

# the Behavior Therapist

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### PRESIDENT'S MESSAGE

## ABCT's Response to Systemic Racism and Discrimination

*Martin M. Antony,  
Ryerson University*



AS I WRITE THIS COLUMN in late July 2020, we are still coming to terms with the recent, horrific murders of Breonna Taylor, George Floyd, Chantel Moore, and countless other victims of systemic racism in the United

States and Canada, especially toward Black and indigenous people. Although racism and discrimination have been around forever, these recent acts of violence, and the protests that followed, have led many institutions and organizations around the world to examine the ways in which they contribute to systemic racism and discrimination. ABCT is no exception. On June 4, 2020, ABCT sent to all members our Statement on Racism and Discrimination. In the statement, we committed to listening, learning, and improving how we deal with issues related to racism, discrimination, equity, diversity, and inclusion.

This "president's message" is a natural follow-up to my June column where I discussed ABCT's response to the COVID-19 pandemic. Although COVID-19 impacts all of us, it affects marginalized communities disproportionately. In this column, I focus on ABCT's recent steps to address systemic racism, equity, and related issues. Some of these initiatives began months ago, some are new, and some are still in the planning stages.

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## 2020 Annual Meeting of Members

### NOTICE TO MEMBERS:

The Annual Convention will be held from November 19 through 22. As we get closer to the meeting, we will send an email to each member with information on the date and time of the virtual meeting. This is your opportunity to hear what has been accomplished over the past year and where we are headed in 2021 and beyond. It is also an opportunity to thank our outgoing officers and committee chairs. There's much that's going on at ABCT, and you will benefit from learning more about our future directions. Looking forward to your attendance at this meeting.

## 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=TB>): *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](mailto: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.

We are already well into our process of examining all that that we do from an equity, diversity, and inclusion lens. Last year, ABCT launched the Task Force to Promote Equity, Inclusion, and Access.<sup>1</sup> The Task Force includes subcommittees working on four main areas: (a) a member survey, (b) convention and continuing education, (c) publications, and (d) awards and membership. In an email to all members, we shared preliminary results of the member survey, based on responses from around 400 individuals. A more detailed summary of these findings is planned for publication in the January 2021 issue of *the Behavior Therapist* (*tBT*). Although the Task Force is still working on their final report, we expect it to include a list of recommendations related to a range of topics, including addressing diversity and inclusion related to: the ABCT convention (e.g., speakers, content, site selection, scheduling), publications (e.g., authors, editorial board membership, topics of published papers, special issues), membership and leadership (e.g., board membership, committee membership, recruiting members from diverse backgrounds, reducing financial barriers for underrepresented groups), awards (e.g., rewarding culturally sensitive practice and research, a travel award for students from disadvantaged backgrounds), and improving communication with members about how we are addressing these issues. We will share more information about these recommendations and our resulting actions as they become available.

I now turn my attention to some initiatives that are already under way. As you may recall, ABCT began a process of collecting resources related to racism, discrimination, equity, inclusion. We put out

a call to all members to suggest resources, and we received over 350 suggestions from more than 40 members. By the time this column is published, a list of these resources will be available from a link on our homepage. The plan is to ensure that this list remains current and useful, so we welcome feedback on the listed resources and suggestions for new resources that we might consider adding. These can be sent to Amanda Marmol, [amarmol@abct.org](mailto:amarmol@abct.org), at the ABCT central office.

The Annual Convention is one of ABCT's most visible and valued activities. This year's Program Committee prioritized submissions related to racism, discrimination, and equity in order to bring these issues to the forefront of members' convention experience.

Our ABCT editors are committed to publishing more work by BIPOC (Black, Indigenous, and People of Color) clinicians and researchers, and to hosting important professional dialogue regarding these issues. A special series is planned for *Cognitive and Behavioral Practice*, focusing on Cultural Responsiveness of Cognitive-Behavioral Therapy for People of Color, to be guest edited by Drs. Juliette McClendon and Kimberlye Dean. *Behavior Therapy* is also prioritizing manuscripts related to this important issue. An article on microaggressions is scheduled for publication this fall. Finally, *tBT* is planning several initiatives. The current issue includes articles on effective White allyship, thoughtful approaches to addressing structural racism in clinical research, and considerations for clinicians dealing with clients' prejudices. The October issue of *tBT* will focus on the psychologist's role in advocating to support the health of marginalized populations. Finally, a special

issue of *tBT* (to be published in spring of 2021, most likely) is being developed by the Native American Issues in Behavior Therapy and Research Special Interest Group.

We are aware that effective and inclusive change should not be a top-down process. For past 2 years or so, ABCT has worked to develop a vision of dissemination and implementation based on inclusion, and on enriching our organization's perspective through engaging with a greater diversity of stakeholders and communities. To that end, with diverse stakeholder input, the ABCT Board recently approved the formation of the Dissemination, Implementation, and Stakeholder Engagement Committee. Once formed, this committee will, in part, serve in an advisory role to ensure that our work related to dissemination and implementation of evidence-based practices embraces active engagement with stakeholders, including those from underrepresented communities.

The ABCT Board of Directors, coordinators, and senior staff recently held a strategic planning retreat (online, of course) to begin discussions on leading ABCT into the future. I am happy to say that issues related to structural racism, equity, and inclusion were at the forefront of our discussions. While pleased with the changes we are making, we recognize that there is much work ahead of us.

As always, I welcome your input and suggestions. I can be reached at [mantony@ryerson.ca](mailto:mantony@ryerson.ca).

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<sup>1</sup>Members of the Task Force to Promote Equity, Inclusion, and Access include: Anu Asnaani, RaeAnn Anderson, Sierra Carter, Ryan DeLapp, Brian Feinstein, Christine (Cho) Laurine, Cristina López, Sandra Pimentel, Jae Puckett, Shireen Rizvi, and Laura Seligman.

## Call for Submissions



**Special Issue:**  
Cultural Responsiveness of Cognitive-Behavioral Therapy for People of Color

**Guest Editors:**  
Juliette McClendon, Ph.D.  
[juliette.mcclendon@gmail.com](mailto:juliette.mcclendon@gmail.com)

Kimberlye Dean, Ph.D.  
[deankimberlye@gmail.com](mailto:deankimberlye@gmail.com)

The goals of this special issue are to address these gaps in the literature to enhance cultural responsiveness of CBT for people of Color. We seek papers that address: strategies for enhancing CBT initiation, engagement (e.g., completion of between session homework, treatment completion), satisfaction and/or symptom reduction among people of color, including (but not limited to) cultural adaptations; dissemination and implementation of culturally adapted CBT programs within communities of color; and CBT-informed approaches to mitigating the impact of racism on mental health.

Authors or author groups with questions about potential submissions are invited to contact the Guest Editor team.

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

Mary Jane Eimer, *Executive Director*



MARTIN ANTONY, our ABCT President, gave an excellent overview of the work our members in governance have been doing in 2020—no easy feat when you take into consideration the

changes COVID-19 has wrought on our professional and personal lives. Indeed, their tireless, attentive work and time spent during this crisis have revealed their exceptional devotion to this membership. Your leadership is committed to seeing us through these challenging times while continuing to ensure that ABCT remains a valuable resource in a variety of ways in a variety of settings.

Since my last column, our staff of nine has had a “soft” opening for those who were ready and willing to return to the office on Monday, July 6. Generally, we have three staff members per day. Our building is taking numerous precautions in the public space, and we are handling our office space according to the guidelines from our building, NYC, and New York State.

We have had the ability to work remotely for several years and really upped our game using Zoom. The Board monthly meetings use Zoom, and we transitioned earlier this year to staff hosting our Continuing Education Committee’s webinars. We now can accommodate up to 500 attendees on a webinar, and all staff will be trained to host a webinar.

During these turbulent times, we have tried to be mindful in providing useful resources and benefits. We have been updating the website weekly with resources on coping with COVID as well as free webinars, such as “What You Need to Know to Run Your First Online Class,” by Daniel Beck; Kate Morrison’s “Primer on Telehealth”; Dean McKay’s “Surviving a Dangerous Time and Preparing for a Better One”; and, most recently, “Stabilizing Chaos: Fostering Psychological Resilience

in the Wake of Adverse Events,” with Lata McGinn.

We lowered the price of our archived webinars and reduced the price of the live webinars so members could earn continuing education credits easily. It’s been a great success for us, and we hope you’re among the beneficiaries of these great offerings at low rates.

As I write this column, our online survey regarding the November convention is under way. The survey was sent to approximately 4,000 members and non-member presenters. We have already received over 2,000 responses—the best response we have ever had to a survey. Thank you to those that responded. This data will help the Board determine how the November convention will be handled. It will also provide insights for leadership and staff on how to envision future conventions, online learning formats, creating more continuing education opportunities throughout the year, and creative ways to promote networking.

Stephen Crane, our Convention Manager, has worked with Program Chair Shannon Wiltsey Stirman and Associate Program Chair Daniel M. Cheron to schedule the meeting traditionally. Stephen has been taking a certificate program in virtual meeting planning in addition to learning the new modules available from Cadmium, our convention submission and convention itinerary program. This week 5 of our staff are attending Cad Con, Cadmium’s annual conference, to learn the new platforms and live streaming. We are ready to pivot once the decision is made for the Philadelphia convention.

You may recall that a major project staff has been working on is transitioning from our 10-year proprietary database to a commercial company that offers seamless integration of our directories, expanded capabilities for marketing, and a few more bells and whistles. David Teisler, our Director of Communications, and Dakota McPherson, our Membership and Market-

ing Manager, are doing a deep dive into what works, what is missing, and what needs to be improved. The database is integral to all we do in the Central Office and will drive the revised website. We want the system to be user-friendly and up to the expectations of membership, committee chairs, and staff. A tall order, indeed.

David has been putting together a group of members to help us review our specialties. We have about 150 specialties in our AMS and directory; that is unwieldy. We’ve often attempted work on this front, but with the coming new database, it’s imperative we address this now so that we create a list that is useful for all the directories and entities that will pull from it: Find a CBT Therapist; Speaker’s Bureau; Mentorship Directory; Medical Educator Directory; and Membership Directory; as well as *Behavior Therapy*; *Cognitive and Behavioral Practice*; *the Behavior Therapist*; and the Annual Convention. There are lots of details to address to ensure a smooth transition and the desired outcome.

Please continue to be active in ABCT by renewing your membership and registering for the convention. Participate in our list serve or in one of our Special Interest Groups. We promoted the Call for Officers heavily with a deadline for nominations on September 2. Our online voting portal is open the month of November. This is your organization and your opinion and participation matters. The Board listens, as does the staff. We are counting on you.

You are always welcome to contact me directly at [mjeimer@abct.org](mailto:mjeimer@abct.org).

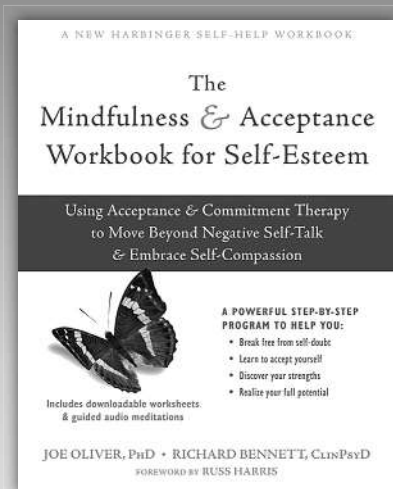
Stay safe and positive, everyone. Until next time!

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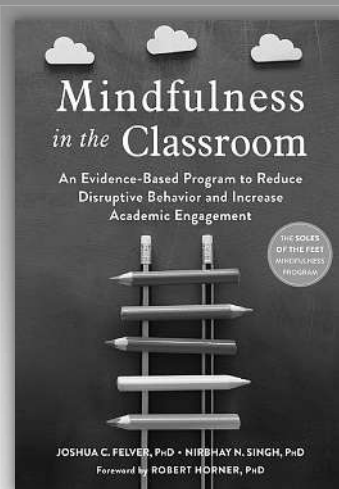
**Correspondence to** Mary Jane Eimer, CAE, Executive Director, ABCT, 305 Seventh Ave., Suite 1601, New York, NY 10001; [mjeimer@abct.org](mailto:mjeimer@abct.org)



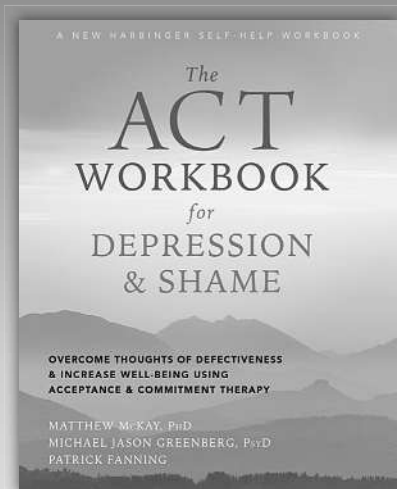
# Essential Resources for Your Practice



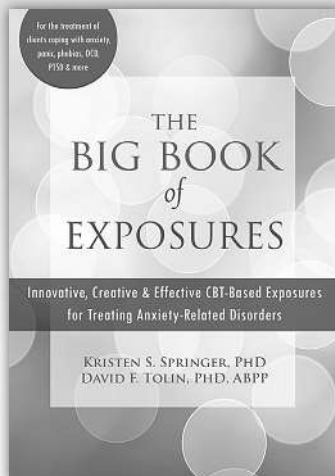
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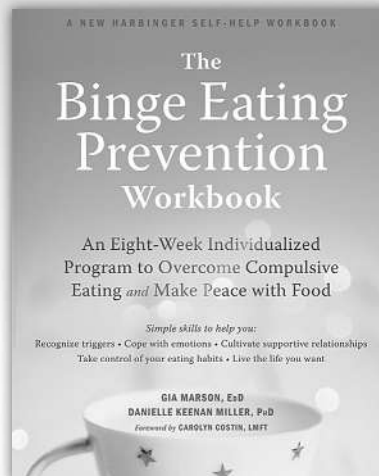
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# The Ethical Obligation of Allyship: Why and How White Behavioral and Cognitive Therapy Professionals Need to Foster Black Equity

Destiny M. B. Printz Pereira and Jamilah R. George,  
*University of Connecticut*

WITH RACIAL DISPARITIES in COVID-19 deaths and yet another wave of Black murders by police and civilian vigilantes, structural racism has become a widely discussed topic this year. Consistent news coverage, federal and local policy discussions, and antiracist statements released by professional organizations and academic institutions may create the perception that addressing systemic racism is primarily the job of politicians and policymakers. However, this perception cannot serve to diminish the responsibility of our profession to engage in making meaningful change now.

This article, primarily addressed to our White colleagues, will discuss White mental health professionals' ethical obligation to promote equity for Black Americans and operationalize White allyship. This article will also offer actionable items to help propel engagement in White allyship within the profession, with a particular focus on clinical work, research, and psychological assessment. The work of White allyship is important for numerous marginalized groups, as well as Black individuals with intersecting marginalized identities (e.g., LGBTQ+, disability, socioeconomic status). Although portions of this article may be applicable across marginalized identities, it does not address their distinctive needs, as the focus will remain on Black Americans.

## Black Inequities and Behavioral and Cognitive Therapies

Mental health research and practice is failing Black Americans. Racial disparities in mental health services are a well-documented, historical issue (e.g., McGuire & Miranda, 2008). For almost 30 years, the National Institutes of Health (NIH) has attempted to diversify research by requiring the inclusion of non-White participants (NIH, 1993, 2017). Despite this effort, Black Americans are consistently

underrepresented in mental health research (e.g., Ford et al., 2008; Mendoza et al., 2012), undermining the generalizability of study findings and potential benefit for Black individuals. Disparities in clinical outcomes persist as well. In comparison to White Americans, Blacks receive reduced quality of mental health care (Primm & Lawson, 2010; U.S. Department of Health and Human Services [HHS], 2001) and less access to evidence-based (Wang et al., 2000) or guideline-based treatment (Gonzalez et al., 2010).

Numerous factors contribute to these disparities, including that most behavioral and cognitive therapies (BCTs) were developed to address individual, not societal or structural factors. Although current BCTs target various mechanisms, the majority have roots in the cognitive model proposed by Aaron Beck in the 1960s. The basic tenet of Beck's original model was that mental illness results from inaccurate or unrealistic thinking about the self, the world, or one's future (Beck, 2011). Yet for those who experience structural racism, negative beliefs about the world or one's future within that world may be both accurate and realistic. More generally, because most BCTs were developed by White scholars with limited experience of systemic or interpersonal discrimination, they include little guidance on how to conceptualize and address the mental health impact of structural racism. The lack of guidance from our theoretical models, coupled with the White professionals' incomprehension, discomfort, or dismissal of acknowledging the importance of structural racism when utilizing and studying BCTs, can contribute to inequalities. This, however, is not a justification for the lack of action by mental health professionals. Inaction demonstrates complacency and is in opposition to our professional code of ethics.

## White Allyship and Our Code of Ethics

Every mental health professional holds an ethical obligation to ensure that Black Americans equitably benefit from the application and research of BCTs. Fields such as social work and marriage and family therapy have explicit expectations to support vulnerable populations within their code of ethics (American Association for Marriage and Family Therapy [AAMFT], 2015; National Association of Social Workers [NASW], 2017). For other mental health professions, we share the less explicit obligations of integrity, nonmaleficence, and justice (American Medical Association [AMA], 2016; American Psychological Association [APA], 2017). We are duty bound to ensure benefit across communities in all aspects of our professional contributions (e.g., leadership, mentorship, teaching, research). We are responsible for the impact our biases have on individuals affected by our work and to mitigate the harm it can cause. These efforts are required throughout your profession.

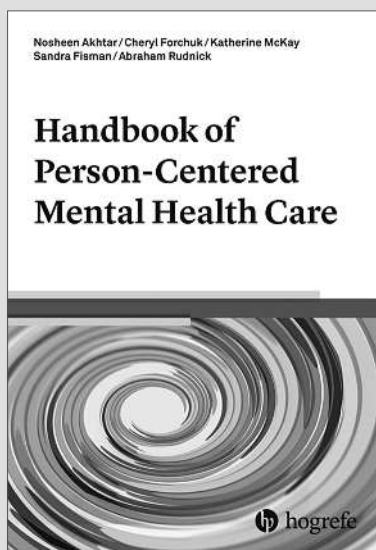
Oftentimes professionals believe that studying, treating, or advocating for Black issues in BCTs is a topic outside of their scope of work; however, this is a fallacy. Professionals with focuses other than marginalized populations still serve marginalized populations. It is rare that an experience, disorder, health outcome, or any other topic of interest is not experienced by Black Americans. Regardless of your area of expertise, Black individuals can benefit from your work if the work is equitable. Thus, we are all responsible and ethically bound to ensure that our work closes gaps in disparities for Black Americans.

Succinctly termed, "White allyship" signifies White mental health professionals' ethical obligation to improve Black equity. An interdisciplinary definition of White allyship includes responsibility for and intentional consideration of one's own racialized thoughts, behaviors, and biases (Spanierman & Smith, 2017). White allies seek and utilize knowledge pertaining to structural racism and White privilege. Most important, allies actively work to create new norms rooted in justice (Spanierman & Smith). Given the social advantage afforded to them, White allies are essential to the work of eliminating

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“This is a ground-breaking volume that goes beyond the standard set of well-accepted principles for person-centered mental health care to (finally) operationalizing these principles in terms of concrete practice.”

Larry Davidson, Ph.D., Professor of Psychiatry and Director of the Program for Recovery and Community Health of the Yale University School of Medicine, New Haven, CT



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Person-centered mental health care is essential for keeping service users at the center of care. This handbook uses practical examples across health care, research, education, and leadership to illustrate how to implement person-centered approaches for and with the growing population of service users who have mental health challenges. Looking at the different service user encounters enables service providers to envision the effective, comprehensive implementation of person-centered care.

Each chapter follows a concrete example exploring different techniques, tools, and resources that can be used with service users who have mental health challenges. An appendix provides the handouts in online, printable form. Written by experts in person-centered care who have diverse experiences with mental health-related practices, policies, research, and education, this comprehensive handbook is a valuable resource for psychiatrists and other mental health practitioners, researchers, educators, and policy makers who work with people who have mental health challenges as well as for service users and their families.

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mental health disparities among Black Americans.

Becoming an ally can be personally and professionally challenging. It requires identification and the deconstruction of White-centric beliefs and customs, confronting uncomfortable or shameful race-based topics through education, and advocacy amid potential peer opposition. Despite the difficulty, the key to White allyship is consistency. Inequities for Black Americans will remain long after the attention from media and professional organizations inevitably wanes. White allies must resist the temptation to return to the status quo and commit to a career-long effort to redirect the course of our field.

To aid in this effort, we have provided actionable items that may assist in your progress towards effective White allyship. The following is not an exhaustive list of options, but instead an invitation to commit to small- and moderate-sized efforts to address Black inequities and improve allyship.

### Addressing Black Inequities

Addressing Black equity in mental health and BCTs may initially feel intimidating or overwhelming; however, allyship is a progressive process. White allyship comes in small steps, beginning with an honest self-evaluation of your racialized beliefs and behaviors. As you read through these potential efforts, reflect on your level of knowledge and action in each category. We then invite you to create a list of short and long-term “specific, measurable, attainable, realistic, and time-bound” (S.M.A.R.T.) goals (Doran, 1981, p. 36) to integrate equity efforts into your area of work and hold yourself accountable for those efforts.

### Gain Knowledge About Racism More Broadly

Appropriate and effective action first requires education; however, only learning about disparities in your field is not sufficient. Structural racism can be challenging to identify for many Whites (Kendi, 2019; Vaught & Castagno, 2008), much like identifying water can be difficult for a fish until they experience dry land. Structural racism has permeated our country’s legal, educational, cultural, and interpersonal domains for hundreds of years, making it difficult to identify for those unaffected by the consequences. The field of mental health, and us as individuals, is not immune to this inundation. Thus, White

allies must first be able to identify structural racism and its personal and professional impact before addressing Black inequities in mental health. This requires a deeper understanding of “dry land,” or the historical and modern experiences of racism often neglected by our society.

In your educational journey, it is imperative to recognize that modern race-based issues are the legacy of our country’s history. Our current racial divide is a remnant of slavery, intentionally sewn to prevent women and Whites of low-income from building coalition with Blacks to usurp power from wealthy White landowners. Our “history” of racism is not far behind us. Most mental health professionals or their parents were alive to see the signing of the Civil Rights Act of 1964; the same year, a poll revealed most White New Yorkers believed the “civil rights movement had gone too far” (*New York Times*, 1964).

As our past greatly impacts our present, your education should include the horrendous, often neglected, truths about slavery, Jim Crow, the civil rights movement, and modern racism. Topics can include disparities in generational wealth related to the Government Issue Bill (G.I. Bill), the demonization and incarceration of Black Panther party leaders through illegal Federal Bureau of Investigations (FBI) activities, and mass incarceration. Your education may also include gruesome or triggering historical accounts, such as federally funded and coerced sterilization, the Tulsa Race Massacre, and the practice of collecting and selling Black body parts as souvenirs after a lynching. These events, and countless more, lay the foundation for contemporary attitudes and policies that disenfranchise Black Americans (e.g., redlining, Stop and Frisk, voter suppression).

White allies should approach education as a continual process of enlightenment and self-reflection. This education should be implemented on systemic, interpersonal, and individual levels. These efforts can include infusion into graduate education, small reading groups with intentional discussions about racism and bias, and personal engagement in historically accurate documentaries. It may seem intuitive to rely on Black clients, participants, or colleagues for general information, educational resources, or personal antidotes to facilitate your understanding. Although it can be important to understand Black individuals’ varying experiences, it is inappropriate to place the burden of education and disclosure on Black Americans. Fortu-

nately, many scholars have willingly provided knowledge that can aid you in your growth—some of these resources are featured in this article’s Appendix.

### Replace Color-Blind Ideology With Antiracism

Racial color-blindness, an ideology espousing that individuals should “not see” racial differences, attempts to promote racial equality through shared commonalities between individuals, regardless of race. Color-blind ideology can appear desirable at face value and many White individuals espouse these beliefs to support claims that they oppose racism. It may then come as a surprise that racial color-blindness actually perpetuates contemporary racism (e.g., Richeson & Nussbaum, 2004).

The belief that all people have equal value is certainly something to cherish and cultivate. However, a color-blind lens forces a White-centric perspective of Black Americans, as the White observer’s view of commonalities is informed by their own experiences and socialization. Color-blindness prevents Whites from acknowledging racial inequities, as White Americans do not experience structural racism. Refusing to acknowledge an individual’s Blackness (i.e., their non-White-centric experiences) also ignores their treasured Black customs, ideas, cultures, and histories. Just as White Americans have a breadth of experience across different ethnicities, states, and socioeconomic classes, so do Black Americans. Blackness is not a monolith: It is a rich and uniquely expressed identity. Color-blind ideology robs Black Americans of their diversity, whether done intentionally or not, and results in racist passivism.

Color-blind ideology perpetuates racist ideals, whether done intentionally or not, and results in racial passivism. Due to a nonsocialized and “simplistic understanding of racism,” many White individuals will say that they are not racist (DiAngelo, 2018). However, it is important to note that this concept is fundamentally different from being an antiracist. Espousing that you are not racist requires no action and can cultivate individual complacency with interpersonal and systemic issues. An antiracist person is active in the initiation and support of efforts to reduce racial inequities. To bring forth racial justice, White professionals must engage in practices that are antiracist, which require deliberate attention to systems of oppression and how they impact the livelihood and overall well-being of Black Americans.



### ***Gain Knowledge and Address Inequities Within the Field***

Mental health professionals should become knowledgeable about Black inequities and mitigation efforts in their areas of expertise or interest. Much like other academic endeavors, you can read peer-reviewed articles, books, and attend conference sessions on Black American disparities. We also encourage you to join local or national Black equity-based professional organizations. Gaining topic-specific knowledge can be fairly straightforward; however, improving Black equity also requires knowledge pertaining to structural concerns within our field and actionable steps to mitigate disparities.

- *BCTs and clinical considerations.* Inequities in clinical care are due, in part, to a lack of access to culturally adapted treatments (e.g., Hall et al., 2016, Primm & Lawson, 2010). Black clients, especially those who are experiencing distress due to racism, may benefit from additional cultural considerations in our usage of BCTs. Clinicians should reflect on tenets or com-

ponents of BCTs that may perpetuate Black inequities or enact privilege within the therapeutic relationship. For example, Black Americans may hold a more negative worldview than Whites (e.g., Zoellner et al., 1999), which may be driven by experiences of structural racism. Challenging negative worldviews or assessing the “helpfulness” of these thoughts can invalidate the client’s lived experience and the realities of structural racism.

When addressing race-related issues, clinicians should first validate the client’s experience and then collaboratively explore and address issues that may in part result from race-based stress. Clients may also benefit from stress reduction and distress tolerance skills. For example, your client, a Black parent, has set a stricter curfew for their teenager due to worries they will die in a police encounter. Your client is experiencing distress due to increasing parent-child conflict related to the curfew change. After asking clarifying questions and remembering information from your educational efforts, you recognize that your client’s concern for their

teen’s safety is a normative response to structural racism (e.g., a cluster of reports surrounding police violence). You may then assist your client in problem-solving ways to improve the relationship while keeping the teen safe and teach them deep breathing and other emotion regulation strategies to utilize when in conflict. Conversely, a White-centric conceptualization would fail to recognize or avoid openly addressing the paralyzing and disabling nature of systemic racism underlying the client’s distress. Such a dismissal could result in cultural mistrust and a harmful mischaracterization of the client’s symptom presentation, increasing the likelihood of early termination (Williams, George, et al., 2020). Identifying and properly utilizing effective interventions for race-based issues is essential in the effort to reduce inequities.

- *Research and assessment.* It is our ethical obligation to ensure that our assessment measures and research reduce Black inequities. To achieve this, we must ensure that our racial biases do not impact evaluations. Black Americans experience dispari-



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ties in diagnosis across several psychological disorders, which can be exacerbated by evaluator bias (Williams, George, et al., 2020). For example, clinicians are more likely to perceive Blacks as aggressive and emotionally dysregulated when compared to White counterparts, increasing their likelihood of receiving a diagnosis of bipolar disorder (Mackin et al., 2006). Our diagnostic measures may also contribute to inequities in assessment, due to a lack of consideration for cultural factors and the impact of racism on symptomology. Black Americans are more likely to endorse paranoia due to experiences of structural racism (Mosley et al., 2017), which may lead to an increase in schizophrenia diagnoses (Bell et al., 2015). Mental health assessments do not include items specific to race-based stress, despite its impact on symptomology. For instance, a systematic review on racial trauma found that 70% of endorsed posttraumatic stress symptoms were significantly associated with perceived discrimination (Kirkinis et al., 2018). For these reasons it is imperative that we use measures that are well validated in Black American samples. If your preferred measures are not well validated, you can lead or collaborate on the necessary validation study.

When conducting research, low rates of Black participation or high rates of attrition can impact the generalizability of study findings. Studies suggest that Blacks may not differ from Whites in terms of willingness and eligibility to participate in research; however, they are asked to participate less often (e.g., Wendler et al., 2006) and may experience increased mistrust of research, stigma, and economic barriers (George et al., 2014). Thus, researchers must actively recruit Black Americans to create more equitable research.

Subjects can be offered weekend or evening meetings to reduce conflicts between participation and employment. If this is not feasible, study compensation should adequately cover time off from work. Research can also be conducted in community settings to increase access and reduce the burden of travel. Recruitment materials should include photos of Black Americans and research study personnel, if the team is racially diverse. In diverse cities or counties, community-based research can also facilitate inclusion by incorporating community input from study conception to dissemination, ensuring protocols are reflective of the communities' needs and expectations.

Recruitment efforts should aim to oversample Black participants, enabling researchers to detect potential race-based differences in study outcomes. White researchers are encouraged to foster equity-driven collaborations with professionals well versed in Black issues to increase comfortability and familiarity with new recruitment procedures.

- *Discuss race and privilege.* Openly acknowledging your White privilege in professional spaces may be the most intimidating and advanced step we will encourage. This suggestion can be difficult at first, but discussing race not only improves Black equity but can also increase positive affect for Whites (Williams, Kanter, et al., 2020). Black professionals and clients may avoid discussing racism with Whites in a professional space due to potential repercussions or racist reactions. This is especially true when the relationship is hierarchical. Thus, White professionals may not know if racist experiences occur that are relevant to their working relationship (e.g., client is distressed by being followed in a store, Black colleague experiences microaggressions from a team member). This lack of communication can also increase feelings of isolation for Black clients and professionals.

Across professional domains, whether you are meeting a new client or working with a Black colleague or graduate student, bringing up racial discordance early on in a relationship can indicate that race and racism are safe topics to discuss with you. Introducing racial discordance can be as simple as (a) acknowledging that you are White and may have different experiences due to your race, (b) letting the client/colleague/etc. know that they can come to you if they have difficult race-based experiences, and, most important, (c) following through in an antiracist manner if and when they choose to disclose. It is important not to force disclosure or belabor the topic, but instead to create an open invitation to discuss if warranted.

If a Black professional or client does disclose a racist event to you, how you respond can not only impact your working relationship, but the individual's short- and long-term well-being. When in doubt, treat disclosures of discrimination and race-based stress as you would any other traumatic or distressing event. Do not question their account of the experience or try to defend the perpetrator. Instead, address their emotions and the impact the event had on their well-being. With Black profes-

sionals, offer emotional and instrumental support. With Black clients, you may work through their cognitive distortions or their feeling of responsibility for the event.

It may be increasingly difficult to address disclosures when a Black client, participant, or professional perceives your behaviors or sentiments as prejudice. For many individuals, the initial reaction is to convince the other person that they are not racist. Although it may be helpful to discuss your intent later in the conversation, what matters most is the impact of your actions or words. Thus, your first order of action is to listen with curiosity and an open mind. As you are working towards becoming an effective White ally, you will have missteps, and this type of feedback can help you refine your allyship. Be willing to learn from mistakes, express your desire to become a stronger ally, and repair the relationship if needed.

## Conclusion

Fulfilling ethical obligations through White allyship may be challenging, but it can mitigate Black Americans' far more challenging experience of inequities in mental health. As a means to embrace the ethical obligation of White allyship, White mental health professionals should actively address Black inequities in mental health by gaining more knowledge about racism, replacing color-blind ideology with antiracism, and addressing inequities in the field. A part of becoming invested in the ethical obligation of White allyship is to seek out resources on your own. However, we have provided a brief list of additional resources as an Appendix to this article to provide a starting point and fuel your engagement in this work.

Although there are no easy solutions, all mental health professionals are responsible for taking consistent, long-term action towards equity. Without action, your empathy proves useless to the Black struggle to survive. The centuries-old plague of structural racism will not resolve itself, and Black Americans should not be expected to shoulder the burden of progress alone. So we ask you, ally, when and how do you intend to act?

## References

- American Association for Marriage and Family Therapy. (2015). *Code of ethics*. Retrieved from [https://www.aamft.org/Legal\\_Ethics/Code\\_of\\_Ethics.aspx](https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx)
- American Medical Association. (2016). *AMA principles of medical ethics*.

- Retrieved from <https://www.ama-assn.org/delivering-care/ama-principles-medical-ethics>
- American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/index.html>
- Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). Guilford Press.
- Bell, C. C., Jackson, W. M., & Bell, B. H. (2015). Misdiagnosis of African-Americans with psychiatric issues - Part II. *Journal of the National Medical Association*, 107(3), 35–41. [https://doi.org/10.1016/S0027-9684\(15\)30049-3](https://doi.org/10.1016/S0027-9684(15)30049-3)
- Doran, G. T. (1981). There's a S.M.A.R.T. way to write management's goals and directives. *Management Review*, 70(11), 35–36.
- Ford, J. G., Howerton, M. W., Lai, G. Y., Gary, T. L., Bolen, S., Gibbons, M. C., Tilburt, J., Baffi, C., Tanpitukpongse, T. P., Wilson, R. F., Powe, N. R., & Bass, E. B. (2008). Barriers to recruiting under-represented populations to cancer clinical trials: A systematic review. *Cancer*, 112(2), 228–242. <https://doi.org/10.1002/cncr.23157>
- George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal of Public Health*, 104(2), e16–e31. <https://doi.org/10.2105/AJPH.2013.301706>
- González, H. M., Vega, W. A., Williams, D. R., Tarraf, W., West, B. T., & Neighbors, H. W. (2010). Depression care in the United States: Too little for too few. *Archives of General Psychiatry*, 67(1), 37–46. <https://doi.org/10.1001/archgenpsychiatry.2009.168>
- Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A Meta-Analysis of Cultural Adaptations of Psychological Interventions. *Behavior Therapy*, 47(6), 993–1014. <https://doi.org/10.1016/j.beth.2016.09.005>
- Kendi, I. X. (2019). *How to be an antiracist*. One World.
- Kirkinis, K., Pieterse, A. L., Martin, C., Agiliga, A., & Brownell, A. (2018). Racism, racial discrimination, and trauma: A systematic review of the social science literature. *Ethnicity & Health*, 1–21. <https://doi.org/10.1080/13557858.2018.1514453>
- McGuire, T. M & Miranda, J. (2008). New evidence regarding ethnic and racial disparities in mental health: Policy implications. *Health Affairs*, 27(2), 393–403. <https://doi.org/10.1377/hlthaff.27.2.393>
- Mackin, P., Targum, S. D., Kalali, A., Rom, D., & Young, A. H. (2006). Culture and assessment of manic symptoms. *Journal of Mental Science*, 189, 379–380.
- Mendoza, D. B., Williams, M. T., Chapman, L. K., & Powers, M. (2012). Minority inclusion in randomized clinical trials of panic disorder. *Journal of Anxiety Disorders*, 26(5), 574–582. <https://doi.org/10.1016/j.janxdis.2012.02.011>
- Mosley, D. V., Owen, K. H., Rostosky, S. S., & Reese, R. J. (2017). Contextualizing behaviors associated with paranoia: Perspectives of Black men. *Psychology of Men & Masculinity*, 18(2), 165–175. <https://doi.org/10.1037/men0000052>
- National Association of Social Workers. (2017). *NASW code of ethics*. Retrieved from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>
- National Institutes of Health. (1993). *National Institutes of Health Revitalization Act of 1993: Clinical research equity regarding women and minorities*. Retrieved from <https://orwh.od.nih.gov/sites/orwh/files/docs/NIH-Revitalization-Act-1993.pdf>
- National Institutes of Health. (2017). *NIH policy and guidelines on the inclusion of women and minorities as subjects in clinical research*. Retrieved from [http://grants.nih.gov/grants/funding/women\\_min/guidelines\\_amended\\_10\\_2001.htm](http://grants.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm)
- New York Times. (1964, September 21). *Poll shows Whites in city resent civil rights drive*. Retrieved from <https://www.nytimes.com/1964/09/21/archives/poll-shows-whites-in-city-resent-civil-rights-drive-majority.html>
- Primm, A. B., & Lawson, W. B. (2010). African Americans. In P. Ruiz & A. Primm (Eds.), *Disparities in psychiatric care: Clinical and cross-cultural perspectives*. Lippincott Williams & Wilkins.
- Richeson, J. A., & Nussbaum, R. J. (2004). The impact of multiculturalism versus color-blindness on racial bias. *Journal of Experimental Social Psychology*, 40, 417–423. <https://doi.org/10.1016/j.jesp.2003.09.002>
- Spanierman, L. B., & Smith, L. (2017). Roles and responsibilities of White allies: Implications for research, teaching, and practice. *The Counseling Psychologist*, 45(5), 606–617. <https://doi.org/10.1177/0011000017717712>
- U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Vaught, S. E., & Castagno, A. E. (2008). “I don’t think I’m a racist”: Critical race theory, teacher attitudes, and structural racism. *Ethnicity and Education*, 11(2), 95–113 <http://doi.org/10.1080/13613320802110217>
- Wang, P. S., Berglund, P., & Kessler, R. C. (2000). Recent care of common mental disorders in the United States. *Journal of General Internal Medicine*, 15(5), 284–292. <https://doi.org/10.1046/j.1525-1497.2000.9908044.x>
- Wendler, D., Kington, R., Madans, J., Wye, G. V., Christ-Schmidt, H., Pratt, L. A., Brawley, O. W., Gross, C. P., Emanuel, E., & Gill, P. (2006). Are racial and ethnic minorities less willing to participate in health research? *PLoS Medicine*, 3(2), e19. <https://doi.org/10.1371/journal.pmed.0030019>
- Williams, M. T., Kanter, J. W., Peña, A., Ching, T. H., & Oshin, L. (2020). Reducing microaggressions and promoting interracial connection: The racial harmony workshop. *Journal of Contextual Behavioral Science*, 16, 153–161. <https://doi.org/10.1016/j.jcbs.2020.04.008>
- Williams, M. T., George, J. R., & Printz, D. M. B. (2020). Behavioral health service delivery with African Americans. In L. T. Benuto, F. Gonzalez, & J. Singer (Eds.), *Handbook for Cultural Factors in Behavioral Health: A Guide for the Helping Professional*. Springer.
- Zoellner, L. A., Feeny, N. C., Fitzgibbons, L. A., & Foa, E. B. (1999). Response of African American and Caucasian women to cognitive behavioral therapy for PTSD. *Behavior Therapy*, 30(4), 581–595. [https://doi.org/10.1016/S0005-7894\(99\)80026-4](https://doi.org/10.1016/S0005-7894(99)80026-4)

## APPENDIX

### Additional Resources

#### • Understanding Race and History

- Alexander, M. (2020). *The new Jim Crow: Mass incarceration in the age of color-blindness* (Anniversary ed.). The New Press.
- Coates, T. (2015). *Between the world and me*. Spiegel & Grau.
- Hannah-Jones, N. (Host). (2019). *1619 Project* [Audio podcast]. New York Times. <https://www.nytimes.com/column/1619-project>
- Jenkins, M. (2018). *This will be my undoing: Living at the intersection of Black, female, and feminist in (White) America*. HarperCollins.



