported, we do not yet have the evidence base to support the efficacy of specific recommended adjustments.

Finally, we would note that the current pandemic also carries implications for individuals who struggle with illness anxiety disorder. While the two disorders largely overlap, illness anxiety can be distinguished from OCD on the basis that those with the former tend to focus more on bodily sensations, have less awareness of the irrationality of their fears, and engage in maladaptive responses to their anxiety that is more based in reality (scouring medical websites; seeking persistent consultation/reassurance from health care professionals) than is sometimes the case with OCD (engaging in tapping, counting, or other superstitious behaviors to prevent the onset of an illness). While some of the recommendations here are relevant to those with illness anxiety, the focus of the article will be OCD.

Amid Restricted Exposures, Emphasize Response Prevention

Many of the traditional approaches to implementing ERP for contamination-related symptoms run in direct contrast to Centers for Disease Control (CDC) guidelines around managing risk of exposure to the virus. Standard contamination-focused exposures commonly include touching publicly used items such as doorknobs, light-switches, toilet levers, and sink handles and cross-contaminating to one's body and face. Also common are exposures such as touching the bottom of one's shoes, sitting on floors, handling garbage, and using public transportation. Postexposure washing behaviors have strict limitations to foster new learning around the perceived contaminant, resultant anxiety, and ritualistic behavior. Although specific approaches can vary by provider, standard ERP procedures recommend setting firm limits on handwashing such that it is restricted to only following bathroom use or prior to eating, or if hands are visibly soiled. Even still, these restrictions can become tighter depending on the specific symptom presentation. For example, a patient with no capacity to tolerate not washing their hands after using the bathroom might be encouraged to occasionally resist handwashing altogether.

These standards for ERP came about, in part, as a result of acknowledging the distinction between probability and possibility, and the evidence that OCD is characterized by an overestimation of threat (Carr, 1974; Salkovskis & Warwick, 1988). That is, although it is possible that engaging in exposures like those described can result in illness, the *probability* is lower than the perceived threat. Further, in the event that engaging in such exposures did result in illness, they likely did not result in the individual's feared outcome occurring (e.g., slow, painful decompensation and death).

In the midst of the COVID-19 crisis, these variables have changed. Although it is still statistically unlikely that an individual following basic precautions will die from the disease, estimates during the peak of community spread suggest that the likelihood of becoming infected is relatively high. Given the high rates of transmission, wide variation in symptom presentation, and preponderance of individuals vulnerable to the disease (including the elderly and those with underlying medical conditions), the probability of creating harm by engaging in ERP as usual is categorically higher than it was prior to this outbreak. The intention of ERP is to learn something new about one's capacity to navigate perceived threats, rather than deliberately confronting actual threats (which is why driving blindfolded, licking used petri dishes, or jumping into a pit of snakes would not constitute appropriate exposures). Therefore, adjustments to our approach are necessary.

Because of this, where standard exposures may introduce higher than normal risk, we suggest that providers *focus on maintaining high fidelity response prevention*. Anxiety is in no short supply these days; thus, fear structures are activated across the board. Even in the event that a patient does not have pronounced COVID-19-related distress (indeed, there is not yet evidence to suggest that an individual with OCD has more virus-related fear than the general population), simply interacting with the world in a manner that is free of rituals will likely bring about

"therapeutic" levels of anxiety. Thus, naturalistic exposures abound. Patients can still work on reducing frequency of handwashes, length of showers, and eliminating avoidances. The CDC has laid out clear guidelines for minimizing risk of infection that include handwashing for 20 seconds, avoiding touching one's face, sneezing inside of one's elbow or into a tissue, and disinfecting frequently used surfaces. A patient should be encouraged to notice the ways that OCD "wants more" insofar as it will pull for an exaggeration of these guidelines to the point where it is functionally impairing. For example, a patient may think "if 20 seconds is recommended, 40 seconds must be even better." Efforts to resist touching one's face may result in avoidances of brushing one's hair or teeth or bringing a cup to one's mouth to drink. Patients may take a "surgical hands" approach following a handwash, making careful efforts to avoid contact with items in their living space for as long as possible between handwashes. Disinfecting surfaces can become a multitiered, exhaustive, hours-long production. Clinicians should encourage patients to adhere to the guidelines and to go no further. Patients should be encouraged to expect, and indeed invite, the experience of lingering anxiety and "not just right" experiences following the completion of a CDC-approved handwash or disinfecting procedure. Helping patients to adhere to CDC guidelines without moving beyond them can constitute an exposure in and of itself, and can serve as a useful exercise in self-assessment so as to understand the underlying processes that maintain OCD.

Be Creatively Precise With Exposures

The heterogeneity of OCD extends both across and within symptom-based categories. While it is reasonable to think that treating contamination OCD is the approach most affected by the pandemic, it is important not to make such assumptions and abandon functional analysis. The public health crisis does not directly impact all symptom presentations of contamination OCD. For many presentations, exposure will require little to no adaptation in the era of COVID-19. For patients with contamination OCD, it is especially important to get specific about the underlying core motivation of OC symptoms and the function of rituals. By doing so, it is likely that even a high percentage of contamination OCD exposures can proceed effectively. In some cases, there may be even more opportunities than usual for appropriate exposure.

For example, patients who fear being poisoned from household chemicals will have more chances to practice exposure as their use is increasingly encouraged, and patients who fear vomiting from slightly

expired food may have more reason to push their boundaries in this domain as nonessential grocery trips are discouraged. For patients whose contamination or harm obsessions are quite specific to COVID-19, situational exposures will need to be adapted and alternative methods of exposures can be used to expose patients to their core fear. For example, imaginal exposure scripts about contracting the virus or spreading it to others may be helpful. Imaginal exposures are particularly helpful for individuals who fear that simply having the thoughts increases the likelihood of harm (thought action fusion; Shafran et al., 1996), with feared outcomes that cannot be tested (e.g., Will I go to hell?), and/or fear a catastrophic event coming true (e.g., dying or causing death due to COVID-19). With an imaginal exposure, an individual can allow themselves "to go there" with the worst-case scenario, in turn, giving their thoughts about the possibility of this outcome less power.

Moreover, in the time of COVID-19, there may be a subset of patients who feel like they have permission to engage in their rituals and/or avoidance. This certainly applies to compulsions functioning to prevent the spread of contamination (e.g., washing), but may also extend to comorbid conditions of social anxiety whereby patients feel relief to stay home and "social distance" themselves. A maladaptive behavior (i.e., washing hands, staying at home) now becomes adaptive. However, it is important for patients, who are generally motivated to engage in these behaviors out of fear, to continue to push themselves outside of their comfort zone. For someone with washing compulsions who now feels safe after washing for 20 seconds, they could retrigger their fear after washing by intentionally bringing on the thought, "It's possible that I could still contract coronavirus." For individuals who avoid social situations due to anxiety, they can initiate and participate in video chats.

Function Over Form—
Two Functions Versus One

Some individuals have made the observation that, given the CDC guidelines around handwashing, disinfecting, and social distancing, it can appear that "everyone has OCD." This, of course, is not actually the case. While vast swaths of the population make efforts collectively to "flatten the curve," their experiences while doing so are likely qualitatively different than those who actually struggle with obsessions and

corresponding compulsive behavior. What is this difference?

It reduces to a *core function of the behaviors* in question. Imagine two people in a bathroom approaching the sinks to wash their hands. One has OCD, and the other does not. The person without OCD is washing their hands *primarily* to accomplish a single goal: to adhere to social and medical guidelines around personal hygiene. The person with OCD is washing their hands to accomplish multiple goals: while ostensibly they are also attempting to follow the given guidelines, they are at the same time attempting to control their inner experience (i.e., reduce anxiety, disgust, or "not just right" experiences) and eliminate uncertainty. This can manifest as excessive thoroughness, repeating behaviors, rigidity around the handwashing procedure, and an inability to end the handwash until a particular emotional state is achieved.

In treating OCD, emphasis should be placed on this core distinction, particularly in the age of COVID-19. Patients should be invited to *notice the intention* behind their behaviors when navigating the world. Indeed, the reality is that we need to wash our hands frequently to minimize risk of infection. The reality is also that there is a level of anxiety that goes along with this and other recommended behaviors irrespective of clinical diagnosis—many people are beginning to experience some level of emotional discomfort that exists between the moment they return from the grocery store to the moment they are able to access the hand sanitizer. However, there is a difference between washing hands to follow a guideline and washing hands as a means of eliminating all perceived possibility of infection. The guidelines are not intended to be emotion regulation strategies. No matter how much news we consume or statistics we track, there is nothing on the internet that will tell you, definitively, whether *you* will die from COVID-19. Further, there is a level of anxiety and uncertainty that will persist irrespective of the amount of wipes we use or how carefully we socially distance.

Whether or not someone struggles with symptoms of OCD (or any other anxiety-based disorder), we all contend with seeds of doubt or uncertainty around our safety and the safety of those around us, and if we are doing "everything" we can to maintain that safety to remain functional amid this new normal. It is necessary to accept this uncertainty in order to move forward and participate in daily activities. Thus, if the impetus behind our behaviors is to make

reasonable efforts to stay safe (akin to buckling a safety belt) rather than eliminate all discomfort, risk, and doubt in an effort to gain 100% certainty, we protect against our behaviors from becoming ritualistic and therein interfering with treatment mechanisms (cf. Thwaites & Freeston, 2005).

Address Context and Relationship
With Anxiety and Uncertainty

In the context of this pandemic, we feel that it is important that the rationale for treatment is discussed in a manner that fits best with the realities of the situation while remaining consistent with the evidence base. Although ERP has been considered a gold-standard intervention for OCD for nearly four decades, there is ongoing discussion around the mechanisms of action.

Two major approaches include the seminal emotion processing theory (EPT; Foa & Kozak, 1986) versus the more recent inhibitory learning theory (ILT; Craske et al., 2008). Conducting ERP based on traditional EPT tends to focus on habituation, such that patients are tasked with completing exposures via a fear hierarchy and only moving up the list when the anxiety subsides. Ostensibly, patients learn that anxiety is transient and that rituals are unnecessary as a means of controlling distress or preventing disaster. Given the equivocal data around the utility of habituation as a predictor of treatment outcome (Craske et al.), the ILT model deemphasizes habituation and instead posits that expectancy violation is the critical mechanism. Under the ILT model, patients complete exposures as a means of building distress tolerance, placing them in a position to learn that anxiety can be withstood in the face of multiple different triggers across a variety of contexts. This violates the patient's threat-associations with their obsessional content, and helps to develop and access new "inhibitory" or safety associations. The respective emphases of these models may lead OCD clinicians to frame ERP a bit differently, depending on their own training and other idiosyncratic experiences.