Smedley, A., & Smedley, B. D. (2012). *Race in North America: Origin and evolution of a worldview* (4th ed.). Westview Press.

Wallis, J. (2015). *America's original sin: Racism, white privilege, and the bridge to a new America*. Baker Publishing Group.

#### • *Growing in White Allyship*

Akbar, M. (2020). *White allyship: The pursuit of racial justice*. Publish Your Purpose Press.

DiAngelo, R. (2018). *White fragility: Why it's so hard for white people to talk about racism*. Beacon Press.

Irving, D. (2014). *21-Day Racial Equity Habit Building Challenge*. <https://debbyirving.com/21-day-challenge/>

Kendi, I. X. (2019). *How to be an antiracist* (1st ed.). Random House.

Kivel, P. (2017). *Uprooting racism: How white people can work for racial justice* (4th ed.). New Society Publishers.

Oluo, I. (2019). *So you want to talk about race*. Basic Books.

#### • *Allyship in Professional Practice*

American Psychiatric Association. (n.d.). *Diversity & health equity education: African Americans*. Retrieved July 24, 2020, from <https://www.psychiatry.org/psychiatrists/cultural-competency/education/african-american-patients>

American Psychological Association. (2018). *RESilience: Uplifting youth through healthy communication about race*. <https://www.apa.org/res>

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A Meta-Analysis of Cultural Adaptations of Psychological Interventions. *Behavior Therapy*, 47(6), 993–1014.

Structural Competency. (n.d.). *Structural competency: New medicine for inequalities that are making us sick*. Retrieved July 20, 2020, from <https://structural-competency.org/>

Williams, M. T., George, J. R., & Printz, D. M. B. (2020). Behavioral health service delivery with African Americans. In L. T. Benuto, et al. (Eds.), *Handbook for Cultural Factors in Behavioral Health*. Springer.

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OP-ED

## Responding to Calls for Racial Justice in Intervention Science: The Dialectic

Carolyn Ponting, Louise E. Dixon De Silva, Gia Chodzen, Elizabeth S. Bocanegra, and Denise A. Chavira, *UCLA*

THE RECENT MURDERS of Ahmaud Arbery, Breonna Taylor, and George Floyd have energized a national conversation about systemic racism. The insidious and deadly ways in which racism impacts Black communities is not new, and a robust though undervalued literature points to the negative health outcomes associated with racism and discrimination. The disproportionate effects of the coronavirus pandemic on Black and Latinx communities and the police killings of countless Black Americans were not surprising to most Black, Indigenous, and People of Color (BIPOC)<sup>1</sup> and those who conduct research on racism and health disparities. However, several metrics demonstrate that, for many, the magnitude of these inequities was jolting and served as a call to action.

Lately, we have been saturated with statements, webinar invitations, and diversity trainings from our workplaces, local governments, and corporations. Largely, the intent has been to condemn racism and, in some cases, to discuss positive structural change. Yet, leaders in the field of race and equity have argued that statements and trainings alone are not enough. There is a sentiment that institutional condemnations of racism and affirmations of Black Lives Matter have become performative and trendy—a sort of virtue signaling without plans for substantive change (McKenzie, 2020). Statements from our universities and professional societies engaged in psychological intervention science, while well-intentioned, can seem similarly empty.

The field of clinical psychology has the capacity to address a variety of inequities that plague communities of color and be a driving force of positive change. However, in order to do so, it is necessary to respond instead of react, adhering at all times to the principle of beneficence. In efforts to contribute to sustained action in our field, many clinical scientists are thinking about how to increase recruitment of BIPOC in their studies and considering how their research contributes to issues of equity (e.g., expanding access to quality services for BIPOC). While the increased attention to systemic racism and accompanying urge to act is encouraging and necessary for meaningful social change, we hold a parallel truth. Research and clinical engagement with BIPOC without thoughtful preparation has historically been iatrogenic, widening disparities in care and furthering mistrust of the scientific community. Without dismantling and correcting a White ethnocentric system of conducting intervention research, these endeavors will continue to be seen as culturally unresponsive, lacking in cultural fit, and, at times, harmful.

Notwithstanding, meeting the mental health needs of BIPOC is urgent. Data from the United States Census Bureau (2020) show that rates of depression and anxiety among all Americans more than tripled since the beginning of the coronavirus pandemic, and these rates spiked even higher among Black Americans following the murder of George Floyd, whereas rates among White Americans stayed the same (<https://www.census.gov/householdpulse->

<sup>1</sup>We use the term BIPOC in this article when we describe the shared ways in which systemic racism and the biases of our field have negatively impacted several minoritized ethnic and racial groups. We are aware of the controversies around this term and we do not aim to contribute to the erasure of any group, or to insinuate that the histories of these groups are equivalent. When results or discussions pertain to a particular group, we have made that clear.



data). As clinical scientists, this is our call to action; yet, we must be vigilant about the potentially harmful effects of our intervention efforts. In order to do so, we propose a nonexhaustive set of considerations for clinical scientists in order to maximize the benefits of our research and clinical services for BIPOC.

### 1. Do No Harm in Therapy

Potentially harmful therapy (PHT) is defined as an intervention that helps some clients while harming others (e.g., causes symptom worsening), improves some symptoms while worsening others (e.g., improves substance use but worsens depression), harms family members and/or friends (e.g., worsens relationships, causes family conflict), or helps in the short term but causes long-term harm (e.g., short-term symptom reduction with higher rates of relapse; Wendt et al., 2015). Research on

PHT rarely attends to how racial and ethnic group membership and identity affect these iatrogenic outcomes. However, BIPOC are particularly vulnerable to PHT due to the White ethnocentricity of evidence-based interventions, specifically the lack of trials that include BIPOC, Western-based conceptualizations of illness and outcomes, and top-down approaches to treatment (Wendt et al., 2015).

The exclusion of BIPOC from our intervention trials has exposed underrepresented clients to clinical care that may lack relevance to their lived experiences. In addition, uninformed tailoring of our interventions for BIPOC can be problematic. To avoid harm we must be wary of adaptations for particular racial or ethnic groups when they lack theoretical grounding, change or dilute intervention components or cause reactance (Huey et al., 2014).

To illustrate, we can learn from a study that tested the efficacy of an expressive writing intervention for aggression and emotional lability among Black youths living in neighborhoods with high crime rates (Kliewer et al., 2011). Youths were randomized to a standard expressive writing condition or to an “enhanced” culturally adapted condition, where they were able to write stories, skits, songs, or poetry; both conditions asked youths to write about their thoughts and feelings about violence. Authors explained that they included the adapted version of the writing task because of the importance of oral traditions, and the popularity of rap and spoken word in the Black community. There was no mention of community input or pilot testing of the adapted writing task. Results showed that at posttreatment, youth assigned to the culturally adapted writing condition showed no intervention benefit, while those in the standard condi-



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tion were rated as less aggressive and emotionally labile by their teachers (Kliewer et al.). The results were unexpected, but authors hypothesized that the culturally adapted intervention fell short due to youths' focus on a creative product at the expense of their thoughts, feelings, personal experiences about violence—weakening the process by which expressive writing can restructure one's understanding of a stressor. Another possibility is that the inclusion of explicit cultural adaptations (i.e., youth randomized to the adapted intervention were read lyrics from musical artist Tupac Shakur as a sample product before writing) may unintentionally lead to disengagement or efforts to disprove racialized stereotypes or for some BIPOC (Huey et al., 2014), especially if those delivering the intervention are not considered part of the community.

As another example, nonindigenous psychologists have contributed to a history of ineffective and stigmatizing substance use interventions for indigenous communities due to a lack of understanding of the cultural context and historical oversights that reveal substance use problems as connected to European colonialism and historical loss (Wendt et al., 2019). Despite the preference among indigenous communities for socially and spiritually focused, strengths-based interventions (e.g., Satel & Lilienfeld, 2014), substance use treatments have overwhelmingly focused on the individual, been deficit-based, and overemphasized symptom reduction. These goals are discordant with those of indigenous communities and often perpetuate stigma associated with substance use disorders (i.e., substance use as a personal weakness or character flaw) and community disempowerment (Wendt et al., 2019).

These exemplars highlight the need for purposeful and nuanced engagement with BIPOC when trying to improve interventions to meet the needs of the community. In order to understand these needs (inclusive of culturally attuned strategies, outcomes, and targets of treatment), we must continue to increase the representation of BIPOC in our trials, and when we do, we must do our homework and partner with community experts *a priori* (as discussed later) to avoid implementing and disseminating interventions that fall short of expectations.

## 2. Measure Harm in Therapy

We can also reduce the potential for intervention harm by rethinking our mea-

surement practices in clinical science. Therapist and session-level factors, such as therapist-client racial/ethnic match and cultural competence, warrant more consideration as they are known to affect engagement and treatment gains for BIPOC seeking therapy. Meta analytic data show that Black clients report a strong preference for treatment by Black clinicians (Townes et al., 2009) and have slightly better clinical outcomes when matched with a Black clinician (Cabral & Smith, 2011). We need to take client preferences seriously. Unfortunately, despite data supporting the beneficial effects of respecting clients' requests for a clinician with a cultural or racial match, the lack of diversity in the mental health services workforce is a limiting factor in prioritizing these preferences. According to a 2015 APA survey (2016), while 86% of the psychology workforce in the U.S. was White, only 2.6% were Black—making Black clinicians severely underrepresented compared to the U.S. general population, which is about 13% Black. In order to meet the preferences and needs of BIPOC, systemic change, which includes training and employing a more diverse workforce, is critical.

In the absence of an accessible diverse workforce, it behooves us to try to understand the potential mediating processes that begin to explain differential outcomes for BIPOC. For example, client perceptions of their therapist's ease and fluidity engaging in conversations about culture (i.e., cultural comfort) are associated with treatment gains, but only for BIPOC; perceptions of therapist cultural comfort are unrelated to symptom improvements in White participants (Kivlighan et al., 2019). We know that most BIPOC experience microaggressions in therapy, which can take the form of pathologizing a client's cultural values, ignoring an important aspect of a client's identity, or asserting understanding of a nonshared experience (e.g., racism; Sue et al., 2007). Microaggressions are associated with worse therapeutic alliance (Owen et al., 2014), therapy outcomes (i.e., psychological well-being; Owen et al., 2011), and likely precede early termination (Davis et al., 2016). Thorough examination of these in-session processes (e.g., patient-provider communication, microaggressions) may improve our training efforts to develop cultural competencies in all clinicians and allow us to minimize the negative therapeutic experiences which BIPOC continue to report at disproportionately high rates (Crawford et al., 2016).

In addition to our recommendation for greater assessment of therapeutic processes, we also propose intervention science needs to be more inclusive of culturally relevant outcomes. Our standard approaches for measuring the impact of our interventions have often been too narrow. While we have been effective at measuring symptom-based outcomes in our trials, we have typically failed to measure the impact of our interventions on potentially culturally salient outcomes such as familial functioning and community-level factors. For example, the effect of the implementation and dissemination of an intervention on community mental health stigma is an important variable to measure when we are considering the potential sustainability of an intervention among BIPOC (e.g., Bryan & Morrow, 2011). Expanding our secondary outcomes to include measurements of community engagement variables (e.g., use of health or social services, acceptability of services) is one way to ensure that our interventions are not having unintended negative consequences at a macro level.

A recent study by Goodkind and colleagues (2020) exemplifies a study design that goes beyond examining symptom reduction in a BIPOC community. In this randomized controlled trial, recent Afghan, Syrian, Great Lakes African, and Iraqi refugees received a multilevel strengths-based intervention to address psychological distress resulting from physical, social, educational, and cultural stressors. Investigators examined the effect of the intervention on depression and anxiety symptoms in addition to intrapersonal/individual factors (English proficiency, connection to home culture), interpersonal/microsystem factors (social support, social role, connection to American culture), and exosystem/macrosystem factors (access to resources, reduction of unfair treatment)—outcomes which were informed by refugees and stakeholders. Findings showed that compared to the waitlist control group, individuals who received the intervention demonstrated significant increases in identification with both home and American culture, whereas those in the waitlist control showed decreases in connection to both home and American culture over time. Furthermore, the intervention group demonstrated significantly greater social support from their broader community and lower levels of anxiety and depression over time. This work highlights the importance of expanding our assessment of intervention outcomes to include community, system, and

family factors that affect well-being given their protective nature alongside psychopathology outcomes. Studies like this one are the exception. However, as we go forward in these times of unprecedented mental health need, clinical scientists have the opportunity to do better by considering strength-based protective factors and other outcomes that matter most to BIPOC.

### 3. Involve Community Members as Experts

Thoughtful choices regarding intervention selection and measurement of treatment outcomes with BIPOC bring us closer to equitable care. However, these decisions require the involvement of community stakeholders, including BIPOC scholars, to maximize beneficence and minimize harm. Community Based Participatory Research (CBPR) is one methodological approach that may be particularly useful in this context. CBPR requires that community members “... gain a seat at the table—and stay at the table, having a real voice in decision making affecting their lives” (Minkler, 2010). The sustained involvement of community members within a CBPR framework also has the capacity to increase the speed at which communities benefit from their participation in intervention research through immediately offering access to the novel and stakeholder-informed therapeutic strategies. CBPR is especially well-positioned to tackle health disparities due to public health and social-political emergencies by serving as a mechanism for needs assessments related to urgent challenges being faced in communities of color. Unfortunately, research evaluating community perspectives on mental health, especially investigated qualitatively, is considered “low priority” in our field. Biases about the rigor of these methodologies and concerns about their generalizability often make this work difficult to publish (Greenhalgh et al., 2016) and may contribute to investigators’ hesitancy to utilize methods that can help us to adequately understand and address disparities in mental health treatment.

The Healthy African American Families (HAAF) Project, a community-partnered research organization in Los Angeles that has addressed social institutional and policy determinants of health equity in the Black community for over 25 years, provides a case study on community-centered methodology (Ferré et al., 2010). To start, HAAF created a community advisory

board with *paid* community leaders and gatekeepers. Then, in the planning phases, which included defining the scope and definition of the project, researchers and community members directly addressed distrust of institutional scientific endeavors. One tangible result of those discussions was the creation of “A Dictionary of Bad Words,” where common research terms were “translated” by community members, revealing negative connotations for the following: “researchers” translated to “takers,” “anonymous” to “secret purpose,” “data” to “stolen goods” (Ferré et al., 2010). These early steps taken by HAAF facilitated by community-partnered and narrative methodologies were part of a paradigm shift that helped to engender trust. The community was not a subject of research; instead, they worked with a university to respond to community-identified needs (Ferré et al.), a corrective experience given historical abuses of BIPOC by the scientific community.

Community participation can be invaluable for building trust and engagement. By acting on community recommendations and gaining explicit support from stakeholders, we can more effectively address issues of acceptability, relevance, and effectiveness of our interventions. Further, compensated advisory boards can help to hold researchers accountable for providing benefits in addition to intervention receipt (e.g., political advocacy for policy change)—demonstrating a vested interest in community goals (Moreno et al., 2009; Vaughn et al., 2017). In the wake of crises with notable psychological sequelae like Hurricane Katrina, and epidemics like HIV that have disproportionately affected Black communities, structural mistrust has been a barrier to seeking mental health care among BIPOC (Novacek et al., 2020). Though data examining differential use of mental health care by race or ethnicity are not available for the current pandemic and ongoing socio-political crises, without intentional efforts to engage community perspectives, this pattern is likely to repeat itself.

We see community partnership and work with paraprofessionals (e.g., lay counselors, community health workers, *promotorx*) as a way to increase representation of BIPOC at all levels of psychological care—from intervention trials to community clinics. In addition to data supporting their emerging success in delivering evidence-based interventions for mental health problems (e.g., depression and anxiety), paraprofessionals are particu-

larly effective at facilitating entry into mental health services, and enhancing adherence to treatment (Barnett et al., 2018). As such, working with paraprofessionals may be a way to increase trustworthiness and engagement with communities that are appropriately wary of academic institutions and mental health care systems.

### 4. Target Relevant Outcomes

Many BIPOC have expressed the psychological toll of witnessing the disproportionate social and economic impact of the pandemic, the killings of unarmed Black men and women (Price, 2020; Richardson, 2020), as well as other instances of racial violence. These lived and vicarious experiences have been conceived of as forms of racial trauma and are linked to depressive and trauma symptoms among BIPOC (e.g., Tynes et al., 2019). Racial trauma refers to repeated individual and collective injuries due to experiences of racial discrimination, including harm, humiliating/shaming events, and witnessing maltreatment to other BIPOC due to racism (Carter, 2007). On one hand, it may be particularly important to address racial trauma in the context of therapy. Interventions that do not acknowledge and address racial trauma—such as police brutality and discrimination—may not meet the mental health needs of BIPOC managing distress following acute or persistent experiences of racism (Williams et al., 2018). On the other hand, it may be that treating an individual’s racial trauma further pathologizes a natural response to systemic oppression, and that intervention efforts ought to target systemic determinants of mental health impacted by racism (e.g., economic opportunities, living conditions; Alegría et al., 2018). For interventions to be optimally useful, it is critical that we increase our research on the impact of racial trauma on mental health and the social determinants that affect treatment change.

Additionally, it is important to recognize that treatment modifications may not be interchangeable across diverse BIPOC spaces; local knowledge must guide intervention goals. It will be critical to consider the intersectional identities of BIPOC and the associated interlocking systems of oppression (i.e., racism, sexism, and heterosexism) that influence an individual’s mental health and experience within psychological treatment (Cole, 2009). For example, intervention endeavors that partner with faith-based organizations will



likely facilitate engagement for certain Black and Latinx groups (Bolger et al., 2018), whereas for others who also identify as sexual and gender minorities, these relationships may be more complicated (Graham, 2014; Severson et al., 2013). The Healing Ethno and Racial Trauma (HEART) framework (Chavez-Dueñas et al., 2019) provides a compelling example of how psychologists can build interventions to address the sequelae of structural trauma that are intersectional and attend to the individual, family, community, and oppressive policies.

### Moving Forward in Intervention Science

The call to action for research that addresses the needs of BIPOC experiencing unprecedented physical and emotional distress is a dialectic: action towards a more equitable research agenda cannot be delayed *and*, at the same time, we must proceed mindfully, taking pause before furthering research that perpetuates inequities. Engaging in intervention research without doing the required homework limits the overall impact of this work and may even create harm in communities we are aiming to support. Nonetheless, prioritizing the needs of BIPOC is long overdue, and it is essential that clinical scientists respond to the calls for racial justice in intervention science.

Psychologists have written about the role of mental health professionals in combating racism in their clinical and research roles for decades (see Sue, 1978; Tinsley-Jones, 2001; Williams, 1974). It behooves us to read and internalize these historical perspectives and calls for change before taking “corrective action.” In fact, in an important article on guidelines for research on race and racism in clinical science, Miller and colleagues (2019) remind researchers to be mindful of historical patterns of oppression. A clear recognition of psychology’s perpetuation of racism in the United States allows for a more objective science and better prepares us to engage with the community-centered work necessary for the ethical and effective intervention work with BIPOC.

Going forward it will be necessary to evaluate the impact of the coronavirus pandemic and current racial violence on BIPOC who have been disproportionately affected by these events. In doing so, it will be important to conduct community-based needs assessments that adequately assess the priorities of BIPOC. Next, it is critical

to consider the many ways that the current socio-political climate has impacted risk for psychopathology in BIPOC as well as factors that have buffered against such risk (at multiple levels of influence: familial, community, etc.). Further, greater attention needs to be focused on how our interventions can address treatment targets relevant to BIPOC—by reducing the psychological sequelae of racism and moving beyond models of individual-level coping to system-level targets.

At this point, we are left holding multiple truths. Racial injustices corrode the physical and mental health of BIPOC and they pervade psychological intervention research in unintentional ways. Clinical scientists have contributed to stigma in communities of color by disseminating interventions that are unsustainable and of poor cultural fit and we are capable of doing better when it comes to serving the mental health needs of BIPOC. We must not go back to the complicit status quo. Further efforts to make intervention science antiracist must not be rushed or done in silos. Systemic change requires that psychologists with expertise outside of health disparities, culture, and implementation science join this call to action. It also requires humility, self-reflection, and the use of privilege to push forward the agendas of those already embedded in this work. Grappling with these challenges requires collective action. Our field is part of a system that maintains racial injustice. The time is now to mindfully disrupt the practices that contribute to and sustain inequitable mental health services and actively promote transformative intervention science.

### References

- Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., & Alvarez, K. (2018). Social determinants of mental health: Where we are and where we need to go. *Current Psychiatry Reports*, 20(11), 95. <https://doi.org/10.1007/s11920-018-0969-9>
- APA. (2016). *2015 Survey of Psychology Health Service Providers*. Retrieved from [www.apa.org/workforce/publications/15-health-service-providers/index.aspx](http://www.apa.org/workforce/publications/15-health-service-providers/index.aspx)
- Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing community health workers to address mental health disparities for underserved populations: A systematic review. *Administration and Policy in Mental Health*, 45(2), 195–211. <https://doi.org/10.1007/s10488-017-0815-0>
- Bolger, D., Tinsley, C., & Ecklund, E. H. (2018). Heaven and health: How Black, Latino, and Korean Christians view the relationship between faith and health. *Review of Religious Research*, 60(3), 389–402. <https://doi.org/10.1007/s13644-017-0321-6>
- Bryan, C. J., & Morrow, C. E. (2011). Circumventing mental health stigma by embracing the warrior culture: Lessons learned from the Defender's Edge program. *Professional Psychology: Research and Practice*, 42(1), 16. <https://doi.org/10.1037/a0022290>
- Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, 58(4), 537. <https://doi.org/10.1037/a0022290>
- Carter, R. T. (2007). Racism and psychological emotional injury: Recognizing and assessing race-based traumatic stress. *Counseling Psychologist*, 35, 13–105. <https://doi.org/10.1177/0011000006292033>
- Chavez-Dueñas, N. Y., Adames, H. Y., Perez-Chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist*, 74(1), 49. <https://doi.org/10.1037/amp0000289>
- Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, 64(3), 170. <https://doi.org/10.1037/a0014564>
- Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., ... Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: Results of a national survey. *British Journal of Psychiatry*, 208(3), 260–265. <https://doi.org/10.1192/bjp.bp.114.162628>
- Davis, D. E., DeBlaere, C., Brubaker, K., Owen, J., Jordan, T. A., Hook, J. N., & Van Tongeren, D. R. (2016). Microaggressions and perceptions of cultural humility in counseling. *Journal of Counseling & Development*, 94(4), 483–493. <https://doi.org/10.1002/jcad.12107>
- Ferré, C. D., Jones, L., Norris, K. C., & Rowley, D. L. (2010). The Healthy African American Families (HAAF) project: From community-based participatory research to community-partnered participatory research. *Ethnicity & Disease*, 20(102), S2.
- Goodkind, J. R., Bybee, D., Hess, J. M., Amer, S., Ndayisenga, M., Greene, R. N., Choe, R., Isakson, B., Baca, B., & Pannah, M. (2020). Randomized controlled trial of a multilevel intervention to address



- social determinants of refugee mental health. *American Journal of Community Psychology*, 65, 272-289.
- Graham, L. F. (2014). Navigating community institutions: Black transgender women's experiences in schools, the criminal justice system, and churches. *Sexuality Research and Social Policy*, 11(4), 274-287. <http://doi.org/10.1007/s13178-014-0152-y>.
- Greenhalgh, T., Annandale, E., Ashcroft, R., Barlow, J., Black, N., Bleakley, A., ... Ziebland, S. (2016). An open letter to the BMJ editors on qualitative research. *BMJ (Online)*. <https://doi.org/10.1136/bmj.i563>
- Huey Jr, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology*, 10, 305-338. <https://doi.org/10.1146/annurev-clinpsy-032813-153729>
- Kivlighan, D. M., Drinane, J. M., Tao, K. W., Owen, J., & Liu, W. M. (2019). The detrimental effect of fragile groups: Examining the role of cultural comfort for group therapy members of color. *Journal of Counseling Psychology*, 66(6), 763-770. doi:<http://dx.doi.org/10.1037/cou0000352>
- Kliwer, W., Lepore, S. J., Farrell, A. D., Allison, K. W., Meyer, A. L., Sullivan, T. N., & Greene, A. Y. (2011). A school-based expressive writing intervention for at-risk urban adolescents' aggressive behavior and emotional lability. *Journal of Clinical Child & Adolescent Psychology*, 40(5), 693-705. <https://doi.org/10.1080/15374416.2011.597092>
- McKenzie, L. (2020, June 8). *Words Matter for College Presidents, but So Will Actions*. <https://www.insidehighered.com/news/2020/06/08/searching-meaningful-response-college-leaders-killing-george-floyd>
- Miller, A. L., Stern, C., & Neville, H. (2019). Forging diversity-science-informed guidelines for research on race and racism in psychological science. *Journal of Social Issues*, 75(4), 1240-1261. <https://doi.org/10.1111/josi.12356>
- Minkler, M. (2010). Linking science and policy through community-based participatory research to study and address health disparities. *American Journal of Public Health*, 100(S1), S81-S87. <https://doi.org/10.2105/AJPH.2009.165720>
- Moreno, G., Rodríguez, M. A., Lopez, G. A., Bholat, M. A., & Dowling, P. T. (2009). Eight years of building community partnerships and trust: the UCLA family medicine community-based participatory research experience. *Academic Medicine*, 84(10), 1426. <https://doi.org/10.1097/ACM.0b013e3181b6c16a>
- Novacek, D. M., Hampton-Anderson, J. N., Ebor, M. T., Loeb, T. B., & Wyatt, G. E. (2020). Mental health ramifications of the COVID-19 pandemic for Black Americans: Clinical and research recommendations. *Psychological Trauma: Theory, Research, Practice, and Policy*. <http://dx.doi.org/10.1037/tra00007961>
- Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counseling and Psychotherapy Research*, 11(3), 204-212. <https://doi.org/10.1080/14733145.2010.491551>
- Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, 45(4), 283-290. <https://doi.org/10.1037/a0037420>
- Price, M. (2020, June 3). *Please stop showing the video of George Floyd's death*. <https://www.nytimes.com/2020/06/03/opinion/george-floyd-video-social-media.html>
- Richardson, A. V. (2020, May 8). *Why cell phone videos of black people's deaths should be considered sacred, like lynching photographs*. <https://theconversation.com/why-cellphone-videos-of-black-peoples-deaths-should-be-considered-sacred-like-lynching-photographs-139252>
- Satel, S., & Lilienfeld, S. O. (2014). Addiction and the brain-disease fallacy. *Frontiers in Psychiatry*, 4, 141.
- Severson, N., Muñoz-Laboy, M., & Kaufman, R. (2014). 'At times, I feel like I'm sinning': the paradoxical role of non-lesbian, gay, bisexual and transgender-affirming religion in the lives of behaviourally-bisexual Latino men. *Culture, health & sexuality*, 16(2), 136-148. , <http://dx.doi.org/10.1080/13691058.2013.843722>
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*, 62(4), 271. <https://doi.org/10.1037/0003-066X.62.4.271>
- Sue, S. (1978). *Ethnic minority research: Trends and directions*. <https://files.eric.ed.gov/fulltext/ED170430.pdf>
- Tinsley-Jones, H. A. (2001). Racism in our midst: Listening to psychologists of color. *Professional Psychology: Research and Practice*, 32(6), 573. <https://doi.org/10.1037/0735-7028.32.6.573>
- Townes, D. L., Chavez-Korell, S., & Cunningham, N. J. (2009). Reexamining the relationships between racial identity, cultural mistrust, help-seeking attitudes, and preference for a black counselor. *Journal of Counseling Psychology*. <https://doi.org/10.1037/a0015449>
- Tynes, B. M., Willis, H. A., Stewart, A. M., & Hamilton, M. W. (2019). Race-related traumatic events online and mental health among adolescents of color. *Journal of Adolescent Health*, 65(3), 371-377. <https://doi.org/10.1016/j.jado-health.2019.03.006>
- United States Census Bureau. (2020). *Measuring household experiences during the coronavirus (COVID-19) pandemic*. <https://www.census.gov/householdpulse-data>
- Vaughn, L. M., Jacquez, F., Lindquist-Grantz, R., Parsons, A., & Melink, K. (2017). Immigrants as research partners: a review of immigrants in community-based participatory research (CBPR). *Journal of Immigrant and Minority Health*, 19(6), 1457-1468. <https://doi.org/10.1007/s10903-016-0474-3>
- Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and multicultural counseling: Bridging two disciplinary discourses. *Counseling Psychology*, 43(3), 334-358. <https://doi.org/10.1177/0011000014548280>
- Wendt, D. C., Hartmann, W. E., Allen, J., Burack, J. A., Charles, B., D'Amico, E. J., ... Walls, M. L. (2019). Substance use research with indigenous communities: Exploring and extending foundational principles of community psychology. *American Journal of Community Psychology*, 64, 146-158. <http://doi.org/10.1002/ajcp.12363>
- Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations*, 3(4), 242-260. <https://doi.org/10.1037/pri0000076>
- Williams, R. (1974). A history of the Association of Black Psychologists: Early formation and development. *Journal of Black Psychology*, 1(1), 9-24. <https://doi.org/10.1177/0095798474001010102>
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## Address, Avert, or Avoid? Navigating Conflicts in Client-Clinician Beliefs During Polarized Times

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YOUR CLIENT ARRIVES to session. During the check-in, your client remarks on the week's news: "I'm so over all these Black Lives Matter people causing chaos." Your client then goes on to share views about race, the president, and the police.

*What do you think? How do you feel? What do you say?*

Empathy is a foundational skill in clinical work. Rogers (1980) describes empathy as "perceiving the internal frame of reference of another with accuracy and with the emotional components and meanings ... without ever losing the 'as if' condition" (p. 14). The "as if" quality refers to understanding the client's experience as if it were one's own, yet with the ability to remain distinct (Rogers, 1957). Further operationalized in motivational interviewing (MI), expressing empathy is used to be gently persuasive and to "roll with resistance." As such, it involves communicating respect, listening rather than telling, and emphasizing freedom of choice (Miller et al., 1999). In one MI adherence system, the highest levels of empathy are described as follows: showing evidence of a deep understanding of the client's point of view, not just what has been explicitly stated, but what the client means and has not said; expressing clear and obvious warmth, concern, and acceptance; and possibly making compassionate attempts to relate to another's experience (Moyers et al., 2016).

Clinicians often work with clients who hold beliefs that differ from or oppose their own. Our ethical principles require that we actively identify our own biases and remain neutral, objective, and fair (American Psychological Association [APA], 2017a). As a field, we recognize our biases as many, including being predominantly White (Lin

et al., 2018), liberal (Inbar & Lammers, 2012), educated and financially secure (Henrich et al., 2010), and nonreligious (Gross & Simmons, 2009). Biases can impact clinical care and decision making. For example, Green and colleagues (2007) showed that non-Black (i.e., White, Hispanic, Asian, and other) health care providers held implicit (but not explicit) biases against Black patients that led to substandard care. Similarly, many social and personality psychologists who identify as politically liberal indicated that they would discriminate against openly conservative colleagues (Inbar & Lammers, 2012). Our field rightly places an important emphasis on cultural competence or humility, which involves maintaining an interpersonal stance that is other-oriented rather than self-focused, and characterized by respect, curiosity, and a lack of superiority toward an individual's cultural background and experience (Hook et al., 2013). Although not as often discussed, this might include intersecting identities, such as class and educational level (Case & Deaton, 2020; Chetty et al., 2020).

How should clinicians handle situations where it becomes clear that their client holds beliefs that are harmful, racist, xenophobic, homophobic, transphobic, or misogynistic? Recent political and societal events (e.g., the 2016 presidential election, Black Lives Matter movement, #MeToo movement, debates about the rights of people who identify as LGBTQIA, debates about immigration, COVID-19 pandemic) make differences in these beliefs and attitudes more polarizing than ever. In cognitive-behavioral therapy (CBT), disclosure of personal beliefs (e.g., political views) may be much less likely than in other types

of therapy. Generally speaking, clinician self-disclosure in CBT is used selectively and can help to promote the therapy process, such as a clinician demonstrating personal understanding of a particular client's struggle in order to build rapport and therapeutic trust. But as clinicians trained in identifying our clients' maladaptive or unhelpful thoughts, at what point should clinicians try to *change* their client's beliefs versus simply reflect or redirect them? At what point should we consider referring a client to another clinician?

Professional ethical guidelines provide somewhat conflicting guidance. APA's (2017a) ethical guidelines require that we seek to safeguard the welfare and rights of those with whom we work, establish trust, ensure access of the benefits of psychology to all, and take precautions for our own biases and boundaries of competence. The guidelines also call us to promote justice, to object to unjust practices or activities of others that are based on prejudices, and to protect the rights and welfare of vulnerable communities (APA, 2017a). When such groups are deprived of rights, it is "incumbent upon us as individual psychologists ... to address those challenges" (p. 787, Leong et al., 2017). These conflicting ethical imperatives beg the question: If a client makes a sexist or racist remark, do we ignore it or does our silence condone it? Chen (2013) describes how many professional ethical codes expect selflessness and encourage clinicians to turn a "professional blind eye" to prejudice in clinical contexts. Returning to the case example of the client who expressed hostility for the Black Lives Matter movement, as clinicians we must find a way to balance validation of the client's frustration and anger, while also not implicitly condoning related racist statements.