Given the consistent and steadily rising anxiety across the world at this time, the rationale for ERP should center around addressing the patient's relationship with anxiety and uncertainty. Habituation can be a tough sell in the current environment. Propping up ERP as a means of eliminating anxiety (via habituation) may inadvertently reinforce the notion that anxiety is something that needs to be eliminated.

This is problematic even in the absence of the current crisis, but overemphasizing habituation at this time runs the risk of pathologizing that which is perhaps not pathological. Developing a healthy coexistence with distress via acceptance of its presence is a reasonable alternative.

Clinicians may run into similar problems if they push the idea that exposure is a means to learn that feared consequences are unlikely. Our knowledge around what actually is likely or not likely appears to change by the day, and an overemphasis on taking solace in low probabilities can interfere with a patient's efforts to sit with their distress. Placing renewed emphasis on tolerating uncertainty fits better with these uncertain times.

Taken together, acceptance of distress and tolerance of uncertainty constitute a cultivation of flexibility—a patient is encouraged to develop a richer behavioral repertoire in the face of difficult inner experiences. Common third-wave ERP augments, such as acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT), provide useful language and approaches in helping patients to understand acceptance and develop less antagonistic relationships with distress and uncertainty. For example, an exposure carried out from an ACT framework may emphasize engaging in value-driven behavior amidst intrusive thoughts (e.g., a patient might write out thoughts about harm coming to family members on pieces of paper and then post them on the walls of their apartment before initiating a Face-Time conversation with their family) whereas the traditional ERP approach may be structured such that an intrusive thought is read repeatedly until the patient experiences a decrease in their distress.

Expand Definition of Ritualistic Behavior

Ritualistic handwashing, cleaning, disinfecting, checking, and avoiding are fairly easy for clinicians and patients to spot, as are mental rituals such as neutralizing and reviewing. In the context of COVID-19, it is prudent for patients to expand the definition of rituals and avoidances. For example, it is difficult to classify a patient who fears public transportation and public restrooms as "avoidant" in the current climate. However, there are other behaviors individuals struggling with OCD symptoms may engage in that serve as important targets for treatment.

Repetitive negative thinking (RNT), such as rumination and worry, can be particularly prevalent during such times of social isolation and lack of structure. Although they likely serve to perpetuate distress, engagement in these processes serves a function. Worry, for example, is historically thought to serve as experiential avoidance of distressing imagery. More recent accounts posit that engaging in worry may serve as a "contrast avoidance," i.e., perpetuating a negative mood state so as to prevent being emotionally blindsided by a catastrophic event (Newman et al., 2011). For example, persistently worrying about harm coming to a family member is a way of avoiding the unpleasant experience of a rapid "shift" from positive/neutral (in the event that worrying was not occurring) to negative emotional state that would be brought on by receiving a phone call that said family member has fallen ill.

Engagement in RNT can be accompanied by behaviors that set the occasion for continued RNT—individuals may avoid watching a funny show, having a virtual get-together with friends, engaging in exercise, or interacting with loved ones because they are "too anxious." On the other end of the spectrum, it is easy to avoid potentially uncomfortable tasks and turn to immediately gratifying behaviors. This can result in disrupted sleep schedules, neglect of personal hygiene and physical health, alcohol and substance use, arguments with significant others, etc. While these behaviors technically fall outside the scope of OCD, they can all be conceptualized as a means to avoid an unwanted inner experience. This, of course, runs counter to the very crux of ERP. Clinicians would do well to monitor such behaviors and invite them to consider it part of their OCD treatment to keep them in check. Framing RNT and accompanying avoidant behaviors as just as insidious and deleterious as "standard" OCD rituals can help patients understand the insidious nature of the disorder and make their self-monitoring approaches more nuanced.

It may be useful to patients to expand the definition of rituals and avoidances to include all types of emotion-driven behavior. For example, as the COVID-19 pandemic unfolded it was important to stay up to date with current information and recommendations. However, as anxiety in response to current information increases, the desire to "gather more information" may increase—following the same slippery slope as the more overt rituals described above. These behaviors may increase even

more after reading sensationalized headlines. Thus, it is important to balance staying up to date with not using information gathering as a method for avoiding uncertainty. Limiting news consumption and focusing on getting updates from reputable sources (such as the CDC) in a planful way is important. It may be that a clinician discusses only getting news updates once per day while inviting a patient to consider watching goofy videos on YouTube instead of reading yet another coronavirus-related article as an exposure to sit with the uncertainty of not knowing the most recent headlines. The CBT framework provides a multitude of tools for addressing RNT, including applying mindfulness, defusion, "worry time," and problem solving.

Leveraging Telehealth

While tele-ERP was gaining a good deal of traction long before COVID-19, we suddenly all find ourselves thrust into providing this service. Many clinicians bemoan this change, given the sense that there are elements of in-person therapy that simply cannot be re-created when the clinician and patient are relegated to faces in boxes on screens. However, telehealth can serve as a boon to ERP practitioners. An individual's triggers can often be found in the home, irrespective of specific symptom subtype. This can provide extensive opportunities for tele-ERP coaching. There might be emotionally contaminated items to touch, stoves and windows to leave unchecked, Bibles to defile, school papers to write imperfectly, or family photos of individuals to wish harm upon. A therapist may task a patient with posting triggering images or thoughts on pieces of paper around their living space. Because the tele-therapy applications are usable on portable devices like smartphones, a clinician could coach a patient through handwashes or other activities of daily living by having the patient "bring them into" the bathroom and perch the device on a countertop.

In Craske and colleague's (2014) seminal paper on how to apply inhibitory learning to maximize exposure therapy, the authors outline "multiple contexts" as an important therapeutic strategy. Access to multiple contexts via telehealth may prevent context renewal. Context renewal involves the return of fear to a trigger in an environment that is different from which exposure therapy was conducted (e.g., Mineka et al., 1999). Conducting exposure and response prevention in multiple contexts might offset context renewal in

patients with OCD, given these findings in human laboratory studies (e.g., Balooch & Neumann, 2011) and in a clinical analog study of exposure therapy (Vansteenwegen et al., 2007). Physical distancing has prevented clinicians and patients from completing in vivo exposures in a variety of contexts. However, telehealth allows patients to access "home visits" such that behavior therapists can coach patients through exposures in their own home, as mentioned above. Additionally, while COVID-19 prevents some in vivo exposures, this may be a time to prioritize internal contexts, such as a patient's physiological and cognitive state by practicing interoceptive and imaginal exposures, respectively (Craske et al., 2014). For example, a patient might be coached to practice both willingly bringing in an intrusive image about acting on impulses to harm others in public while at the same time allowing for resultant physiological sensations such as rapid heartbeats, muscle tension, and physiological arousal.

Finally, being brought into the home also affords the therapist an opportunity to closely assess the patient's physical environment and make suggestions so as to reduce its conduciveness to ritualizing. Therapists might encourage patients to cover or remove mirrors to reduce checking behaviors in patients with body dysmorphic disorder or body-focused repetitive behaviors (e.g., trichotillomania, excoriation disorders), rearrange furniture to make it less likely that a patient sits in the chair in which they typically mentally review, or posttreatment-related cues on their fridge to remind them to resist rituals when preparing food. Through screensharing functions, therapists can coach patients through writing or reading exercises, view images, or watch videos. We are in as good a position as we have ever been to deliver ERP to our patients remotely, given the flexibility of the software and ubiquity of the hardware.

Considering the Impact on Treaters

For some treaters this may be a unique time where the distance between their own anxiety and uncertainty and that experienced by the people they serve is closer than ever (or even overlapped). As is always the case, but is even clearer now, we are attempting to enact the principles that we share with those we serve in our own lives. It is important for us to *investigate the functions of our own behaviors* in response to coronavirus. For our ongoing interac-

tions with those we serve, maintaining or initiating professional consultations may be important. Having regular check-ins with loved ones and discussing the ways we are coping and supporting each other can also support our work in addition to ourselves. It is prudent for treaters to stay informed about the current recommendations for "flattening the curve," but we are also vulnerable to perseverating on pandemic-related news. Professional agencies, including ABCT, have been rapidly releasing helpful resources (e.g., Weir, 2020). Gathering information in a limited and routine fashion from trusted sources (e.g., CDC, World Health Organization) has been widely recommended. Indeed, there is some evidence that gathering information from traditional news sources (newspapers and broadcast news) rather than social media is associated with less fear and more engagement with effective protective behaviors in response to emerging health threats (Chan et al., 2018).

Routine and intentionality are also important for treaters to maintain their effectiveness. Regularizing one's sleep schedule by focusing on keeping waking times consistent (i.e., arising within 1 hour of the same time each day, regardless of external demands on one's schedule) can help maintain circadian rhythms, which will benefit the quality of nighttime sleep as well as daytime mood and functioning (Monk et al., 2003; Walker, Walton, DeVries, & Nelson, 2020). Light daily exercise and diet are also valuable. Taking opportunities to engage in pleasurable and present-moment-focused activities and experiences (e.g., listening to music, eating a favorite snack, watching a funny TV show) are not a "waste" of time but important behavioral activation maintenance factors. Perhaps most important, continued engagement with one's values and valued action is expected to distinguish those who cope well with this uncertain and anxious time. Taking time to pause and take stock of what matters to you and then identifying realistic and meaningful goals for the short- and longer-term has been suggested as a viable intervention for individuals facing the stress of serious illness (Folkman & Greer, 2000). Appropriately for times like these, Folkman and Greer suggest that what might be most important is a focus on opportunities for personal control over actions that align with one's values. Thankfully, for many treaters, providing care to others is an important value and engaging in our work with those we serve may be nourishing and

protective to our psychological functioning during this time. Finally, practicing flexibility in response to the rapidly changing professional and personal landscape is a necessity. Many treaters develop systems to manage their time and these may be upended. It is invaluable for treaters to give themselves compassion and accept that pandemic will have an impact on them as well.

Conclusion

The intention of this article was to offer some core constructs to reflect upon when considering adjustments to the implementation of ERP amidst the current pandemic. Although we do not yet have data that provides evidence for the efficacy of these adjustments under these circumstances, we considered the state of the science in making these suggestions, and consider them highly likely to preserve treatment integrity. The COVID-19 crisis is perhaps irrevocably changing the way that we live our lives. The OCD treatment community does a service to its patients by modeling flexible adaptation to the circumstances.