A clear understanding of our clinical and ethical responsibilities, skills, and biases is critical. What are our responsibilities to clients who hold beliefs that are different—or, in some cases, directly opposed—to our own? What if those beliefs are harmful—or even abusive—to us, the clinician? Below, we describe how validation provides a useful framework for understanding how to address or avert (i.e., redirect) in response to these interactions. In the following section, we discuss several options and introduce case examples from each author's firsthand experience. Ultimately, there may be a value judgment required of clinicians to understand where a line needs to be drawn, and this is not a one-size-fits-all approach. As

beliefs are developed within a certain environmental and developmental context, clinicians may need to recognize where to draw this line. Real-world case examples based on the authors' experiences illustrate how these decisions might be enacted.

### Option 1: Integrate Into Case Formulation and Treatment Planning

In many cases, it will be appropriate to incorporate the client's beliefs into the CBT case formulation and address them as part of the treatment plan. Basic clinical skills of empathy and validation do not require *agreement* with the client's views or actions. Although similar to the Rogerian concept of empathy, validation explicitly notes objectivity and highlighting what is relevant for clinical goals (Linehan, 1997). But remaining objective also means that the clinician is both a participant in the client's world and simultaneously an observer of that world and, as such, should not "validate that which is invalid" (p. 356, Linehan, 1997). For example, a client with social anxiety may be fearful that everyone at the upcoming social gathering will find him drab and boring. In providing validation, a clinician will not confirm or deny that this fear is true, but will validate the distress, while encouraging the client to consider other perspectives, test predictions in real life, and tolerate uncertainty.

In this way, validation as a clinical tool also has as its goal a clinical outcome. Therefore, if a client expresses a belief that, for example, "Asians shouldn't be in this country because they only cause problems, like this virus," a clinician *might* formulate this client's beliefs as coming from their problems with generalized anxiety, a socioeconomically disadvantaged background, and a tendency towards rigid thinking that could be alleviated through CBT strategies, focusing on considering alternative perspectives and seeing issues in shades of grey. Clinicians choosing this option might also pinpoint something about the client that one can identify with or respect. For example, perhaps the client values their role as a parent or works hard at their job. Such strategies may help with approaching the client with increased empathy (Zaki, 2014).

#### Case Example

As a feminist, cisgender, liberal, White woman working in a Veterans Affairs (VA) setting, I worked with an older White veteran man who frequently expressed sexist

and misogynistic views. These statements offended me, and I found myself feeling relieved if the client cancelled their session. The client had a longstanding diagnosis of posttraumatic stress disorder (PTSD) and depression, was unemployed, unpartnered, and presented with significant interpersonal dysfunction, anger, and distrust of others. My approach in working with this client was to focus on the client's wish for interpersonal connection and his track record as a loving and caring dog owner—things I could easily empathize with and respect. Another strategy that helped was to conceptualize the misogyny as a way of avoiding and pushing others away to protect himself from interpersonal rejection. We discussed the utility of these views in relation to his goals for connection. I also considered that his positive relationship with me, which at that time was one of the only relationships he had, might be helpful in providing evidence that countered his negative views towards women.

### Option 2: Validate and Redirect to Clinical Goals

A clinician may also choose to not attend to certain beliefs or comments that are irrelevant or do not affect the client's progress and instead redirect clients to focus on treatment goals. This approach might be used in CBT more than in other approaches, as CBT involves establishing treatment targets linked to behavioral indices at the outset of treatment as opposed to being exploratory in nature. Linehan (1997) seems to support this option, while also recognizing the role of values in validation: "At times differences between clients and therapists are of opinions and values. Respecting these differences, while not assuming superiority, is an essential component of validation. It is easy when one is the therapist to assume a 'one-up' position whereby one's own opinions and values are viewed as more respectable than the client, thereby invalidating the client's point of view" (pp. 375–376). Another way to understand this approach is that the clinician is prioritizing the ethical principle of access to care and welfare of the client (i.e., beneficence) over and above the equally important ethical principle of not condoning injustice (i.e., justice). Focusing on clinical goals is likely to come relatively easy for CBT-trained clinicians. In many cases, the opposing views and values do not relate directly to therapy goals and thus focusing (and refocusing as

needed) on the delivery of the appropriate CBT skills may help to make progress.

In some situations, this will be much easier said than done. Clinical work is demanding, much more so when there are comments that may be abrasive or conflict with our own values. For clinicians choosing this option, it may be helpful to prioritize consultation and engaging in self-care. Those providing consultation should seek to validate and balance the ethical values of beneficence and justice.

#### Case Example

As a cisgender, Black woman clinician, I was treating a conservative, cisgender White male for PTSD. After several months, the client began using the first 5 minutes of session to share about his children's increased interest in politics. He stated his family was very conservative and that in "these days," he was concerned they would "turn" liberal. He shared his pride in his children being Trump supporters and believed the national spotlight on police brutality was "nonsense." In general, I did not engage in these topics and quickly moved to the session agenda. Having already worked with this client for several months and understanding the nature of his PTSD symptoms, I conceptualized this behavior as an avoidance strategy that functioned to (a) avoid and/or delay the in-session imaginal exposures about his trauma and (b) delay admission that he had not completed his in vivo exposure homework assignments (a pattern for the client). Rather than engage, I first validated and then shifted back to clinical goals: "It sounds like you are really proud that your children are becoming more interested in politics. I'm wondering if there's a part of you that would rather talk to me about that than your trauma memory." Likely due to the rapport that had already been established, the client's response was laughter and acknowledgment of the pattern. It is not clear this approach would have been as effective or preferred with a less familiar or insightful client.

#### Case Example

As a liberal, gay, atheist (but culturally Jewish), cisgender, White man providing psychotherapy prior to the national legalization of same-sex marriage, I worked with a client who sought treatment for generalized anxiety disorder who soon began to share her negative views toward same-sex marriage and "the gay agenda." I chose not to engage on this topic and instead redirected the client back to our session



agenda, reminding the client that we had “so much to cover today” and asking permission to return back to our agenda.

During the 2016 presidential election, I worked with a different VA client who was vocal in his support for Donald Trump. He often started session by expressing his support for recent statements made by Donald Trump and denigrating Democrats, often with pejorative labels. The client would ask for my opinion in a way suggesting that I agreed with him. I chose not to provide an opinion. Given that the client and I were engaged in cognitive processing therapy, I redirected, stating instead, “While I can tell you are passionate about this topic, discussing this probably isn’t going to help with your PTSD symptoms.” The client quickly agreed, and we proceeded to setting the agenda. While this scenario was repeated in subsequent sessions, the client eventually began to redirect himself before I needed to intervene.

### **Option 3: Draw a Line Based on Your Competencies or Values and Act Accordingly**

The above options may not be adequate for all circumstances. A third option is to draw a line based on competencies or values and refer or speak out. As clinicians, we are trained to continually assess our objectivity. If objectivity is impaired, it may be useful to seek additional training and consultation or refer out. This need not be viewed as a personal failure; there are simply clinical situations that may be beyond our expertise, impeding our ability to be effective, or would be personally harmful to us as clinicians. In these situations, we have an ethical responsibility towards beneficence, which may include referring a client out if we think we cannot work with that individual effectively, even with adjunctive training and consultation. Clinicians should not refer out based on socio-political demographic characteristics of clients alone; however, there may be circumstances when a client expresses views that would be considered abusive or personally threatening to the clinician. Clinicians must balance their professional ethical responsibilities to provide care with the need to protect themselves from harm and use referral options judiciously as needed.

The expression of clearly harmful views also raises the question of our ethical responsibility to draw a line and speak up against such views. Failing to challenge views that are harmful to society and vulnerable, oppressed communities may fur-

ther contribute to or condone injustice. It may, at times, be appropriate to directly address prejudicial statements, declare them unacceptable, and move on. For example, in the case example presented above with the client who expressed concerns about “the gay agenda,” the clinician might have instead stated, “We have been working together for a long time now and I really value our relationship. When you make comments about gay marriage, it makes me think that you don’t respect or value me, because I am gay. I wanted to bring this up because I want to ensure we can still work together successfully.” Such statements may be conceptualized as self-disclosure that functions to preserve the therapeutic and working relationship. We recognize the decision to speak out may be influenced by a number of clinician factors, including identity within a marginalized group, level of experience, and personal values. Therefore, in addition to competency, each clinician should understand their values and where personal boundaries may lie. It is imperative that each clinician assess and critically reflect on one’s professional ethics and personal boundaries, ideally in the context of consultation and/or supervision.

### **Case Example**

A heterosexual, cisgender Asian-American supervisor, my supervisee was a heterosexual, nonreligious White woman who was working with an undocumented, gay, Latino man who was a devout Christian, holding religious beliefs that homosexuality is a sin, and sought treatment for depression. Distress about his sexual orientation was exacerbated by his relationship with his mother, who was also very religious and with whom he was very close. The supervisee viewed such religious beliefs as unjust and against her values, and expressed difficulty empathizing with the client’s religious values, even after seeking consultation. As a result, we considered referring the client out. However, important considerations in making this decision were the trainee’s training goals and professional development in diversity, including understanding religion and immigration (APA, 2017b), as well as internalized homophobia and family-of-origin considerations within lesbian, gay, and bisexual populations (APA, 2011). Conceptualizing the client’s struggles as internalized self-hatred from having an identity that close others rejected and experiences of disempowerment in society at large while highlighting his resilience gave the trainee a

greater sense of empathy and genuine respect for the client. Through supervision, we role-played ways she could avoid minimizing her own values, while also expressing her support for the client with cultural humility: “As we have been working together for quite some time and I hope there is some trust now built between us, I wanted to share with you that I don’t believe that homosexuality is a sin. In fact, I feel very strongly that your being gay is a very good thing that shouldn’t be suppressed or changed; however, I know that I also don’t come from the same religious and cultural background as you and will support you in figuring out what is best for you.” The clinician was eventually able to approach the client’s religiosity with a sense of curiosity and a nonjudgmental attitude, and focus on increasing his sense of agency through empowering the client to clarify his own goals and navigate family relationships utilizing family-based resources.

### **Case Example**

In another situation, I assigned a new child intake to my supervisee, an upper-middle class, bisexual, mixed race but White-passing, cisgender man. After meeting with the child’s mother, the trainee came to supervision describing the woman negatively, noting her low level of education and that she was a “Trump supporter” who had made racist comments: Upon their first few minutes of meeting, the mother expressed with relief, “I’m so glad you’re White” and went on to complain about how her daughter was spending too much time with the mostly Latinx children in the neighborhood, which she believed was the cause of her child’s behavioral problems. As this significantly affected the clinician and it seemed unethical to remain silent, the clinician addressed this directly, with the goal of initiating a conversation with the client. “You mentioned in our last meeting a few statements about race, especially being White. My father is from Iran. I wonder how it makes you feel to work with someone like me?” The client responded by minimizing and backtracking on her previous statements but continued to engage in care. As the client sought an assessment for ADHD, I ultimately assigned this case to the trainee, as it appeared to benefit the trainee’s ability to work with diverse (i.e., socioeconomically, politically) clients while a sense of objectivity was maintained through the mostly standardized psychodiagnostic assessment process. I also checked in with the trainee



about his well-being throughout, as he came from a very politically active background. Had the clinician felt harmed by working with this client or the treatment goal was therapy instead, I may have assigned this case to another trainee.

## Discussion

The three options described above highlight the importance of empathy and validation in CBT, especially in our polarized political and social climate. The discussion of these options also highlights many unanswered questions. With the recent George Floyd protests, is not addressing a client's overt, prejudicial attitudes a condonement of injustice? As the COVID-19 pandemic continues to thrive, what if a client reports that they believe the pandemic is a liberal conspiracy? When is a clinician imposing her or his own beliefs on a client? When should clinicians seek additional cultural humility training in working with clients with differing worldviews? What is the role of harmful client beliefs on the clinician—when might this affect their own mental and physical health? Do all of the above depend on the particular clinician? And the particular client?

We authors have had limited experience personally with referring out based on what may be viewed as a client's harmful beliefs, even though we have each experienced these, at times, anger-provoking comments. This could be due to the nature of professional boundaries that often prioritizes client well-being, access to consultation with others that may minimize the impact of harmful statements, or simply because this option is rarely discussed in clinical settings. We suggest that it is possible to view certain beliefs as inexcusable, while also maintaining a compassionate, empathic, and validating clinical stance. Beliefs are, after all, developed within a particular context, and clinicians are trained to find that "kernel of truth" of client beliefs, no matter how maladaptive or destructive. However, we also recognize that there is a line. Where this line is drawn and whether or not to speak out against certain beliefs will depend on both professional competencies and an individual's personal values. Ultimately, the treatment process includes both the client and the clinician, and neither should be undervalued in the relationship. We encourage open discussion of these issues in clinical settings, especially training contexts and supervisory and consultation relationships. Our ethical principles encourage both beneficence and jus-

tice, and we should strive to uphold both equally.

## References

- American Psychological Association (2011). *Practice guidelines for LGB clients: Guidelines for psychological practice with lesbian, gay, and bisexual clients*. Retrieved from: <https://www.apa.org/pi/lgbt/resources/guidelines>. Last accessed June 11, 2020.
- American Psychological Association (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, 70, 832-864.
- American Psychological Association (2017a). *Ethical principles of psychologists and code of conduct*. Retrieved from: <https://www.apa.org/ethics/code/>. Last accessed June 11, 2020.
- American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Retrieved from: <http://www.apa.org/about/policy/multicultural-guidelines.pdf>. Last accessed June 26, 2020.
- Case, A., & Deaton, A. (2020). *Deaths of despair and the future of capitalism*. Princeton University Press.
- Chen, P. (2013, July 25). When the patient is racist. *The New York Times*. Retrieved from: <https://well.blogs.nytimes.com/2013/07/25/when-the-patient-is-racist/>
- Chetty, R., Hendren, N., Jones, M. R., & Porter, S. (2020). Race and economic opportunity in the United States: An intergenerational perspective. *Quarterly Journal of Economics*, 135, 711-783.
- Green, A.R., Carney, D. R., Pallin, D. J., Ngo, L. G., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine*, 22, 1231-1238.
- Gross, N., & Simmons, S. (2009). The religiosity of American college and university professors. *Sociology of Religion*, 70, 101-129.
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, 33, 61-135.
- Hook, J.N., Davis, D.E., Owen, J., J., Worthington, J., E.L., Utsey, S.O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, 60, 353-366.
- Inbar, Y., & Lammers, J. (2012). Political diversity in social and personality psychology. *Perspectives on Psychological Science*, 7, 496-503.
- Kirschenbaum, H., & Henderson, V. L. (1989). *The Carl Rogers reader: Selections from the lifetime work of America's pre-eminent psychologist*. Houghton Mifflin.
- Leong, F.T.L., Pickren, W.E., & Vasque, M.J.T. (2017). APA efforts in promoting human rights and social justice. *American Psychologist*, 72, 778-790.
- Lin, L., Stamm, K., & Christidis, P. (2018). *Demographics of the U.S. psychology workforce. Findings from the 2007-16 American Community Survey*. Retrieved from: <https://www.apa.org/workforce/publications/16-demographics/report.pdf>. Last accessed July 29, 2020.
- Linehan, M. M. (1997). Validation and psychotherapy. In A. Bohart & L. Greenber (Eds.), *Empathy reconsidered: New directions in psychotherapy* (p. 353-392). American Psychological Association.
- Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1999). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. National Institute on Alcohol Abuse and Alcoholism. <http://casaa.unm.edu/download/MET.pdf>.
- Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The motivational interviewing treatment integrity code (MITI 4): Rationale, preliminary reliability and validity. *Journal of Substance Abuse Treatment*, 65, 36-42.
- Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.
- Rogers, C.R. (1980). *A way of being*. Houghton Mifflin.
- Zaki, J. (2014). Empathy: A motivated account. *Psychological Bulletin*, 140, 1608-1647.
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# Stress, Functioning, and Coping During the COVID-19 Pandemic: Results From an Online Convenience Sample

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COVID-19 (SARS-CoV-2) has escalated into one of the biggest and most destructive pandemics of the 21st century. As of early May 2020, COVID-19 had spread to 214 countries, with 4.23 million cases confirmed worldwide (U.S. Department of Health and Human Services 2020b). The United States had reported the highest number of confirmed cases (1.34 million) in the world, and more than 82,000 of those cases had resulted in death (U.S. Department of Health and Human Services, 2020a). In an attempt to curtail the spread of this virus, numerous states implemented physical distancing and stay-at-home orders, which significantly altered everyday American life (Secon, 2020). All nonessential businesses were mandated to suspend in-person operations throughout state stay-at-home orders, leading to a record-setting 14.7% unemployment rate (U.S. Bureau of Labor Statistics, 2020). Additionally, governors of 48 states either advocated or demanded that schools close for the remainder of the 2019–2020 academic year (Chavez & Moshtaghian, 2020). The health and economic devastation of this pandemic has prompted mental health professionals to question not whether there will be psychological repercussions but rather what will be the extent of this human suffering and how can we address this surging mental health need (Gruber et al., 2020).

Early data indicate the COVID-19 pandemic has caused significant psychological distress, particularly among young adults, health care workers, persons of color, and low-income communities, and the rising

rates of depression, anxiety, insomnia, substance abuse, suicide, and posttraumatic stress disorder (PTSD) are alarming but unfortunately unsurprising (Achenbach, 2020; American Psychological Association, 2020; Huang & Zhao, 2020; Lai et al., 2020; McGinty et al., 2020). The profound health, economic, and social consequences of COVID-19 are likely to be distressing for many, regardless of whether or not they have had direct exposure to the virus. Although most trauma survivors do not typically develop PTSD,<sup>1</sup> rates of traumatic stress and other forms of psychological distress from the ongoing COVID-19 pandemic are anticipated to be pervasive. For reference, 59% of survivors from the 2003 SARS outbreak met criteria for a *Diagnostic and Statistical Manual of Mental Disorders* (DSM; 4th edition) psychiatric disorder, primarily PTSD or major depressive disorder, in the months following their recovery (Mak et al., 2009). More recently, 64% of health care workers responding to the 2015 MERS outbreak endorsed hyperarousal, avoidance, intrusive thoughts, and/or sleep difficulties, and 52% reported clinically elevated PTSD symptoms (Lee et al., 2018). Even though the COVID-19 pandemic represents an unprecedented stressor, it is expected that this collective trauma will precipitate an upsurge of traumatic stress, as well as an urgent need for widespread implementation of effective mental health interventions.

An instrumental factor in determining the development and severity of psychological distress after a traumatic event is the use of coping strategies. For example, seek-

ing social support, finding hope, and positive reframing have been identified as effective coping strategies for managing psychological distress, whereas use of avoidance coping strategies (e.g., using substances, avoiding intrusive memories or thoughts about the traumatic event, avoiding situations that serve as reminders of the traumatic event) have been shown to exacerbate trauma-related suffering (Clohessy & Ehlers, 1999; Ehring et al., 2011). Accordingly, to progress toward addressing the psychological and functional impact of COVID-19, it will be important to understand how individuals are managing their stress and to promote the use of effective coping strategies among those in need.

The current study sought to understand how individuals are experiencing and responding to stress related to the COVID-19 pandemic. More specifically, this study aimed to: (a) estimate the prevalence of traumatic stress during the COVID-19 pandemic; (b) assess the functional impact of the COVID-19 pandemic; (c) identify coping strategies that individuals are using to manage stress; and (d) evaluate the perceived helpfulness of various coping strategies. Findings from this study will lend insights into the psychological impact of the COVID-19 pandemic on Americans—as well as illuminate opportunities for supporting individuals' mental health needs as the nation recovers from this crisis.

## Method

This study was classified as exempt by the Institutional Review Board of the University of California, Los Angeles.

## Procedure

Adults (18 years or older) living in the United States were invited to participate in this study through Amazon's Mechanical Turk (MTurk), a crowdsourcing website that is commonly used for online survey administration. Study announcements were posted on May 6 and 7, 2020, and all surveys were completed within 48 hours of postings. Upon completing the survey, participants received \$1.00 in payment and were directed to a list of free mental health resources, including the National Suicide Prevention Lifeline, Crisis Text Line, and National Alliance on Mental Illness Helpline.

## Participants

Individuals ( $N = 408^2$ ) from 42 states completed the online survey. Participants identified predominantly as early adults (70% 25–44 years old), European Ameri-

<sup>1</sup>Individuals may be exposed to actual or threatened death, serious injury, or sexual violence and/or may experience intrusive thoughts, avoidance, negative thoughts or mood, and hyperarousal without meeting criteria for a DSM-5 diagnosis of PTSD.

<sup>2</sup>Power analysis determined a necessary sample size of 400 for a power of .80 at  $\alpha = .05$  to detect a small to medium effect size for up to 10 predictors on levels of stress and functioning. These associations will be explored in a separate manuscript.

cans (60%), and men (57%). Participants reported that they were living with an average of 3.57 ( $SD = 4.90$ ) other individuals at the time of survey administration. See Table 1 for additional demographic information.

### Measures

The survey was hosted through the Qualtrics online survey platform and included questions related to demographics, traumatic stress, functioning, and use and perceived helpfulness of coping strategies.

- **Background Questionnaire.** This questionnaire is a 14-item self-report measure that prompts individuals to report on their personal demographics (e.g., age, gender, race/ethnicity, education, employment), as well as their exposure to COVID-19. Specifically, participants were asked to indicate whether they, someone they lived with, and/or someone they knew has symptoms of COVID-19 (e.g., fever, cough, difficulty breathing), got tested for COVID-19, tested positive for COVID-19, needed to be hospitalized for COVID-19 complications, and/or died from COVID-19.

- **PTSD Checklist for DSM-5 (PCL-5).** The PCL-5 (Weathers et al., 2013) is a 20-item self-report measure that assesses for symptoms of PTSD, as defined by the DSM-5. This measure prompts respondents to indicate the extent to which they are bothered by intrusion symptoms, persistent avoidance, negative cognitions and mood, and hyperarousal using a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*), with higher scores indicating greater symptom severity. The PCL-5 has demonstrated strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). For the purposes of this study, slight modifications were made to the instructions (i.e., specifying “keeping in mind your experiences during the COVID-19 pandemic...” and one item (i.e., changing “suddenly feeling or acting as if the stressful experience were actually happening again” to “suddenly feeling or acting as if you were in danger”).

- **Functional Assessment.** This measure is a 12-item self-report questionnaire that prompts individuals to compare their current functioning with their prepandemic functioning along various indices of functioning (e.g., appetite, hygiene, sleep; see Tables 3 and 4 for a list of the indices of

functioning that were assessed). As an example, participants were asked to indicate any changes in their appetite using a 5-point Likert scale ranging from “much less than usual” to “much more than usual.”

- **Coping Strategies Questionnaire.** This measure is a self-report questionnaire that assesses use and perceived helpfulness of 20 different coping strategies (e.g., getting social support, using alcohol; see Tables 5 and 6 for the full list of coping strategies). This measure first prompts respondents to indicate the frequency with which they have used each coping strategy (i.e., “Below is a list of ways that people sometimes cope with a very stressful experience. Over the last 2 weeks, how often have you done the following to cope with stress?”) using a 4-point Likert scale ranging from 0 (*not at all*) to 3 (*nearly every day*), with higher scores indicating greater use. This measure then asks respondents to rate the helpfulness of each coping strategy (i.e., “In your opinion, how helpful are the following ways of coping with stress?”) using a 5-point Likert scale ranging from 0 (*not at all helpful*) to 4 (*extremely helpful*), with higher scores indicating greater perceived helpfulness.

## Results

Nearly half of participants (45%) reported that they knew someone who tested positive for COVID-19; 5% of participants endorsed that they tested positive for COVID-19 (see Table 2 for more information about the health impact of COVID-19 among this sample).

### Traumatic Stress

Participants scored an average of 28.26 ( $SD = 20.09$ ) on the PCL-5. Most participants endorsed at least one symptom related to intrusive recollections (62%), persistent avoidance (68%), negative mood and cognitions (71%), or hyperarousal (72%). Fifty-five percent of participants endorsed at least one symptom from all four symptom clusters. Thirty-seven percent of participants reported experiencing clinically elevated symptoms of traumatic stress, as indicated by a PCL-5 score of 38 or higher (cf. Hoge et al., 2014).

### Functioning

Many participants reported changes in their daily functioning as a result of the COVID-19 pandemic (see Figures 1 and 2). Specifically, 76% of participants endorsed changes in their number of social interactions; 65% in their physical activity; 61% in

**Table 1.** Participant Demographics

Participant Demographics	%
<b>Age</b>	
18-24 years old	6%
25-34 years old	45%
35-44 years old	25%
45-54 years old	13%
55-64 years old	7%
Over 65 years old	3%
<b>Gender (male)</b>	57%
<b>Race</b>	
European American	60%
Latinx	17%
Mixed race	10%
African American	6%
Asian American	4%
<b>Religion (Roman Catholic)</b>	46%
<b>Marital status (married or in a domestic relationship)</b>	64%
<b>Education (Bachelor's degree)</b>	53%
<b>Employment status (full-time)</b>	71%
<b>Essential worker</b>	42%
<b>Living with child or adolescent</b>	58%
<b>Annual family income</b>	
Less than \$40,000	25%
\$40,000 to \$79,999	51%
Over \$80,000	22%

their time spent working; 57% in their time spent caregiving; 57% in their sleep; 55% in their mood; 51% in their quality of social interactions; 49% in their quality of caregiving; 49% in their appetite; 48% in their quality of work; 47% in their hygiene; and 46% in their concentration.

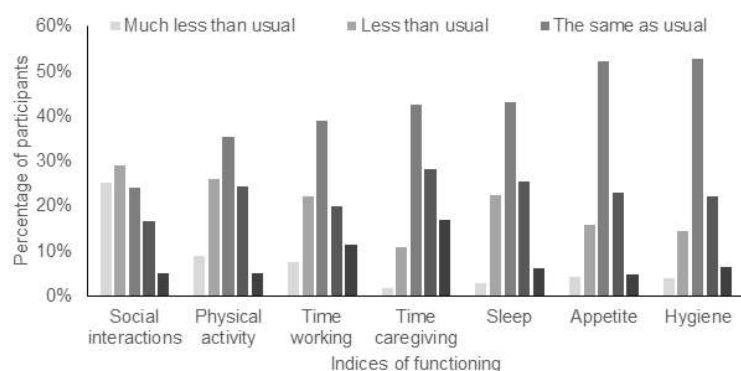
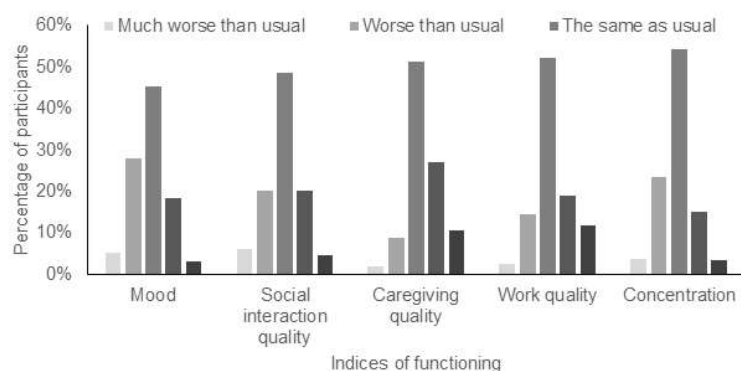
Logistic regression analyses revealed that relative to participants with minimal or subthreshold symptoms of traumatic stress (as indicated by a PCL-5 score of 37 or lower), significantly more participants with clinically elevated symptoms of traumatic stress (as indicated by a PCL-5 score of 38 or higher) reported changes in their quality of work ( $OR = 4.03, p < .001$ ; 15% vs. 51% better or much better than usual, respectively), mood ( $OR = 3.52, p < .001$ ; 10% vs. 37% better or much better than usual), bathing ( $OR = 3.30, p < .001$ ; 15% vs. 45% more or much more than usual), time spent working ( $OR = 3.01, p < .001$ ; 18% vs. 49% more or much more than usual), quality of caregiving ( $OR = 2.85, p < .001$ ; 26% vs. 51% better or much better than usual), concentration ( $OR = 2.71, p < .001$ ; 6% vs. 35% better or much better than usual), and sleep ( $OR = 2.62, p < .001$ ; 22%



**Table 2.** Health Impact of COVID-19

COVID Health Status	Someone Participants Knew	Someone Participants Lived With	Participants
Experienced symptoms (e.g., fever, coughing, shortness of breath)	643%	20%	7%
Got tested	45%	15%	12%
Tested positive	45%	15%	5%
Needed to be hospitalized	40%	15%	6%
Died	40%	15%	–

*Note.* As of May 2020, the United States was making concerted efforts to test individuals who were symptomatic—and, in some cases, asymptomatic, as individuals without any symptoms might still be at risk of spreading the virus to others.

**Figure 1.** Functional impact of COVID-19: Duration of activities**Figure 2.** Functional impact of COVID-19: Quality of activities

vs. 45% more or much more than usual) (see Tables 3 and 4).

### Use of Coping Strategies

Participants endorsed using a variety of coping strategies (see Table 5). The five most common coping strategies that participants used were: (1) taking precautions to keep themselves safe (e.g., physical distancing, disinfecting items) ( $M = 2.15$ ,  $SD = .88$ ); (2) engaging in pleasurable activities ( $M = 1.99$ ,  $SD = .85$ ); (3) engaging in mastery activities ( $M = 1.82$ ,  $SD = .92$ ); (4) adjusting to the “new normal” ( $M = 1.80$ ,  $SD = .91$ ); and (5) following a routine ( $M = 1.79$ ,  $SD = .88$ ). The five least commonly used coping strategies were: (1) using marijuana or other recreational substances ( $M = .87$ ,  $SD = 1.04$ ); (2) using tobacco products ( $M = .93$ ,  $SD = 1.10$ ); (3) using alcohol ( $M = .91$ ,  $SD = 1.00$ ); (4) journaling ( $M = .94$ ,  $SD = .97$ ); and (5) seeking help from a professional ( $M = 1.01$ ,  $SD = 1.02$ ).

Independent samples *t*-tests showed that compared with participants with minimal or subthreshold symptoms of traumatic stress, participants with clinically elevated symptoms of traumatic stress engaged in significantly more help-seeking from a professional [ $t(372) = -13.98$ ,  $p < .001$ ], emotional spending [ $t(372) = -12.38$ ,  $p < .001$ ], journaling [ $t(371) = -11.91$ ,  $p < .001$ ], emotional eating [ $t(373) = -9.44$ ,  $p < .001$ ], tobacco use [ $t(374) = -9.24$ ,  $p < .001$ ], alcohol use [ $t(371) = -9.10$ ,  $p < .001$ ], relaxation techniques [ $t(375) = -9.07$ ,  $p < .001$ ], marijuana use [ $t(371) = -8.50$ ,  $p < .001$ ], avoidance of triggering thoughts [ $t(373) = -7.15$ ,  $p < .001$ ], positive reframing [ $t(373) = -5.52$ ,  $p < .001$ ], prayer [ $t(373) = -5.30$ ,  $p < .001$ ], and mindfulness [ $t(371) = -4.03$ ,  $p < .001$ ]. Participants with minimal or subthreshold symptoms of traumatic stress engaged in more safety planning, pleasurable activities, mastery activities, routines, and acceptance than participants with clinically-elevated symptoms of traumatic stress, although these differences were not significant after applying a Bonferroni correction of  $\alpha = .05/20$ .

### Perceived Helpfulness of Coping Strategies

Participants indicated that many coping strategies could be helpful for managing stress (see Table 6). Participants identified the five most helpful coping strategies as: (1) taking precautions ( $M = 2.68$ ,  $SD = 1.10$ ); (2) engaging in pleasurable activities ( $M = 2.66$ ,  $SD = 1.02$ ); (3) engaging in mastery activities ( $M = 2.54$ ,  $SD = 1.03$ ); (4) following a routine ( $M =$



**Table 3.** Functional Impact on Duration of Activities by Level of Traumatic Stress

Indices of Functioning	Much/ less than usual		The same as usual		Much/ more than usual		Logistic regression statistics		
	Minimal Stress	Elevated Stress	Minimal Stress	Elevated Stress	Minimal Stress	Elevated Stress	OR	SE	<i>p</i>
Number of social interactions	70%	34%	24%	25%	6%	41%	.94	.25	.813
Physical activity	42%	26%	36%	34%	21%	40%	1.11	.22	.628
Time spent working	32%	26%	50%	25%	18%	49%	3.01	.23	<.001**
Time spent caregiving	14%	11%	50%	34%	36%	55%	1.92	.23	.005*
Sleeping	25%	25%	53%	30%	22%	45%	2.62	.22	<.001**
Eating	21%	17%	58%	45%	21%	38%	1.70	.21	.012*
Bathing	19%	17%	66%	37%	15%	45%	3.30	.22	<.001**

Note. \* $p < .05$ , \*\* $p < .004$  (Bonferroni correction of  $\alpha = .05/12$ ), as determined by logistic regression analyses testing the association between level of traumatic stress (minimal or subthreshold versus clinically-elevated) and change in functioning (the same as usual versus more or less than usual).

**Table 4.** Functional Impact on Quality of Activities by Level of Traumatic Stress

Indices of Functioning	Much/ worse than usual		The same as usual		Much/ better than usual		Logistic regression statistics		
	Minimal Stress	Elevated Stress	Minimal Stress	Elevated Stress	Minimal Stress	Elevated Stress	OR	SE	<i>p</i>
Quality of social interactions	32%	19%	54%	41%	14%	40%	1.71	.21	.011*
Mood	32%	35%	58%	28%	10%	37%	3.52	.23	<.001**
Quality of caregiving	9%	11%	64%	39%	26%	51%	2.85	.23	<.001**
Concentration	29%	24%	65%	41%	6%	35%	2.71	.22	<.001**
Quality of work	17%	15%	67%	34%	15%	51%	4.03	.23	<.001**

Note. \* $p < .05$ , \*\* $p < .004$  (Bonferroni correction of  $\alpha = .05/12$ ), as determined by logistic regression analyses testing the association between level of traumatic stress (minimal or subthreshold versus clinically-elevated) and change in functioning (the same as usual versus better or worse than usual).

2.51,  $SD = 1.04$ ); and (5) engaging in physical activity ( $M = 2.50$ ,  $SD = 1.10$ ). The five coping strategies that were perceived to be least helpful were: (1) using tobacco products ( $M = 1.13$ ,  $SD = 1.28$ ); (2) using marijuana or other recreational substances ( $M = 1.22$ ,  $SD = 1.32$ ); (3) using alcohol ( $M = 1.23$ ,  $SD = 1.26$ ); (4) emotional spending ( $M = 1.62$ ,  $SD = 1.21$ ); and (5) journaling ( $M = 1.62$ ,  $SD = 1.29$ ).

Independent samples *t*-tests showed that compared with participants with minimal or subthreshold symptoms of traumatic stress, participants with clinically elevated symptoms of traumatic stress perceived more benefit from tobacco use [ $t(374) = -14.13$ ,  $p < .001$ ], emotional eating [ $t(374) = -10.49$ ,  $p < .001$ ], journaling [ $t(354) = -8.60$ ,  $p < .001$ ], marijuana use

[ $t(348) = -8.49$ ,  $p < .001$ ], alcohol use [ $t(324) = -8.12$ ,  $p < .001$ ], emotional spending [ $t(330) = -7.45$ ,  $p < .001$ ], avoiding triggering thoughts [ $t(374) = -5.66$ ,  $p < .001$ ], searching for information [ $t(359) = -5.43$ ,  $p < .001$ ], seeking help from a professional [ $t(333) = -5.16$ ,  $p < .001$ ], praying [ $t(375) = -3.65$ ,  $p < .001$ ], mindfulness [ $t(320) = -3.37$ ,  $p < .001$ ], and positive reframing [ $t(316) = -3.37$ ,  $p < .001$ ]. Participants with minimal or subthreshold symptoms of traumatic stress perceived more benefit from safety planning, engaging in mastery activities, engaging in physical activity, and following a routine than participants with clinically elevated symptoms of traumatic stress, but these differences were not significant.

## Discussion

The present study sought to provide an initial glimpse into how Americans experienced and responded to stress in the early months of the COVID-19 pandemic. Findings showed that approximately half of participants were acquainted with at least one individual whose health had been compromised by COVID-19, including a sizeable proportion of individuals whose lives were lost from this virus. These statistics are grim, especially considering that the number of cases and deaths in the United States are expected to continually increase in the coming months and that experts are warning about a second peak when the economy begins to reopen (World Health Organization, 2020).

**Table 5.** Use of Coping Strategies

	Minimal Stress	Elevated Stress	<i>t</i>	<i>p</i>
Taking precautions to keep myself safe	2.28 (.93)	2.02 (.80)	2.84	.005*
Doing activities that I enjoy	2.06 (.89)	1.96 (.81)	1.04	.298
Focusing on my work or other productive activities	1.93 (.96)	1.72 (.87)	2.10	.037*
Following a routine	1.83 (.95)	1.76 (.80)	.77	.445
Adjusting to the “new normal”	1.82 (1.01)	1.78 (.79)	.40	.693
Searching for the most up-to-date information	1.63 (1.05)	1.82 (.82)	-1.94	.053
Exercising or being physically active	1.48 (1.06)	1.62 (.88)	-1.34	.183
Getting support from family or friends	1.46 (.98)	1.72 (.89)	-2.65	.008*
Practicing mindfulness	1.29 (1.05)	1.69 (.75)	-4.03	<.001**
Saying encouraging statements to myself	1.24 (1.05)	1.80 (.84)	-5.52	<.001**
Praying or meditating	1.13 (1.15)	1.71 (.89)	-5.30	<.001**
Trying to avoid thinking about the pandemic	1.10 (1.00)	1.80 (.86)	-7.15	<.001**
Deep breathing or other relaxation techniques	.89 (.98)	1.77 (.87)	-9.07	<.001**
Eating for comfort	.89 (.94)	1.80 (.90)	-9.44	<.001**
Buying things to make myself feel better	.64 (.78)	1.68 (.83)	-12.38	<.001**
Using alcohol	.51 (.81)	1.37 (1.00)	-9.10	<.001**
Using marijuana or other drugs	.48 (.90)	1.32 (1.02)	-8.50	<.001**
Using cigarettes or other tobacco products	.47 (.94)	1.43 (1.05)	-9.24	<.001**
Seeking help or advice from a professional	.47 (.76)	1.68 (.92)	-13.98	<.001**
Journaling	.46 (.77)	1.49 (.90)	-11.91	<.001**

Note. \* $p < .05$ , \*\* $p < .0025$  (Bonferroni correction of  $\alpha = .05/20$ ), as determined by independent samples *t*-tests evaluating the association of level of traumatic stress on use of coping strategies.

Given these circumstances, there is an urgent need to develop formal supports for attending to the mental health concerns of the general population. After 5 months of growing cases (e.g., Holshue et al., 2020) and 2 months of mandated physical distancing (e.g., County of San Mateo, 2020) (as of May 2020), there are already disquieting rates of stress and functional impairment. Consistent with rates of psychological distress following previous pandemics, more than one-third of participants in this study endorsed clinically elevated symptoms of traumatic stress, and many endorsed increased functional impairment as a result of the pandemic. Interestingly, as many as one-third of participants reported improved functioning since the start of the pandemic, and the reasons behind the differential functional impact of the COVID-19 pandemic warrants further exploration. For example, it is possible that individuals with relative privilege may be experiencing

less stress and functional impairment than those from traditionally underserved communities (e.g., persons of color, families living in poverty) or those whose physical, emotional, and/or financial well-being has been directly compromised by COVID-19 (e.g., essential workers, loved ones grieving a COVID-19 death, individuals facing unemployment). Another possibility is that state stay-at-home orders may have forced some individuals to reallocate their time (e.g., spending more time working and/or caregiving than usual), resulting in increased distress but perhaps improved quality of certain activities. Although levels of stress and functional impairment among the general population may improve when COVID-19 cases and deaths eventually begin to decrease, the health, economic, and social consequences of this pandemic are likely to have mental health repercussions that could last a generation without

active prevention and early intervention efforts.

Unlike the medical field, which has been forced to respond to COVID-19 with a limited supply of personal protective equipment, hospital beds, and ventilators, the field of mental health may be uniquely equipped to flatten the curve of the anticipated mental health pandemic. That is, hundreds of evidence-based treatments have been developed, tested, and shown to be efficacious for addressing a variety of mental health concerns (Chorpita et al., 2011), including treatments for traumatic stress in postdisaster contexts (e.g., CATS Consortium, 2007; Hamblen et al., 2009). In other words, the mental health field is entering this pandemic with an ample supply of treatments for addressing the psychological and functional impairment caused or exacerbated by COVID-19. However, to meet the elevated mental health needs of the nation, it will be imperative to complete the challenging but achievable tasks of disseminating these evidence-based treatments to front-line providers and of promoting the widespread implementation of this mental health programming.

Accordingly, this is a call to action for mental health professionals to use their expertise and to leverage the vast evidence base on effective mental health interventions to promote psychological recovery and well-being in the months and years to come (cf. Gruber et al., 2020). Encouragingly, results from this study show that many members of the general population are already aware of and using evidence-informed coping strategies, such as safety planning, engaging in behavioral activation, and following a routine. At the same time, some coping strategies with great potential to promote human well-being (e.g., journaling, seeking help from a professional) seem to be underutilized and/or perceived to have little benefit. Additionally, ineffective coping strategies, such as alcohol or substance use, emotional eating, and emotional spending, were seen to have greater use and perceived helpfulness than desired, particularly among individuals reporting clinically elevated symptoms of traumatic stress. Therefore, concerted efforts are necessary to disseminate evidence-informed coping strategies to individuals in need, promote appropriate and consistent use of coping strategies, and reduce use of avoidance coping strategies that can have harmful consequences. As such, potential action items include the following:

- Distilling the extensive evidence base on effective treatments to identify the best-fitting strategies for addressing the mental health needs stemming from this pandemic;
- Preparing a mental health workforce for implementing these evidence-informed strategies through the provision of training, supervision, and consultation;
- Considering ways for these evidence-informed strategies to reach the general population, particularly individuals with barriers to receiving mental health services such as stigma, limited access to technology, or poor mental health literacy;
- Brainstorming innovative options for implementing evidence-informed strategies that may be difficult or impractical to practice under current circumstances (e.g., engaging in pleasurable activities while complying with public health guidelines);
- Partnering with professionals from other disciplines to facilitate dissemination of evidence-informed coping strategies and to take an interdisciplinary approach to addressing the health, economic, and social consequences of this multifaceted stressor.

Although this study has several strengths, including its data-based description of COVID-19-related stress, functioning, and coping among a large sample of Americans, some caveats are in order. First, this study features an online convenience sample of predominantly middle-class, non-Hispanic White participants and, therefore, these findings may not be generalizable to individuals from different backgrounds. Further attention should be granted to identifying and implementing strategies for promoting mental health and well-being among communities disproportionately affected by the COVID-19 pandemic (e.g., persons of color, homeless persons; Baggett et al., 2020; Webb Hooper et al., 2020). Second, this study includes only self-report data, which is subject to response bias, and may not reflect actual rates of PTSD symptoms, functional impairment, or use of coping strategies. Relatedly, given the unprecedented nature of the COVID-19 pandemic, functioning and coping in this context were assessed using measures that have not yet been validated. Additionally, this cross-sectional study was designed to

**Table 6.** Perceived Helpfulness of Coping Strategies

	Minimal Stress	Elevated Stress	<i>t</i>	<i>p</i>
Taking precautions to keep myself safe	2.79 (1.18)	2.59 (1.00)	1.75	.082
Doing activities that I enjoy	2.67 (1.10)	2.70 (.90)	-.22	.827
Focusing on my work or other productive activities	2.62 (1.07)	2.49 (.96)	1.19	.233
Exercising or being physically active	2.59 (1.18)	2.44 (.99)	1.29	.198
Following a routine	2.56 (1.12)	2.45 (.90)	1.02	.306
Getting support from family or friends	2.46 (1.18)	2.50 (.98)	-.32	.753
Adjusting to the “new normal”	2.25 (1.26)	2.31 (1.01)	-.46	.650
Practicing mindfulness	2.04 (1.25)	2.48 (1.03)	-3.37	.001**
Saying encouraging statements to myself	2.02 (1.40)	2.49 (.95)	-3.37	.001**
Deep breathing or other relaxation techniques	2.02 (1.25)	2.37 (1.03)	-2.69	.007
Praying or meditating	1.87 (1.45)	2.37 (1.15)	-3.65	<.001**
Searching for the most up-to-date information	1.87 (1.21)	2.52 (1.00)	-5.43	<.001**
Seeking help or advice from a professional	1.72 (1.22)	2.39 (1.10)	-5.16	<.001**
Trying to avoid thinking about the pandemic	1.68 (1.25)	2.39 (1.12)	-5.66	<.001**
Eating for comfort	1.06 (1.18)	2.32 (1.11)	-10.49	<.001**
Buying things to make myself feel better	1.20 (1.16)	2.15 (1.09)	-7.45	<.001**
Journaling	1.14 (1.25)	2.24 (1.08)	-8.60	<.001**
Using alcohol	.74 (1.06)	1.77 (1.21)	-8.12	<.001**
Using marijuana or other drugs	.72 (1.18)	1.82 (1.20)	-8.49	<.001**
Using cigarettes or other tobacco products	.44 (.88)	1.97 (1.22)	-14.13	<.001**

*Note.* \* $p < .05$ , \*\* $p < .0025$  (Bonferroni correction of  $\alpha = .05/20$ ), as determined by independent samples *t*-tests evaluating the association of level of traumatic stress on perceived helpfulness of coping strategies.

assess stress, functioning, and coping at a single point in time and relatively early in the pandemic. It is thus possible that these findings may represent reactions to acute stress and that rates of psychological distress may vary encouragingly or discouragingly as the outbreak continues. Future research investigating the psychological impact of the COVID-19 outbreak should consider incorporating more objective measures, such as structured interviews or behavioral observation, and collecting longitudinal data.

## Conclusion

This study offers an initial depiction of stress, functional impairment, and coping related to the COVID-19 pandemic. Results from this study suggest an anticipated upsurge of mental health needs stemming from this unprecedented stressor and call for mental health professionals to mobilize in an effort to facilitate the

widespread implementation of effective coping strategies. These findings shed light on opportunities for promoting mental health and well-being during a time of significant need and for helping individuals recover from this ongoing and compounding crisis. We hope that these findings can normalize some of the difficulties that individuals across the country have been and are currently facing and can inspire and inform efforts for addressing this collective trauma.

## References

- Achenbach, J. (2020, April). *Coronavirus is harming the mental health of tens of millions of people in U.S., new poll finds*. Retrieved from [https://www.washingtonpost.com/health/coronavirus-is-harming-the-mental-health-of-tens-of-millions-of-people-in-us-new-poll-finds/2020/04/02/565e6744-74ee-11ea-85cb-8670579b863d\\_story.html](https://www.washingtonpost.com/health/coronavirus-is-harming-the-mental-health-of-tens-of-millions-of-people-in-us-new-poll-finds/2020/04/02/565e6744-74ee-11ea-85cb-8670579b863d_story.html)



- American Psychological Association (2020, May). *Stress in America 2020: Stress in the time of COVID-19* [Press release]. Retrieved from <https://www.apa.org/news/press/releases/stress/2020/report>.
- Baggett, T. P., Keyes, H., Sporn, N., Gaeta, J. M. (2020) Prevalence of SARS-CoV-2 infection in residents of a large homeless shelter in Boston. *JAMA*. doi:10.1001/jama.2020.6887
- Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, 28(6), 489-498. <https://doi.org/10.1002/jts.22059>.
- CATS Consortium. (2007). Implementing CBT for traumatized children and adolescents after September 11: Lessons learned from the Child and Adolescent Trauma Treatments and Services (CATS) project. *Journal of Clinical Child and Adolescent Psychology*, 36(4), 581-592. <https://doi.org/10.1080/15374410701662725>.
- Chavez, N., & Moshtaghian, A. (2020, May). *48 states have ordered or recommended that schools don't reopen this academic year*. Retrieved from <https://www.cnn.com/2020/04/18/us/schools-closed-coronavirus/index.html>
- Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B. J., ... Smith, R. L. (2011). Evidence-based treatments for children and adolescents: An updated review of indicators of efficacy and effectiveness. *Clinical Psychology: Science and Practice*, 18(2), 154-172. <https://doi.org/10.1111/j.1468-2850.2011.01247.x>
- Clohesy, S., & Ehlers, A. (1999). PTSD symptoms, response to intrusive memories and coping in ambulance service workers. *British Journal of Clinical Psychology*, 38(3), 251-265. <https://doi.org/10.1348/014466599162836>.
- Ehring, T., Razik, S., & Emmelkamp, P. M. (2011). Prevalence and predictors of posttraumatic stress disorder, anxiety, depression, and burnout in Pakistani earthquake recovery workers. *Psychiatry Research*, 185(1-2), 161-166. <https://doi.org/10.1016/j.psychres.2009.10.018>
- Gruber, J., Prinstein, M., Abramowitz, J. S., Albano, A. M., Aldao, A., Borelli, J., ... Weinstock, L. (2020). *Flattening the mental health curve in the time of COVID-19: A call to action for clinical psychological science*. <https://doi.org/10.31234/osf.io/desg9>
- Hamblen, J. L., Norris, F. H., Pietruszkiewicz, S., Gibson, L. E., Naturale, A., & Louis, C. (2009). Cognitive behavioral therapy for postdisaster distress: A community based treatment program for survivors of Hurricane Katrina. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(3), 206-214. <https://doi.org/10.1007/s10488-009-0213-3>.
- Holshue, M. L., DeBolt, C., Lindquist, S., Lofy, K. H., Wiesman, J., Bruce, H., ... Diaz, G. (2020). First case of 2019 novel coronavirus in the United States. *New England Journal of Medicine*, 382, 929-936. doi: 10.1056/NEJMoa2001191
- Huang, Y., & Zhao, N. (2020). Generalized anxiety disorder, depressive symptoms and sleep quality during COVID-19 outbreak in China: A web-based cross-sectional survey. *Psychiatry Research*, 288, 112954.
- Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., ... Tan, H. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA*.
- Lee, S. M., Kang, W. S., Cho, A. R., Kim, T., & Park, J. K. (2018). Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients. *Comprehensive Psychiatry*, 87, 123-127.
- Mak, I. W. C., Chu, C. M., Pan, P. C., Yiu, M. G. C., & Chan, V. L. (2009). Long-term psychiatric morbidities among SARS survivors. *General Hospital Psychiatry*, 31(4), 318-326.
- McGinty, E. E., Presskreischer, R., Han, H., & Barry, C. L. (2020). Psychological distress and loneliness reported by US adults in 2018 and April 2020. *JAMA*.
- Silver, R. C., Poulin, M., Holman, E. A., McIntosh, D. N., Gilrivas, V., & Pizarro, J. (2005). Exploring the myths of coping with a national trauma: A longitudinal study of responses to the September 11th terrorist attacks. *Journal of Aggression, Maltreatment & Trauma*, 9(1-2), 129-141. [https://doi.org/10.1300/J146v09n01\\_16](https://doi.org/10.1300/J146v09n01_16)
- U.S. Bureau of Labor Statistics. (2020, May). *Labor force statistics from the current population survey*. Retrieved from [https://data.bls.gov/timeseries/LNS140000000](https://data.bls.gov/timeseries/LNS14000000).
- U.S. Department of Health and Human Services. (2020a, May). *Coronavirus disease 2019 (COVID-19): Cases in the US*. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.
- U.S. Department of Health and Human Services. (2020b, May). *Coronavirus disease 2019 (COVID-19): World map*. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/global-covid-19/world-map.html>
- Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. Scale available from the National Center for PTSD at [www.ptsd.va.gov](http://www.ptsd.va.gov).
- Webb Hooper, M., Nápoles, A. M., & Pérez-Stable, E. J. (2020). COVID-19 and racial/ethnic disparities. *JAMA*, 10.1001/jama.2020.8598.
- World Health Organization. (2020, May 25). *Coronavirus disease (COVID-19) pandemic [Press release]*. Retrieved from <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>.

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## Welcome From the Program Chairs



**Shannon Wiltsey Stirman, Ph.D., *Program Chair***, Dissemination and Training Division, National Center for PTSD and Department of Psychiatry and Behavioral Sciences, Stanford University



**Daniel M. Cheron, Ph.D., ABPP, *Associate Program Chair***, Judge Baker Children's Center, Harvard Medical School

As the 2020 Program Chair and Associate Chair, we welcome you to our 54th Annual Convention with the recognition that this year has brought unprecedented challenges, but also new opportunities to improve the responsiveness and effectiveness of the work that we all do. ABCT's mission is to enhance public health and well-being through the application of science, a goal that is reflected in our 2020 theme, "Better Access, Better Outcomes: Enhancing the Impact of Behavioral and Cognitive Therapies." At the time that this theme was selected, we had no idea that 2020 would present our field with the formidable challenge of providing uninterrupted access to care during a global pandemic, while sheltering in place. Many of our members rapidly transitioned to providing treatment through telehealth, and grappled with questions about how best to provide access to those who lacked the resources or technology to engage in care. We also saw our society—and our field—called to action to ensure that individuals who continue to experience systemic discrimination throughout their whole lives receive equitable treatment and opportunity. We have asked ourselves whether the treatments that we develop, study, and provide truly meet the needs of all we serve, and whether and how we can continue to improve their impact. These are questions that keep us up at night and fuel our own work, and we have worked to bring the same commitment in these roles as your Program Chair and Associate Chair. We are truly honored to have the opportunity to serve our organization, which has provided us with intellectual stimulation, friendships, and support for over two decades.

Developing a program amidst rapid changes in our society has been enormously rewarding. We have heard from our membership about ways that ABCT can grow and support diversity in our membership and respond to the important challenges that the individuals we serve face every day. We were fortunate that many of our members submitted highly relevant work in areas related to access to care and meeting the needs of diverse communities, and we hope that their presentations will inspire continued dialogue, action, and more innovation and research.

We have some exciting programming specific to increasing the impact of CBT. We are joined this year by a panel of experts who have pioneered methods related to treatment selection and personalization. Michelle Craske will moderate a panel with Aaron Fisher, Greg Siegle, Jacqueline Persons, and Robert DeRubeis on the approaches they have developed and tested to ensure that clients receive tailored, effective, and efficient treatment. Drs. Aaron Beck and Judy Beck will present remarks on the evolution of CBT and reflections on the conference theme.

Additionally, you will see a number of presentations on access to care during the COVID-19 pandemic. A key challenge has been

not only to provide continuity and equitable access to care, but to do so in a way that ensures that outcomes are commensurate, or even improve upon traditional face-to-face care. Innovations in digital health and integration of recent findings on ways to personalize care to improve outcomes also remain highly relevant in the current environment. As Program Chairs, it has been our role to work with our committee to consider how we can address these concerns within the program we have sought to create over the past year.

Some of our featured speakers will also be sharing their work that is geared toward disseminating, implementing, and increasing access to evidence-based treatment. Eric Youngstrom will be speaking about his pioneering efforts to develop open source strategies to disseminate psychological science and provide greater access to evidence-based assessment and information about behavioral and emotional disorders.

Dr. Allison Harvey's work spans the continuum from treatment development to implementation, and we look forward to hearing her work towards identification of novel intervention targets related to sleep and memory that are safe, powerful, inexpensive and scalable. Dr. Zindel Segal will share advances in Mindfulness-Based Cognitive Therapy, including recent digital mental health studies. We are also delighted that our 2019 Lifetime Achievement Award Winner, Dr. Phil Kendall, will present on his influential work, which has also focused on both improving clinical outcomes for child anxiety and, increasingly, on implementing these interventions. Finally, in his presidential address, Dr. Martin Antony will speak to us about the challenges and opportunities for CBT in the era of COVID.

This year, we continued innovating in our program process:

- We piloted a student reviewer program, and 55 students co-reviewed abstracts with their mentors.
- For the first time, posters will be virtual. This will allow you to attend more live programming and still browse posters in the topic areas that interest you.

It has been our privilege to serve as your Program Chairs this year, and we are grateful to Dr. Martin Antony and the ABCT Board for entrusting us with these duties. We also want to thank Janice Svendsen for her administrative support and willingness to roll up her sleeves to help with the many tasks associated with program review and correspondence. We also would like to thank Drs. Alyssa Ward and Cameo Stanick (2019 Program Chair and Assistant) and Dr. Katharina Kircanski (Coordinator of Convention and Education Issues and 2017 Program Chair) for their support and guidance. This program comes to you via the substantial efforts of virtually hundreds of our members who have



contributed to its creation. This includes the 2020 Program Committee, composed of over 280 members and 110 super reviewers, for their expertise, careful reviews, and flexibility during the peer review process. We simply would not have a convention without their dedication and service.

We also thank the chairs of the Convention and Education Issues Committee for their tireless work and exceptional job developing this year's excellent program: Brian Baucom (AMASS Chair), Christina Boisseau (Workshops Chair), Courtney Benjamin Wolk (Master Clinician Seminars Chair), Cole Hooley (Research & Professional Development Chair), Samantha Farris (Institutes Chair), and Gregory Chasson (2021 Program Chair). We can't express enough appreciation for Mary Jane Eimer and the Central Office team—most especially the unflappable Stephen Crane—who gracefully and thoughtfully worked to develop the best convention possible under unprecedented circumstances and tremendous uncertainty. Finally, we are forever grateful to our families, who have been so loving and tolerant of the time and work that went into the development of this convention.

We hope that you experience this as an engaging convention that inspires new scientific collaborations that increase our collective impact! Thanks for joining us this year.

**NOTE** Program details such as educational objectives, session level, fees, presenter credentials, and number of CE credits that can be earned may be found in the program book on ABCT's website. Program subject to change.

# Itinerary Planner

\* Available Late September \*

- > *Browse by day, time, or session type*
- > *Search by author or keyword*

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2020 convention. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner. Feel free to access the Itinerary Planner at [www.abct.org/conv2020](http://www.abct.org/conv2020). To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can *search* by session type, date, time, presenter, title, category, or keyword, or you can view the entire schedule at a glance. After reviewing this special Convention 2020 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!



Search | Find | Plan



[www.abct.org/conv2020](http://www.abct.org/conv2020)

## Continuing Education Credits

At the ABCT Annual Convention, there are ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and general sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. Below is a list of organizations that have approved ABCT as a CE sponsor. Note that we do not currently offer CMEs.

### *Psychology*

**American Psychological Association** to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content.

### *Social Work*

**National Association of Social Workers** (Approval # 886427222) for 27 continuing education contact hours.

### *Counseling*

**NBCC** (National Board for Certified Counselors) as an Approved Continuing Education Provider, ACEP No. 5797. Programs that do not qualify for NBCC credit are clearly identified. The Association for Behavioral and Cognitive Therapies is solely responsible for all aspects of the programs.

### *Marriage and Family Therapy*

**California Association of Marriage and Family Therapists** (CAMFT)-approved Continuing Education Provider (#133136). The ABCT Annual Convention meets the qualifications for 28 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences.

For full information about our CE program, visit:

<https://www.abct.org/Conventions/index.cfm?m=mConvention&fa=ceOpportunities>

## CIT 1 | **Mobile Apps for Mental Health: Understanding Technologies for Use and Application in Cognitive and Behavioral Therapies**

♦ Participants earn 7 continuing education credits

Stephen Schueller, Ph.D., *University of California, Irvine*

The number of mobile apps for mental health is regularly growing, with estimates that over 10,000 to 15,000 of such products exist. These tools are also more frequently entering into therapy, either by being introduced by providers or brought in by consumers. However, training in how to understand and use these tools in cognitive and behavioral practices is lagging beyond their development. As such, many clinicians report a desire to use these tools but an uncertainty around which tools to use and how. This training will provide clinicians with an overview of mobile apps for mental health and will focus on how to evaluate these tools and integrate them into clinical practice. Furthermore, this overview will be supplemented with presentations from several app companies to illustrate the functionality, evidence, and utility of these products. This training will address general competencies for the use of such tools while using specific tools as examples. Different models of integration into care will also be considered, including tools that add new treatment strategies, tools that extend treatment strategies, and ways to use tools, such as introducing consumers to cognitive and behavioral strategies or assisting in termination and booster sessions.

## CIT 2 | **SPACE: Parent Based Treatment for Childhood Anxiety and OCD**

♦ Participants earn 7 continuing education credits

Eli R. Lebowitz, Ph.D., *Yale School of Medicine*

Despite advances in treatment for childhood anxiety and related disorders, current treatments are not effective in up to 50% of cases. In recent years, there has been rapidly increasing interest in family accommodation, or the changes that parents make to their own behavior to help a child avoid or alleviate distress related to anxiety. Although it is intended to reduce anxiety in the short term, family accommodation is associated with greater symptom severity and impairment.

SPACE (Supportive Parenting for Anxious Childhood Emotions) is a theory-driven intervention informed by research into parental entanglement in the symptoms of childhood anxiety and by the biology of mammalian parental behavior. SPACE teaches parents to recognize their accommodating behaviors, and to implement specific plans for reducing the accommodation while maintaining a supportive attitude towards the child. SPACE also includes tools for the following: increasing parents' ability to work cooperatively together; coping with responses to the reduced accommodation, including anger and distress; and enlisting the support of family and friends in what can sometimes be a difficult process. This session will present an overview of family accommodation and its associations with child anxiety, introduce SPACE and its treatment components, and review findings from clinical trials demonstrating the efficacy of SPACE.

## President's Address



### **CBT in the Era of COVID-19**

*Martin M. Antony, Ph.D.,  
Ryerson University*

♦ Participants earn 1 CE credit

This year, the world has faced challenges unlike those that many of us have encountered in our lifetimes, including living through the COVID-19 pandemic, beginning to confront systemic racism and discrimination, and navigating ongoing political divisions. This presentation will focus on the impact of recent events on the work that we do, and how our efforts to alleviate human suffering through science can have an impact on the world around us. Some topics that will be touched on include the effects of COVID-19 on mental health and efforts to treat psychological distress, the challenges of adapting CBT during the pandemic, the politicization of public health and science, the intersection of COVID-19 with racism, equity, and access, and a possible role for CBT in helping people transition to a postpandemic time.

*Designed for clinical practitioners, discussions and display of specific intervention techniques.*

## Institute 1

◆ Participants earn 7 continuing education credits.

### **Desirable Difficulties: Optimizing Exposure Therapy for Anxiety Through Inhibitory Learning**

Jonathan S. Abramowitz, Ph.D., *University of North Carolina at Chapel Hill*

Ryan J. Jacoby, Ph.D., *Massachusetts General Hospital/Harvard Medical School*

Shannon M. Blakey, Ph.D., *VA Mid-Atlantic Mental Illness Research, Education & Clinical Center (MIRECC)/Durham VA Health Care System*

## Institute 2

◆ Participants earn 7 continuing education credits.

### **Radically Open DBT Skills Training: It's Not What You Say, It's How You Say It**

Thomas R. Lynch, Ph.D., *University of Southampton*

J. Nicole Little, Ph.D., *Radically Open Canada*

## Institute 3

◆ Participants earn 5 continuing education credits.

### **Supervision Essentials for Cognitive-Behavioral Therapy**

Cory F. Newman, ABPP, Ph.D., *Perelman School of Medicine at the University of Pennsylvania*

Danielle A. Kaplan, Ph.D., *New York University School of Medicine*

## Institute 4

◆ Participants earn 5 continuing education credits.

### **Introduction to Process-Based CBT**

Stefan G. Hofmann, Ph.D., *Boston University*

Steven Hayes, Ph.D., *University of Nevada, Reno*

David N. Lorscheid, B.S., *Radbound University*

## Institute 5

◆ Participants earn 5 continuing education credits.

### **Everything You Always Wanted to Know About Interpersonal Psychotherapy for Adolescents (IPT-A) and Never Had the Chance to Ask**

Laura H. Mufson, Ph.D., *Columbia University and New York State Psychiatric Institute*

Jami Young, Ph.D., *Children's Hospital of Philadelphia/University of Pennsylvania Perelman School of Medicine*

## Institute 6

◆ Participants earn 5 continuing education credits.

### **Fostering Resilience: An MBCT Approach for Mental Health Professionals**

Mark A. Lau, Ph.D., *Vancouver CBT Centre*

& *University of British Columbia*

## Institute 7

◆ Participants earn 5 continuing education credits.

### **Trauma-Informed Mindfulness: Integrating Mindfulness-Based Practices Into Psychotherapy With Traumatized Clients**

Terri L. Messman-Moore, Ph.D., *Miami University*

Noga Zerubavel, Ph.D., *Duke University Medical Center*

## Institute 8

◆ Participants earn 5 continuing education credits.

### **Improving Access to Teen Sleep Treatments: How to Deliver Evidence-Based Techniques to Help Young Adults**

Colleen E. Carney, Ph.D., *Ryerson University*

# Advanced Methodology and Statistics Seminars

*A special series of offerings for applied researchers, presented by nationally renowned research scientists.* TICKETED SESSIONS

## Encore AMASS back by popular demand from 2019

## AMASS 1

◆ Participants earn 4 continuing education credits.

### **Open Science Practices for Clinical Researchers: What You Need to Know and How to Get Started**

Jessica Schleider, Ph.D., *Professor of Social and Quantitative Psychology, Stony Brook University*

Michael Mullarkey, M.A., *University of Texas at Austin*

## AMASS 2

◆ Participants earn 4 continuing education credits.

### **Analyzing Longitudinal Data Collected During the Coronavirus Pandemic**

Vivian C. Wong, Ph.D., *University of Virginia*



# Master Clinician Seminars

TICKETED SESSIONS

*These seminars involve the presentation of case material, session videotapes, and discussion to enable participants to further understand the application of cognitive and behavioral techniques.*

## MCS 1

♦ Participants earn 2 continuing education credits

### **The Stanley-Brown Safety Planning Intervention to Reduce Suicide Risk**

Gregory K. Brown, Ph.D., *Perelman School of Medicine at the University of Pennsylvania*  
Barbara Stanley, Ph.D., *Columbia University Medical Center*

## MCS 2

♦ Participants earn 2 continuing education credits

### **Envy: A Cognitive Behavioral Approach**

Robert L. Leahy, Ph.D., *American Institute for Cognitive Therapy*

## MCS 3

♦ Participants earn 2 continuing education credits

### **Conceptualization and Treatment of Disgust in Anxiety and Obsessive-Compulsive Disorders**

Dean McKay, Ph.D., *Fordham University*

## MCS 4

♦ Participants earn 2 continuing education credits

### **Whether We "Like" It or Not, Psychologists Need to Embrace Social Media**

Simon A. Rego, PsyD, ABPP, A-CBT, *Montefiore Medical Center/Albert Einstein College of Medicine*

## MCS 5

♦ Participants earn 2 continuing education credits

### **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**

Richard Gallagher, Ph.D., *NYU School of Medicine*  
Jenelle Nissley-Tsiopinis, Ph.D., *Children's Hospital of Philadelphia*  
Christina DiBartolo, LCSW, *Children's Hospital of Philadelphia*

## MCS 6

♦ Participants earn 2 continuing education credits

### **Everything Old Is New Again: The Role of Worksheets in Growing (and Measuring) CBT Competence**

Torrey A. Creed, Ph.D., *Perelman School of Medicine, University of Pennsylvania*

## MCS 7

♦ Participants earn 2 continuing education credits

### **AND: Adolescents Need Dialectics! Leveraging Dialectical Strategies and Philosophy to Improve Your DBT With Teens and Their Families**

Esme A.L. Shaller, Ph.D., *UCSF & UC Berkeley*

## MCS 8

♦ Participants earn 2 continuing education credits

### **When the Feared Outcome Is Potentially Lethal: Exposures for Children With Anxiety Disorders in the Context of Food Allergies**

Katherine K. Dahlsgaard, Ph.D., ABPP, *Children's Hospital of Philadelphia*

# Workshops

TICKETED SESSIONS

*Workshops provide up-to-date integration of theoretical, empirical, and clinical knowledge about specific issues or themes*

## Workshop 1

♦ Participants earn 3 continuing education credits

### **How to Apply Cognitive Behavioral Principles to Transgender Care: An Evidence-Based Transdiagnostic Framework**

Colleen A. Sloan, Ph.D., *VA Boston Healthcare System*  
Danielle Berke, Ph.D., *Hunter College*

## Workshop 2

♦ Participants earn 3 continuing education credits

### **Acceptance and Commitment Therapy: Working With Parents of Adolescents With Anxiety and OCD**

Lisa W. Coyne, Ph.D., *McLean Harvard Medical School*  
Phoebe S. Moore, Ph.D., *University of Massachusetts Medical School*

## Workshop 3

♦ Participants earn 3 continuing education credits

### **Alliance-Focused Training for CBT: Strategies for Improving Retention and Outcome by Identifying and Repairing Ruptures in the Therapeutic Alliance**

J. Christopher Moran, Ph.D., *Gordon F. Derner School, Adelphi University*  
Catherine F. Eubanks, Ph.D., *Yeshiva University, Ferkauf Graduate School of Psychology*

## Workshop 4

♦ Participants earn 3 continuing education credits

### **CBT for GI Disorders: Clinical Training Plus Print and Digital Dissemination**

Melissa G. Hunt, Ph.D., *University of Pennsylvania*

#### Workshop 5

♦ Participants earn 3 continuing education credits

##### **Cognitive Therapy for Suicide Prevention**

Kelly Green, Ph.D., *University of Pennsylvania*  
Gregory K. Brown, Ph.D., *Perelman School of Medicine at the University of Pennsylvania*

#### Workshop 6

♦ Participants earn 3 continuing education credits

##### **Coordinated Interventions for School Refusal: Advanced Skills for Working With Families and Schools**

Brian C. Chu, Ph.D., *Rutgers University*  
Laura C. Skinner, Ph.D., *Evidence-Based Practitioners of New Jersey*

#### Workshop 7

♦ Participants earn 3 continuing education credits

##### **Deliberate Practice for Cognitive-Behavioral Therapy: Training Methods to Enhance Acquisition of CBT Skills**

James F. Boswell, Ph.D., *University at Albany, SUNY*  
Tony Rousmaniere, Psy.D., *University of Washington School of Medicine*

#### Workshop 8

♦ Participants earn 3 continuing education credits

##### **Engaging Teenagers With ADHD in Therapy: Motivational Strategies, Turning Skills Into Habits, and Partnering With Parents**

Margaret Sibley, Ph.D., *University of Washington School of Medicine*

#### Workshop 9

♦ Participants earn 3 continuing education credits

##### **Evidence-Based Treatment for Prolonged Grief Disorder**

Natalia A. Skritskaya, Ph.D., *Columbia University*  
Katherine Shear, M.D., *Columbia University School of Social Work*

#### Workshop 10

♦ Participants earn 3 continuing education credits

##### **Facilitating Personal Recovery in Bipolar Disorder**

Steven H. Jones, Ph.D., *Lancaster University*  
Elizabeth Tyler, Psy.D., *Lancaster University*

#### Workshop 11

♦ Participants earn 3 continuing education credits

##### **Improving Treatment for Impulsive, Addictive, and Self-Destructive Behaviors: Strategies From Mindfulness and Modification Therapy**

Peggilee Wupperman, Ph.D., *John Jay College/City University of New York*  
Jenny "Em" Mitchell, M.A., *John Jay College/City University of New York*

#### Workshop 12

♦ Participants earn 3 continuing education credits

##### **Microaggressions in Therapy: Effective Approaches to Managing, Preventing, and Responding to Them**

Monnica T. Williams, ABPP, Ph.D., *University of Ottawa*  
Matthew D. Skinta, ABPP, Ph.D., *Roosevelt University*

#### Workshop 13

♦ Participants earn 3 continuing education credits

##### **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**

Teri L. Bourdeau, ABPP, Ph.D., *PracticeWise, LLC*  
Kimberly Becker, Ph.D., *University of South Carolina*  
Bruce Chorpita, Ph.D., *University of California, Los Angeles*

#### Workshop 14

♦ Participants earn 3 continuing education credits

##### **Rediscovering Exposure: Enhancing the Impact of Cognitive Behavioral Therapy for Eating Disorders**

Glenn C. Waller, Ph.D., *University of Sheffield*  
Carolyn B. Becker, Ph.D., *Trinity University*  
Nicholas Farrell, Ph.D., *Rogers Memorial Hospital*

#### Workshop 15

♦ Participants earn 3 continuing education credits

##### **Unraveling PTSD: Using Case Conceptualization to Enhance Identification and Targeting of Key Beliefs in Cognitive Processing Therapy**

Stefanie T. LoSavio, ABPP, Ph.D., *Duke University Medical Center*  
Gwendolyn (Wendy) Bassett, LCSW, *Yale University School of Medicine*

# General Sessions

NO TICKET REQUIRED

*Panel Discussions, Symposia, Clinical Round Tables, Mini Workshops are part of the general convention program: no tickets are required. Visit [abct.org](http://abct.org) for a complete listing of general sessions.*

## ■ PANEL DISCUSSIONS

♦ *Participants earn 1.5 continuing education credits*

### **Adaptations in Mental Healthcare Treatment Delivery and Research Conducted in Response to the COVID-19 Pandemic in an Urban Setting**