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CLINICAL PRACTICE FORUM

Resources and Recommendations for Engaging Children and Adolescents in Telemental Health Interventions During COVID-19 and Beyond

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THE RAPID SPREAD of the novel coronavirus (COVID-19) in the past several months has created unprecedented challenges across multiple domains of life. In an attempt to slow the spread of the virus and minimize the dangers associated with overburdening health care systems, authorities across the United States have implemented physical distancing measures, asking people to stay at home and avoid nonessential travel and outings. In order to continue providing services while adhering to physical distancing measures, many mental health care providers have transitioned to providing therapy via telehealth technology, but are unsure of how to adapt procedures and materials. In particular, youth-focused providers may be uncertain how to shift therapy online while keeping children and adolescents actively engaged during sessions.

We aim to provide guidance to youth-focused practitioners who are considering transitioning therapy services to a telehealth format. We have developed these recommendations based on our experience providing home- and school-based telemental health services, as well as training predoctoral clinical psychology interns to do so through the Telehealth Outreach Program (TOP) within the Mental Health Disparities and Diversity Program at the Medical University of South Carolina (MUSC). Although TOP was not formally established until 2015, practitioners from MUSC have been delivering evidence-based mental health treatments to underserved children and adolescents through telehealth technology since 2011 (see Jones et al., 2014, and Stewart, Orengo-Aguayo, Gilmore, et al., 2017, for more detail).

A Brief Overview of Telemental Health

Telemental health refers to the use of interactive real-time technologies (e.g., videoconferencing) to deliver mental health care to clients (Centers for Medicare and Medicaid Services, 2020). Use of telehealth technology can extend the reach of evidence-based care and address health disparities by minimizing logistical barriers to help-seeking (e.g., distance from the clinic, lack of transportation or childcare; Myers & Comer, 2016; Yellowlees et al., 2008). Within the last decade, there has been an exponential increase in empirical studies investigating the effectiveness of telemental health interventions, which have been proven to be effective at treating various disorders, including depression, anxiety, posttraumatic stress disorder (PTSD), and substance use disorders (Hilty et al., 2013). Additionally, research has shown that telemental health is an effective treatment modality for both adults and children (Gloff et al., 2015; Hilty et al.), and across diverse racial and ethnic groups (Hilty et al.). Furthermore, research suggests telemental health interventions may be as effective as in-person treatment and youth and their caregivers report high sat-

isfaction with telemental health services (Bashshur et al., 2016; Stewart, Orengo-Aguayo, Cohen, et al., 2017). Children and adolescents in particular seem to enjoy telemental health services, perhaps because of their status as "digital natives," having grown up with technology present for all of their lives (Alvord, 2020; Myers et al., 2017). Although no specific theoretical orientation has been contraindicated for delivery via telehealth technology, cognitive behavioral approaches are the most commonly studied in the literature and are well-suited to the telehealth format due to their structure and skill-building focus (Nelson & Duncan, 2015).

Providers contemplating offering telehealth services can find many guidelines regarding programmatic and logistical considerations in the extant literature. For instance, the American Telemedicine Association (Myers et al., 2017), the American Psychiatric Association (Shore et al., 2018), the American Psychological Association (American Psychological Association, 2013), and the American Academy of Child and Adolescent Psychiatry (American Academy of Child and Adolescent Psychiatry, 2017; Myers & Cain, 2008) have all created practice guidelines to assist providers in establishing videoconferencing-based telemental health services. In general, providers first need to familiarize themselves with local, state, and federal regulations related to delivering care through videoconferencing (e.g., billing, licensure requirements, confidentiality, consent, mandated reporting guidelines). Next, providers need to ensure they have the appropriate equipment and software for telemental health service delivery. At a minimum, providers should have access to a computer or laptop with a webcam and a reliable internet connection, with sufficient bandwidth to detect accurate visual, auditory, and interactional cues from clients. Though not required, it is also recommended that providers have a headset with a microphone, dual monitors, and a sound machine, if available. Additionally, providers need access to software that complies with Health Insurance Portability and Accountability Act (HIPAA) specifications and has screen sharing capabilities. Of note, the U.S. Department of Health and Human Services has temporarily relaxed HIPAA requirements for the duration of the COVID-19 national emergency (Office for Civil Rights, 2020). In order to receive telehealth services, clients need to have access to a computer, tablet, or smartphone

with a reliable internet connection, and headphones are recommended, if possible.

While there is widespread availability of information about programmatic and logistical considerations for telehealth service delivery, there are fewer guidelines pertaining to adaptations to therapy delivery itself. Generally, experts advise that practitioners working with children and adolescents via telehealth need to be more dynamic and interactive than they would be during in-person visits and should deliberately amplify their animation during sessions to keep clients engaged (Myers & Cain, 2008). Recently, Seager van Dyk and colleagues (2020) put forth a set of recommendations for how this might look in practice. For example, they recommend using exaggerated facial expressions and hand gestures such as virtual high fives, increasing use of summary statements to make it clear to clients that providers are listening, and seeking more verbal confirmations of mutual understanding (Seager van Dyk et al.). Jones and colleagues (2014) also underscore the importance of being interactive, suggesting that providers can either mail handouts and session materials to youth and their caregivers ahead of time, or share and alter documents in real time through the use of their videoconferencing software's screen sharing function. However, applied examples and explanations of actual telehealth resources practitioners can use in clinical practice with children and adolescents are scant.

Purpose

Given the heightened need for mental health providers to transition their cases to a telehealth format in the midst of COVID-19 and the relative scarcity of guidelines and resources for telehealth service delivery with children and adolescents specifically, we aim to put forth a set of recommendations informed by our experience delivering an evidence-based treatment (Trauma-Focused Cognitive Behavioral Therapy; TF-CBT) via telehealth to children and adolescents. In addition to outlining specific recommendations for setting up telehealth services with youth and making adaptations to therapy, we also illustrate how these recommendations could look in practice and describe resources we have created for telemental health service delivery with children and adolescents (freely available at www.telehealthfortrauma.com). While the resources described were developed within the context of a trauma-focused service setting, they are broadly applicable across cognitive

behavioral interventions for a range of disorders.

Recommendations

Recommendations for Setting Up Telehealth Services for Youth

• *Recommendation #1: Orient clients to telehealth services and obtain consent.* In the midst of the COVID-19 emergency, many providers and youth who were previously engaged in office-based treatment have had to abruptly transition to telehealth because of new physical distancing requirements. This brings up unique issues regarding informed consent. We recommend that providers transitioning their existing caseloads to telehealth orient their clients to the risks and benefits of telehealth services, inform them that they have the right to decline telehealth services at any time, and provide an overview of how the transition may impact billing and insurance coverage. Providers should also consult with their institution and state licensing board regarding requirements for procuring informed consent for telehealth services. Various options for acquiring informed consent for telehealth treatment during the COVID-19 emergency include obtaining verbal consent with a witness, sending a consent form electronically, or mailing a physical copy of a consent form to the family and asking them to sign and return it.

• *Recommendation #2: Model proper use of telehealth equipment.* Depending on the age of the client, providers may need to demonstrate proper use of telehealth equipment with youth and their caregivers. Although they may have previous experience with technology and be comfortable with video chatting, clients may be unfamiliar with the functions of a specific telehealth platform. Providers should also show clients how to position their chair or device to keep their full face in view of the webcam. While adolescents will likely understand proper telehealth "etiquette" with little explanation, younger children may require additional review and practice across several sessions.

• *Recommendation #3: Discuss expectations for therapy sessions.* Expectations regarding proper attire, body position in front of the webcam, scheduling, and removing distractions (e.g., television off, silencing phones) should be discussed with both caregivers and youth. Setting clear expectations from the outset can help families adjust to the new therapeutic setting and

decrease time spent troubleshooting these issues during subsequent sessions.

• *Recommendation #4: Identify a private location for telehealth services.* Sessions should be held in a location that allows the youth to have some privacy. We recommend youth find a location with a chair or table where the telehealth device can be supported, giving youth the freedom to move and engage in physical activities. It has been our experience that youth often choose to use their bedrooms for home-based sessions. Although this is acceptable, we recommend youth not sit on their bed if possible, as the surface may be unstable and limit mobility. However, if this is the only surface available, boundaries should be put in place (e.g., youth should be dressed, should not be under covers during session). Youth should be in a private location for sessions; however, it is important that caregivers are still able to gain access to the youth in the case of an emergency (i.e., youth should not be in a room with a locked door). We recommend providers hold this discussion at the outset of therapy with both the youth and caregiver present. Together they can determine the ideal location for sessions and agree upon allowing the youth private time without disruptions from family members or friends. Privacy can also be enhanced with the use of headphones, a code word to indicate that someone has entered the room, and the youth "giving the clinician a tour" of the space where the session will occur.

• *Recommendation #5: Develop an emergency protocol with the caregiver(s) and youth.* When conducting home-based telehealth sessions, it is recommended that a caregiver always be present in the home and reachable by phone for the entire duration of the youth's session. From our experience, caregivers often trust their child to initiate sessions on their own and assume that the caregiver can arrive at the home later for their own time with the provider. While it may be true that youth, and older adolescents in particular, are capable of initiating sessions on their own, an adult should still be accessible, regardless of the youth's age. It is also important for the clinician to develop a protocol for what will happen in the case of an emergency (e.g., if the child says they want to harm themselves or if the child leaves the view of the webcam unexpectedly). This protocol should be explained to the youth and caregiver at the outset of treatment. For school-based telehealth sessions, providers should be familiar with and adhere to the school's

existing emergency protocol, and a school staff member should be available to the provider by phone to assist in the event of an emergency.

• *Recommendation #6: Establish a routine to transition into and out of therapy sessions.* We recommend providers orient families to telehealth sessions by establishing a "starting routine" that includes turning off devices (e.g., televisions, radios), silencing phones, getting comfortable at their therapy chair, and initiating the telehealth session. In similar fashion, clinicians are encouraged to assist families in establishing an "ending routine," which includes a pleasurable activity at the end of session between the youth and provider (e.g., board game, relaxation exercise, drawing) and/or an activity for the youth and caregiver to do together in order to facilitate an easier transition back to everyday activities after the therapy session.

Recommendations for Adaptations to Therapy Delivery

• *Recommendation #7: Use interactive activities.* Similar to in-person psychotherapy, telehealth sessions should be interactive and engaging in order to build rapport and keep the child actively engaged in the therapy sessions. Telehealth allows the provider to use online interactive tools, which are attractive and enjoyable to children, as well as traditional psychotherapy tools, such as feelings cards and books, to accomplish this. For example, we have created a number of interactive games using Microsoft PowerPoint that providers can use during the initial phase of treatment to build rapport and deliver psychoeducation (see Therapy Trivia on www.telehealthfor-

trauma.com, Figure 1). In addition to helping the child grow comfortable with the provider and the telehealth format, these games also allow for the provider to begin assessing the child's knowledge of therapeutic themes such as safety, family support, and coping skills.

• *Recommendation #8: Take frequent breaks to keep children engaged.* Unlike in-person services, telehealth delivery of services may involve distractions within the youth's home environment (e.g., toys in the bedroom, family activities overheard from an adjacent room). Additionally, during the current COVID-19 emergency, many children are being asked to focus attention on a screen throughout the day for distance schoolwork, social connection with family and friends, and now, for therapy. Given this context, it is particularly important that providers are aware of the need for small breaks throughout session to enhance children's ability to focus and engage for longer periods of time. Many resources are available online to facilitate these activity breaks, including free or low-cost books, Excel or PowerPoint games, or videos uploaded to YouTube. Younger children will likely need more breaks than adolescents, and the types of activities used during breaks may differ depending on the child's age.

• *Recommendation #9: Utilize physical things in the child's environment.* Creating a therapeutic setting in a home-based environment can often be challenging to therapists. Even with thorough assessment and clear guidelines for families, distractions may still occur, as children readily have access to toys and other objects that may pull their attention away from therapy.
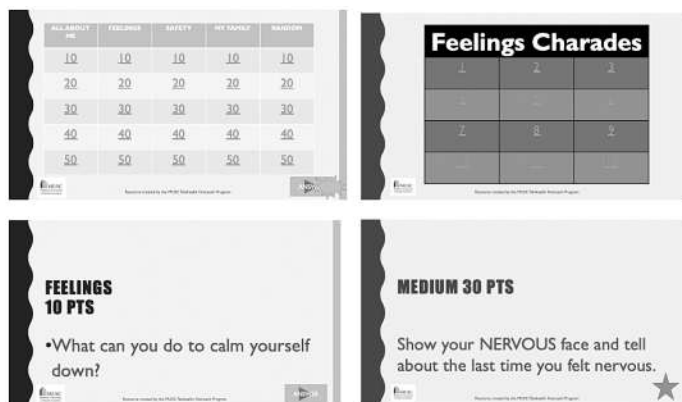

Figure 1. Sample interactive PowerPoint games. For a full explanation of the purpose of these games, as well as instructions for their use in therapy, visit www.telehealthfortrauma.com

This is where creativity can come into play and a provider can use the environment to their advantage. For example, a provider in our program was working with an 8-year-old girl who was often very distracted by a toy doll during session. Rather than asking that the doll be put away during session, the provider asked the child if the doll would like to participate and answer questions. The child then utilized the doll to respond to questions and activities throughout the session, which resulted in an increase in engagement.

Often when providers transition to telehealth delivery of services, they defer to only using electronic documents during session. However, providers can also mail items (e.g., stress balls, mindfulness cards, bubbles, markers and paper, fidget toys) to the home or school so that the child can physically manipulate objects during sessions. While this requires a provider to plan ahead for what may be needed, it allows them to venture beyond simply using screen sharing to facilitate interactive activities in session.

• *Recommendation #10: Tailor activities to each child's interests to enhance engagement.* While the use of interactive games and other engagement strategies usually helps foster children's sustained attention, some youth may require additional efforts on the part of the therapist to get them to "buy in" to certain therapeutic activities. For example, one resource our team created (see Relaxation: Breathing and Soccer

on www.telehealthfortrauma.com) was developed specifically for a 15-year-old Hispanic male who was hesitant to practice relaxation skills and complained that some of the other activities the provider had employed (e.g., diaphragmatic breathing) seemed "babyish." However, the provider knew the youth played soccer and was an enthusiastic fan. As such, the clinician developed a PowerPoint presentation with images explaining how important diaphragmatic breathing is for soccer players' success. The tool also included images of famous soccer players from the teen's favorite Latin American team. Taking the time to learn about the child's interests and values, and incorporating this information into therapy, facilitates therapeutic rapport and shows clients that their therapist cares about and respects them and their cultural background. We encourage providers to tailor online resources as needed to make them more suitable for their client population.

• *Recommendation #11: Adapt worksheets and activities for digital use.* CBT for youth is often interactive, involving the use of worksheets and activities to introduce key concepts and increase engagement in the therapeutic process. It has been our experience that many CBT worksheets and activities can be easily adapted for telehealth use (see Figure 2). For example, many providers use games like charades to teach younger children how to identify emotions and associated physiological responses

(e.g., clenching of fist when upset). Providers can create similar activities for telehealth using Microsoft PowerPoint and then use the screen-sharing function of their telehealth platform to involve the youth (see Feelings Charades on www.telehealthfortrauma.com). For older children and adolescents, providers can create digital versions of worksheets that can be completed using MS Word (see Cognitive Coping Fill-In on www.telehealthfortrauma.com). When adapting worksheets and activities, it is important to consider the age of the client. Younger children are typically more engaged in session when frequent experiential exercises are incorporated. Any written materials used with younger children should have minimal text (displayed in large font) and medium-to-large images. For older children and adolescents, it may be useful to incorporate a combination of worksheets and experiential exercises.

• *Recommendation #12: Use technology to your advantage.* Historically, providers unfamiliar with telehealth have expressed worry about potential drawbacks of delivering therapy through videoconferencing, while the unique advantages afforded by telehealth are often overlooked. First, telehealth may allow providers to gain a better understanding of the local social context in which their clients are living. For example, when discussing discipline issues in traditional office-based settings, the provider is forced to imagine the home layout and possible barriers that may interfere with intervention recommendations. With videoconferencing software, the provider can actually see the home setting and provide more precise recommendations. For instance, when we teach time-out to families, we often ask to see the room where time-out will occur in order to practice and identify possible distractions, which should increase adherence and likelihood of follow-through in real-life scenarios.

Our team has also used technology to enhance in vivo exposures. Utilizing technology to virtually accompany a child during exposure activities can help with compliance and problem solving in the moment. For example, one of our clinicians was working with a medically compromised youth who experienced significant anxiety symptoms in public settings related to fears of being injured by falling objects crushing him. The child was instructed to take a tablet and headphones with him to stores and restaurants to complete exposures, with the therapist provid-
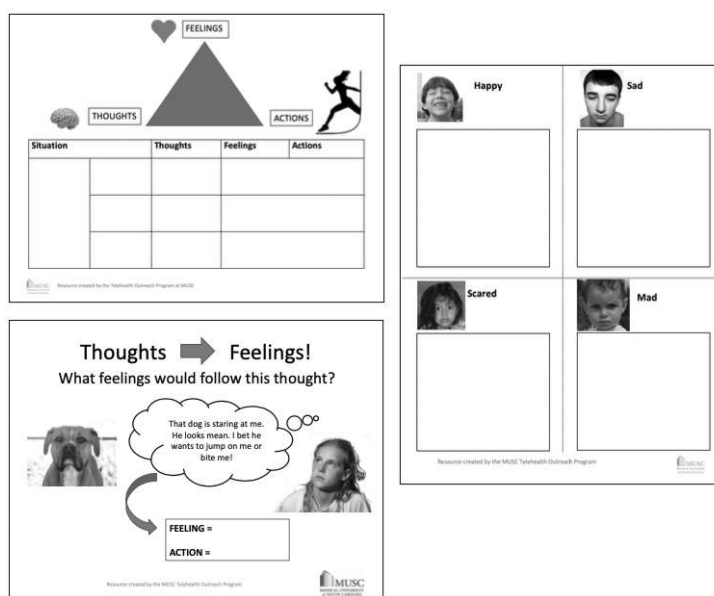

Figure 2. Sample CBT worksheets adapted for telehealth. For a full explanation of the purpose of these worksheets, as well as instructions for their use in therapy, visit www.telehealthfortrauma.com.

ing live coaching remotely and ensuring exposures were completed appropriately.

Many videoconferencing software platforms also include features that can enhance communication during the telehealth session. For instance, many platforms have chat features that can bolster engagement with clients, particularly adolescents. Therapists can utilize the chat feature to promote continued contact if an adolescent refuses to engage verbally, or to scaffold discussion of emotionally charged topics. Another useful feature available in some platforms is a white board or drawing tool. This allows the provider and child to interact through the technology and contribute jointly to drawings, which can be particularly useful when working with younger children. Allowing the child to draw in session can help foster the therapeutic alliance, increase cooperation, and create additional content to be utilized throughout session. Providers can then copy and paste drawings into worksheets or save them for later activities.

Troubleshooting

A unique, and potentially frustrating, characteristic of telehealth sessions is the possibility of experiencing technical difficulties. With the increasing growth and expansion of telehealth, videoconferencing platforms have become more user friendly and efficient, and are prone to fewer technical issues than they once were. Nevertheless, it is important for clinicians to familiarize themselves with the different features and capabilities of their chosen platform and be aware of the technical issues that could arise. For example, two of the most common issues we have experienced are problems with audio and video connectivity. It is helpful for providers to have some basic knowledge of the technology in order to help youth and caregivers diagnose and fix problems. This knowledge can usually be acquired through completing test calls and reviewing frequently asked questions on the videoconference platform website. Providers may also consider creating troubleshooting guides that can be shared with families at the outset of telehealth services. In addition, providers should investigate how to get technical support if they are not able to resolve an issue directly (e.g., through the videoconference platform help desk or through their own technology department at their organization). It is important for clinicians to remember that as they use the videoconference platform more frequently, they will begin to feel more confident in its use. Clinicians should

also be flexible and creative in the event that the technology may fail during a session. For example, we have resorted to the use of telephone audio to supplement telehealth sessions when the client's video is working but their audio is not. As a last resort, finishing a session over the telephone (without videoconferencing software) may be appropriate depending on the age of the client and the planned session content.

Discussion

Practitioners working with children and adolescents may need to make adjustments when transitioning therapy services to a telehealth format, particularly in the context of COVID-19, which has created massive disruptions to most youths' daily routines. In addition to taking sufficient time to orient youths and their families to telehealth services and increasing use of interactive activities during sessions, providers should also allow space for conversations with their clients about the myriad ways in which COVID-19 has impacted them. Although it may feel like a detour from planned session content, we encourage providers to be flexible, as allowing time for youths and their families to acclimate to telehealth services and process the impact of COVID-19 will likely contribute to increased engagement in the long term.

We hope that the recommendations offered above, in conjunction with case examples and resources from our collective experience, can provide guidance to practitioners who are feeling uncertain of how to manage young clients while delivering therapy via videoconferencing software. In sum, being creative and flexible, and finding strategies to increase interaction and engagement of youth in telehealth sessions, is the key to success. While the resources and recommendations provided here were developed within the context of a trauma-focused service setting, they are broadly applicable across cognitive behavioral interventions for a range of disorders. We encourage practitioners to use these resources and suggestions as templates and tailor them to fit the needs of their own programs and services.