*Moderator:* Julianne W. Tirpak, M.A., Boston University  
*Panelist:* Lisa Smith, Ph.D., Boston University Center for Anxiety and Related Disorders  
*Panelist:* Todd Farchione, Ph.D., Boston University Center for Anxiety and Related Disorders  
*Panelist:* Barbara W. Kamholz, Ph.D., VA Boston Healthcare System  
*Panelist:* Ryan Madigan, Psy.D., Boston Child Study Center  
*Panelist:* Jason Krompinger, Ph.D., McLean OCDI, McLean Hospital OCD Institute

♦ *Participants earn 1.5 continuing education credits*

### **Blackademia: Challenges for Black Graduate Students and Professionals in the Academy**

*Moderator:* Jamilah R. George, M.S., University of Connecticut  
*Moderator:* Destiny Printz Pereira, M.S., University of Connecticut  
*Panelist:* Jessica R. Graham-LoPresti, Ph.D., Suffolk University  
*Panelist:* Darlene M. Davis, Ph.D., Parents Zone, LLC  
*Panelist:* Alexandria N. Miller, M.S., Suffolk University  
*Panelist:* Broderick Sawyer, Ph.D., Behavioral Wellness Clinic

♦ *Participants earn 1.5 continuing education credits*

### **Can a Brief Vacation Fix Your Problems? Strengthening the Impact of CBT Through Intensive and Short-Term Interventions**

*Moderator:* Michael Friedman, B.A., Rutgers University  
*Moderator:* Melissa Pedroza, B.A., Rutgers University  
*Panelist:* Jon Abramowitz, Ph.D., University of North Carolina at Chapel Hill  
*Panelist:* Cheryl B. McNeil, Ph.D., West Virginia University  
*Panelist:* Thomas H. Ollendick, ABPP, Ph.D., Virginia Tech  
*Panelist:* Jessica L. Schleider, Ph.D., Stony Brook University  
*Panelist:* Denise M. Sloan, Ph.D., Boston University School of Medicine

♦ *Participants earn 1.5 continuing education credits*

### **CBT Campfire Storytelling Session**

*Moderator:* Simon A. Rego, ABPP, Psy.D., Montefiore Medical Center  
*Panelist:* Anne Marie Albano, Ph.D., Columbia University Clinic for Anxiety and Related Disorders  
*Panelist:* Martin E. Franklin, Ph.D., Rogers Behavioral Health Philadelphia  
*Panelist:* Michael A. Southam-Gerow, Ph.D., Virginia Commonwealth University  
*Panelist:* Maureen L. Whittal, ABPP, Ph.D., Vancouver CBT Centre/University of British Columbia

♦ *Participants earn 1.5 continuing education credits*

### **CBT During a Global Pandemic: Lessons Learned About Access to Information and Care, Professional Mental Health and Utilizing Current CBT Evidence to Inform Novel Decision Making**

*Moderator:* Rebecca Sachs, ABPP, Ph.D., CBT Spectrum  
*Panelist:* Rebecca Sachs, ABPP, Ph.D., CBT Spectrum  
*Panelist:* Anne Marie Albano, Ph.D., Columbia University Clinic for Anxiety and Related Disorders  
*Panelist:* Lena S. S. Andersen, Ph.D., University of Cape Town  
*Panelist:* Destiny Printz Pereira, M.S., University of Connecticut  
*Panelist:* Jessica Stern, Ph.D., NYU Langone Medical Center  
*Panelist:* Caleb W. Lack, Ph.D., University of Central Oklahoma  
*Panelist:* Jonathan Kaplan, Ph.D., SoHo CBT + Mindfulness Center

♦ *Participants earn 1.5 continuing education credits*

### **Clinical Considerations for Culturally Tailored Treatment With Underserved Youth**

*Moderator:* Angela W. Wang, Rutgers University  
*Moderator:* Tian Saltzman, B.A., Rutgers University  
*Panelist:* Shalonda Kelly, Ph.D., Rutgers University  
*Panelist:* Jeffrey P. Winer, Ph.D., Boston Children's Hospital/Harvard Medical School  
*Panelist:* May Yeh, Ph.D., San Diego State University, Child & Adolescent Services Research Center, University of California, San Diego  
*Panelist:* Denise A. Chavira, Ph.D., UCLA  
*Panelist:* Kevin Chapman, Ph.D., Kentucky Center for Anxiety and Related Disorders

♦ *Participants earn 1.5 continuing education credits*

### **Closing the Gap: Transporting Evidence-Based Interventions to Diverse "Real World" Settings via Community-Partnered Research**

*Moderator:* Sheila Rouzitalab, PsyM, Rutgers University  
*Panelist:* Christine J. Laurine, PsyM, Rutgers University, GSAPP  
*Panelist:* Anu Asnaani, Ph.D., University of Utah  
*Panelist:* Tara Mehta, Ph.D., University of Illinois at Chicago  
*Panelist:* Nuwan D. Jayawickreme, Ph.D., Manhattan College

♦ *Participants earn 1.5 continuing education credits*

### **Cultural Adaptations and Considerations for Delivering Evidence-Based Treatments: Enhancing the Impact of Interventions Through Community Healing and Intergenerational Narratives**

*Moderator:* Alexandra Hernandez-Vallant, B.S., University of New Mexico  
*Panelist:* Keri Kirk, Ph.D., Department of Defense  
*Panelist:* Dawn Henderson, Ph.D., Duke University; Collective



Health and Education Equity Research Collaborative  
*Panelist:* Samara Toussaint, Psy.D., Path2Growth Counseling Services  
*Panelist:* Kamilla Venner, Ph.D., University of New Mexico, Center on Alcoholism, Substance Abuse, and Addictions  
*Panelist:* Carrie Winterowd, Ph.D., Oklahoma State University  
*Panelist:* Christina S. Lee, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

**Empowering Clients and Families With Information: Efforts to Disseminate Information About Evidence-Based Practices Directly to Consumers**

*Moderator:* Rachel Haine-Schlagel, Ph.D., San Diego State University/CASRC  
*Panelist:* Anna Van Meter, Ph.D., The Feinstein Institutes for Medical Research  
*Panelist:* John D. Guerry, Ph.D., Perelman School of Medicine at the University of Pennsylvania/Children's Hospital of Philadelphia  
*Panelist:* Brad J. J. Nakamura, Ph.D., University of Hawaii at Manoa  
*Panelist:* Mian Li Ong, Ph.D., Mayo Clinic  
*Moderator:* Lauren Brookman-Frazee, Ph.D., University of California, San Diego

◆ *Participants earn 1.5 continuing education credits*

**Expanding Access to Behavioral and Cognitive Therapies in Resource Constrained Settings: Lessons Learned From Global Mental Health Research**

*Moderator:* Lena S. S. Andersen, Ph.D., University of Cape Town  
*Panelist:* Jessica F. F. Magidson, Ph.D., University of Maryland  
*Panelist:* Laura Murray, Ph.D., Johns Hopkins University School of Public Health  
*Panelist:* Lauren Ng, Ph.D., UCLA  
*Panelist:* Conall O'Cleirigh, Ph.D., Harvard Medical School  
*Panelist:* Eve S. Puffer, Ph.D., Duke Global Health Institute, Duke University  
*Panelist:* Steven Safren, Ph.D., University of Miami

◆ *Participants earn 1.5 continuing education credits*

**Expanding Access to Treatment Through Cognitive Behavioral Peer Support**

*Moderator:* Steven D. Hollon, Ph.D., Vanderbilt University  
*Panelist:* Steven D. Hollon, Ph.D., Vanderbilt University  
*Moderator:* Noah Robinson, M.S., Vanderbilt University  
*Panelist:* Noah Robinson, M.S., Vanderbilt University  
*Panelist:* Michelle Craske, Ph.D., UCLA  
*Panelist:* Brandon Bergman, Ph.D., Harvard Medical School  
*Panelist:* Karen Fortuna, Ph.D., Dartmouth College  
*Panelist:* Daisy R. Singla, Ph.D., University of Toronto, Sinai Health

◆ *Participants earn 1.5 continuing education credits*

**Helicopter Parenting: Implications for Cognitive-Behavioral Interventions Across the Developmental Spectrum**

*Moderator:* Camilo Ortiz, Ph.D., Long Island University-Post  
*Panelist:* Anne Marie Albano, Ph.D., Columbia University Clinic for Anxiety and Related Disorders  
*Panelist:* Richard Gallagher, Ph.D., Hassenfeld Children's Hospital at NYU Langone Medical Center  
*Panelist:* Lenore Skenazy, LetGrow.Org

*Panelist:* Danielle R. Novick, M.S., University of Maryland-College Park

*Panelist:* Melanie Stearns, Ph.D., University of Missouri

◆ *Participants earn 1.5 continuing education credits*

**Innovative Research Methods to Improve the Effectiveness, Practice Relevance, and Uptake of Evidence-Based Practices**

*Moderator:* Joel Sherrill, Ph.D., Division of Services & Intervention Research, NIMH  
*Panelist:* Rinad S. S. Beidas, Ph.D., University of Pennsylvania Perelman School of Medicine; Penn Implementation Science Center at the Leonard Davis Institute of Health Economics  
*Panelist:* Tina R. Goldstein, Ph.D., University of Pittsburgh School of Medicine  
*Panelist:* Philip C. Kendall, ABPP, Ph.D., Temple University  
*Panelist:* Aaron Lyon, Ph.D., University of Washington  
*Panelist:* Jonathan Purtle, Drexel University Dornsife School of Public Health  
*Panelist:* Elizabeth A. Stuart, Ph.D., Johns Hopkins Bloomberg School of Public Health

◆ *Participants earn 1.5 continuing education credits*

**Innovative Strategies for Representative Inclusion of Latinx individuals in Training, Research, Assessment, and Treatment**

*Moderator:* Gabriela A. Nagy, Ph.D., Duke University  
*Panelist:* Maria M. Santos, Ph.D., California State University, San Bernadino  
*Panelist:* Juan I. Prandoni, Ph.D., El Futuro Inc.  
*Panelist:* Stephanie Salcedo, Ph.D., Durham VA Medical Center  
*Panelist:* Sylvanna Vargas, M.P.H., M.A., West Los Angeles Veterans Association

◆ *Participants earn 1.5 continuing education credits*

**Interdisciplinary Training in an Academic Medical Center: The Role of the Psychologist**

*Moderator:* Lindsay Brauer, Ph.D., University of Chicago  
*Panelist:* Yasmin Asvat, Ph.D., University of Chicago Medicine  
*Panelist:* Sheehan Fisher, Ph.D., Northwestern University Feinberg School of Medicine  
*Panelist:* Fabiana N. Araujo, Ph.D., University of Chicago

◆ *Participants earn 1.5 continuing education credits*

**Intersectional Experiences of Marginalization in Academia: Enhancing the Accessibility and Effectiveness of Interventions Through Inclusivity and Systemic Change in Doctoral Training**

*Moderator:* Broderick Sawyer, Ph.D., Behavioral Wellness Clinic  
*Moderator:* R. Sonia Singh, Ph.D., VA South Central MIRECC  
*Panelist:* Alexandra Hernandez-Vallant, B.S., University of New Mexico  
*Panelist:* Alexander A. Jendrusina, Ph.D., Ann Arbor Veterans Healthcare System  
*Panelist:* Yash Bhambhani, Ph.D., Montefiore Medical Center  
*Panelist:* Nestor Noyola, M.A., Clark University  
*Panelist:* Terence Ching, Ph.D., University of Connecticut

◆ *Participants earn 1.5 continuing education credits*

**Latinx Mental Health in 2020: Current Trends, Challenges, and Future Directions**

*Moderator:* Giovanni Ramos, M.A., UCLA

*Panelist:* Denise A. Chavira, Ph.D., UCLA

*Panelist:* Omar G. Gudiño, ABPP, Ph.D., University of Kansas

*Panelist:* Armando A. Pina, Ph.D., Arizona State University

*Panelist:* Antonio Polo, Ph.D., DePaul University

*Panelist:* Catherine D. Santiago, Ph.D., Loyola University Chicago

◆ *Participants earn 1.5 continuing education credits*

**Learning to Lead: Fostering Organizational Leadership Skills in Psychology**

*Moderator:* H. Gemma Stern, B.S., Rutgers University

*Moderator:* Emily Badin, M.A., Rutgers University

*Panelist:* Anne Marie Albano, Ph.D., Columbia University Clinic for Anxiety and Related Disorders

*Panelist:* Kevin Chapman, Ph.D., Kentucky Center for Anxiety and Related Disorders

*Panelist:* Brian C. Chu, Ph.D., Rutgers University

*Panelist:* Simon A. Rego, ABPP, Psy.D., Montefiore Medical Center

*Panelist:* Antonette M. Zeiss, Ph.D., Retired

◆ *Participants earn 1.5 continuing education credits*

**Moving Forward in Increasing Equity and Diversity in Our Ranks: A Solution-focused Approach**

*Moderator:* Sasha Gorrell, Ph.D., University of California San Francisco

*Panelist:* Lynn F. Bufka, Ph.D., American Psychological Association

*Panelist:* Shawn Jones, Ph.D., Virginia Commonwealth University

*Panelist:* Sandra Pimentel, Ph.D., Montefiore Medical Center

*Panelist:* Simon A. Rego, ABPP, Psy.D., Montefiore Medical Center

*Panelist:* Laura D. Hovey, ABPP, Ph.D., University of Texas Rio Grande Valley

*Panelist:* Jillian Shipherd, Ph.D., VHA LGBT Health, US Department of Veterans Affairs

◆ *Participants earn 1.5 continuing education credits*

**Mutual Capacity Building in Psychology Research: Working to Close the Global Mental Health Gap**

*Moderator:* Kristen S. Regenauer, B.A., University of Maryland-College Park

*Panelist:* Miya Barnett, Ph.D., University of California, Santa Barbara

*Panelist:* Lauren Ng, Ph.D., UCLA

*Panelist:* Eve S. Puffer, Ph.D., Duke Global Health Institute, Duke University

*Panelist:* Catherine Carlson, Ph.D., MSW, University of Alabama

*Panelist:* Jessica F. F. Magidson, Ph.D., University of Maryland

◆ *Participants earn 1.5 continuing education credits*

**Navigating Barriers to Suicide Treatment and Research Among High-Risk Populations During Critical Care Transitions**

*Moderator:* Caroline S. Holman, Ph.D., Brown University &

Providence VA Medical Center

*Panelist:* Melanie L. Bozzay, Ph.D., Brown University & Providence VA Medical Center

*Panelist:* Lauren Weinstock, Ph.D., Brown University

*Panelist:* Jennifer Barredo, Ph.D., Brown University & Providence VA Medical Center

*Panelist:* Heather Schatten, Ph.D., Brown University & Butler Hospital

*Panelist:* Jennifer Primack, Ph.D., Brown University & Providence VA Medical Center

◆ *Participants earn 1.5 continuing education credits*

**Opening the Toolbox: Expanding Access to Clinical Psychological Science Through Open Science Practices**

*Moderator:* Matthew W. Southward, Ph.D., University of Kentucky

*Moderator:* Kathryn P. Linthicum, B.A., Ph.D., Florida State University

*Panelist:* Aaron J. Fisher, Ph.D., University of California at Berkeley

*Panelist:* Bethany A. Teachman, Ph.D., University of Virginia-

*Panelist:* Jessica L. Schleider, Ph.D., Stony Brook University

*Panelist:* Thomas L. Rodebaugh, Ph.D., Washington University in St. Louis

*Panelist:* Lauren S. Hallion, Ph.D., University of Pittsburgh

◆ *Participants earn 1.5 continuing education credits*

**Past, Present and Future: Presidential Perspectives on ABCT, CBT, and the Field of Psychotherapy!**

*Moderator:* Simon A. Rego, ABPP, Psy.D., Montefiore Medical Center

*Panelist:* Anne Marie Albano, Ph.D., Columbia University Clinic for Anxiety and Related Disorders

*Panelist:* David H. Barlow, ABPP, Ph.D., Boston University Center for Anxiety and Related Disorders

*Panelist:* Michelle Craske, Ph.D., UCLA

*Panelist:* Linda C. Sobell, ABPP, Ph.D., Nova Southeastern University

*Panelist:* Terence Wilson, Ph.D., Rutgers University

◆ *Participants earn 1.5 continuing education credits*

**Provision of Culturally Robust Interventions in 2020 and Beyond: Truths, Myths, and Opportunities for Growth**

*Moderator:* Giovanni Ramos, M.A., UCLA

*Moderator:* Tommy Chou, B.A., M.A., M.S., Florida International University

*Panelist:* Denise A. Chavira, Ph.D., UCLA

*Panelist:* Stanley J. Huey, Jr., Ph.D., University of Southern California

*Panelist:* Wei-Chin Hwang, Ph.D., Claremont McKenna College

*Panelist:* Anna Lau, Ph.D., UCLA

*Panelist:* Armando A. Pina, Ph.D., Arizona State University

◆ *Participants earn 1.5 continuing education credits*

**Service Utilization by Asian Americans With Psychosis**

*Moderator:* Ivy R. Tran, M.A., Hofstra University

*Panelist:* Nadine Chang, Ph.D., Gracie Square Hospital

*Panelist:* Emily He, M.A., Clark University

◆ *Participants earn 1.5 continuing education credits*

**Shouting From the Rooftops: Sharing Evidence Based Treatment in the Age of (Mis) Information**

*Moderator:* Daniel L. Hoffman, ABPP, Ph.D., Long Island Jewish Medical Center of Northwell Health

*Panelist:* David F. Tolin, ABPP, Ph.D., Anxiety Disorders Center, Institute of Living

*Panelist:* Dean McKay, ABPP, Ph.D., Fordham University

*Panelist:* L. Kevin Chapman, Ph.D., Kentucky Center for Anxiety and Related Disorders

*Panelist:* Sara Becker, Ph.D., Brown University School of Public Health

*Panelist:* Regine Galanti, Ph.D., Long Island Behavioral Psychology

*Panelist:* Stevie N. Grassetti, Ph.D., West Chester University of Pennsylvania

◆ *Participants earn 1.5 continuing education credits*

**So You Want to Make an App? Taking Digital Mental Health Ideas From Vision to Execution**

*Moderator:* Timothy L. Verduin, Ph.D., NYU Langone Health

*Panelist:* Helen L. Egger, M.D., NYU Langone Medical Center

*Panelist:* Katherine Driscoll, M.P.H., Hassenfeld Children's Hospital at NYU Langone Medical Center

*Panelist:* Rachel Podbury, B.A., Hassenfeld Children's Hospital at NYU Langone Medical Center

◆ *Participants earn 1.5 continuing education credits*

**Strategies for Identifying Key Intervention Components for Sexual and Gender Minority Populations**

*Moderator:* Brian A. Feinstein, Ph.D., Northwestern University

*Panelist:* Abigail W. Batchelder, M.P.H., Ph.D., Massachusetts General Hospital/ Harvard Medical School

*Panelist:* Danielle S. Berke, Ph.D., Hunter College, CUNY Graduate Center

*Panelist:* Conall O'Cleirigh, Ph.D., Harvard Medical School

*Panelist:* Matthew D. Skinta, ABPP, Ph.D., Roosevelt University

*Panelist:* Colleen A. Sloan, Ph.D., VA Boston Healthcare System

◆ *Participants earn 1.5 continuing education credits*

**Supporting Doctoral Students of Color: Practical Suggestions for Psychology Departments**

*Moderator:* Alexandria N. Miller, M.S., Suffolk University

*Panelist:* Linda E. Guzman, M.A., University of Arkansas

*Panelist:* Ana J. Bridges, Ph.D., University of Arkansas

*Panelist:* Vaishali V. Raval, Ph.D., Miami University

*Panelist:* Akanksha Das, B.S., Miami University

*Panelist:* Gabriela A. Nagy, Ph.D., Duke University

*Panelist:* Sarah A. Hayes-Skelton, Ph.D., University of Massachusetts, Boston

◆ *Participants earn 1.5 continuing education credits*

**Taking the Road Less Traveled: Increasing Access to CBT via Unique Careers**

*Moderator:* Ilyse Dobrow DiMarco, Ph.D., North Jersey Center for Anxiety and Stress Management

*Moderator:* Amelia Aldao, Ph.D., Together CBT

*Panelist:* Ilyse Dobrow DiMarco, Ph.D., North Jersey Center for Anxiety and Stress Management

*Panelist:* Amelia Aldao, Ph.D., Together CBT

*Panelist:* Andrea N. Niles, Ph.D., Youper

*Panelist:* Michelle Drapkin-Clarke, Ph.D., CBT Center of Central NJ

*Panelist:* Shirley Wang, Ph.D., Queen Mary University of London

◆ *Participants earn 1.5 continuing education credits*

**Technology Use in Mental Healthcare: Real Life Opportunities and Challenges**

*Moderator:* Jennifer Gentile, Psy.D., Boston Children's Hospital/Harvard Medical School, Leso Digital Health

*Panelist:* Adrienne S. Juarascio, Ph.D., Drexel University

*Panelist:* Sabine Wilhelm, Ph.D., Massachusetts General Hospital

*Panelist:* Michelle G. Newman, Ph.D., Pennsylvania State University

◆ *Participants earn 1.5 continuing education credits*

**The Direct Impact of People With Lived Experience on Training and Research in Mental Healthcare**

*Moderator:* Charlie A. Davidson, Ph.D., Mercer University; Emory University; Atlanta Center for Cognitive Therapy

*Panelist:* Elizabeth Thomas, Ph.D., Temple University

*Panelist:* Emily Treichler, Ph.D., VA San Diego MIRECC/ University of California, San Diego

*Panelist:* Teresa Ford, M.A., Emory University/Candler School of Theology

*Panelist:* Caroline Mazel-Carlton, B.A., Hearing Voices Research and Development Project

*Panelist:* Mary B. Kleinman, M.P.H., University of Maryland-College Park

◆ *Participants earn 1.5 continuing education credits*

**The Founding and Vision of a New International Consortium to Advance Research on Exposure Therapy**

*Moderator:* Kiara R. Timpano, Ph.D., University of Miami

*Panelist:* Joanna Arch, Ph.D., University of Colorado Boulder

*Panelist:* Jon Abramowitz, Ph.D., University of North Carolina at Chapel Hill

*Panelist:* Jasper Smits, Ph.D., University of Texas at Austin

*Panelist:* Michael Otto, Ph.D., Boston University Center for Anxiety and Related Disorders

*Panelist:* Andre Wannemüller, Ph.D., Ruhr-Universität Bochum

*Panelist:* Annabelle DiVita, B.A., University of Texas at Austin

◆ *Participants earn 1.5 continuing education credits*

**The Impact of the COVID-19 Pandemic: Dissemination, Intervention, and Training Efforts in a Panicked Society**

*Moderator:* Daniel L. Hoffman, ABPP, Ph.D., Long Island Jewish Medical Center of Northwell Health

*Panelist:* Joanna Yost, Ph.D., University of Virginia School of Medicine

*Panelist:* Casey Cavanaugh, Ph.D., University of Virginia

*Panelist:* Peter J. D'Amico, ABPP, Ph.D., Child & Adolescent Psychology, Northwell Health Zucker Hillside Hospital

*Panelist:* Shane Owens, ABPP, Ph.D., Farmingdale State College



◆ *Participants earn 1.5 continuing education credits*

**The Truth about of Having it All: Struggles and Solutions for Working Parents in Psychology**

*Moderator:* Andrea B. Temkin, Psy.D., Weill Cornell Medical College/NYP

*Panelist:* Shannon M. Bennett, Ph.D., Weill Cornell Medicine

*Panelist:* Daniel Cheron, Ph.D., Judge Baker Children's Center / Harvard Medical School

*Panelist:* David Langer, Ph.D., Suffolk University

*Panelist:* Sannisha Dale, Ph.D., University of Miami

*Panelist:* Janie Hong, Ph.D., Redwood Center for CBT and Research and University of California - Berkeley

*Panelist:* Christine J. Cho, PsyM, Rutgers University, Graduate School of Applied and Professional Psychology

◆ *Participants earn 1.5 continuing education credits*

**Thinking Pragmatically When Designing Suicide Prevention Effectiveness Research**

*Moderator:* Stephen O'Connor, Ph.D., National Institute of Mental Health

*Panelist:* Shireen L. Rizvi, ABPP, Ph.D., Rutgers University

*Panelist:* Nadia S. Locey, Ph.D., University of Nevada, Reno

*Panelist:* Anthony Pisani, Ph.D., University of Rochester School of Medicine

*Panelist:* David B. Goldston, Ph.D., Duke University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**This Panel Is For You (Yes, You!): Creating an Inclusive Culture of Allyship to Fix the "Leaky Pipeline"**

*Moderator:* Lauren S. Hallion, Ph.D., University of Pittsburgh

*Moderator:* Broderick Sawyer, Ph.D., Behavioral Wellness Clinic

*Panelist:* Jessica R. Graham-LoPresti, Ph.D., Suffolk University

*Panelist:* Elizabeth Roemer, Ph.D., University of Massachusetts Boston

*Panelist:* R. Sonia Singh, Ph.D., VA South Central MIRECC

*Panelist:* Matthew D. Skinta, ABPP, Ph.D., Roosevelt University

◆ *Participants earn 1.5 continuing education credits*

**Treating Obesity Among Black Women Patients Using a Culturally Sensitive, Evidence-Based, Behavioral Obesity Treatment Program Implemented in Community Primary Care Clinics**

*Moderator:* Carolyn Tucker, Ph.D., University of Florida

*Panelist:* Carolyn Tucker, Ph.D., University of Florida

*Panelist:* Meagan A. Henry, M.A., University of Florida

*Panelist:* Kirsten Klein, M.A., University of Florida

*Panelist:* Stephen Anton, Ph.D., University of Florida

*Panelist:* Nipa Shah, M.D., University of Florida

◆ *Participants earn 1.5 continuing education credits*

**Unique Considerations in Training Masters-Level Evidence-Based Practitioners: What We Do, How We Do It, and Why We Like It**

*Moderator:* Matthew Capriotti, Ph.D., San Jose State University

*Panelist:* Stacy S. Forcino, Ph.D., California State University, San Bernardino

*Panelist:* Maria M. Santos, Ph.D., California State University, San Bernardino

*Panelist:* Georganna Sedlar, Ph.D., University of Washington

*Panelist:* Caleb W. Lack, Ph.D., University of Central Oklahoma

*Panelist:* Annesa Flentje, Ph.D., University of California, San Francisco

◆ *Participants earn 1.5 continuing education credits*

**Using Telemedicine to Implement Evidence-Based Treatments and Training Programs: Lessons Learned From the Covid-19 Coronavirus Pandemic**

*Moderator:* Casey T. O'Brien, Psy.D., Cognitive Behavioral Consultants

*Panelist:* Amber Ufford, Ph.D., Cognitive and Behavioral Consultants

*Panelist:* Chad Brice, Ph.D., Cognitive Behavioral Consultants

*Panelist:* Elizabeth Byrnes, Psy.D., Cognitive Behavioral Consultants

*Panelist:* Esme A L. Shaller, Ph.D., Child and Adolescent Services, University of California San Francisco

*Panelist:* Alison Yaeger, Psy.D., McLean Hospital/Harvard Medical School

*Panelist:* Armida R. Fruzzetti, Ph.D., McLean Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**What Do We Expect and How Do We Get There? Using Evidence-Based Strategies to Teach Core Clinical Competencies to Undergraduates**

*Moderator:* Susan Wenzel, Ph.D., Lafayette College

*Panelist:* Stephanie M. Ernestus, Ph.D., Stonehill College

*Panelist:* CJ Fleming, Ph.D., Elon University

*Panelist:* Kerstin K. Blomquist, Ph.D., Furman University

*Panelist:* James F. Boswell, Ph.D., University at Albany, SUNY

*Panelist:* Tony T. Wells, Ph.D., Oklahoma State University

◆ *Participants earn 1.5 continuing education credits*

**What Works and What Doesn't? Challenges and Solutions in Implementing Technology-Enhanced Psychotherapy**

*Moderator:* David J. Miklowitz, Ph.D., UCLA Semel Institute for Neuroscience & Human Behavior

*Panelist:* Patricia Walshaw, Ph.D., UCLA Semel Institute for Neuroscience & Human Behavior

*Panelist:* Louisa Sylvia, Ph.D., Massachusetts General Hospital

*Panelist:* Eric Granholm, Ph.D., University of California San Diego

*Panelist:* Marc J. Weintraub, Ph.D., UCLA Semel Institute

◆ *Participants earn 1.5 continuing education credits*

**When It's Not Over: Understanding, Preventing, and Treating Ongoing and Pervasive Exposure to Trauma**

*Moderator:* Rachel R. Ouellette, M.S., Florida International University

*Moderator:* Loreen S. Magarino, M.S., Florida International University

*Panelist:* Marc S. Atkins, Ph.D., University of Illinois at Chicago

*Panelist:* Rochelle F. Hanson, Ph.D., Medical University of South Carolina

*Panelist:* Sierra Carter, Ph.D., Georgia State University

*Panelist:* Michael A. Lindsey, M.P.H., Ph.D., MSW, NYU McSilver Institute, New York University

◆ *Participants earn 1.5 continuing education credits*

**When Small Effects Leave Big Problems: Understanding and Augmenting the Modest Effectiveness of Cognitive and Behavioral Therapies for Youth Depression**

*Moderator:* Rachel Vaughn-Coaxum, Ph.D., University of Pittsburgh School of Medicine

*Panelist:* Dikla Eckshtain, Ph.D., Massachusetts General Hospital, Harvard Medical School

*Panelist:* V. Robin Weering, Ph.D., San Diego State University

*Panelist:* Meredith Gunlicks-Stoessel, Ph.D., University of Minnesota

*Panelist:* Jessica Jenness, Ph.D., University of Washington

*Panelist:* Erika Forbes, Ph.D., University of Pittsburgh

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◆ *Participants earn 1 continuing education credit*

**A Broad View of Efficacy and Mechanisms: Cognitive-Behavioral Interventions for Substance Use Disorders**

*Chair:* Molly Magill, Ph.D., Brown University

*Discussant:* Kathleen M. Carroll, Ph.D., Yale School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**A Close Examination of Interpersonal Behavior Associated with Intimate Partner Violence**

*Chair:* Alexandra K. Wojda, M.A., University of North Carolina at Chapel Hill

*Discussant:* K. Daniel O'Leary, Ph.D., Stony Brook University

◆ *Participants earn 1 continuing education credit*

**A Complexity Perspective on Comorbidity: Identifying Replicable Patterns Using a Network Approach**

*Chair:* Daniel P. Moriarity, M.A., Temple University

*Chair:* Payton J. Jones, M.A., Harvard University

*Discussant:* Stefan G. Hofmann, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

**Adaptations to Improve Access and Quality of Evidence-based Treatments: Processes for Selecting, Reporting, and Evaluating**

*Chair:* Clara Johnson, B.A., National Center for PTSD

*Discussant:* Anna Lau, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

**Adapting Transdiagnostic Cognitive Behavioral Therapies for Novel Settings**

*Chair:* Nicole J. LeBlanc, Ph.D., Massachusetts General Hospital

*Discussant:* Luana Marques, Ph.D., Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Addressing Diagnostic Challenges in OCD, Psychosis, and Autism Spectrum Disorder**

*Chair:* Jennifer L. Buchholz, M.A., UNC Chapel Hill

*Discussant:* Monica E. Calkins, Ph.D., Perelman School of Medicine, University of Pennsylvania

◆ *Participants earn 1.5 continuing education credits*

**Advances in Idiographic Clinical Science: Highlighting the Clinical Utility of the Person-specific Approach**

*Chair:* Jonathan W. Reeves, M.A., University of California, Berkeley

*Chair:* Hannah G. Bosley, M.A., University of California, Berkeley

*Discussant:* Thomas L. Rodebaugh, Ph.D., Washington University in St. Louis

◆ *Participants earn 1.5 continuing education credits*

**Advancing the Clinical Evidence Base for Irritability: New Insights Across Development and Diagnostic Boundaries**

*Chair:* Spencer C. Evans, Ph.D., Harvard University

*Discussant:* Jeffrey D. Burke, Ph.D., University of Connecticut

◆ *Participants earn 1 continuing education credit*

**An Examination of the Psychological Mediation Framework and Its Relation to Self-injurious Thoughts and Behaviors Among LGBTQ Individuals from Early Adolescence to Adulthood**

*Chair:* Christianne Esposito-Smythers, Ph.D., George Mason University

*Discussant:* Mitch J. Prinstein, Ph.D., UNC Chapel Hill

◆ *Participants earn 1.5 continuing education credits*

**Assessing and Addressing Barriers to Treatment Among Survivors of Sexual Assault**

*Chair:* Amie R. Newins, Ph.D., University of Central Florida

*Chair:* Laura Wilson, Ph.D., University of Mary Washington

*Discussant:* Terri Messman-Moore, Ph.D., Miami University

◆ *Participants earn 1.5 continuing education credits*

**Assessing Demographics in Research: How Important Is It, Really?**

*Chair:* Alexandria N. Miller, M.S., Suffolk University

*Discussant:* Lizabeth Roemer, Ph.D., University of Massachusetts Boston

◆ *Participants earn 1.5 continuing education credits*

**Assessing the Damage of Stigma: A Comprehensive Evaluation of Variables Affecting Public and Internalized Stigma Experienced by Active Duty Service Members and Veterans**

*Chair:* Sean A. Lauderdale, Ph.D., A&M-Commerce

*Discussant:* Adam P. McGuire, Ph.D., VISN 17 Center of Excellence for Research on Returning War Veterans

◆ *Participants earn 1.5 continuing education credits*

**Assessing, Anticipating, and Treating Suicidality in Trauma Survivors with and Without Posttraumatic Stress Disorder**

*Chair:* Skye Fitzpatrick, Ph.D., York University

*Discussant:* Lily A. Brown, Ph.D., University of Pennsylvania

◆ *Participants earn 1.5 continuing education credits*  
**Barriers to Behavioral Health Treatment Entry, Engagement, and Outcomes in the Criminal Justice System**  
*Chair:* Mandy Owens, Ph.D., University of Washington  
*Chair:* Kelly Moore, Ph.D., East Tennessee State University  
*Discussant:* Craig Henderson, Ph.D., Sam Houston State University

◆ *Participants earn 1.5 continuing education credits*  
**Barriers to Mental Health Treatment Access Among Marginalized Racial and Ethnic Groups**  
*Chair:* Alexandra L. Silverman, B.A., University of Virginia  
*Discussant:* Crystal L. Barksdale, M.P.H., Ph.D., National Institute of Mental Health

◆ *Participants earn 1.5 continuing education credits*  
**Bayesian Approaches to Modeling Psychiatric Vulnerability and Treatment Mechanisms**  
*Chair:* Caitlin A. Stamatis, M.S., University of Miami  
*Discussant:* Donald J. Robinaugh, Ph.D., Massachusetts General Hospital

◆ *Participants earn 1 continuing education credit*  
**Best Practices in Disseminating CBT Through Digital Apps**  
*Chair:* Melissa G. Hunt, Ph.D., University of Pennsylvania  
*Discussant:* Sabine Wilhelm, Ph.D., Massachusetts General Hospital

◆ *Participants earn 1.5 continuing education credits*  
**Better Access and Better Outcomes: Relationship Education Programs During the Perinatal Period**  
*Chair:* Maggie O'Reilly-Treter, M.A., University of Denver  
*Discussant:* Brian D. Doss, Ph.D., University of Miami

◆ *Participants earn 1.5 continuing education credits*  
**Between Cognitive and Behavioral Therapies and Psychedelics: Toward Integration and Optimized Therapeutic Outcomes**  
*Chair:* Richard J.J. Zeifman, M.A., Ryerson University  
*Discussant:* Steven C. Hayes, Ph.D., University of Nevada, Reno

◆ *Participants earn 1.5 continuing education credits*  
**Biopsychosocial Determinants of Anxiety, Trauma, and Health-related Quality of Life (HRQOL) in Gastrointestinal Conditions**  
*Chair:* Cecelia I. Nelson, M.S., West Virginia University  
*Discussant:* Laura Reigada, Ph.D., City University of New York, Brooklyn College and the Graduate Center

◆ *Participants earn 1.5 continuing education credits*  
**Body Image Concerns and Disordered Eating in Male and Female College Students**  
*Chair:* Lauren A. Stutts, Ph.D., Davidson College  
*Discussant:* Drew A. Anderson, Ph.D., University at Albany, SUNY

◆ *Participants earn 1.5 continuing education credits*  
**Building a Rainbow Bridge Between Research and Practice: Improving Access to Affirming, Evidence-based Care for Suicidal Sexual and Gender Minority Youth**  
*Chair:* Ilana Seager van Dyk, M.A., Ohio State University  
*Chair:* Lucas Zullo, Ph.D., UCLA  
*Discussant:* Shelley Craig, Ph.D., University of Toronto

◆ *Participants earn 1.5 continuing education credits*  
**Can Technology Really Enhance Mental Health in Older Adults?**  
*Chair:* Jan Mohlman, Ph.D., William Paterson University  
*Discussant:* Fred Muench, Ph.D., Center on Addiction

◆ *Participants earn 1.5 continuing education credits*  
**"Can't Fight This Feeling..." Emerging Constructs and New Perspectives on Affective Theories of Eating Disorders**  
*Chair:* Erin E. Reilly, Ph.D., Hofstra University  
*Chair:* Irina Vanzhula, M.S., University of Louisville  
*Discussant:* Edward Selby, Ph.D., Rutgers University

◆ *Participants earn 1.5 continuing education credits*  
**Challenges and Opportunities in the Quantitative Study of Sexual and Gender Minorities**  
*Chair:* Benjamin A. Katz, M.A., Hebrew University of Jerusalem  
*Discussant:* Susan E. Walch, Ph.D., University of West Florida

◆ *Participants earn 1.5 continuing education credits*  
**Cognitive Bias Modification in the Clinic**  
*Chair:* Courtney Beard, Ph.D., McLean Hospital/Harvard Medical School  
*Discussant:* Nader Amir, Ph.D., San Diego State University

◆ *Participants earn 1.5 continuing education credits*  
**Cognitive Bias Modification: Novel Strategies to Improve Access and Outcomes in Children, Adolescents, and Adults**  
*Chair:* Deepika Bose, M.S., Florida International University  
*Chair:* Akanksha Das, B.S., Miami University  
*Discussant:* Bethany A. Teachman, Ph.D., University of Virginia

◆ *Participants earn 1.5 continuing education credits*  
**Combined and Unimodal Treatment for Childhood Mental Health Disorders: The Impact of the Four Landmark NIMH-Funded Trials on the Subsequent Use of Psychopharmacological and Psychosocial Treatment**  
*Chair:* Fiona L. Macphee, M.S., Florida International University  
*Chair:* William E. Pelham, Jr., Ph.D., Florida International University  
*Discussant:* Robert J. DeRubeis, Ph.D., University of Pennsylvania



◆ *Participants earn 1 continuing education credit*

**Contextual Challenges in Conditions of Ongoing Stress and Adversity: A Mixed-methods Exploration of Culturally Relevant Assessment and Treatment Approaches in Low- and Middle-income Countries**

*Chair:* Anushka Patel, M.A., Trauma Recovery Center, University of California San Francisco; The University of Tulsa

*Chair:* Sriramya Potluri, B.S., University of Massachusetts Boston

*Discussant:* Luana Marques, Ph.D., Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Cost-Effectiveness and Cost-benefit Analyses of CBT and Alternative Interventions for Childhood Attachment, Anxiety, Depression, Alcohol Abuse, and Suicide Prevention: Methods as Well as Findings**

*Chair:* Brian T. Yates, Ph.D., American University

*Discussant:* Michael C. Freed, Ph.D., National Institute of Mental Health

◆ *Participants earn 1.5 continuing education credits*

**Cultural and Contextual Factors Affecting Individuals with Schizophrenia-Spectrum Disorders Across the Illness Trajectory**

*Chair:* Daisy Lopez, B.A., M.S., University of Miami

*Discussant:* Irwin Rosenfarb, Ph.D., Alliant International University

◆ *Participants earn 1.5 continuing education credits*

**Developing the Workforce to Meet the Mental Health Needs of Older Adults**

*Chair:* Patrick J. Raue, Ph.D., University of Washington School of Medicine

*Discussant:* Joel Sherrill, Ph.D., Division of Services & Intervention Research, NIMH

◆ *Participants earn 1.5 continuing education credits*

**Direct-to-consumer Marketing of Evidence-based Mental Health Interventions: Innovative Approaches to Increasing the Appeal**

*Chair:* Alexandra Werntz, M.A., University of Virginia

*Chair:* Bethany A. Teachman, Ph.D., University of Virginia

*Discussant:* Kelsie H. Okamura, Ph.D., Continuous Quality Improvement Specialist, State of Hawai'i, Department of Health, Child & Adolescent Mental Health Division

◆ *Participants earn 1.5 continuing education credits*

**Discrimination and Mental Health: Examining the Impacts of a Chronic Stressor**

*Chair:* Kimberlie E. Dean, Ph.D., Massachusetts General Hospital

*Chair:* Juliette McClendon, Ph.D., VA Boston Healthcare System

*Discussant:* Jillian Shipherd, Ph.D., Director VHA LGBT Health, US Department of Veterans Affairs

◆ *Participants earn 1.5 continuing education credits*

**Eating Pathology in Sexual and Gender Minority Populations: Sociocultural Risk Factors, Assessment Considerations, and Treatment Outcomes**

*Chair:* Kimberlie E. Dean, Ph.D., Massachusetts General Hospital

*Chair:* Juliette McClendon, Ph.D., VA Boston Healthcare System

*Discussant:* Jillian Shipherd, Ph.D., US Department of Veterans Affairs

◆ *Participants earn 1.5 continuing education credits*

**Emerging Trends in Social Media and Alcohol Use Among Young Adults**

*Chair:* Mai-Ly N. Steers, Ph.D., Duquesne University

*Discussant:* Mai-Ly N. Steers, Ph.D., Duquesne University

◆ *Participants earn 1.5 continuing education credits*

**Enhancing Access and Outcomes of Psychological Care: Development and Adaptations of Acceptance- and Mindfulness-based Interventions for Medical Populations**

*Chair:* Christina M. Luberto, Ph.D., Harvard Medical School/MGH

*Chair:* Miryam Yusuf, Ph.D., Harvard Medical School

*Discussant:* Joanna Arch, Ph.D., University of Colorado Boulder

◆ *Participants earn 1.5 continuing education credits*

**Enhancing Employment Success Through Community-based Social Anxiety Treatment**

*Chair:* Richard T. LeBeau, Ph.D., UCLA

*Discussant:* Risa B. Weisberg, Ph.D., VA Boston HCS/Boston University

◆ *Participants earn 1.5 continuing education credits*

**Enhancing Evidence Based Treatment Approaches for Adolescents With Suicidality and Self-Harm by Engaging Caregivers and Families**

*Chair:* Molly Adrian, Ph.D., University of Washington

*Discussant:* Elizabeth McCauley, ABPP, Ph.D., University of Washington School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Enhancing Impact by Increasing Access: Implementation of Evidence-based Trauma Treatments Across the Lifespan and Diverse Delivery Systems**

*Chair:* Stefanie T. LoSavio, ABPP, Ph.D., Duke University Medical Center

*Discussant:* Rochelle F. Hanson, Ph.D., Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

**Enhancing the Clinical Impact of Trauma-Focused CBT: Access, Individual Differences, Process, and Neurobiology**

*Chair:* John R. Keefe, Ph.D., Weill Cornell Medical College

*Discussant:* Carmen P. McLean, Ph.D., National Center for PTSD

◆ *Participants earn 1 continuing education credit*

**Enhancing the Impact of Behavioral and Cognitive Therapies by Identifying and Addressing Sleep Problems**

*Chair:* Reut Gruber, Ph.D., McGill University

*Discussant:* Merrill Wise, M.D., Mid-South Pulmonary and Sleep Specialists

◆ *Participants earn 1.5 continuing education credits*

**Enhancing the Impact of Evidence-based Practices Through Task-shifting**

*Chair:* Brenna Maddox, Ph.D., Perelman School of Medicine at the University of Pennsylvania

*Discussant:* Kimberly Hoagwood, Ph.D., New York University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Enhancing the Precision and Impact of Cognitive and Behavioral Therapies with Neuroscience: New Predictors and New Approaches**

*Chair:* Andrada D. Neacsu, Ph.D., Duke University Medical Center

*Discussant:* Stefan G. Hofmann, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

**Evidence-based Assessment to Improve Diagnosis, Case Formulation, and Outcomes: Online Resources to Improve Practice**

*Chair:* Margaret Crane, M.A., Temple University

*Discussant:* Amanda Jensen-Doss, Ph.D., University of Miami

◆ *Participants earn 1.5 continuing education credits*

**Evidence-based Interventions for College Student Health Behaviors: Improving Buy-in and Navigating Barriers to Implementation**

*Chair:* Laura Holt, Ph.D., Trinity College

*Discussant:* Meredith Ginley, Ph.D., East Tennessee State University

◆ *Participants earn 1.5 continuing education credits*

**Expanding Access to CBT Through Primary Care: Pilot Data on Brief Interventions for Mental and Behavioral Health Concerns**

*Chair:* Robyn L. Shepardson, Ph.D., VA Center for Integrated Healthcare

*Discussant:* Jeffrey Goodie, ABPP, Ph.D., Director of Clinical Training, Uniformed Services University of the Health Sciences

◆ *Participants earn 1.5 continuing education credits*

**Expanding the Reach of Mental Health Services Through Effective Engagement with Families**

*Chair:* Rebecca Y. Woo, M.A., University of Texas at Austin

*Discussant:* Rachel Haine-Schlagel, Ph.D., San Diego State University/CASRC

◆ *Participants earn 1.5 continuing education credits*

◆ *Participants earn 1.5 continuing education credits*

**Expanding the Reach of Transdiagnostic Interventions: Adapting the Unified Protocols for Children and Adolescents to Non-internalizing Disorders and Alternative Treatment Delivery Formats**

*Chair:* Sarah M. Kennedy, Ph.D., Children's Hospital

Colorado/University of Colorado, School of Medicine

*Chair:* Jill Ehrenreich-May, Ph.D., Professor, University of Miami

*Discussant:* Michael A. Southam-Gerow, Ph.D., Virginia Commonwealth University

◆ *Participants earn 1.5 continuing education credits*

**Extending Our Understanding of Suicidality and Self-harm in Obsessive Compulsive and Anxiety Related Disorders**

*Chair:* Samantha N. Hellberg, B.A., University of North Carolina at Chapel Hill

*Chair:* Jon Abramowitz, Ph.D., University of North Carolina, Chapel Hill

*Discussant:* Adam B. Miller, Ph.D., University of North Carolina at Chapel Hill

◆ *Participants earn 1.5 continuing education credits*

**Extending the Impact of Cognitive and Behavioral Therapies Through the Integration of Health Outcomes: A Closer Look at Emotion Regulation Processes**

*Chair:* Laura J. Dixon, Ph.D., University of Mississippi

*Chair:* Aaron A. Lee, Ph.D., University of Mississippi

*Discussant:* Kim L. Gratz, Ph.D., University of Toledo

◆ *Participants earn 1.5 continuing education credits*

**Extensions of Culturally Sensitive Trauma-Informed Care to Diverse Populations**

*Chair:* Molly Franz, Ph.D., Boston University School of Medicine & National Center for PTSD

*Discussant:* Debra Hope, Ph.D., University of Nebraska-Lincoln

◆ *Participants earn 1.5 continuing education credits*

**Five Year Outcomes and Implementation Advances in the Raise-early Treatment Program First Episode Psychosis Trial**

*Chair:* Shirley Glynn, Ph.D., UCLA

*Discussant:* Kim Mueser, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

**Fostering Intimacy and Emotional Connection in Diverse Couples Across Relational Contexts**

*Chair:* Karena Leo, M.S., University of Utah

*Chair:* Jessica Kansky, M.A., University of Virginia

*Discussant:* Mikhila Wildey, Ph.D., Grand Valley State University

◆ *Participants earn 1.5 continuing education credits*

**From Computation to Implementation: Successes and Setbacks in Scaling-up Brief Interventions**

*Chair:* Jessica L. Schleider, Ph.D., Stony Brook University

*Discussant:* Bruce F. Chorpita, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

**From Emotion to Rash Action: Understanding Within-Person Urgency in Psychopathology**

*Chair:* Sarah H. Sperry, M.S., University of Illinois at Urbana-Champaign; Medical University of South Carolina Addiction Sciences Division & Bipolar Disorder Research Program

*Chair:* Rebecca Fortgang, Ph.D., Harvard University

*Discussant:* Donald Lynam, Ph.D., Purdue University

◆ *Participants earn 1 continuing education credit*

**From Risk to Resilience: Enhancing Our Understanding of Mental Health Disparities in Transgender and Gender Diverse Individuals**

*Chair:* Amelia M. Stanton, Ph.D., Harvard Medical School/Massachusetts General Hospital

*Chair:* James A. Scholl, Ph.D., VA Boston Healthcare System

*Discussant:* Jillian Shipherd, Ph.D., Director VHA LGBT Health, US Department of Veterans Affairs

◆ *Participants earn 1.5 continuing education credits*

**From Symptoms to Functioning in Children and Adolescents Across Care Settings**

*Chair:* Andrew Freeman, Ph.D., University of Nevada, Las Vegas

*Discussant:* Eric A. Youngstrom, Ph.D., University of North Carolina at Chapel Hill

◆ *Participants earn 1.5 continuing education credits*

**From the Classroom to the Community: Increasing Access to Evidence-based Mental Health Support for College Students**

*Chair:* Carla D. Chugani, Ph.D., University of Pittsburgh School of Medicine

*Discussant:* Alec Miller, Psy.D., Cognitive Behavioral Consultants

◆ *Participants earn 1.5 continuing education credits*

**From Theory to Practice: Applying Minority Stress and the Psychological Mediation Framework to LGBTQ+ Populations**

*Chair:* Kelly Davis, M.A., University of Montana

*Discussant:* Kelly Davis, M.A., University of Montana

◆ *Participants earn 1.5 continuing education credits*

**Identifying Ethnic Minority Adolescents at Greatest Risk of Mental Health Problems: Assessing Intervention Targets and Enhancing Engagement in Care**

*Chair:* Josephine Shih, Ph.D., Saint Joseph's University

*Discussant:* Anna Lau, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

**Identifying Risk Factors and Preventing Suicide in Autistic Individuals**

*Chair:* Brenna Maddox, Ph.D., Perelman School of Medicine at the University of Pennsylvania

*Discussant:* E David Klonsky, Ph.D., University of British Columbia

◆ *Participants earn 1.5 continuing education credits*

**If You Build It, They Still May Not Come: Utilizing Telehealth Technology to Increase Access and Sustain Evidence-based Mental Health Treatments**

*Chair:* Regan Stewart, Ph.D., Medical University of South Carolina

*Discussant:* Carolyn Turvey, Ph.D., US Department of Veterans Affairs

◆ *Participants earn 1.5 continuing education credits*

**Improving Access and Efficacy: Novel Interventions to Target Transdiagnostic Mechanisms of Anxiety Disorders**

*Chair:* Laurel Sarfan, M.A., Miami University

*Discussant:* Courtney Beard, Ph.D., McLean Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Improving Child and Adolescent Behavioral Health Service Access and Outcomes: Novel Treatment Scale-outs, Empirical Mechanisms, and Implementation Models**

*Chair:* Samuel O. Peer, Ph.D., Idaho State University

*Discussant:* Miya Barnett, Ph.D., University of California, Santa Barbara

◆ *Participants earn 1.5 continuing education credits*

**Improving Outcomes by Understanding Technology and Sleep in Young Adults**

*Chair:* Nicole E. Carmona, M.A., Ryerson University

*Discussant:* Kathryn A. Roecklein, Ph.D., University of Pittsburgh

◆ *Participants earn 1.5 continuing education credits*

**Improving Outcomes from Exposure Therapy for Anxiety-related Disorders: Social, Behavioral, Physiological, and Neural Factors**

*Chair:* Cynthia L. Lancaster, Ph.D., University of Nevada, Reno

*Discussant:* Stefan G. Hofmann, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

**Improving Treatment Outcomes for Comorbid Chronic Pain and Posttraumatic Stress: Recent Translational Findings**

*Chair:* Nicole A. Short, Ph.D., University of North Carolina at Chapel Hill

*Chair:* Andrew H. Rogers, M.A., University of Houston

*Discussant:* Sheila A. Rauch, Ph.D., Emory University School of Medicine/VA Atlanta HCS



◆ *Participants earn 1.5 continuing education credits*

**Improving Usability and Implementation of Evidence-based Psychotherapies: A Human-Centered Design Approach**

*Chair:* Brenna N. Renn, Ph.D., University of Nevada, Las Vegas  
*Discussant:* Adam J. Haim, Ph.D., National Institute of Mental Health

◆ *Participants earn 1.5 continuing education credits*

**Incorporating Fear, Anxiety, and Interoception into Eating Disorder Research and Treatment: New Directions, Paradigms, and Treatments**

*Chair:* Tiffany A. A. Brown, Ph.D., University of California, San Diego  
*Chair:* K. Jean Forney, Ph.D., Ohio University  
*Discussant:* April Smith, Ph.D., Miami University

◆ *Participants earn 1.5 continuing education credits*

**Increasing Access to Care Through Advances in Innovative Interventions for Serious Mental Illnesses**

*Chair:* Emily Treichler, Ph.D., VA San Diego MIRECC/University of California, San Diego  
*Discussant:* William Spaulding, Ph.D., University of Nebraska, Lincoln

◆ *Participants earn 1.5 continuing education credits*

**Increasing Access to Evidence-Based Care Through Lay-Counselor-Delivered Interventions: Outcomes from Randomized Controlled Trials in Low- and Middle-income Countries**

*Chair:* Katherine E. Venturo-Conerly, B.A., Harvard University  
*Discussant:* Eve S. Puffer, Ph.D., Duke Global Health Institute, Duke University

◆ *Participants earn 1.5 continuing education credits*

**Increasing Access to Evidence-based Services in Pediatric Primary Care**

*Chair:* Jami Young, Ph.D., Children's Hospital of Philadelphia, University of Pennsylvania Perelman School of Medicine  
*Discussant:* Laura H. Mufson, Ph.D., Columbia University Vagelos College of Physicians and Surgeons and New York State Psychiatric Institute

◆ *Participants earn 1 continuing education credit*

**Innovations in School-based Interventions for Internalizing Disorders: Expanding Access to Evidenced-based Interventions**

*Chair:* Golda Ginsburg, Ph.D., University of Connecticut  
*Discussant:* Jonathan Comer, Ph.D., Florida International University

◆ *Participants earn 1.5 continuing education credits*

**Innovative Approaches for Advancing Research on Treatment and Prevention of Mood Disorders**

*Chair:* Autumn Kujawa, Ph.D., Vanderbilt University  
*Discussant:* Scott A. Langenecker, Ph.D., University of Utah

◆ *Participants earn 1.5 continuing education credits*

**Interpersonal Dysfunction: Understanding the Mechanisms and Potential Targets of Treatment for People with Chronic Social Impairment**

*Chair:* Kibby McMahon, M.A., Duke University  
*Discussant:* M. Zachary Rosenthal, Ph.D., Duke University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**It's All in the Family: Integrating Family into the Treatment of Suicidality and BPD**

*Chair:* Lauren B. Yadlosky, Ph.D., McLean Hospital, Harvard Medical School  
*Discussant:* Alan Fruzzetti, Ph.D., McLean Hospital, Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Latinx Youth At-risk for Suicide: The Interplay Between Family, Social and Psychiatric Processes**

*Chair:* Jazmin Reyes-Portillo, Ph.D., Montclair State University  
*Discussant:* Regina Miranda, Ph.D., Hunter College

◆ *Participants earn 1.5 continuing education credits*

**Leveraging Claims Data to Examine EBP Implementation Outcomes in Children's Mental Health**

*Chair:* Joyce Lui, Ph.D., UCLA  
*Discussant:* Carrie Comeau, LCSW, Philadelphia Department of Behavioral Health and Intellectual Disability Services

◆ *Participants earn 1.5 continuing education credits*

**Leveraging Systems to Improve Accessibility in Child and Adolescent Mental Health**

*Chair:* Jennifer Blossom, Ph.D., Seattle Children's Hospital  
*Discussant:* Jonathan Comer, Ph.D., Florida International University

◆ *Participants earn 1.5 continuing education credits*

**Making Distress Tolerance a Focal Point of Prevention and Treatment Models for Diverse Mental Health Conditions**

*Chair:* Christopher C. Conway, Ph.D., Fordham University  
*Discussant:* Kathryn R. McHugh, Ph.D., McLean Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Mathematics for Mechanisms: Using Computational Modeling-informed Approaches to Understand the Processes That Promote Eating Disorders**

*Chair:* Ann F. Haynos, Ph.D., University of Minnesota  
*Chair:* Shirley B. Wang, M.A., Harvard University  
*Discussant:* Pamela K. Keel, Ph.D., Florida State University

◆ *Participants earn 1 continuing education credit*

**Mechanisms and Moderators of Outcome in the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Global Contexts**

*Chair:* Elizabeth H. Eustis, Ph.D., Boston University  
*Discussant:* David H. Barlow, ABPP, Ph.D., Boston University Center for Anxiety and Related Disorders

- ◆ *Participants earn 1.5 continuing education credits*

**Mechanisms of Attention and Reward in Self-Injurious Thoughts and Behaviors**

*Chair:* Beverlin Del Rosario, M.A., The Graduate Center, City University of New York

*Chair:* Aliona Tsypes, Ph.D., University of Pittsburgh

*Discussant:* Matt Nock, Ph.D., Harvard University

- ◆ *Participants earn 1.5 continuing education credits*

**Mechanisms of Novel Relationship Education Programs for Low-income Couples**

*Chair:* Brian D. Doss, Ph.D., University of Miami

*Discussant:* Kristina Coop Gordon, Ph.D., University of Tennessee-Knoxville

- ◆ *Participants earn 1 continuing education credit*

**Mediators of Cognitive-behavioral Interventions for Depression: Evidence from Treatment and Prevention Trials**

*Chair:* Steven Brunwasser, Ph.D., Rowan University

*Chair:* Judy Garber, Ph.D., Vanderbilt University

*Discussant:* Steven D. Hollon, Ph.D., Vanderbilt University

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**Meeting Clients Where They Are: The Use of Technology to Increase the Reach of Evidence-based PTSD Treatments**

*Chair:* Stephanie Y. Wells, Ph.D., Durham VA Health Care System/VISN 6 Mid-Atlantic MIRECC

*Discussant:* Stephen M. Schueller, Ph.D., University of California Irvine

- ◆ *Participants earn 1.5 continuing education credits*

**Mental Health and Substance Use Among Diverse Sexual Minority Men: Diverse Methods to Better Understand How to Increase Treatment Outcomes**

*Chair:* Trevor A. Hart, Ph.D., Ryerson University

*Discussant:* Christopher Martell, ABPP, Ph.D., University of Massachusetts Amherst

- ◆ *Participants earn 1 continuing education credit*

**Mental Health Interventions on College Campuses**

*Chair:* Katherine R. Buchholz, Ph.D., Wellesley Centers for Women

*Chair:* Tiffany Arttime, Ph.D., Pacific Lutheran University

- ◆ *Participants earn 1.5 continuing education credits*

**Methodological Advances in Research on Sexual and Gender Minority Health: Accounting for New Terminology, Multiple Identities, and Within-Group Variability**

*Chair:* Brian A. Feinstein, Ph.D., Northwestern University

*Discussant:* Debra Hope, Ph.D., University of Nebraska-Lincoln

- ◆ *Participants earn 1.5 continuing education credits*

**Mindfulness and Acceptance Based Approaches for Psychosis: Current Evidence and Future Directions**

*Chair:* Lyn A. Ellett, Ph.D., Royal Holloway, University of London

*Chair:* Brandon Gaudiano, Ph.D., Brown University/Butler Hospital

*Discussant:* Roger Vilardaga, Ph.D., Duke University

- ◆ *Participants earn 1 continuing education credit*

**Minority Stress and Health Disparities: Indications for Intervention Development and Adaptation to Increase Treatment Access and Outcomes for Diverse Substance Using Individuals**

*Chair:* Trevor A. Hart, Ph.D., Ryerson University

*Discussant:* David Pantalone, Ph.D., University of Massachusetts Boston

- ◆ *Participants earn 1.5 continuing education credits*

**Neurocognitive Mechanisms and Applications of Psychosocial Interventions in Bipolar Disorders Across the Lifespan**

*Chair:* Heather MacPherson, Ph.D., Warren Alpert Medical School of Brown University

*Chair:* Snezana Urosevic, Ph.D., Minneapolis VAMC

*Discussant:* Lauren B. Alloy, Ph.D., Temple University

- ◆ *Participants earn 1.5 continuing education credits*

**New Directions in Clarifying the Role of Substance Use in Suicide Risk**

*Chair:* Matthew T. Tull, Ph.D., University of Toledo

*Chair:* Margaret Baer, B.A., University of Toledo

*Discussant:* Richard Liu, Ph.D., Brown University

- ◆ *Participants earn 1.5 continuing education credits*

**New Directions in Exposure Therapy for Eating Disorders**

*Chair:* Rachel Butler, M.A., Temple University

*Discussant:* Jon Abramowitz, Ph.D., University of North Carolina at Chapel Hill

- ◆ *Participants earn 1.5 continuing education credits*

**New Directions in Means Safety Interventions: Enhancing Engagement and Outcomes**

*Chair:* Gabriela K. Khazanov, Ph.D., Corporal Michael J. Crescenzi VA Medical Center

*Discussant:* Peter C. Britton, Ph.D., Canandaigua V. A. Medical Center

- ◆ *Participants earn 1.5 continuing education credits*

**New Research at the Interface of Values and Psychopathology**

*Chair:* Todd B. Kashdan, Ph.D., George Mason University

*Discussant:* Steven C. Hayes, Ph.D., University of Nevada, Reno

- ◆ *Participants earn 1.5 continuing education credits*

**Novel Analytic Methods for Clinical Science: Recent Approaches to Modeling Psychopathology**

*Chair:* Duncan G. Jordan, Ph.D., Murray State University

*Discussant:* Donald J. Robinaugh, Ph.D., Massachusetts General Hospital

◆ *Participants earn 1.5 continuing education credits*

**Novel Approaches to Explore Proximal Risk for Suicide and Self-injury**

*Chair:* Esther C. Park, B.A., Florida State University

*Discussant:* Xieying Huang, M.S., Florida State University

◆ *Participants earn 1.5 continuing education credits*

**Novel Avenues in the Study of Fear Learning Mechanisms: Implications for Pediatric Anxiety and Its Treatment**

*Chair:* Rany Abend, Ph.D., NIMH

*Discussant:* Katharina Kircanski, Ph.D., NIMH

◆ *Participants earn 1.5 continuing education credits*

**Novel Intervention and Implementation Approaches to Improve Behavioral Health Care Access and Outcomes in Primary Care Settings**

*Chair:* Alex R. Dopp, Ph.D., RAND

*Discussant:* V. Robin Weering, Ph.D., San Diego State University

◆ *Participants earn 1.5 continuing education credits*

**On the Importance of Gender and Sexual Minority Identity in the Study of Predictors and Consequences of and Interventions for Alcohol and Cannabis Use and Co-use**

*Chair:* Bradley T. Conner, Ph.D., Colorado State University

*Discussant:* Brian Borsari, Ph.D., University of California, San Francisco

◆ *Participants earn 1.5 continuing education credits*

**Outside the Traditional Clinic: Incorporating Data Science into the Delivery of Evidence-based Treatment Before, During, and After Service Utilization**

*Chair:* Xin Zhao, M.S., Florida International University

*Chair:* Adela Timmons, Ph.D., Florida International University

*Discussant:* Jonathan Comer, Ph.D., Florida International University

◆ *Participants earn 1 continuing education credit*

**Paradigm Shifts in the Study of Attention Biases from Infancy to Adulthood**

*Chair:* Tracy A. Dennis-Tiwary, Ph.D., Hunter College and the Graduate Center of the City University of New York

*Chair:* Amy K. Roy, Ph.D., Fordham University

*Discussant:* Brandon E. Gibb, Ph.D., Binghamton University

◆ *Participants earn 1 continuing education credit*

**Personalizing Parent Management Training: Innovative Approaches for Improving Treatment Outcomes**

*Chair:* Raelyn Loiselle, M.A., University of North Carolina at Chapel Hill

*Discussant:* Mary Rooney, Ph.D., NIMH

◆ *Participants earn 1 continuing education credit*

**Phase I Tests of Culturally Adapted Behavioral and Mindfulness-based Interventions to Improve Mental Health Using Online and in Person Methods for Latinxs**

*Chair:* Natalie Arbid, Ph.D., Harbor UCLA

*Discussant:* Christina S. Lee, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

**Pizza, Mirrors, and Fullness, Oh My! Understanding Mechanisms of Change Underlying Exposure Interventions for Eating Disorders**

*Chair:* D. Catherine Walker, Ph.D., Union College

*Chair:* Erin E. Reilly, Ph.D., Hofstra University

*Discussant:* Carolyn B. Becker, Ph.D., Trinity University

◆ *Participants earn 1.5 continuing education credits*

**Pragmatic Strategies for Assessing Psychotherapy Quality in Practice: Balancing Rigor and Efficiency**

*Chair:* Mary Rooney, Ph.D., NIMH

*Discussant:* Joel Sherrill, Ph.D., NIMH

◆ *Participants earn 1.5 continuing education credits*

**Promoting Family Engagement in Evidence-based Treatments for ADHD Across Diverse Populations of Children and Adolescents**

*Chair:* Jenelle Nissley-Tsiopinis, Ph.D., Children's Hospital of Philadelphia

*Discussant:* Thomas J. Power, Ph.D., ABPP, Children's Hospital of Philadelphia; University of Pennsylvania Perelman School of Medicine

◆ *Participants earn 1 continuing education credit*

**Psychologists as Social Justice Advocates: Intertwining Research and Advocacy to Improve Mental Health and Equity Among Marginalized Groups**

*Chair:* Emily Treichler, Ph.D., VA San Diego MIRECC/University of California, San Diego

*Chair:* Jennifer N. Crawford, Ph.D., Division of Community Behavioral Health, University of New Mexico Health Sciences Center

*Discussant:* Colleen A. Sloan, Ph.D., VA Boston Healthcare System

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**Psychology's Role in the Implementation of Evidence-based Practice in Pediatric Acute Care Settings**

*Chair:* Elizabeth Reynolds, Ph.D., Johns Hopkins University School of Medicine

*Chair:* Mackenzie S. Sommerhalder, Ph.D., Johns Hopkins University School of Medicine

*Discussant:* Elisabeth Frazier, Ph.D., Brown University

◆ *Participants earn 1.5 continuing education credits*

**Quantifying Minority Stress: Treatment-related Targets and Attitudes Among Sexual and Gender Minorities**

*Chair:* Mallory Dobias, B.S., Stony Brook University

*Chair:* Kathryn Fox, Ph.D., University of Denver

*Discussant:* Aaron Blashill, Ph.D., San Diego State University



◆ *Participants earn 1.5 continuing education credits*

**Reaching Beyond Disruptive Behavior Disorders: New Directions for Parent-child Interaction Therapy (PCIT) Research**

*Chair:* Corey Lieneman, M.S., West Virginia University

*Chair:* Cheryl B. McNeil, N/A, Ph.D., West Virginia University

*Discussant:* Jonathan Comer, Ph.D., Florida International University

◆ *Participants earn 1.5 continuing education credits*

**Real-Time Monitoring of Suicide Risk to Understand, Predict, and Prevent Suicide**

*Chair:* Daniel Coppersmith, M.A., Harvard University

*Chair:* Aleksandra Kaurin, Ph.D., University of Pittsburgh

*Discussant:* Matt Nock, Ph.D., Harvard University

◆ *Participants earn 1.5 continuing education credits*

**Relationship Conflict in Minority Couples**

*Chair:* Michelle Leonard, Ph.D., University of Michigan Dearborn

*Discussant:* Michael E. Newcomb, Ph.D., Northwestern University Feinberg School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Remembering (Not) to Fear: Understanding the Development and Treatment of Anxiety and PTSD Through Translational Research on Fear Memory and Learning**

*Chair:* M. Alexandra Kredlow, Ph.D., Harvard University

*Chair:* Joseph K. Carpenter, M.A., Boston University

*Discussant:* Michael Otto, Ph.D., Boston University Center for Anxiety and Related Disorders

◆ *Participants earn 1.5 continuing education credits*

**Repetitive and Addictive? Evaluating the Behavioral Addiction Model for Body-focused Repetitive Behaviors**

*Chair:* Abel S. Mathew, M.S., University of Wisconsin, Milwaukee

*Chair:* Han Joo Lee, Ph.D., University of Wisconsin, Milwaukee

*Discussant:* Douglas Woods, Ph.D., Marquette University

◆ *Participants earn 1.5 continuing education credits*

**Responses to Reward and Threat Across the Translational Pipeline: Improving Outcomes and Access**

*Chair:* Anna Franklin, M.A., University of Pennsylvania

*Chair:* Gabriela K. Khazanov, Ph.D., Corporal Michael J. Crescenzi VA Medical Center

*Discussant:* Michelle Craske, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

**School-based Interventions for Underserved Communities: Increasing the Reach and Impact of Evidence-Based Practice**

*Chair:* Maya M. Boustani, Ph.D., Loma Linda University

*Discussant:* Steven W. Evans, Ph.D., Ohio University

◆ *Participants earn 1.5 continuing education credits*

**Setting Matters: Unique and Shared Considerations for the Implementation of Evidence-based Practices in Schools and Clinics**

*Chair:* Allison S. Nahmias, Ph.D., MIND Institute, University of California, Davis

*Chair:* Lauren Brookman-Frazee, Ph.D., University of California, San Diego

*Discussant:* Aaron Lyon, Ph.D., University of Washington

◆ *Participants earn 1.5 continuing education credits*

**Sexual Minority Stress and Health Disparities: Indications for Intervention Development and Adaptation to Increase Treatment Access and Outcomes for Diverse Populations of Sexual Minority Individuals**

*Chair:* Jacklyn D. Foley, Ph.D., Massachusetts General Hospital

*Discussant:* David Pantalone, Ph.D., University of Massachusetts Boston

◆ *Participants earn 1.5 continuing education credits*

**Social Media and Mental Health: Exploring Cognitive and Behavioral Mechanisms Using Diverse Methodologies**

*Chair:* Lauren A. Rutter, Ph.D., Indiana University Bloomington

*Discussant:* Jacqueline Nesi, Ph.D., Brown University

◆ *Participants earn 1.5 continuing education credits*

**Social Processes and Psychopathology: Effects of Disorders and Symptoms on Relationships Across the Lifespan**

*Chair:* Melanie Fischer, Ph.D., Heidelberg University Hospital; University of Heidelberg

*Discussant:* Norman B. Epstein, Ph.D., School of Public Health, University of Maryland

◆ *Participants earn 1.5 continuing education credits*

**Social Relationships and Addictive Behaviors: A Transdiagnostic Perspective**

*Chair:* Katherine McDermott, M.S., Florida State University

*Chair:* Brittany M. Mathes, M.S., Florida State University

*Discussant:* Julia D. Buckner, Ph.D., Louisiana State University

◆ *Participants earn 1.5 continuing education credits*

**Steps in the Real-world: Exploring Adaptations to Improve Access and Feasibility While Maintaining High Quality Care**

*Chair:* Sarah Tannenbaum, Psy.D., Judge Baker Children's Center at Harvard Medical School

*Discussant:* Carla C. Allan, Ph.D., Children's Mercy/University of Missouri-Kansas City School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Strengthening CBT by Shifting Our Focus from Treatments to Therapists**

*Chair:* Jacqueline B. Persons, Ph.D., Oakland CBT Center

*Discussant:* Tony Rousmaniere, Psy.D., University of Washington School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Targeting Nontraditional Cognitions in the Treatment of Angry, Aggressive, and Antisocial Behavior: The Role of the Honor Code and Criminogenic Thinking**

*Chair:* Ray A. DiGiuseppe, ABPP, Ph.D., St. John's University

◆ *Participants earn 1.5 continuing education credits*

**Tech for Two: Utilizing Technology to Improve Access to Effective Couples' Interventions**

*Chair:* Kayla Knopp, Ph.D., VA San Diego Healthcare System

*Discussant:* Howard Markman, Ph.D., University of Denver

◆ *Participants earn 1.5 continuing education credits*

**The Impact of Social Factors on the Onset and Maintenance of Self-injurious Thoughts and Behaviors**

*Chair:* Christianne Esposito-Smythers, Ph.D., George Mason University

*Discussant:* Adam B. Miller, Ph.D., University of North Carolina at Chapel Hill

◆ *Participants earn 1 continuing education credit*

**The Role of Parenting Cognitions for Engaging Parents in Treatments to Manage Disruptive Child Behavior**

*Chair:* Hali Kil, Ph.D., Centre for Addiction and Mental Health

*Discussant:* Brendan F. Andrade, Ph.D., Centre for Addiction and Mental Health

◆ *Participants earn 1.5 continuing education credits*

**The Role of Religion and Therapeutic Implications for Muslim Americans**

*Chair:* Merranda McLaughlin, B.A., University of Miami

*Discussant:* Amy Weisman de Mamani, Ph.D., University of Miami

◆ *Participants earn 1 continuing education credit*

**The Unique Roles of Self-injury Imagery and Image Exposure in Assessing and Treating Self-injurious Thoughts and Behaviors**