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ORIGINAL RESEARCH

Changes in College Students' Opinions on Parenting: Undergraduate Education as Primary Prevention

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Importance of Dissemination

THE FIELD OF PSYCHOLOGY has become increasingly interested in dissemination and implementation science, as evidenced by dissemination and implementation being one of ABCT's strategic initiatives (ABCT Board of Directors, 2018) and the current petition to create a unique division of the American Psychological Association devoted to implementation science (Society for Implementation Research Collaboration: https://societyforimplementation-researchcollaboration.org/?page_id=2401. This focus is reasonable given the significant advances in understanding which interventions have empirical support for effectively helping individuals with a variety of mental health and behavioral concerns. For instance, the field has advanced to the point that the popular book *A Guide to Treatments That Work*, by Nathan and Gorman (2015), is now in its fourth edition.

Importance of Evidence-Based Parenting Interventions

One of the many forms of effective treatments the field of psychology has been able to develop and evaluate is the treatment of dysfunctional parenting (e.g., engaging in ineffective disciplinary practices and failing to reinforce appropriate behaviors) for the prevention and treatment of child behavior problems (e.g., Eyberg & Child Study Lab, 1999; Forehand & Long, 2010; Kazdin, 2005; Sanders et al., 2001; Webster-Stratton, 2005). The reduction of dysfunctional parenting, especially dysfunctional discipline, has important societal implications due to its correlations with negative short- and long-term consequences. For instance, both mothers' and fathers' overreactive discipline is a significant unique predictor of the parent engaging in parent-to-child aggression (Slep & O'Leary, 2007) and corporal punishment has been associated with at least 11 detrimental short- and long-term consequences

for the child receiving it, such as externalizing problems in childhood and adult antisocial behavior (Gershoff & Grogan-Kaylor, 2016). Research has consistently shown that parent management interventions are effective at modifying parenting practices (Sanders et al., 2014) and improving important child outcomes, such as externalizing behavior problems (Mingebach et al., 2018).

Difficulties With Dissemination

Despite the availability of effective, empirically backed parenting prevention and intervention programs, there are still large percentages of the population unable to access and benefit from these programs (Committee on Supporting the Parents of Young Children, 2016). Two frequent modalities for the programs are individual therapy, such as that provided by Parent Management Training (Kazdin, 2005), and group treatment, such as that provided by The Incredible Years Program (Webster-Stratton, 2005). Unfortunately, both of these modalities are necessarily limited—because of time and resource constraints—in how many individuals they can reach. An additional dissemination avenue has been through the media. For instance, many effective programs have published user-friendly books available for purchase in popular press formats (e.g., Forehand & Long, 2010) and other media tools such as apps, websites, blogs, and podcasts (e.g., https://www.triplep-parenting.com/us/triple-p/). However, given the proliferation

of parenting advice available in these alternative formats (as of February 5, 2020, a Google search for "parenting advice" yielded approximately 285,000,000 results), it is easy for parents to become overwhelmed by the amount of advice, and thus it is difficult to determine what is effective. As such, it is important to continue to explore potential avenues for dissemination of empirically supported treatments, including parenting programs. Researchers have taken up this charge and are exploring the feasibility of dissemination through multiple means, such as very brief interventions (Tully & Hunt, 2016), electronic interventions (Breitenstein et al., 2019), and telehealth interventions (Forgatch & Kjøbli, 2016).

Despite the fact that prevention is typically more cost-effective than intervention, the dissemination of prevention programs for dysfunctional parenting may present additional challenges, and thus remains a top priority for future work on addressing mental health issues facing children and their families (Odar et al., 2013). Mental health services are underutilized for both adults (Kessler et al., 2005) and youth, even when the youth have significant symptomatology (Merikangas et al., 2011). It is thus not surprising that it is difficult to motivate large groups of potential or current parents to engage in truly preventive interventions prior to any problems developing (Ingoldsby, 2010). However, many parenting researchers are employed in academia with easy access to a large portion of the population given the fact that the rates of undergraduate enrollment have increased dramatically since 2000 and are projected to continue to increase through at least 2028 (National Center for Education Statistics, 2019). It is thus possible that the college classroom could serve as a relatively easy setting in which to expose large groups of the population to the knowledge base of empirically supported parenting strategies, even if the students are not formally participating in an empirically supported parenting prevention program. Fleming and Borrego (2019) presented evidence that undergraduate students' attitudes towards the use of various discipline behaviors mediated the relationship between the types of discipline they received and the type of discipline they intend to utilize, providing preliminary support that modifying students' attitudes related to discipline may modify their later parenting behaviors.

Present Study

The purpose of the present study is to determine if participation in a psychology class focused on parenting is an effective method to modify students' beliefs about ideal parenting practices utilizing other psychology classes as a control group. This pilot study is necessary to establish whether it is possible to modify students' beliefs prior to embarking on a more resource-intensive research program to determine if undergraduate coursework in parenting can truly be utilized as a primary prevention intervention. Given previous research indicating dysfunctional discipline (e.g., overreactive discipline and corporal punishment) is an important predictor for both short- and long-term undesired outcomes in children, this study focused on changes in students' support for overreactive discipline and corporal punishment in particular. I hypothesized that students enrolled in the psychology class focused on parenting would reduce their endorsement of parents' use of overreactive discipline and corporal punishment behaviors as ideal parenting behaviors from the start to the end of the semester more than students in other psychology classes.

Method

Participants

Undergraduate students enrolled in a senior-level undergraduate psychology class, Psychology of Parenting, and three junior-level undergraduate psychology classes (Developmental, Learning, and Social) were recruited in their classes to participate in this study. A total of 116 students consented and completed at least some portion of the pre- or postassessment. Forty-nine students were enrolled in the Psychology of Parenting class, 38 in Learning, 18 in Developmental Psychology, and 11 in Social Psychology. Students could be enrolled in more than one class at the same time. Due to the low number of participants in Developmental and Social, two groups were created: parenting students and other students. If a student was enrolled in the Psychology of Parenting class, they were put in the parenting students group regardless of their enrollment in other classes, with all other students in the other students group.

Thirty-two students were removed from analyses: 23 other students (2 due to having taken the Psychology of Parenting class in the past, 5 due to failure to complete the pre-assessment sufficiently to obtain scores, and 16 due to only complet-

ing the pre- or postassessment); 9 parenting students were removed due to only completing the pre- or postassessment, resulting in a final sample of 84 students (40 parenting students). There were no significant differences on demographics between students who completed both assessments and those who did not.

The students analyzed were primarily female (86.9%), Caucasian (61.9%) or Black (34.5%), upperclassmen (98.8% were sophomores or above), and psychology majors (65.5%). Four participants had at least one child (all children were under the age of 5). Participants' average age was 20.63 ($SD = 1.78$). There were significant differences between groups on year in school and age (the parenting students were further in sequence and thus older by approximately 1 year), and major (there were more nonmajors in the other courses), but no other demographic characteristics.

Class Descriptions

Students who had passed an Introductory Psychology class and were at least in their second year of college were able to enroll in any of these classes. Thus, while the intention is that students take the junior-level courses before senior-level courses, professors must design all of these classes so that students can succeed with only minimal background knowledge. All classes had a maximum capacity of 55 students with actual enrollments ranging between 48–53 students per class. All classes met for the same length of time across the semester with the junior-level courses meeting 3 days per week for 50-minute class periods and the Psychology of Parenting class meeting twice per week for 75-minute class periods.

The Psychology of Parenting class, taught by the author, was designed to teach undergraduate students relevant theories and research related to parenting from the point of considering becoming a parent through parenting an adolescent, as well as empirically supported parenting strategies. Students completed out-of-class readings and assignments related to the topics and the class met a total of 29 times, including examination days. The course was structured so that the first nine classes were devoted to learning about background knowledge (e.g., theories of parenting) and broad recommendations (e.g., broad recommendations for parenting during infancy). Then eight class periods were devoted to learning about positive parenting practices (e.g., use of positive reinforce-

ment and effective commands). The following class period introduced discipline, including the potential issues with the use of punishment and how to make punishment more effective. The next class period was devoted to reviewing meta-analyses and other studies related to corporal punishment. Finally, five class periods were spent learning about effective discipline methods (e.g., time-out and ignoring and attending).

Students in the Learning and Developmental Psychology classes were also taught by the same professor (the author). Portions of their readings and brief portions of class periods were devoted to information related to optimal parenting practices, the potential negative effects of corporal punishment, and some information on effective parenting practices, but none of these topics were covered in the same depth as the Psychology of Parenting class. The Social Psychology class, taught by another professor, covered aggression as a topic but did not cover corporal punishment nor effective parenting practices.

Procedure

Approval for this study was given by the Institutional Review Board of the large university in the southern United States where the study took place. A research assistant attended the end of the second day of class to inform students enrolled in the Psychology of Parenting class about participating in the study. After receiving information about the study, students were given an information sheet and packet of questionnaires. Students who consented to have their data used for the study were told to complete an optional demographic sheet and place it in a manila envelope that would not be opened until after final grades had been submitted (thus protecting them from potential coercion). All students completed the packet of parenting questionnaires during the second and last week of classes as an out-of-class assignment and only the data for those who had completed the optional demographics questionnaire were utilized for this study (96% consented).

Students in the other classes were given information about the study via an announcement on the university's online learning platform during the first week of classes and were told to follow a link to a Qualtrics website to give consent and complete the questionnaires online in order to participate in the study and receive credit. During the last week of classes, students who participated in the pre-assessment via

Qualtrics were sent an email requesting their participation in the postassessment.

All students who completed the postassessment were sent an email 3 months after the semester requesting they complete the questionnaires again for a chance to win one of four $25 Amazon gift cards. Too few students completed this to analyze the data.

Completion of this study was one of many options for students to receive points that went towards their final grade in the course(s) they were enrolled in and they were entered into a raffle for one of four $25 Amazon gift cards if they completed the follow-up measurement 3 months later. The professors were blind to which students completed the questionnaires because a research assistant informed the professors how many points they earned through any of the available methods to earn points.

Questionnaires

DEMOGRAPHICS

A demographic questionnaire was created for this study to obtain participants' age, year in school, major/minor, and previous psychology courses completed. The demographics section of the Dimensions of Discipline Inventory (DDI; Straus & Fauchier, 2011) was also given and asked about demographics such as sex and racial/ethnic identity.

PARENTING QUESTIONNAIRES

The following three questionnaires were utilized in order to evaluate students' beliefs about parenting behaviors with different ages of children. The questionnaires utilized also made it possible to capture students' beliefs about a wide variety of parenting behaviors.