*Chair:* Hannah R. Lawrence, M.A., Alpert Medical School of Brown University

*Discussant:* Christine B. Cha, Ph.D., Teachers College, Columbia University

◆ *Participants earn 1 continuing education credit*

**Therapeutic Alliance in Treatments for Individuals with Autism Spectrum Disorder**

*Chair:* Erin Kang, Ph.D., Montclair State University

*Discussant:* Matthew D. Lerner, Ph.D., Stony Brook University

◆ *Participants earn 1.5 continuing education credits*

**Toward Personalization: Examining Cognitive Risk Factors for Obsessive-Compulsive Disorder**

*Chair:* Robert E. E. Fite, M.A., Miami University

*Discussant:* Sabine Wilhelm, Ph.D., Massachusetts General Hospital

◆ *Participants earn 1.5 continuing education credits*

**Transdiagnostic Cognitive-behaviour Therapy for Anxiety Disorders in Community-based Care**

*Chair:* Martin D. Provencher, Ph.D., Université Laval

*Discussant:* Debra Hope, Ph.D., University of Nebraska-Lincoln

◆ *Participants earn 1.5 continuing education credits*

**Transdiagnostic Mechanisms of Emotion Regulation in Treatment: Perspectives Across Mood, Anxiety, and Personality Disorders**

*Chair:* Matthew W. Southward, Ph.D., University of Kentucky

*Discussant:* Katherine L. Dixon-Gordon, Ph.D., University of Massachusetts Amherst

◆ *Participants earn 1.5 continuing education credits*

**Transdiagnostic Treatment Approaches to Improving Access and Outcomes Among Veterans**

*Chair:* Amanda M. Raines, Ph.D., Southeast Louisiana Veterans Health Care System

*Chair:* Cassidy A. Gutner, Ph.D., Boston University

*Discussant:* David H. Barlow, ABPP, Ph.D., Boston University Center for Anxiety and Related Disorders

◆ *Participants earn 1.5 continuing education credits*

**20 Years of Studying CBT and Medications for Adults with OCD: What Have We Learned?**

*Chair:* Blair Simpson, M.D., Ph.D., Columbia University/New York State Psychiatric Institute

*Chair:* Edna Foa, Ph.D., University of Pennsylvania

*Discussant:* David F. Tolin, ABPP, Ph.D., Anxiety Disorders Center, Institute of Living

◆ *Participants earn 1.5 continuing education credits*

**Uncovering Dynamic Clinical Processes: Statistical Approaches for Intensive Longitudinal Data**

*Chair:* Craig Henderson, Ph.D., Sam Houston State University

*Chair:* Ki Eun Shin, Ph.D., Columbia University, Teachers College

*Discussant:* Michelle G. Newman, Ph.D., Pennsylvania State University

◆ *Participants earn 1.5 continuing education credits*

**Understanding and Promoting Access to Family Involvement in Treatment for PTSD**

*Chair:* Lillian Reuman, Ph.D., BU School of Medicine/VA Boston Healthcare System

*Discussant:* Keith D. Renshaw, Ph.D., George Mason University

◆ *Participants earn 1 continuing education credit*

**Understanding and Targeting Mechanistic "Overcontrol" Across the Lifespan: How Children, Adolescents and Adults Exhibit Overcontrolled Tendencies and Respond to Treatment**

*Chair:* Kirsten Gilbert, Ph.D., Washington University in St. Louis

*Discussant:* Anthony Pinto, Ph.D., Northwell Health Zucker Hillside Hospital

◆ *Participants earn 1.5 continuing education credits*

**Understanding Factors Associated with Treatment Acceptability, Preference, and Satisfaction for Evidence-based Treatments for Elementary Aged Children**

*Chair:* Jenelle Nissley-Tsiopinis, Ph.D., Children's Hospital of Philadelphia

*Chair:* Theresa Egan, Ph.D., Children's Hospital of Philadelphia

*Discussant:* Frances Wymbs, Ph.D., Ohio University

◆ *Participants earn 1.5 continuing education credits*

**Understanding the Therapeutic Process of Exposure Therapy to Optimize Treatment**

*Chair:* Sophie A. Palitz Buinewicz, M.A., Temple University

*Chair:* Jennifer L. Buchholz, M.A., UNC Chapel Hill

*Discussant:* David F. Tolin, ABPP, Ph.D., Institute of Living

◆ *Participants earn 1.5 continuing education credits*

**Using an Interpersonal Framework to Better Understand BPD Pathology and Self-injury**

*Chair:* Katherine L. Dixon-Gordon, Ph.D., University of Massachusetts Amherst

*Chair:* Lauren Haliczzer, M.A., University of Massachusetts Amherst

*Discussant:* Brianna J. Turner, Ph.D., University of Victoria

◆ *Participants earn 1.5 continuing education credits*

**Using Technology-facilitated Methods to Improve Understanding of Romantic Couple Interactions**

*Chair:* Darren J. Garcia, M.S., University of Tennessee - Knoxville

*Discussant:* Richard E. Heyman, Ph.D., New York University

◆ *Participants earn 1.5 continuing education credits*

**Websites, Apps, and Chatbots: Evaluating the Potential of Technology-based Interventions to Expand Access to Evidence-based Treatments and Improve Clinical Outcomes**

*Chair:* Robert J. DeRubeis, Ph.D., University of Pennsylvania

*Chair:* Akash Wasil, M.A., University of Pennsylvania

*Discussant:* Robert J. DeRubeis, Ph.D., University of Pennsylvania

◆ *Participants earn 1.5 continuing education credits*

**What You Don't Know About the Menstrual Cycle May Hurt You(r Patients): Applications for Effective Assessment, Research, and Clinical Practice**

*Chair:* Jessica R. Peters, Ph.D., Brown University

*Discussant:* Kim L. Gratz, Ph.D., University of Toledo

◆ *Participants earn 1.5 continuing education credits*

**What's Love Got to Do with It? Romantic Relationship Risk and Protective Factors for Mental Health and Well-being in Sexual and Gender Minorities of Different Identities**

*Chair:* Anna L. Gilmour, M.A., University of Colorado Boulder

*Discussant:* Joanne Davila, Ph.D., Stony Brook University

◆ *Participants earn 1.5 continuing education credits*

**Who Gets the Most Bang for Their Buck? Predictors of Intensive Treatment Response for Youth Anxiety and Related Disorders**

*Chair:* Jami M. Furr, Ph.D., Florida International University

*Discussant:* Donna B. Pincus, Ph.D., Boston University Center for Anxiety and Related Disorders

◆ *Participants earn 1.5 continuing education credits*

**Why Are We Seeking Therapy? Caregiver-Youth (Dis)Agreement on Targets for Youth Psychotherapy: Implications for Treatment Processes and Outcomes**

*Chair:* Olivia M. Fitzpatrick, B.A., Harvard University

*Discussant:* Eric A. Youngstrom, Ph.D., University of North Carolina at Chapel Hill

◆ *Participants earn 1 continuing education credit*

**Youth Global Mental Health and Implementation Science: Past Evidence and Future Directions**

*Chair:* Katherine E. Venturo-Conerly, B.A., Harvard University

*Discussant:* Laura Murray, Ph.D., Johns Hopkins University School of Public Health

## ■ CLINICAL ROUND TABLES

◆ *Participants earn 1.5 continuing education credits*

**Addressing Race-based Stress and Trauma in Cognitive-Behavioral Treatment with People of Color**

*Moderator:* Juliette McClendon, Ph.D., Psychologist, VA Boston Healthcare System

*Panelists:* Maurice Endsley, Jr., Ph.D., Staff Psychologist, Edward Hines, Jr. VA Hospital

Keisha Ross, Ph.D., Staff Psychologist, St. Louis Veterans Health Care System

Clarice Wang, Ph.D., Clinical Psychologist, VA St. Louis Healthcare System

Veronica L. Shead, Ph.D., Clinical Psychologist in Palliative Care, St. Louis VA Health Care System

Asale Hubbard, Ph.D., Psychologist, San Francisco VA Healthcare System

◆ *Participants earn 1.5 continuing education credits*

**Assessment and Treatment of Perinatal Mental Health: Increasing Access to Evidence-based Care for a Vulnerable Population**

*Moderator:* Samantha N. Hellberg, B.A., Doctoral Student, University of North Carolina at Chapel Hill

*Moderator:* Paul Geiger, Ph.D., Postdoctoral Fellow, University of North Carolina at Chapel Hill

*Panelists:* Margaret M. Howard, Ph.D., Professor of Psychiatry and Human Behavior, Brown University/Women & Infants Hospital of Rhode Island

Fiona L. Challacombe, Ph.D., NIHR Clinical Lecturer, Dr

Pamela Wiegartz, Ph.D., Associate Director, Psychology; Chief, CBT Clinic, Brigham and Women's Hospital/Harvard Medical School

Tiffany Hopkins, Ph.D., Perinatal DBT Program Director; Clinical Psychologist, University of North Carolina at Chapel Hill



Crystal Schiller, B.S., M.A., Ph.D., Assistant Professor; Co-Director, Perinatal Psychiatry Program, University of North Carolina at Chapel Hill

◆ *Participants earn 1.5 continuing education credits*

**Challenges Accepted, Lessons Learned: Implementing Evidence-based Practices in the Nation's Largest Certified Community Behavioral Health Organization (CCBHO)**

**Moderator:** Deborah R. Frost, Ph.D., Ph.D., VP of Corporate Services, Compass Health

**Panelists:** Paul Thomlinson, Ph.D., Executive Director—Research, Compass Health Network

Michaela Muehlbach, Psy.D., Deputy Chief Clinical Officer, Compass Health Network

Sarah E. Lea, Ph.D., Licensed Psychologist, Compass Health Network

◆ *Participants earn 1.5 continuing education credits*

**Clinical Considerations for Engaging African American Couples and Families in Practice**

**Moderator:** Aleja Parsons, Ph.D., Assistant Professor, NYU

**Panelists:** Shalonda Kelly, Ph.D., Associate Professor, Clinical Core Faculty, Rutgers University

Shawn Jones, Ph.D., Assistant Professor, Virginia Commonwealth University

Anthony L. Chambers, ABPP, Ph.D., Chief Academic Officer, Northwestern University

Gihane Jeremie-Brinker, Ph.D., Assistant Professor, William Paterson University

◆ *Participants earn 1.5 continuing education credits*

**Comparing and Contrasting Motivational Interviewing and Rational Emotive Behavioral Therapy for Treating Substance Use with Sexual Minority Male Clients**

**Moderator:** Carlo C. DiClemente, ABPP, Ph.D., Emeritus Professor of Psychology, University of Maryland Baltimore County

**Panelists:** Tyrel J. Starks, Ph.D., Associate Professor, Hunter College, City University of New York

Ray DiGuiseppe, ABPP, Ph.D., Professor, St. John's University, Psychology Department

Carlo C. DiClemente, ABPP, Ph.D., Emeritus Professor of Psychology, University of Maryland Baltimore County

Steven Safren, Ph.D., Professor, University of Miami

David Pantalone, Ph.D., Professor, University of Massachusetts Boston

◆ *Participants earn 1.5 continuing education credits*

**Flexible Use of Evidence-based Treatments for Women's Mental Health**

**Moderator:** Lindsay Brauer, Ph.D., Assistant Professor, University of Chicago

**Panelists:** Candice Norcott, Ph.D., Assistant Professor, University of Chicago

Sheehan Fisher, Ph.D., Assistant Professor, Northwestern University Feinberg School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Improving Evidence-based Therapies for Culturally Diverse Patients: Perspectives from Multiple Treatment Contexts**

**Moderator:** Janie Hong, Ph.D., Partner and Assistant Clinical Professor, Redwood Center for CBT and Research and University of California - Berkeley

**Moderator:** Christine J. Laurine, PsyM, Doctoral Student, Rutgers University, GSAPP

**Panelists:** Janie Hong, Ph.D., Partner and Assistant Clinical Professor, Redwood Center for CBT and Research and University of California - Berkeley

Christine J. Laurine, PsyM, Doctoral Student, Rutgers University, GSAPP

Nancy H. Liu, Ph.D., Director of Psychology Clinic & Center for Assessment, Assistant Clinical Professor, University of California, Berkeley

Ariane Ling, Ph.D., Psychologist, NYU Langone Medical Center

Adrian Aguilera, Ph.D., Associate Professor, University of California at Berkeley

◆ *Participants earn 1.5 continuing education credits*

**In the Face of a COVID-19: Clinical Considerations When Delivering Evidence-based Treatments During a Crises and Applications Going Forward**

**Moderator:** Colleen Cullen, Psy.D., Clinical Director, Columbia University Medical Center

**Panelists:** Zachary Blumkin, Psy.D., Director, Columbia Day Program, Columbia University Medical Center

Erica Gottlieb, Ph.D., Assistant Clinical Director, Columbia Day Program, Columbia University Medical Center

Jennifer Sayrs, ABPP, Ph.D., Executive Director, EBTCS & Director, DBT Center & Clinical Psychologist, Anxiety Center, Evidence Based Treatment Centers of Seattle

Shireen L. Rizvi, ABPP, Ph.D., Associate Professor, Rutgers University

◆ *Participants earn 1.5 continuing education credits*

**Intensive Delivery of Evidence-based Treatment for PTSD across Diverse Contexts: Successes, Challenges, and Strategies for Implementation**

**Moderator:** Jennifer S. Wachen, Ph.D., Clinical Research Psychologist, National Center for PTSD and Boston University School of Medicine

**Panelists:** Kris Morris, Ph.D., Clinical Psychologist, Fort Belvoir Community Hospital

Edward C. Wright, ABPP, Ph.D., Psychologist, Massachusetts General Hospital

Cynthia Yamokoski, Ph.D., Clinical Psychologist, National Center for PTSD

Tara E. Galovski, Ph.D., Director, Women's Health Sciences Division, VA National Center for PTSD

◆ *Participants earn 1.5 continuing education credits*

**Not an ASD Expert? Not a problem! Watch and Learn How You Can Use the Fundamentals of CBT to Treat Patients With Autism and Increase Access to Care**

**Moderator:** Rebecca Sachs, ABPP, Ph.D., Founder & Clinical Psychologist, CBT Spectrum

**Panelists:** Anne Marie Albano, Ph.D., Professor of Medical

Psychology in Psychiatry, Columbia University Clinic for Anxiety and Related Disorders  
 Connor M. Kerns, Ph.D., Assistant Professor, The University of British Columbia  
 Matthew D. Lerner, Ph.D., Associate Professor, Stony Brook University  
 Lauren Moskowitz, Ph.D., Associate Professor, St. John's University  
 Sandra Pimentel, Ph.D., Chief, Child & Adolescent Psychology, Montefiore Medical Center  
 Tamara E. Rosen, Ph.D., Graduate Student, JFK Partners, University of Colorado School of Medicine

◆ *Participants earn 1.5 continuing education credits*

#### **Reaching Further: Expanding the Impact of Exposure Therapy via Novel Delivery Methods and Applications to New Clinical Areas**

**Moderator:** Nicholas Farrell, Ph.D., Clinical Director, Rogers Behavioral Health  
**Panelists:** Jon Abramowitz, Ph.D., Professor, University of North Carolina at Chapel Hill  
 Carolyn B. Becker, Ph.D., Professor, Trinity University  
 Melanie Harned, ABPP, Ph.D., VA Puget Sound Health Care System & University of Washington  
 Brett J. Deacon, Ph.D., Psychologist, Illawarra Anxiety Clinic  
 Dean McKay, ABPP, Ph.D., Professor, Fordham University  
 Laura Simons, Ph.D., Associate Professor, Stanford University

◆ *Participants earn 1.5 continuing education credits*

#### **Stuck on a Feeling: Targeting the Mechanism of Cognitive Inflexibility Through CBT to Improve Psychiatric Outcomes in Autism Spectrum Disorders**

**Moderator:** Lauren Kenworthy, Ph.D., Pediatric Neuropsychologist, Children's National Hospital  
**Panelists:** Cara Pugliese, Ph.D., Assistant Professor, Children's National Hospital  
 Amy Keefer, ABPP, Ph.D., Clinical Psychologist, Center for Autism and Related Disorders, Kennedy Krieger Institute/ Johns Hopkins University School of Medicine  
 Katherine Gotham, Ph.D., Assistant Professor, Rowan University  
 Matthew D. Lerner, Ph.D., Associate Professor, Stony Brook University  
 Connor M. Kerns, Ph.D., Assistant Professor, The University of British Columbia  
 Julia Bascom, Executive Director, Autistic Self Advocacy Network

◆ *Participants earn 1.5 continuing education credits*

#### **Taking Care of Us to Better Serve Them: Impact of Clinician Well-being on Patient Outcomes**

**Moderator:** Caitlin B. Shepherd, Ph.D., Lecturer, Smith College  
**Panelists:** Amanda R. McGovern, Ph.D., McGovern Psychotherapy, LLC  
 Erin K. Engle, Psy.D., Clinical Director, Columbia University Medical Center  
 Megan Feltenberger, Ph.D., Clinical Assistant Professor, Weill Cornell Medicine  
 Colleen Morrisette, Psy.D., Private Practice  
 Jared O'Garro-Moore, Ph.D., Clinical Psychologist, Columbia University Medical Center

Jenae A. Richardson, Psy.D., Postdoctoral Fellow, Veterans Affairs Palo Alto Health Care System

◆ *Participants earn 1.5 continuing education credits*

#### **Why Does Couple Therapy Sometimes Fail? Let Me Count the Ways**

**Moderator:** Danielle M. Weber, M.A., University of North Carolina at Chapel Hill  
**Panelists:** Donald Baucom, Ph.D., Distinguished Professor, University of North Carolina at Chapel Hill  
 Anthony L. Chambers, ABPP, Ph.D., Chief Academic Officer, Northwestern University  
 Jay Lebow, ABPP, Ph.D., Clinical Professor of Psychology, The Family Institute at Northwestern University  
 Kristina Coop Gordon, Ph.D., College of Arts and Sciences Excellence Professor of Psychology, University of Tennessee-Knoxville  
 Tamara G. Sher, Ph.D., Clinical Professor of Psychology, Family Institute at Northwestern University

◆ *Participants earn 1.5 continuing education credits*

#### **You Better Work: Adapting Evidence-based Practices and Research Protocols for Clinical Work with Sexual and Gender Minorities from Diverse Backgrounds**

**Moderator:** Justin L. Birnholz, Ph.D., Clinical Psychologist, US Department of Veterans Affairs  
**Panelists:** Jeffrey M. Cohen, Psy.D., Instructor of Medical Psychology, Columbia University Medical Center  
 Trevor A. Hart, Ph.D., Professor, Ryerson University  
 Audrey Harkness, Ph.D., Research Assistant Professor, University of Miami  
 Michael S. Borroughs, Ph.D., Assistant Professor, University of Windsor  
 Claire A. Coyne, Ph.D., Assistant Professor of Psychiatry and Behavioral Science, Northwestern University Feinberg School of Medicine  
 Benjamin A. Katz, M.A., Doctoral Candidate, Clinical Psychology, The Hebrew University of Jerusalem

### **CLINICAL GRAND ROUNDS**

#### **Doing Dialectical Behavior Therapy with Sexual and Gender Minority People: A Live Demonstration**

**Chair:** Jeffrey M. Cohen, Psy.D., Instructor of Medical Psychology, Columbia University Medical Center  
**Panelist:** Colleen A. Sloan, Ph.D., Staff Psychologist, VA Boston Healthcare System

### **SPOTLIGHT RESEARCH**

◆ *Participants earn 1.5 continuing education credits*

#### **Adaptation and Implementation of Self-System Therapy for Older Adults with Advanced Lung Cancer**

**Chair:** Timothy Strauman, Ph.D., Professor, Duke University  
**Panelist:** Katherine Ramos, Ph.D., Assistant Professor of Psychiatry, Duke University Medical Center  
**Panelist:** Jennie Riley, M.S., Interventionist, Duke University Medical Center  
**Panelist:** Kaylee Faircloth, M.A., Clinical Research Coordinator, Duke University

◆ *Participants earn 1.5 continuing education credits*

**Augmenting CBT with Real-time fMRI Amygdala Neuro-feedback Training Increases Early Response to Therapy and Long-term Outcomes**

*Chair:* Greg J. Siegle, Ph.D., Associate Professor of Psychiatry, Psychology, and Clinical and Translational Science, University of Pittsburgh School of Medicine

*Panelist:* Kymberly Young, Ph.D., Assistant Professor, University of Pittsburgh School of Medicine

◆ *Participants earn 1.5 continuing education credits*

**Comparative Effectiveness Research in Veterans with PTSD: A Randomized Clinical Trial of Prolonged Exposure and Cognitive Processing Therapy, VA Cooperative Study #591**

*Chair:* Paula P. Schnurr, Ph.D., Executive Director, National Center for PTSD

*Panelist:* Kathleen M. Chard, Ph.D., Associate Chief of Staff/Research, Cincinnati VA Medical Center

*Panelist:* Josef Ruzek, Ph.D., Professor, Palo Alto University

*Panelist:* Brian Marx, Ph.D., Deputy Director, Behavioral Science Division, NCPTSD

◆ *Participants earn 1.5 continuing education credits*

**Mental Health Impact on Community Members Following Mass Violence Incidents: Results from Parkland**

*Chair:* Angela Moreland, Ph.D., Associate Professor, Medical University of South Carolina

*Panelist:* Dean Kilpatrick, Ph.D., Professor, Medical University of South Carolina

## ■ MINI WORKSHOPS

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 1 - Breaking the Fix: Recovery-oriented Cognitive Therapy Targeting Fixed Delusions**

Aaron P. Brinen, Psy.D., Drexel University College of Medicine

Dimitri G. Perivoliotis, Ph.D., VA San Diego Healthcare System, University of California, San Diego

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 2 - Culturally Informed Care for Military Service Members and Veterans: Understanding How to Serve Those Who Have Served**

Jeffrey Goodie, ABPP, Ph.D., Uniformed Services University of the Health Sciences

Larissa Tate, M.S., Uniformed Services University of the Health Sciences

Maegan M. Paxton Willing, M.P.H., Uniformed Services University of the Health Sciences

Jeffrey H. Cook, Ph.D., Uniformed Services University of the Health Sciences

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 3 - Using Acceptance-based Treatment Approaches to Enhance Therapy for Eating Disorders**

Kelsey E. Clark, M.S., Drexel University

Adrienne S. Juarascio, Ph.D., Drexel University

Stephanie M. Manasse, Ph.D., Center for Weight, Eating and Lifestyle Science (WELL Center)

Paakhi Srivastava, Ph.D., Drexel University

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 4 - Assessing and Treating Misophonia: Clinical Considerations for a Novel Condition**

Clair Robbins, Ph.D., Duke University Medical Center

Zachary Rosenthal, Ph.D., Duke University Medical Center

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 5 - What We Didn't Learn in Graduate School: Lessons Learned from Real World Practice**

Patrick B. McGrath, Ph.D., NOCD

Brett J. Deacon, Ph.D., Illawarra Anxiety Clinic

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 6 - Strategies for Engaging in Advocacy as a Psychological Professional: A Skills-based Introduction**

Brian A. Feinstein, Ph.D., Northwestern University

Abigail W. Batchelder, M.P.H., Ph.D., Massachusetts General Hospital/ Harvard Medical School

Anu Asnaani, Ph.D., University of Utah

Lorraine Alire, M.A., University of Massachusetts Boston

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 7 - Developing Academic Careers in Psychosocial Research: Female-specific Challenges and Solutions**

Victoria E. Cosgrove, Ph.D., Division of Child and Adolescent Psychiatry

Louisa Sylvia, Ph.D., Massachusetts General Hospital

Amy E. West, Ph.D., Children's Hospital Los Angeles/

University of Southern California Keck School of Medicine

Mary A. Fristad, Ph.D., Nationwide Children's Hospital

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 8 - Applying Cognitive-behavioral Therapy Principles to Avoidant/restrictive Food Intake Disorder: Children, Adolescents, and Adults**

Helen Burton Murray, Ph.D., Massachusetts General Hospital/Harvard Medical School

Lauren Breithaupt, Ph.D., Massachusetts General Hospital/Harvard Medical School

Kendra Becker, Ph.D., MGH/HMS

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 9 - Behavioral Activation for Later-life Depression**

Ann M. Steffen, Ph.D., University of Missouri-St. Louis

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 10 - Introduction to the "Coping Long Term with Active Suicide Program (CLASP)"**

Ivan W. Miller, Ph.D., Brown University

Brandon Gaudiano, Ph.D., Brown University/Butler Hospital

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 11 - Beyond Butterflies: Delivering CBT for Children and Adolescents with Gastrointestinal Symptoms**

Bradley Jerson, Ph.D., Connecticut Children's and UConn Department of Pediatrics

Amy E. Hale, Ph.D., Boston Children's Hospital/Harvard Medical School

Kari Baber, Ph.D., Children's Hospital of Philadelphia

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 12 - Enhancing Access to CBT with Spirituality**

David H. Rosmarin, ABPP, Ph.D., McLean Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 13 - Navigating Queer Spaces in Supervision with LGBTQ+ Therapists And/or Clients**

Debra Hope, Ph.D., University of Nebraska-Lincoln

Christopher Martell, ABPP, Ph.D., University of Massachusetts Amherst

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 14 - Socratic Dialogue and Collaborative Empiricism: Practical Strategies to Overcome Common Pitfalls**

Scott H. Waltman, ABPP, Psy.D., Center for Dialectical and Cognitive Behavior Therapy

Brittany C. Hall, Ph.D., UT Southwestern Medical Center

Lynn McFarr, Ph.D., Harbor-UCLA Medical Center & CBT California

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 15 - Cognitive-behavioral Therapy to Target Executive Dysfunction in Adults with ADHD**

Mary V. Solanto, Ph.D., Hofstra University

Amanda Spray, Ph.D., NYU Langone Medical Center

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 16 - Sex, Drugs, and Fortnite: How to Help Caregivers Navigate Life's Trickiest Parenting Moments**

Andrea B. Temkin, Psy.D., Weill Cornell Medical College/NYP

Shannon M. Bennett, Ph.D., Weill Cornell Medicine

Samuel Fasulo, Ph.D., New York University School of Medicine

Anthony Puliafico, Ph.D., Columbia University Medical Center

Lisa W. Coyne, Ph.D., McLean/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 17 - Utilizing Criminal Events as the Unit of Analysis in Forensic Case Formulation and Treatment**

Raymond Chip Tafrate, Ph.D., Central Connecticut State University

◆ *Participants earn 1.5 continuing education credits*

**Mini Workshop 18 - Movement, Speed and Flow: A Live, Annotated Demonstration of Dialectical and Stylistic Strategies in Adolescent DBT**

Ashley Maliken, Ph.D., University of California, San Francisco

Maggie Gorraiz, Ph.D., McLean Hospital/Harvard Medical School

Alison Yaeger, Psy.D., McLean Hospital/Harvard Medical School

Esme A L. Shaller, Ph.D., University of California San Francisco

## ■ RESEARCH AND PROFESSIONAL DEVELOPMENT

◆ *Participants earn 1.5 continuing education credits*

**Research and Professional Development 1 - Crafting a Message for the Masses: A Primer on Using Blogs and Twitter to Disseminate Cognitive Behavioral Science Online**

Andres De Los Reyes, Ph.D., University of Maryland at College Park

Carmen P. McLean, Ph.D., National Center for PTSD

Deborah R. Glasofer, Ph.D., Columbia/NY State Psychiatric Institute

Ilana Seager van Dyk, M.A., The Ohio State University

◆ *Participants earn 1.5 continuing education credits*

**Research and Professional Development 2 - Enhancing the Translational Pipeline to Advance Neuroscience-informed Clinical Practice**

Angela Fang, Ph.D., MGH/Harvard Medical School

Greg J. Siegle, Ph.D., University of Pittsburgh School of Medicine

Andrew D. Peckham, Ph.D., Harvard Medical School / McLean Hospital

Maria Kryza-Lacombe, M.A., San Diego State University/University of California, San Diego, Joint Doctoral Program in Clinical Psychology

◆ *Participants earn 1.5 continuing education credits*

**Research and Professional Development 3 - It Never Hurts to Ask! Strategies to Negotiate Academic Job Offers**

Shona N. Vas, Ph.D., University of Chicago

Fabiana N. Araujo, Ph.D., University of Chicago



◆ Participants earn 1.5 continuing education credits

**Research and Professional Development 4 -  
Seeing and Using Open Platforms to Bring  
Evidence-based Psychology to the People  
Who Would Benefit: A Dissemination and  
Implementation Workshop**

Eric A. Youngstrom, Ph.D., University of North  
Carolina at Chapel Hill  
Mian-Li Ong, Ph.D., Mayo Clinic  
Elizabeth D. Wilson, B.S., University of North  
Carolina at Chapel Hill  
Hannah Kim, B.S., Helping Give Away Psycho-  
logical Science  
Emma G. Choplin, B.S., University of Miami

◆ Participants earn 1.5 continuing education credits

**Research and Professional Development 5 -  
Steering Students Towards STEM Grants:  
Writing a Successful National Science Founda-  
tion Graduate Research Fellowship Applica-  
tion in Clinical Psychology**

Kathryn A. Coniglio, M.S., Rutgers University  
Shirley B. Wang, M.A., Harvard University  
Daniel Coppersmith, M.A., Harvard University  
Jonathan W. Reeves, M.A., University of Califor-  
nia, Berkeley  
Rebecca Revilla, B.A., The University of Alabama

◆ Participants earn 1.5 continuing education credits

**Research and Professional Development 6 -  
Dr. Strangeabct Or: how I Learned to Stop  
Worrying and Love the Camera Conducting  
an Effective Television Interview**

Gwilym Roddick, LCSW, The Ross Center  
Kevin Chapman, Ph.D., Kentucky Center for  
Anxiety and Related Disorders  
Emily Bilek, ABPP, Ph.D., University of Michigan  
Ilana Seager van Dyk, M.A., The Ohio State  
University

◆ Participants earn 1.5 continuing education credits

**Research and Professional Development 7 -  
Breaking Bias in Academic Medicine: An  
Interprofessional Prevention Program Target-  
ing Gender Bias Throughout a Medical School**

Presenter: Dr. Marian Tanofsky-Kraff, Ph.D.,  
Uniformed Services University of the Health  
Sciences  
Bernasha Anderson, Ph.D., Uniformed Services  
University of the Health Sciences  
Jeffrey D. Quinlan, M.D., Uniformed Services  
University of the Health Sciences

## Invited Addresses



**LIFETIME ACHIEVEMENT AWARD (2019)**  
**ADDRESS Managing Anxiety in Youth: More  
Action Than Talk | Philip C. Kendall, Ph.D.,  
ABPP, Distinguished University Professor, Laura H.  
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opment to Implementation: Can Transdi-  
agnostic Treatment Approaches and  
Implementation Science Close Critical  
Gaps for Adolescents and Adults With  
Mental Health Problems?**

Allison G. Harvey, Ph.D., DBSM, University of  
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**Helping Give Away Psychological Science:  
Bringing the Best of Our Work to the  
People Who Would Benefit**

Eric Youngstrom, Ph.D., Professor of Psychology and  
Neuroscience and Psychiatry, UNC Chapel Hill



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**Strange Bedfellows Share Mutual Dreams:  
Increasing Access to Mindfulness Based  
Interventions for Mood and Anxiety  
Disorders**

Zindel V. Segal, Ph.D., C.Psych., Distinguished Profes-  
sor of Psychology in Mood Disorders, Graduate Depart-  
ment of Psychological Clinical Science, University of  
Toronto- Scarborough

## Invited Panel



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**Personalizing Treatment to Improve CBT Outcomes**

MODERATOR: Michelle G. Craske, Ph.D., UCLA

PANELISTS: Robert J. DeRubeis, Ph.D., University of Pennsylvania  
Aaron J. Fisher, Ph.D., University of California, Berkeley  
Jacqueline B. Persons, Ph.D., Oakland CBT Center  
Greg Siegle, Ph.D., University of Pittsburgh School of Medicine

# Applying Psychological Science in Government Behavioral Health Settings: A Psychologist's Perspective

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PUBLIC FUNDING SOURCES, such as Medicaid and Children's Health Insurance Programs (CHIP), support the majority of mental health services in the United States (U.S.), with over 70 million Americans or roughly 20% of the U.S. population enrolled (Center for Medicare and Medicaid Services, 2019). Further, there are indications that the coronavirus pandemic and associated economic and social stressors affecting Americans' mental health could result in significant increases in enrollment, as evidenced by the 35 states that have expanded Medicaid and already reported increases in enrollees (Kaiser Family Foundation, 2020). State and local entities play pivotal roles in delivering mental health services to Medicaid and CHIP beneficiaries, with over 5.8 million individuals served in these settings in 2017 (SAMHSA, 2019).

Given the significant role government settings play in providing behavioral health services to many Americans, these systems need guidance around implementing evidence-based strategies and improving efficiency. Mental health professionals with evidence-based training, like the ABCT membership, offer unique expertise that can guide services in a science-based direction and impact the lives of millions. The purpose of this article is to highlight the multifaceted ways in which mental health

professionals can apply scientific, evidence-based principles to these settings. Because the authors are all psychologists, we write from our expertise about the roles of psychologists in particular, but many of these roles may also be applicable to other disciplines.

We offer descriptions of the range of roles for psychologists following from broader macro-level activities to more focused micro-level activities and provide concrete and practical recommendations to those considering government employment settings. We offer different perspectives on how psychologists can have an impact on government systems, aside from the obvious and valuable contribution of direct service to patients. We liken our work to *kintsukuroi*, the Japanese art of repairing broken pottery with gold, silver, or platinum. We acknowledge all that has been built before us, and our goal is not to demolish—rather, it is to fill, augment, and bend with what has already been in place. If we can fill in beautifully, we have embodied our skills as psychologists and all we have learned in graduate school and beyond.

Government settings increasingly rely on skills unique to psychologists. This is evident by the growing number of graduates matriculating into these settings (American Psychological Association

[APA], 2018) and the spotlight attention from academic spaces. For example, ABCT Annual Conventions have started to highlight the impact of psychological science in federal government agencies. Some examples include the Centers for Disease Control (e.g., Schoenwald et al., 2019), the influence of psychologists' roles in implementing practices into public-sector service systems (e.g., Lau & Wiltsey-Stirman, 2018), and several preconference and networking events featuring opportunities to learn first-hand from psychologists in government settings (e.g., the Dissemination and Implementation Science Special Interest Group [<http://groupspaces.com/DISSIG/join/>] preconference).

The authors, all psychologists, represent several state and local behavioral health authorities that are diverse in terms of funding sources, populations, and behavioral health priorities. The Hawaii State Department of Health Child and Adolescent Mental Health Division (CAMHD) is a Medicaid behavioral-health carve-out that consists of a public-private partnership with contracted mental health agencies across the state. The CAMHD serves approximately 2,300 youth with severe functional impairment across six geographically isolated islands with diverse cultures and limited resources (CAMHD, 2019).

The Department of Medical Assistance Services (DMAS) administers the Medicaid program in Virginia. The majority of Medicaid members in Virginia, over 1.6 million individuals, are served through two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus, and nearly a third of all Medicaid members have a behavioral health diagnosis. In 2019, DMAS worked in partnership with the Virginia Department of Behavioral Health and Disability Services to launch an initiative targeting enhancement of the full behavioral health benefit and development of a long-term vision to focus on prevention, early intervention, and the implementation of evidence-based practices (EBPs).

Within Southern California, the authors represent two local systems. The Los Angeles County Department of Mental Health (LACDMH) is the largest county-operated mental health system in the U.S. and consists of both directly operated sites and partnerships to provide services through contracted legal entities and other county departments. LACDMH typically serves over 250,000 consumers with rich diversity in terms of age, race and ethnicity, gender, and language each year

(LACDMH, 2020). The Health Care Agency (HCA) is the regional provider for the 3 million residents of Orange County (OC) and served roughly 25,000 adult and youth consumers during fiscal year 2018–19 across individual, family, and community health services. Services span mental health and substance use disorder services for children, youth, and adults in crisis, prevention, early intervention, outpatient, residential and inpatient contexts.