Parenting Scale–Should (PS-Should; Rhoades & O'Leary, 2007). The PS-Should is a 30-item self-report questionnaire measuring beliefs about what parents should do in discipline situations with 2- to 6-year-olds. Participants rate what they believe parents should do in response to the given child misbehavior on a 7-point scale with anchors of one effective (e.g., "rarely use bad language or curse") and one ineffective strategy (e.g., "almost always use bad language"). The questionnaire results in three factors that are computed by reverse scoring some items and then computing the mean of the relevant items. Scores thus range from 1 to 7 with higher scores indicating higher levels of believing parents should engage in the given discipline style. The three-item Hostile factor was utilized

for this study as a measure of students' beliefs about the appropriateness of these hostile discipline behaviors, including corporal punishment for young children. The five-item Overreactive factor was also utilized because this form of discipline appears to be a final common pathway for risk of parent-to-child aggression (Slep & O'Leary, 2007). The PS-Should has good construct and predictive validity as well as good internal consistency (Rhoades & O'Leary, 2007).

Alabama Parenting Questionnaire-Should (APQ-Should). The original Alabama Parenting Questionnaire (APQ; Frick, 1991) is a 42-item questionnaire designed to measure positive and problematic parenting behaviors. The APQ has good construct and predictive validity and variable reliability across factors (Shelton et al., 1996). The instructions of the APQ were modified so that the APQ-Should asked participants to rate how often they think each of the 42 behaviors should typically occur in an ideal home for a 12-year-old child using a 5-point scale from 1 (*Never*) to 5 (*Always*). The full psychometric properties of the revised scale have not been previously established, but internal consistency was analyzed in this sample. The Corporal Punishment factor was utilized for this study to evaluate beliefs about the use of common corporal punishment behaviors (e.g., spanking) for pre-adolescents (12-year-olds). This factor consists of three items and factor scores are obtained by taking the means of relevant items, such that higher scores indicate higher levels of agreement that parents should engage in these behaviors. Spearman-Brown corrected alphas for this study were .60 (pre) and .69 (post) for the Corporal Punishment factor, which is consistent with the low internal consistency found for this factor on the original APQ by Shelton et al. (1996).

Dimensions of Discipline Inventory (DDI; Straus & Fauchier, 2011). The Adult Recall Form E of the DDI was used, which measures participants' opinions regarding how acceptable they believe it is for parents of a 10-year-old to engage in each of 26 forms of parental discipline. All items are scored on a 4-point scale ranging from 1 (*I think it is never OK*) to 4 (*I think it is always or almost always OK*) and factors are created by calculating the mean of relevant items such that higher scores indicate higher levels of agreement that it is okay to use the given disciplinary behaviors. The four-item Corporal Punishment factor was

utilized for this study to evaluate beliefs about the use of common and more extreme corporal punishment behaviors, such as using objects to hit children, for children (10-year-olds).

Results

A mixed model analysis of variance (ANOVA) was computed for each of the four outcome variables in order to examine the interaction between group (parenting students vs. other students) and time (pre- and postassessment). During data analyses the violations of the assumptions of a mixed model ANOVA were examined. The within-subject equality of variances assumption was violated for the post scores on the Overreactive discipline factor and the APQ Corporal Punishment factor, so the Greenhouse-Geisser corrected F statistic was used for these tests. Finally, planned post-hoc within-subjects t-tests were conducted to examine the within-subjects effects across the semester for each group.[1]

PS-Should Factors

As can be seen in Figure 1, when the PS-Should Hostile parenting factor was the outcome variable, there was a significant, though small, interaction of time and group, $F(1, 82) = 4.52$, $p = .04$, Partial $\eta^2 = .05$. There was a significant, medium effect for parenting students, $t(39) = 4.42$, $p < .001$, $d = .70$, and a significant, small effect for other students, $t(43) = 2.10$, $p = .04$, $d = .32$. The effect size was larger for the parenting students, suggesting the interaction was due to parenting students decreasing their support for the parenting behaviors included in the Hostile factor more than other students.

As can be seen in Figure 2, when the PS-Should Overreactive factor was the outcome variable, there was a significant, medium interaction of time and group, Greenhouse-Geisser corrected $F(1, 82) = 5.09$, $p = .03$, Partial $\eta^2 = .06$. There was a significant, medium effect for parenting students, $t(39) = 4.78$, $p < .001$, $d = .76$, but a marginally significant, small effect for other students, $t(43) = 1.97$, $p = .06$, $d = .30$.

[1] Students completed the full measures for all three questionnaires, but due to the potential for both short- and long-term negative effects of corporal punishment and overreactive discipline, as well as concern for Type I error, only those results are reported. Full results are available upon request.

Figure 1. Parenting Scale-Should Hostile Factor Scores by Group and Time. *Note.* Level of agreement ranges from 1 (*low*) to 7 (*high*). Error bars show 95% confidence interval.
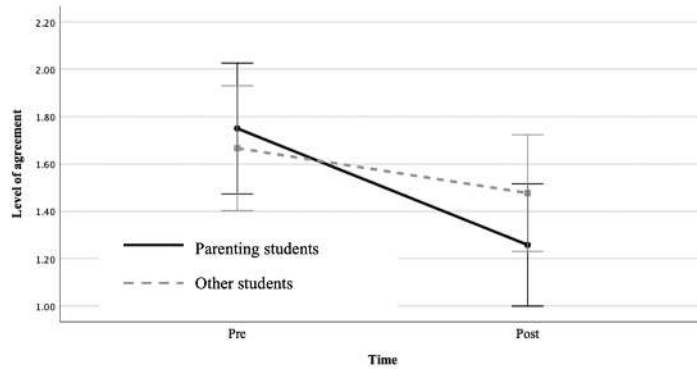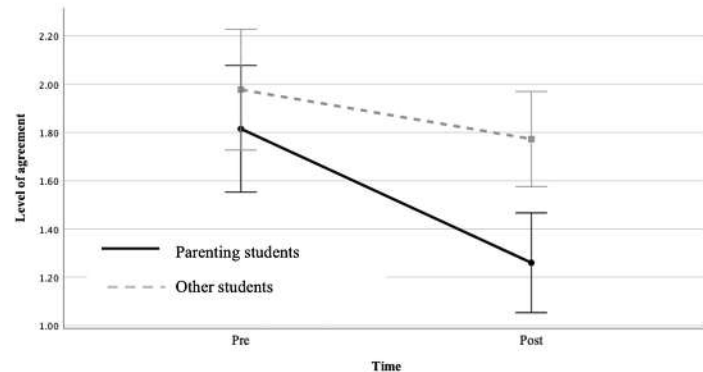

Figure 2. Parenting Scale-Should Overreactive Factor Scores by Group and Time. *Note.* Level of agreement ranges from 1 (*low*) to 7 (*high*). Error bars show 95% confidence interval.
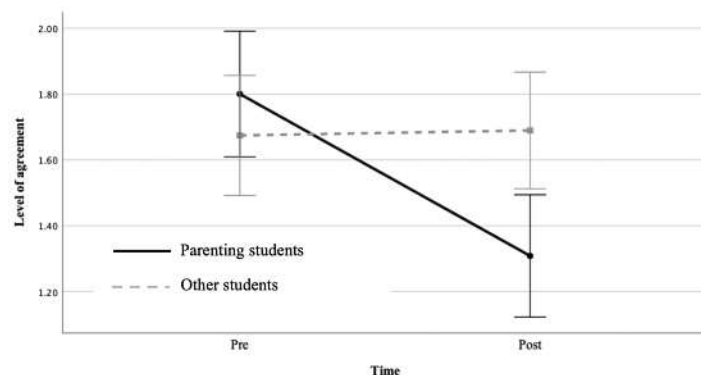

Figure 3. Alabama Parenting Questionnaire-Should Corporal Punishment Factor by Group and Time. *Note.* Level of agreement ranges from 1 (*never*) to 5 (*always*). Error bars show 95% confidence interval.
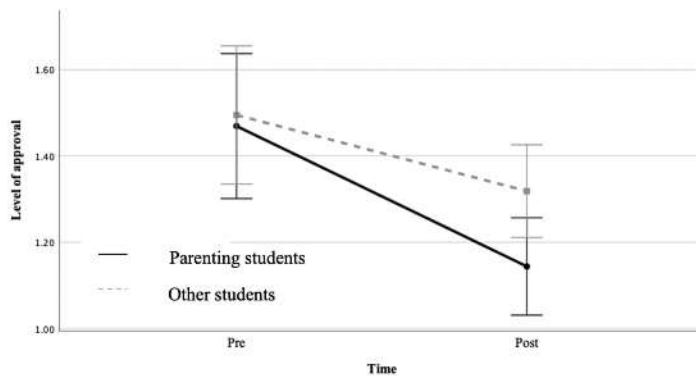
Figure 4. Dimensions of Discipline Inventory Approval for Corporal Punishment Factor by Group and Time. *Note.* Level of approval ranges from 1 (*never OK*) to 4 (*always or almost always OK*). Error bars show 95% confidence interval.

These results also suggest that the interaction was due to parenting students decreasing their support for the parenting behaviors included in the Overreactive factor more than other students.

Corporal Punishment Factors

As can be seen in Figure 3, when the APQ-Should Corporal Punishment factor was the outcome variable, there was a significant, large interaction of time and group, Greenhouse-Geisser corrected $F(1, 82) = 19.29, p < .001$, Partial $\eta^2 = .19$. There was a significant, large effect for parenting students, $t(39) = 5.56, p < .001, d = .88$, but no effect for other students, $t(43) = -.20, p = .84, d = .03$. These results suggest the interaction was due to parenting students decreasing their support for the parenting behaviors included in the APQ-Should Corporal Punishment factor while the other students did not.

As can be seen in Figure 4, when the DDI Corporal Punishment Approval Score was the outcome variable, there was not a significant interaction of time and group, $F(1, 82) = 2.20, p = .14$, Partial $\eta^2 = .03$. There was a significant, large effect for parenting students, $t(39) = 5.12, p < .001, d = .81$, and a significant, small effect for other students, $t(43) = 2.30, p = .03, d = .35$. These results indicate students in both groups decreased their support for parents' use of the parenting behaviors included in the DDI Corporal Punishment factor from the beginning to the end of the semester, but parenting students did not do so significantly more than other students.

Discussion

There was mixed support for my hypothesis that parenting students would reduce their support for parents' use of overreactive discipline and corporal punishment as ideal parenting behaviors more than other students. Significant interaction effects were found when students' support was measured using the PS-Should Hostile and Overreactive parenting factors and the APQ-Should Corporal Punishment factor, but not with the DDI Corporal Punishment Approval factor. One possible reason a significant interaction was not found for the DDI Corporal Punishment factor is that all items on this factor are directly related to corporal punishment that may cause physical pain to the child, whereas all other factors include items that may not cause physical pain to the child, such as yelling at the child. The effect size of the within-subjects *t*-test for the other students on the DDI Corporal Punishment factor was the largest effect for this group ($d = .35$). So, it is possible that these more extreme forms of corporal punishment are addressed sufficiently in the other psychology classes so that students' opinions of physical pain-inducing corporal punishment change more than their opinions on related dysfunctional discipline behaviors.

When examining changes in scores across the semester for each group, it becomes clear that parenting students decreased their support for the dysfunctional discipline behaviors included in the questionnaires more than the other students. For all outcome variables there were

medium or large effect sizes for parenting students and no to small effect sizes for other students. It is interesting to note, though, that small effect sizes were found on three out of the four outcome variables for the other students. This suggests that it may be possible to reduce students' support for dysfunctional discipline behaviors being considered ideal parenting behaviors at least somewhat with minimal education related to parenting behaviors such as that provided in the other classes (e.g., brief coverage of recommendations for how parents should socialize their children). However, higher levels of education, such as that provided to the parenting students, may be required to reduce their support even further.

It is promising to note that students' support for the given behaviors were relatively low, even at the start of the semester, with all mean scores at pre-assessment being below the bottom 37th percentile of possible scores for all outcome variables. However, support decreased on three out of four outcomes for the other students and on all four outcomes for the parenting students, even with this restricted range in the scores. This is promising because it may indicate students are learning these are not ideal parenting behaviors in earlier psychology classes (or from other sources) and their support can be reduced even more with additional education. Future research should explore students' current beliefs related to dysfunctional discipline and utilize a control group outside of psychology to determine the effect of psychology classes specifically.

Atkins et al. (2015) encouraged researchers to explore alternative means to disseminate empirically backed interventions. This study is one such attempt and provides promising preliminary evidence that our undergraduate psychology classrooms are potential venues for meaningful primary prevention of dysfunctional discipline behaviors. Taken with the finding that undergraduate students' beliefs about acceptability of aggressive disciplinary behaviors mediates the relation between aggressive discipline experienced and intent to use aggressive discipline (Fleming & Borrego, 2019), this study suggests that by modifying students' acceptability beliefs, we may be able to modify their intention to use aggressive discipline tactics, and potentially the likelihood that they do so. Therefore, the results of this pilot study, demonstrating that enhanced coursework in parenting can successfully modify students' attitudes, suggests further

research into whether undergraduate coursework in parenting can modify current or future behavior is warranted. Future research should attempt to include more students who are currently parents in addition to potential future parents in order to first determine whether coursework successfully modifies current behaviors. If the results of such a study are promising, it would be beneficial to conduct a longitudinal study following students who are not currently parents until they are parenting a child to determine if there are any impacts on future parenting behaviors.

A final strength of the present study to note is it provides preliminary psychometric support for the APQ-Should. This study demonstrates that the APQ-Should can be successfully utilized to evaluate students' beliefs about what parents should do and the measure is sensitive enough to detect changes in beliefs over time. Finally, this study also provides an estimate of the internal consistency of the Corporal Punishment factor.

Limitations and Future Directions

As noted, this study is intended to be a preliminary study designed to determine if we can successfully utilize our classroom settings as a venue for primary prevention. As such, there are multiple limitations and caveats that future research should address.

First, beliefs about what individuals should do does not necessarily translate into what they actually do. As Rhoades and O'Leary (2007) found, parents knew they should be engaging in less dysfunctional discipline than they reported they did engage in. However, Rhoades and O'Leary also found that parents' beliefs about what they should do was significantly correlated with what they did do, so beliefs may indeed influence actual practices. Similarly, attitudes about the appropriateness of using physical discipline were predictive of the use of physical discipline (Ateah & Durrant, 2005) and were the strongest predictor of parent-to-child aggression for both mothers and fathers in a large, representative community sample (Slep & O'Leary, 2007). Thus, the reduction of students' beliefs that parents should use aggressive discipline tactics could influence actual parenting behaviors and therefore have important implications for preventing parents' use of dysfunctional discipline and engaging in physical child abuse.

A related caveat is that this study was conducted primarily with individuals who do not yet have children, which made it impossible to determine if the intervention had any impact on their parenting behaviors. This study indicates that these classroom educational experiences can assist individuals to become more educated about the topics, raise awareness about effective parenting practices, and reduce their support for dysfunctional discipline, but it remains an open question whether it will change actual behaviors in the future. As already recommended, future research should attempt to follow students for a longer period of time to determine if the intervention does indeed change later behaviors.

The third limitation to keep in mind is that there were some methodological aspects of this study that are not in line with gold-standard intervention studies. Given that the study was conducted in classes where students can freely choose what classes to take, students were not randomly assigned to groups. As such, the parenting students were significantly older and more likely to be psychology majors than the other students. Also, I was the professor of three of the four classes and therefore was not blind to the hypotheses. Therefore, I cannot rule out experimenter bias as a potential cause of these results. In addition, students may have forgotten that the professor would not see their responses and responded with a social desirability bias on the postassessment. Future research should attempt to replicate these results using professors blind to the hypotheses and, if possible, random assignment to groups. Finally, the method through which the groups completed the measures was different, with the parenting students completing paper measures and the other students completing the measures online. Future research should utilize the same methodology for all participants.

Conclusion

This study provides preliminary evidence that we may be able to engage in effective primary prevention of dysfunctional discipline practices in our college classrooms. As with all prevention research, it is not possible to know the full scope of the impact immediately after the preventive intervention. Future research will be needed to determine if exposing undergraduate students to empirically backed parenting interventions not only modifies their beliefs about appropriate parenting strategies, but also modifies their actual parenting strategies if they become parents. This study suggests that the time and effort required to conduct such a research agenda is warranted.

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Find a CBT Therapist

ABCT's **Find a CBT Therapist** directory is a compilation of practitioners schooled in cognitive and behavioral techniques. In addition to standard search capabilities (name, location, and area of expertise), ABCT's Find a CBT Therapist offers a range of advanced search capabilities, enabling the user to take a Symptom Checklist, review specialties, link to self-help books, and search for therapists based on insurance accepted.

We urge you to sign up for the **Expanded Find a CBT Therapist** (an extra $50 per year). With this addition, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars.

To sign up for the Expanded Find a CBT Therapist, click MEMBER LOGIN on the upper left-hand of the home page and proceed to the ABCT online store, where you will click on "Find CBT Therapist."

For further questions, call the ABCT central office at 212-647-1890.

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Now More Than Ever: In Search of ABCT Leadership in 2021 and Beyond

Patricia Marten DiBartolo, *Chair, Leadership and Elections Committee*

WHAT AN EXHAUSTING, extraordinary, and tumultuous time. It is hard not to feel exhausted by the effects and inequalities exposed by the COVID-19 pandemic. Yet, everywhere around me I see people reaching for ways to help and heal. In response to its precarity, this moment has us reaching out to connect with those people and values we hold dear.

In the midst of it all, ABCT's mission—to foster human well-being through evidence-based principles—calls. As misinformation proliferates on social media while systems of medical and psychological health care strain with human suffering, I think about the importance of science in addressing society's challenges. Each year, ABCT's Leadership and Elections Committee works hard to shepherd elections with a slate of candidates who are energized by our organization's mission. Consistent with one of ABCT's central strategic initiatives, we seek to diversify our notions of leadership in order to expand the kinds of professionals who feel like both they and the values they hold dear are reflected in the organization and its leadership.

So, now more than ever, as ABCT gears up for its 2021 election, we ask you to consider, what about you?

For the upcoming 2021 election, we seek nominations for ABCT's next President-Elect (2021–2022; President, 2022–2023; Immediate Past President, 2023–2024), Secretary-Treasurer (2022–2025), and for a Representative-at-Large (RAL; 2021–2024). Each RAL serves as a liaison to one of the governing branches of the association. The representative position open for 2021 will connect and coordinate with the Convention and Education Issues Coordinator and committees. You can nominate any full member in good standing in the organization and there is no limit to the number of nominees you can put forward for any position. Candidates with the most nominations will be the only official names on the ballot once voting commences.

Membership on the Leadership and Elections Committee, approved by ABCT's Board of Directors, includes a chair and two members. Our Chair is Patricia DiBartolo (pdibarto@smith.edu), from Smith College, who has served on the committee since 2016. Kristen Lindgren of the University of Washington School of Medicine is a continuing member (kpl9716@u.washington.edu), and Simon Rego, of Montefiore Medical Center (srego@montefiore.org), is our newest member.

If you do not have time to commit to run, we hope you will express your investment in ABCT's future by voting in the election. One measure we track of whether we have hit our mark as a committee is the percentage of members that cast votes. Last year, we were pleased to see one of the strongest turnouts in years. Never complacent, we seek to increase rates of membership participation in the voting process even further. In 2020, the election will again run in the fall, overlapping with the timing of our Annual Convention. Mark your calendar.

For many of us, ABCT is an intellectual home, one whose mission aligns with our personal commitments. Exert your privileges of ABCT membership so that, together, we can realize the organization's loftiest goals: to enhance and promote human health and wellness. Now more than ever, nominate and vote. We look forward to hearing from you. ◼

I nominate the following individuals:

▶ PRESIDENT-ELECT (2021–2022)

_____

_____

▶ REPRESENTATIVE-AT-LARGE (2021–2024)
Liaison to Convention & Education Issues

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_____

▶ SECRETARY-TREASURER (2022–2025)

_____

_____

▶ NAME (printed)

_____

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.

Only full and new member professionals can nominate candidates. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions. 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. Please complete and sign this nomination form. **Only those nomination forms bearing a postmark on or before September 2, 2020, will be counted.**

Send your form to Patricia DiBartolo, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 by Wednesday, Sept. 2, 2020. Or email to membership@abct.org (Subject line: Nominations)

ABCT 2020

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Plan to attend Thursday Ticketed Sessions

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Jonathan S. Abramowitz, Ph.D., Ryan J. Jacoby, Ph.D., & Shannon M. Blakey, Ph.D.
Desirable Difficulties: Optimizing Exposure Therapy for Anxiety Through Inhibitory Learning

Thomas R. Lynch, Ph.D., & J. Nicole Little, Ph.D.
Radically Open DBT Skills Training: It's Not What You Say, It's How You Say It

■ HALF-DAY INSTITUTES

Cory F. Newman, ABPP, Ph.D. & Danielle A. Kaplan, Ph.D.
Supervision Essentials for Cognitive-Behavioral Therapy

Stefan G. Hofmann, Ph.D., Steven Hayes, Ph.D., & David N. Lorscheid, B.S.
Introduction to Process-Based CBT

Laura H. Mufson, Ph.D., & Jami Young, Ph.D.
Everything You Always Wanted to Know About Interpersonal Psychotherapy for adolescents (IPT-A) and Never Had the Chance to Ask

Mark A. Lau, Ph.D.
Fostering Resilience: An MBCT Approach for Mental Health Professionals

Terri L. Messman-Moore, Ph.D., & Noga Zerubavel, Ph.D.
Trauma-Informed Mindfulness: Integrating Mindfulness-Based Practices Into Psychotherapy With Traumatized Clients

Colleen E. Carney, Ph.D.
Improving Access to Teen Sleep Treatments: How to Deliver Evidence-Based Techniques to Help Young Adults Sleep Better and Feel Better

■ CLINICAL INTERVENTION TRAININGS

Stephen Schueller, Ph.D.
Mobile Apps for Mental Health: Understanding Technologies for Use and Application in Cognitive and Behavioral Therapies

Eli R. Lebowitz, Ph.D.
SPACE: Parent Based Treatment for Childhood Anxiety and OCD

■ AMASS

Jessica Schleider, Ph.D., & Michael Mullarkey, M.A. (*Encore AMASS back by popular demand from 2019*)
Open Science Practices for Clinical Researchers: What You Need to Know and How to Get Started

Brian R.W. Baucom, Ph.D.
Analyzing Longitudinal Data Collected During the Coronavirus Pandemic

Friday and Saturday Ticketed Sessions

■ WORKSHOPS

James F. Boswell, Ph.D., & Tony Rousmaniere, Psy.D.
Deliberate Practice for Cognitive-Behavioral Therapy: Training Methods to Enhance Acquisition of CBT Skills

Steven H. Jones, Ph.D., & Elizabeth Tyler, Psy.D.
Facilitating Personal Recovery in Bipolar Disorder

Melissa G. Hunt, Ph.D.
CBT for GI Disorders: Clinical Training Plus Print and Digital Dissemination

Natalia A. Skritskaya, Ph.D.,
& Katerine Shear, M.D.
Evidence-based Treatment for Prolonged Grief
Disorder

Colleen A. Sloan, Ph.D., & Danielle Berke, Ph.D.
How to Apply Cognitive Behavioral Principles to
Transgender Care: An Evidence-based
Transdiagnostic Framework

Glenn C. Waller, Ph.D., Carolyn B. Becker, Ph.D.,
& Nicholas Farrell, Ph.D.
Rediscovering Exposure: Enhancing the Impact of
Cognitive Behavioral Therapy for Eating Disorders

Stefanie T. LoSavio, ABPP, Ph.D.,
& Gwendolyn (Wendy) Bassett, LCSW
Unraveling PTSD: Using Case Conceptualization to
Enhance Identification and Targeting of Key Beliefs
in Cognitive Processing Therapy

Peggilee Wupperman, Ph.D.,
& Jenny "Em" Mitchell, M.A.
Improving Treatment for Impulsive, Addictive, and
Self-Destructive Behaviors: Strategies From
Mindfulness and Modification Therapy

Margaret Sibley, Ph.D.
Engaging Teenagers with ADHD in Therapy:
Motivational Strategies, Turning Skills into Habits,
and Partnering With Parents

Teri L. Bourdeau, ABPP, Ph.D., Kimberly Becker,
Ph.D., & Bruce F. Chorpita, Ph.D.
Preparing Students as the Workforce of the Future:
Managing and Adapting Practice (MAP) as a
Comprehensive Model for Training in Evidence-
Informed Services for Youth Mental Health

J. Christopher Muran, Ph.D.,
& Catherine F. Eubanks, Ph.D.
Alliance-Focused Training For CBT: Strategies for
Improving Retention and Outcome by Identifying
and Repairing Ruptures in the Therapeutic Alliance

Lisa W. Coyne, Ph.D., & Phoebe S. Moore, Ph.D.
Acceptance and Commitment Therapy: Working
With Parents of Adolescents With Anxiety and OCD

Kelly Green, Ph.D., & Gregory K. Brown, Ph.D.
Cognitive Therapy for Suicide Prevention

Monnica T. Williams, ABPP, Ph.D.,
& Matthew D. Skinta, ABPP, Ph.D.
Microaggressions in Therapy: Effective Approaches
to Managing, Preventing, and Responding to Them

Brian C. Chu, Ph.D., & Laura C. Skriner, Ph.D.
Coordinated Interventions for School Refusal:
Advanced Skills for Working With Families and
Schools

■ MASTER CLINICIAN SEMINARS

Dean McKay, Ph.D.
Conceptualization and Treatment of Disgust in
Anxiety and Obsessive-Compulsive Disorders

Robert L. Leahy, Ph.D.
Envy: A Cognitive Behavioral Approach

Gregory K. Brown, Ph.D.,
& Barbara Stanley, Ph.D.
The Stanley-Brown Safety Planning Intervention to
Reduce Suicide Risk

Richard Gallagher, Ph.D., Jenelle Nissley-
Tsiopinis, Ph.D., & Christina DiBartolo, LCSW
Advancing the Functional Effectiveness of Children
With ADHD at Home and School: Empirically
Supported Programs to Build Organizational Skills
Through Individual, Group, and School Treatments

Esme A.L. Shaller, Ph.D.
AND: Adolescents Need Dialectics! Leveraging
Dialectical Strategies and Philosophy to Improve
your DBT With Teens and Their Families

Torrey A. Creed, Ph.D.
Everything Old Is New Again: The Role of
Worksheets in Growing (and Measuring) CBT
Competence

Katherine K. Dahlsgaard, Ph.D., ABPP
When the Feared Outcome Is Potentially Lethal:
Exposures for Children With Anxiety Disorders in
the Context of Food Allergies

Outreach & Continuing Education Manager

Ever consider working at your professional home? ABCT seeks master's or higher degree in psychology or related field with 2 or more years' experience (including postdoctoral positions) following terminal degree; licensed or license-eligible.

- Academic background in population-based approaches to dissemination (e.g., MPH).
- Knowledge and passion about ABCT: cognitive-behavioral orientation and commitment to science and evidence-based principles.
- Knowledge of CE principles, and familiarity with organizations that sponsor CEs.
- Works well with production schedules; essential in both CE compliance and in developing the educational programs on which they are based
- Expertise in public policy related to behavioral health and in appreciation of the political issues and participants impacting behavioral health care.
- Willingness to work in NYC.
- Experience with professional organizations, building partnerships, project management, and budgeting.
- Excellent communication skills including the ability to communicate effectively with membership, prospective members, governing structure, staff, media contacts, vendors, and general public.
- Expertise with information technology including social media.
- Ability to multi-task, work effectively with deadlines, flexibly accommodate changing priorities and/or goals, and produce accurate and thorough work.
- Ability to work collaboratively.
- Desire to work with incredible ABCT staff!

If up for the challenge, contact Mary Jane Eimer, Executive Director at **mjeimer@abct.org** and send your resume and short letter on why the position appeals to you.

ABCT is committed to the national policy of equal employment opportunity. ABCT will not discriminate in its hiring, promotion, and/or firing of any employee on the basis of race, color, creed, religion national or ethnic origin, sex, sexual orientation, gender identity or expression, age, disability, veteran status, political affiliations, or any other characteristic protected by law.

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COGNITIVE THERAPIES

ABCT's 2020 Champions of Evidence-Based Interventions

This award recognizes outstanding individuals who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT. Importantly, the goal of the award is to identify individuals who translate the impact of research into community health and well-being outside of the scope of their job requirements. Individuals who perform this function as part of their normal job (clinical or research) will not be considered for the award. Champions may not be members of ABCT at the time of their nomination.

▶ **Potential Candidates**

Nominees should demonstrate the characteristics of champions, broadly construed, as recognized in the implementation science literature (see Knudsen, Gutner, & Chorpita, 2019, for examples relevant to ABCT: http://www.abct.org/docs/PastIssue/42n1.pdf). Champions are those individuals who support, facilitate, diffuse or implement the core assets of evidence-based interventions. Champions' efforts expand the scope and impact of evidence-based interventions beyond the reach of researchers alone. They differentiate themselves from others by their visionary quality, enthusiasm, and willingness to risk their reputation for change. Ideal candidates should have demonstrated the following: (1) How the individual has recognized the potential application and impact of evidence-based psychological interventions; (2) How the individual has gone beyond their formal job requirements within an organization to relentlessly promote innovation; and (3) How they actively lead positive social change.

▶ **Recognition**

Nominees will be reviewed in March, June, and October by the ABCT Awards Committee, and those meeting criteria will be forwarded to the ABCT Board of Directors for approval. Recipients will be notified by the ABCT President, and their names and photographs will be posted on the ABCT website, along with the rationale for their recognition. Each year's champions will also be acknowledged at our annual awards ceremony at the ABCT Convention.

▶ **How to Nominate**

Email your nomination to **2020ABCTAwards@abct.org** (link to nomination form is on the Champions web page). Be sure to include "Champions Nomination" in the subject line. Once a nomination is received, an email will be sent from staff, copying the Awards and Recognition Committee Chair. The nomination will be reviewed by the Awards and Recognition Committee, and if deemed appropriate for our program, will be forwarded to the ABCT Board of Directors for final approval. Once reviewed and approved by the Board of Directors, the nominee will be contacted directly by the President, followed up with an ABCT staff member for a final review of the copy to be posted on the ABCT website.

Visit our Champions page to see the full listings and descriptions of ABCT's 2018 and 2019 Champions.

abct.org > **For Members** > **Champions**

SPOTLIGHT
on MENTORS   *call for nominations*

ABCT's Academic Training and Education Standards Committee is currently soliciting nominations for the Spotlight on a Mentor program. The purpose of the Spotlight on a Mentor program is to highlight the diversity of excellent research mentors within the membership ranks of ABCT. Its goal is to spotlight promising early-career and well-established mentors across all levels of academic rank, areas of specialization, and type of institution. To submit a nomination, please complete the nomination form (URL below) and email it to abctmentor@gmail.com by 07/01/2020. Nominations from multiple mentees are encouraged.

ABCT's Spotlight on a Mentor program aims to highlight the diversity of excellent research mentors within the organization's membership ranks. Our goal is to spotlight both promising and accomplished mentors across all levels of academic rank, area of specialization, and type of institution.

If you have any questions please email aleksandra.foxwell@utsouthwestern.edu

Nominate a mentor today: http://www.abct.org/Resources/?m=mResources&fa=spot_Mentor