### **Functional Roles for Psychologists Within Government Settings**

#### ***Advocacy Through Developing Programs and Policy***

As scientists, psychologists are well-suited to apply findings from the research literature and local aggregate data toward strategic planning and system-wide policy development. This is a mindset shift. Generally, we are trained in ways to support individual changes, but driving system changes means working to aggregate individual changes on a population level. Psychologists in administrative roles work to develop legislative proposals and drive cross-agency alignment and stakeholder support to move these proposals towards funding allotment and policy and regulation implementation. Likewise, psychologists participate in task forces that seek to improve behavioral health care systems and develop strategies to communicate key messages simply and effectively to wide audiences. Each of these roles involves a thorough review of evidence to identify service gaps, barriers, facilitators, and policy changes that are aligned with psychological science, maximize care and outcomes for communities, and drive health equity for those we serve in these systems.

Efforts like these require learning and borrowing from adjacent fields. As an example, within the past year, Hawaii's CAMHD developed a strategic communications plan that sources from the organization's guiding documents (e.g., the strategic plan for the division and department), quality improvement (QI) surveys (e.g., consumer and provider satisfaction surveys), focus groups and best practices in health communication strategy (Health and Human Services, Office of Adolescent Health, 2017) to boost the division's internal and external communications. In collaboration with communication and digital media experts, a psychologist regularly develops and vets content (e.g., newsletter articles, social media posts, website material, memos, and infographics) to ensure

that the material is clinically appropriate and understandable. Design is a vehicle for communication and psychologists can be effective in advocating for the end-user experience of communication products and tools. At the onset of the COVID-19 pandemic, when communications were particularly vital, Hawaii psychologists collaborated across disciplines to create simple resources (e.g., telehealth and maintaining infection control) by digesting local, national, and international guidance on continuing mental health services. The final products were posted on a quickly developed website (<https://health.hawaii.gov/bhhsurg/>) and shared across multiple communications channels (i.e., newsletter, webinar, social media) to offer resources to providers. LACDMH similarly partnered with the local Department of Public Health and experts in communication to compile mental health resources (<https://dmh.lacounty.gov/covid-19-information/>) to quickly disseminate relevant and straightforward information to the public. An important lesson learned across these advocacy examples is to be flexible, agile, and collaborative in interdisciplinary settings. Table 1 offers valuable insights into being an "interdisciplinary chameleon" and practical learning opportunities.

#### ***Community-Academic and Cross-System Partnerships***

LACDMH has a long-term collaboration with UCLA for program evaluation. The chief of the LACDMH Office of Clinical Informatics was a co-author on a UCLA paper finding showing that clients enrolled in LACDMH's Full Service Partnership program received significantly higher numbers of outpatient services and a higher proportion of field-based services than did clients in usual care (Starks et al., 2017). Clinical Informatics staff are now collaborating with the same UCLA research group on a similar evaluation of LACDMH's implementation of an Assisted Outpatient Treatment program.

LACDMH also frequently provides data for researchers' own projects, most frequently from UCLA and the University of California, San Diego. As local experts on our systems of care, we consult with principal investigators during the grant-writing phase on how to frame their research questions and analytic plans given our populations served and available data. For example, we often collaborate with researchers to explain nuances of how our diagnostic data are structured (e.g., collected separately at different sites, only

stored when updated rather than at every encounter) and how to best incorporate the data into desired analyses. We also frequently assist with providing context and interpreting research findings.

In Virginia, DMAS engaged in academic partner collaboration for the evaluation of the Virginia's Addiction Recovery and Treatment Services program, as well as to examine the impact of Medicaid expansion. Virginia is the first state to conduct a baseline survey of new members as part of its implementation of Medicaid expansion. With the early success of these implementations and the forward momentum of the proposal for enhancement of behavioral health services, Virginia has also increased internal capacity through hiring licensed clinicians in its Behavioral Health Division, including two psychologists. Recent efforts across all child-serving agencies within the Health and Human Resources Secretariat resulted in a proposal for the formation of an academic partnership to develop a Center for Evidence-Based Practice. Once approved and funded, this center can serve as a hub for cross-agency training, certification, workforce development, implementation support, and evaluation of cross-sector improvement efforts. Table 1 explains in more detail on expanding connections and your network early on to form these partnerships that can aid in advancing psychological science.

#### ***Research Analysis and Reporting/Outcomes Monitoring***

Psychologists hired to fulfill research roles in government settings must often manage large datasets and contribute heavily to written reports meant for a variety of audiences and purposes. The outcome reports are frequently high-profile and high-stakes, as they inform QI efforts and funding decisions for internal and external stakeholders, regularly guide local and state programmatic decisions, and can be used to drive towards goals such as healthcare access and equity. Psychologists' hybrid training in clinical work and advanced research methods and analytics allows them to apply the requisite sensitivity around accurate interpretation and contextualization of findings (see Table 1 for advice on knowing your audience and timing). The novel challenge for psychologists is in interpreting data for stakeholders who often present with various levels of statistical literacy. Often this requires cultivating the art of data visualization to better represent information and producing accurate and relevant interpretations.



At the Orange County HCA, one recent approach has been to produce and share data regularly with programs, traditionally a nonexistent practice unless mandated. Psychologists produce internal bi-annual outcome reports on the Outcome Questionnaire (Lambert et al., 2010), a suite of standardized clinical outcome measures of distress, for programs across outpatient services, emergency shelter, juvenile justice, probation camps, and assertive community treatment. The process has relied heavily on a partnership approach wherein psychologists solicit program context from leadership and clinical staff to interpret results and co-write recommendations and biannual program goals based on findings. A key strategy has been to invest in data visualization strategies and software to best relay information to all stakeholder levels. The process is new for HCA but has been received positively by leadership and staff due to the increased transparency of data sharing for QI efforts. An unintended but notable impact has been the increased literacy in standardized tools and openness to utilize Outcome Questionnaire data pragmatically in clinical and supervisory contexts.

At LACDMH, psychologists in multiple divisions are collaborating to develop a data dashboard for executive management with COVID-related and other key strategic metrics (e.g., service volume, services by telehealth vs. telephone vs. in person). We are providing subject matter expertise and also applying our knowledge of effective data analysis and visualization for this project. Likewise, at DMAS, psychologists are working through a CMS Innovation Accelerator Program to develop dashboards to support monitoring and policy decisions to improve the care of members with serious mental illness. Such dashboards benefit from the clinical expertise of psychologists trained in both process and outcomes research. In Virginia, these dashboards also function as a way to understand utilization patterns and progress towards health equity goals, including access to care for populations made vulnerable by systemic racism and discrimination, injustice, and trauma. These dashboards are invaluable and timely as states grapple with means to drive equity through policy and benefit coverage decisions that support greater access to care and targeted enhancements to services that can reduce reliance on potentially further traumatizing experiences such as temporary detention and institutionalization.

### *Program Evaluation*

Many health care systems need to produce and utilize program evaluation methods to assess the effectiveness of programs and initiatives system-wide. Psychologists trained in applied research methods can significantly contribute to designing and executing these efforts.

Answering questions about the operations of an entire system of care requires critical thinking about data availability, how those data were generated, and how definitions may vary across data sources. In an illustrative example, LACDMH's Office of Clinical Informatics is frequently asked to report "how many homeless/unhoused individuals are seen by LACDMH." The primary location for homelessness data in our electronic health record (EHR) is the Problem List. However, a quick count suggests it is likely underreported here, given the population and the lack of a mechanism to require data entry. Therefore, we have found it is helpful to add information from the data collection instruments specific to LACDMH's field response teams, where staff members will often check a box indicating the client is homeless at the time of the service. Combining these data into one system-wide percentage requires defining "currently homeless/unhoused," similar to the process of creating an analytic plan in research settings. Because clients may be frequently moving between multiple unstable housing situations, we have at times defined a homeless or unhoused client as one who has been reported as homeless at any time in the last 12 months.

This kind of analysis is necessary for answering questions about a system of care and also for informing specific projects. LACDMH is working closely with colleagues in other county departments (e.g., Sheriff, Probation, Health Services) and agencies on multiple programs for unhoused individuals. Evaluation of these programs requires harmonizing and sharing data across these sources. For some initiatives, such as Whole Person Care, we have had the opportunity to assist with formative program evaluation: providing process and outcome metrics frequently in the early months of a program to inform stakeholders' decisions about how to modify their interventions for greater success.

Additionally, the systematic collection and tracking of outcome and demographic markers to inform programmatic decisions is a recent development at the Orange

County HCA. The rollout of the Outcome Questionnaire has allowed for evaluation of clinical change at the program level. The HCA is in the early stages of implementation and has focused efforts on securing solid infrastructure and processes for documentation within our EHR, as well as in training clinicians and leadership on tool administration and clinical utility. As we continue to streamline data collection efforts, program evaluation will advance in terms of analytics and exploration of complex questions within the system of care. For example, Outcome Questionnaire data will eventually allow us to track client progress across time and placements, and to develop predictive models of clinical change.

In addition to large-scale implementation of standardized outcomes, HCA actively collects interview and focus group data from various stakeholders (e.g., consumers, caregivers, providers) to inform programmatic changes. More recently, HCA partnered with the County of Orange Social Services Agency on a collaborative project, Working to End Child Abuse and Neglect (WE CAN) Coalition ([ohealthier-together.org/tiles/index/display?alias=wecan](https://ohealthier-together.org/tiles/index/display?alias=wecan)), to collectively address the intersecting needs of children, families, and communities touched by abuse and neglect. A priority area is addressing barriers to foster youth placement permanency through interventions to increase rates of permanency and decrease rates of reentry to foster shelter. We conducted multiple interviews with youth in foster care, their caregivers, and staff to better understand the barriers and facilitators. Psychologists possess the necessary competencies needed for effectively facilitating interviews with youth, developing interview guides, collecting and analyzing qualitative data, and offering recommendations. The initial challenge faced by psychologists in these settings is showcasing our interdisciplinary competencies.

### *Quality Improvement*

Quality Improvement (QI) efforts similarly involve skill in designing improvement projects, analyzing data, interpreting results, and implementing innovations to make meaningful continuous changes to the system, which are essential skills for psychologists. In California, the State Department of Health Care Services requires that counties have ongoing clinical and nonclinical performance improvement projects each year. The aim of these projects, which are evaluated by a con-



tracted external third-party organization, is to improve processes and outcomes of health care particularly as they relate to quality, timeliness, and access to care for Medi-Cal beneficiaries. The performance indicators in these projects are typically quantitative and in line with measures from the Healthcare Effectiveness Data and Information Set (HEDIS; National Committee for Quality Assurance, 2020). Interventions may include implementing EBPs, standardizing workflows, and enhancing existing protocols.

At LACDMH, we are applying our knowledge of best practices for implementing innovations and data-informed decision-making to move these projects forward as well as introducing more advanced research methods to our analysis. For example, the current clinical project for LACDMH aims to improve the quality of services for consumers with co-occurring mental health and substance use problems by implementing integrated treatment models, such as Seeking Safety, that address these problems simultaneously. The QI team implemented a mixed methods approach of examining quantitative data (e.g., 7-day and 30-day rehospitalization rates, engagement and retention rates) along with qualitative data (e.g., chart review, interviews) to expand upon the data sources and gain further insight into trends. The goal is to use the insights obtained from both sources of data to make real-time adjustments to the interventions and ensure that services are continuously improving. A broader goal is also to disseminate findings of best practices to other state and local entities that may be encountering similar issues and engage internal stakeholders in the data review and decision-making process. In order to expand the use of Continuous Quality Improvement (CQI) throughout a system, it is necessary to build capacity for multiple teams to engage in CQI. The LACDMH QI team aims to build on the knowledge of region-specific experts by training them in CQI practices and offering support to these teams as they develop their understanding and go on to spread knowledge to others within their region.

Similarly, the performance improvement projects at Orange County HCA are heavily led and informed by expertise in partnership and mixed method statistical approaches. The recent project at HCA has focused on systematically evaluating retention rates (i.e., attending >3 visits) and implementing strategies and procedures to attenuate the observed pattern of low

retention. This endeavor involved the system-wide evaluation of retention rates over the course of multiple years to identify baseline rates and patterns. We created a task force consisting of multiple stakeholders (e.g., office support, clinicians, research, clinicians, leadership) to facilitate a true participatory action group process. Similar to LACDMH, the use of mixed method strategies has proven key in addressing low retention rates of services by way of leveraging client engagement strategies. The voice of psychologists in this space has driven agendas to identify health disparities in retention rates and to integrate CQI feedback loops to improve and test strategies in a practical and systematic way.

As another QI effort, state and local MHPs that deliver Medicaid and CHIP funding must administer biannual consumer satisfaction surveys for four different informants: youth, caregivers of youth, adults, and older adults. These surveys are standardized at the federal level and allow for longitudinal analysis of data over time as well as comparison to data from federal, state and local entities. The LACDMH QI team uses survey data to identify and subsequently evaluate targeted efforts to improve services, particularly within smaller regions. An additional goal is to make this data more meaningful for providers and consumers by using data visualization and engaging stakeholders to provide input on the items or subscales of highest value and interest. Psychologists can then use this feedback to tailor data reports and resources to the needs of various audiences, including mental health and allied professionals, community stakeholders, and end users.

The Hawaii State CAMHD also engages in QI efforts through youth, caregiver and contracted provider annual surveys, provider feedback reports, and an annual statewide evaluation of services that is publicly accessible (<https://health.hawaii.gov/camhd/>). These QI activities date back to CAMHD system-reform during the Felix Consent-decree and federal oversight (Higa-McMillan et al., 2011). In the past year, CAMHD has begun to redefine QI based on years of feedback from stakeholders and recommendations from an external evaluation of the system. First, CAMHD created a CQI mission, team, and leader (a psychologist) that integrates the principles of improvement, youth mental health research, and implementation science. The CAMHD defined its CQI mission as an evidence-based system improvement effort that includes the use of local system-spe-

cific data and general research best practices to identify contextual determinants of change, identify and rank applicable innovations, and apply appropriate implementation strategies. Next, CAMHD QI specialists completed the Institute for Healthcare Improvement's Leading Quality Improvement training to inform the development of the CAMHD CQI plan. Additionally, CAMHD has been awarded a 4-year Substance Abuse and Mental Health Services Administration System of Care Expansion and Sustainability Grant with the aim of transforming data to wisdom through (a) maximizing the use of varying sources of data to guide clinical decision-making, (b) coordinating efforts efficiently across child-serving systems, (c) improving system of care principle implementation, and (d) refining in-home services that reduce the risk of out-of-home placement.

Concurrently, CAMHD continued one of its most important CQI initiatives—to embed measurement-based care and data-driven decision-making within the system. As a first step, CAMHD created a measurement-based care guiding document (CAMHD, 2020; <https://health.hawaii.gov/camhd/files/2020/05/Measurement-Based-Care.pdf>) that stated the values, vision, and procedures for using outcome data in client clinical care. This document serves as the foundation for data visualization dashboard development, adjustments to provider feedback reports, and CQI projects. Additionally, CAMHD intends to generate tools and resources (e.g., chunked training videos, infographics, decision trees) for staff and providers through a mixed-method observational study on measurement-based care barriers and facilitators, with the goal of identifying specific sequences of behaviors in the co-managed public-private partnership.

### *Enhancing Inputs*

Health care reform through the mandate of EHRs came to fruition with the passing of the Patient Protection and Affordable Care Act in 2012. One of the most novel areas for psychologists to influence practice is in the conceptualization, building, and ongoing improvement of EHRs. Two examples are detailed below.

In 2016, Hawaii's CAMHD began the process of revitalizing an outdated EHR system through careful needs assessment and clinical workflow documentation. The CAMHD psychologists were called on throughout the process to operationalize the clinical workflow. The multidisciplinary team of system architects, developers,

clinical social workers, and psychologists had the initial goal of building a system that combined the clinical workflow and efficient documentation. This required drilling down to simple behaviors and schedules of reinforcement and was accomplished through the integration of agile methods (Hekler et al., 2016) and implementation science. At the heart of these methods was an iterative and team-based approach to fail fast and often to improve the system (Berger, 1997).

Additionally, the EHR implementation was led by a psychologist and was documented within the Exploration, Preparation, Implementation, and Sustainment framework (EPIS; Aarons et al., 2011) and user-centered design (Dopp et al., 2019). In the exploration phase, we conducted interviews and focus groups on user perspectives, observational field visits, design charrette sessions with stakeholders, competitive user experience research (when available, most often with the EPIC EHR), and defined target users and their needs. In the preparation phase, we collected quantitative surveys on usability and prepared and presented user research reports to carefully weigh the risks and benefits of changing workflow. In the implementation phase, we engaged in iterative development through strategically placed champions across the various role groups within our system, conducted usability tests, and examined automatically generated data within our system. The CAMHD is now in a nascent sustainment phase (1-year postimplementation) and continues to employ all of the strategies mentioned above to iteratively improve the system.

When LACDMH began its transition to an EHR in 2006, the Chief of Clinical Informatics (a psychologist) was appointed the Clinical Director of the EHR project. Since that time, the five psychologists in the Office of Clinical Informatics have been the primary technical developers of new functionality in the EHR. We use our knowledge of clinical practice and implementation science to build new data collection instruments, widgets to display key just-in-time information, and scripts to guide workflow and prevent errors. Similar to CAMHD, we frequently survey clinicians and solicit feedback so we can engage in CQI.

For example, we learned from the psychiatrists on our Clinical Council that it was time-intensive to complete treatment plans as well as medication consent forms, although both are clinically important and required. We were able to address these

concerns by developing a new “combo” form in the EHR. We worked with the supervising psychiatrists to develop templates and checkbox options for them to quickly write the types of treatment plans that are most relevant to their clients, with medication consent fields integrated into the questions. We have received extremely positive feedback on this form, with many psychiatrists reporting it helps them quickly and easily structure these key conversations with clients.

### Summary

Table 1 includes a summary of the authors' lessons learned and recommended learning opportunities for individuals interested in working in government settings. It is important to note a number of limitations in this article. First, the highlighted examples represent a sampling of the current roles psychologists can and do play in our settings and are by no means comprehensive with respect to the multidisciplinary nature of psychological science. There are many other examples of crucial and innovative work across various other disciplines that we hope to include in other forthcoming presentations. Second, although the authors represent a diverse set of behavioral health programs, settings, and ethnic backgrounds, as a team of all women, we would like to acknowledge that there may be biases in what we chose to highlight and what may have been omitted. Finally, we recognize that our systems may not be reflective of other systems and that our experiences may not generalize to other behavioral health settings.

Despite these limitations, our team offers a psychologist's perspective in how psychological science can influence and impact many lives through government applications. One of the most important lessons learned across all authors is presented at the end of Table 1: *Advocate for yourself*. Articulating (sometimes over and over again) and demonstrating your psychological science skillset in a manner that capitalizes on other lessons learned, like flexibility, timing, and understanding your audience, will not only enhance your value in government settings but also the value of your organization and the services delivered to clients and families.

### References

- Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 4-23.
- American Psychological Association. (2018). *Careers in Psychology*. Retrieved from <http://www.apa.org/workforce/data-tools/careers-psychology.aspx>, April 2020.
- Berger, A. (1997). Continuous improvement and kaizen: Standardization and organizational designs. *Journal of Integrated Manufacturing Systems*, 8, 110-117.
- Centers for Medicare and Medicaid Services. (2019). *December 2019 Medicaid & CHIP Enrollment*. Retrieved from <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>, April 2020.
- Child and Adolescent Mental Health Division. (2019). *Fiscal Year 2018 Annual Factbook*. Hawaii State Department of Health, Honolulu, HI.
- Child and Adolescent Mental Health Division (CAMHD), Hawaii Department of Health. (2020). *Measurement-based care: Values, vision and procedures*. Retrieved from <https://health.hawaii.gov/camhd/files/2020/05/Measurement-Based-Care.pdf>.
- Dopp, A. R., Parisi, K. E., Munson, S. A., & Lyon, A. R. (2019). A glossary of user-centered design strategies for implementation experts. *Translational Behavioral Medicine*, 9(6), 1057-1064.
- Health and Human Services, Office of Adolescent Health. (2017, June, 13). *Strategic communications toolkit*. <https://www.hhs.gov/ash/oah/resources-and-training/online-learning-modules/strategic-communications-toolkit/index.html>
- Hekler, E. B., Klasnja, P., Riley, W. T., Buman, M. P., Huberty, J., Rivera, D. E., & Martin, C. A. (2016). Agile science: creating useful products for behavior change in the real world. *Translational Behavioral Medicine*, 6(2), 317-328.
- Higa-McMillan, C. K., Powell, C. K. K., Daleiden, E. L., & Mueller, C. W. (2011). Pursuing an evidence-based culture through contextualized feedback: Aligning youth outcomes and practices. *Professional Psychology: Research and Practice*, 42(2), 137-144.
- Kaiser Family Foundation. (2020, May 1). *Early Look at Medicaid Spending and Enrollment Trends Amid COVID-19*. <https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/>
- Lambert, M. J., Hansen, N. B., & Harmon, S. C. (2010). Outcome Questionnaire System (The OQ System): Development

**Table 1.** Recommendations for Individuals Considering Roles in Government Settings

Lessons Learned	Recommended Learning Opportunities
<b><i>Expect to be an interdisciplinary chameleon</i></b>	
<ul style="list-style-type: none"> <li>• Government settings consist of diverse departments and stakeholders with varied interests. Having an interdisciplinary and collaborative mindset helps bridge these various entities together.</li> <li>• It is crucial to make strategic partnerships and develop buy in and collaboration with multiple different stakeholders by finding common ground and highlighting the unique benefit to all parties.</li> <li>• Use implementation science tools to facilitate this process (e.g., planning when to communicate and to whom, successful methods for attitude and behavior change).</li> <li>• Harness your clinical skills to facilitate meetings, validate points of view, and collaborate with others.</li> </ul>	<ul style="list-style-type: none"> <li>• Seek out training in multiple different disciplines, including those that you may gain exposure to in a psychology graduate training program as well as broader systems work in related fields like business, management, and technology.</li> <li>• Practice systems change in your clinical work. Early family systems theorist Salvador Minuchin (1974) encouraged clinicians to identify the “coin of the realm” in any system with which they wanted to join - the terms or behaviors that would make others feel understood and connected. For various stakeholders, this may be addressing regulatory concerns, consumer experience, or finances.</li> <li>• As with any collaboration, use your clinical skills to learn the language/terminology, culture, speed, reward models, structural relationships, and epistemology of your partners.</li> </ul>
<b><i>Do your research and expand your network</i></b>	
<ul style="list-style-type: none"> <li>• Navigating the work of government jobs is often complicated and systems vary widely in terms of their existing infrastructure and support for implementing evidence-based practices and data-driven decision-making.</li> <li>• The more you learn about a system ahead of time, the more you can determine if there is a good fit and what your role could be, and do not be discouraged early on.</li> </ul>	<ul style="list-style-type: none"> <li>• Find a mentor that works in a government or related setting who can help guide you through the process of applying for and succeeding in these positions.</li> <li>• Research the system in terms of strategies goals and priorities (e.g., how does the system present itself through media?)</li> <li>• Consider participating in a practicum or internship within the setting in which you are interested</li> <li>• To make these mentors more visible, include Psychologists in these settings in career panels and presentations and encourage academic collaborations.</li> </ul>
<b><i>Timing is everything</i></b>	
<ul style="list-style-type: none"> <li>• Government settings are subject to frequent changes that are often dictated by changes to policy and funding.</li> <li>• Priorities may shift and your role may change dramatically.</li> <li>• These settings tend to change slower than other systems, including academia.</li> </ul>	<ul style="list-style-type: none"> <li>• Practice radical acceptance. Remember the core values that may have led you to this work and accept that, although the work may look different over time, you can still act in service of those values.</li> <li>• Be persistent and hopeful. Repeating yourself is not a bad thing.</li> <li>• Practice empathy for how hard it is for systems to change. Having a long-term perspective is helpful.</li> </ul>
<b><i>Know your audience</i></b>	
<ul style="list-style-type: none"> <li>• Government settings involve multiple audiences including internal staff members, beneficiaries, consumers, the general public, and other large related systems.</li> <li>• It is critical to tailor your message to your audience and absorb what that audience is trying to communicate to you.</li> </ul>	<ul style="list-style-type: none"> <li>• Hone your communication skills and practice reciprocal communication with individuals who are different from you.</li> <li>• Be patient and persistent. Sometimes the first message is not the one that resonates. Ask for feedback and try again.</li> </ul>
<b><i>Advocate for yourself</i></b>	
<ul style="list-style-type: none"> <li>• Leaders and collaborators may be unfamiliar with Psychologists’ unique skills and how they may be applied. A part of your role may be educating others on these skills and demonstrating your value by speaking up in meetings and contributing to initiatives and projects.</li> <li>• Negotiate what you are able to up front. You may be able to negotiate a more flexible schedule or benefits (e.g., equipment, office, clinical time, professional development, vacation time, 529 account contributions, and student loan repayment) if a salary adjustment is not an option.</li> </ul>	<ul style="list-style-type: none"> <li>• Get involved in organizations like ABCT, which can help form your professional identity as a Psychologist and provide opportunities for presenting, writing, and being in leadership roles</li> <li>• Gain experiences in training and lean into situations where someone may have a different opinion from you. Reflective listening and responsive communication can be very helpful in changing opinions.</li> <li>• Humbly advocate for your ability to infuse data-based decision making and psychological science into workflow and operations.</li> <li>• Take a negotiating class or seek out mentorship on this topic.</li> </ul>



and practical applications in healthcare settings. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (p. 141–154). Wiley-Blackwell. <https://doi.org/10.1002/9780470687994.ch6>

Lau, A. & Wiltsey-Stirman, S. (2018, November). *Sustaining evidence-based practices within large-scale implementation efforts in public mental health systems*. Symposium presented at the Fifty-Second Annual Convention of the Association for Behavioral and Cognitive Therapies, Washington, DC.

Los Angeles County Department of Mental Health (2020). *About DMH*. <https://dmh.lacounty.gov/about/>

Minuchin, S. (1974). *Families and family therapy*. Harvard University Press.

Schoenwald, S. K., Arias, I., & Puddy, R. (2019, November). *Increasing Impact of Cognitive Behavioral Therapies: Why Public Health?* Panel presentation at the Fifty-Third Annual Convention of the Association for Behavioral and Cognitive Therapies, Atlanta, GA.

Substance Abuse and Mental Health Services Administration. (2019). *Center for Behavioral Health Statistics and Quality. Mental Health Annual Report: 2017. Use of Mental Health Services: National Client Level Data*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Starks, S. L., Arns, P. G., Padwa, H., Friedman, J. R., Marrow, J., Meldrum, M. L., Bromley, E., Kelly, E. L., Brekke, J. S., & Braslow, J. T. (2017). System transformation under the California Mental Health Services Act: Implementation of full-service partnerships in LA County. *Psychiatric Services*, 68(6), 587–595.

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OP-ED

## I Like Vegan Berry Ice Cream and Professor P Likes Vegan Berry Ice Cream Too

William O'Donohue, *University of Nevada, Reno*

THERE ARE A SERIES OF QUESTIONS that frankly have not been properly analyzed or researched, let alone resolved, regarding applications to graduate programs in clinical psychology. There are, of course, longstanding questions regarding how any of the typical components of the application—GPA, prior coursework, quality of undergraduate institution, GRE (and which subscores), personal statement, interview, and so on—either singly or in combination contribute to an accurate prediction of graduate student success. There are also questions about the relative importance/weight to be given to each of these factors. Further complicating the picture, there is variability across graduate programs as well as individual professors on what they are seeking or what they value. A Psy.D. program may be attempting to identify clinicians who are good consumers of research so that their professional behavior can be properly influenced by this research, while a Ph.D. program may be trying to find researchers who can eventually design, implement, and publish high-quality psychological research. There are also deep and vexing and largely unsolved questions in admissions about social justice, fairness in testing, and discrimination that come into play. However, it seems generally that admissions decisions for decades are rarely made actuarially but remain, shall we say, pre-Meehl (Meehl, 1954), i.e., informally, with the opportunity for a variety of well-known heuristics and biases to come into play. Thus, the situation is neither simple nor resolved, either for the applicant or for graduate faculty.

The focus of this paper will be on one common component of the application—the notorious personal statements. These can be notorious because there is a high degree of variability to these and, as a result, these can be vacuous, or overdisclosing, or full of artifice, or simply uninformative. In the following remarks I am not attributing any blame to the graduate applicant—they are trying to do their best to successfully navigate a difficult and unclear process so they can achieve an

important personal goal. These prospective students are putting a huge commitment of time, money, and emotional energy into these applications and they are doing exactly what is being asked of them. My criticisms are directed at the system that has allowed such unclarity to exist so that graduate applicants are faced with trying to comply with what may be problematic admission requirements.

Currently specifications for the personal statement are often quite vague. The University of Nevada, Reno, for example, only specifies “a brief statement of purpose.” Applicants, therefore, often take varying approaches to this vaguely stated task—some begin with their favorite Thoreau quote (e.g., “I went to the woods because I wished to live deliberately...” seems to be a favorite among applicants, but for some strange reason not Thoreau’s, “The cost of a thing is the amount of what I will call life which is required to be exchanged for it, immediately or in the long run”). The favorite quote is often then claimed to have absolutely animated the applicant’s very existence. Others focus on the disclosure of an unfortunate life circumstance or event that made the career choice of clinical psychology to be particularly apt for them; while other applicants provide low-risk summaries of their undergraduate research and service experience. (A rather informal personal observation—in my over 30 years of reading personal statements—I have never once encountered an accepted applicant mention subsequently the Thoreau quote or any other similar quote during their entire graduate career. Thus, on the upside, graduate faculty generally do not need to worry about phenomena such as—“The applicant clearly is heavily influenced by Thoreau—perhaps we are at risk that the applicant will drop out of our program and live a self-reliant, isolated life in the woods.”)

I have also seen some really problematic approaches to the personal statement. Personal statements can be perplexing because there is a high degree of variability to these and, as a result, they can be vacuous (e.g.,



talking about the local shopping opportunities near the university), or overdisclosing (e.g., speaking of one's pedophilia), full of artifice (e.g., utilizing famous quotes but not tying them meaningfully into their message), or simply uninformative (e.g., simply listing their qualifications in a way that is redundant with the CV). All of these parenthetical examples are from actual personal statements.

Eventually, most personal statements get around to the applicant's research interests with statements in the rough form of, "I am interested in topic T and so is Professor P so I would like to work with Professor P." Sometimes (although this varies) there is a bit more provided on this interest—perhaps linking this to the applicant's previous volunteer work, or to previous undergraduate research, but often not much more. I am arguing, however, that this is the most important part of that statement, but it can be much improved upon—and in what follows I present the case for this as well as some specifics for its implementation, which, when not explicated, places the applicant in a difficult situation. To be sure, these avowed research interests need to be taken with a grain of salt—applicants' prior experience has been much more limited than what they will soon be exposed to; and for this reason and others interests often change during graduate training. However, what I am arguing is that what is being missed by the vast majority of applicants is the persuasive burden of this component of their statement, and better addressing this will better serve both the applicant as well as the admissions committee.

The thesis of my argument is that, at best, similar academic interests are relevant but neither a necessary nor a sufficient reason to admit an applicant. The major concern is that the applicant ought not to be led to believe that their entire persuasive burden is met simply by stating similarity of interest. My argument is that there is an additional substantive burden that needs to be met but seldom is, roughly along the lines of:

*I have critically read one (or some larger subset) of Professor P's publications and I have a deep, current, and fairly faithful knowledge of what research Professor P has done within this broad general topic. I am interested in the specifics of this kind of programmatic research. I will show this faithful understanding of some subset of this research by a critical analysis of either a specific paper that I regard as*

*particularly interesting or some broader critical description of this program of research.*

The recommendation being made is that the applicant must then describe (in admittedly a limited space) how the applicant has read at least one of the professor's publications and provide a critical scholarly reaction to this reading. In doing this, substance is provided for the applicant's claim of shared interests, but more important, this task involves something much more criterion valid than simply stating an affinity as one does at an ice cream stand. It is criterion valid as one of the key tasks of a graduate student is a critical appraisal of scholarly activity. I would also argue that this task is in the applicant's interest as it can force a more detailed knowledge of the professor's research and thus the applicant is in a better position to judge if this really matches the applicant's interests.

Here is a rough outline that can help structure the task for applicants:

*Select a publication of the professor you would most like to work with—perhaps what you judge to be a particularly important publication in the context of your interests—and write a critical analysis covering the following points:*

- i. Problem context: What is the general problem that is addressed? What broader ideas are motivating this (e.g., a test of a certain theory)? In general, place this publication in the context of the relevant literature.
- ii. Brief summary of design
- iii. Brief summary of major conclusions/findings
- iv. Positive critical evaluation—what was done well
- v. Limitations—negative comments (e.g., conceptual problems, measurement problems, design problems, data analysis problems)
- vi. Implications and suggested further work

I am not suggesting that this is a template for students to use currently, but rather I am encouraging programs to consider adopting this format for their admissions process in the future. In addition, programs may modify these specifics to better match their individual aims, for example, Psy.D. programs may eliminate the last point as they may care less about the applicant's ability to generate future

research. This is admittedly a demanding task—it might even be described as "very tough." However, it is exactly the kind of task that applicants will repeatedly need to perform not only in graduate school, but for their entire careers. Thus, at a minimum the applicant's performance can serve as a rough baseline (although a larger sample of articles summarized would be ideal) as well as a criterion relevant writing sample. The latter is also important as many admitted students have serious problems in writing. This proposed writing task is arguably more representative of the writing that they would do in graduate school and thus would be more likely to reveal the applicant's initial strengths and weaknesses than the conventional personal statement. Of course, any problems or unclarity can be further explored in any subsequent phone or in-person interview.

There is a line in a play in which Lily Tomlin states, "No matter how cynical you become it's never enough to keep up." Beyond general cynicism for any proposal, there are some possible criticisms of this suggestion. Let me briefly respond to a few of the most important of these:

### **1. This is too demanding for applicants**

It is demanding, but it is unclear why it would be judged as excessively demanding for the majority of applicants. Their undergraduate education was supposed to teach such critical thinking; and because the majority of applicants to clinical psychology graduate programs are psychology majors, critical thinking about psychological research and theory constitutes much of the specifics of what they have been (or should have been) taught. Of course, applicants will not do as well as they eventually will—but it seems that it would be useful to see what they have learned thus far. In addition, an admission committee can judge that a poor performance on this task, as on any component of the application process, may be offset by the applicant's other strengths, but at least the issue is explicated in the proposed format.

### **2. The applicant could cheat and get help on this component**

This is true but this is no more a concern than with the traditional personal statement. Part of this concern can be addressed in subsequent interviews—if the applicant can't recount, defend, or expand upon their analysis, this then can be grist for the mill for the admissions committee in deciding whether the applicant did the work by themselves.

### 3. Currently the personal statement has a limit of 2 pages and thus there is too little space to do this

Given its importance, if there is any page limitation, the personal statement can be expanded by a few pages.

### 4. This is a particularly difficult burden when the applicant is applying to a lot of programs

No matter how many programs to which the applicant is applying, the substantive match of interests between that applicant and a professor remains a central question. Moreover, as stated above, an assessment of the accuracy of this match is in both the applicant's and professor's interest. The applicant can apply to fewer programs (which also may be a natural outcome of a more detailed substantive examination of mutual interests). I would argue that this is a legitimate concern if the applicant wants to apply to 20 or so programs—but again, spending the time to make sure there is a substantive match of interests may still be worth the investment of time and energy. Finally, this could represent an overall cost savings for the applicant in that if this problem is revealed before the personal interview at the university then the applicant can avoid spending a lot of time and money in a way that was not productive.

### 5. Relatedly, this all can be even more complicated when the applicant has several faculty members in which their interests align

A program can decide to either have the applicant execute the task once for the professor they are most interested in, or allow the applicant to do additional article analyses.

### 6. The GRE already has a writing component

This is true, although the GRE writing component is an attempt to measure general writing skills and provides less information about an applicant's critical writing about psychological scholarship. In addition, the proposed task is not simply a measure of generic writing ability but it is much more domain specific as it is an exercise in revealing critical thinking in psychology as well as an exercise to determine if substantive overlap in research interests actually exist.

### 7. This proposal might differentially affect certain groups of graduate students who may not have English as their first language or who might not have access to libraries

The second component of this criticism ought not to be too egregious as many apply when they are enrolled in some sort of undergraduate or graduate program—however, at a minimum, they could write the professor and ask for electronic reprints or professors can have some of their publications on their websites to help students in this task. It is true that this might disadvantage applicants who do not have English as their first language but no more so than the existing personal statement or other application tasks that involve English. Finally, competence in English will be an issue throughout graduate studies and therefore it is relevant to assess at this point too.

### 8. Some faculty may not be open to hearing limitations/criticisms of their theoretical commitments and research

This is undoubtably true. All too often in our field the general positive regard for critical thinking is functionally constrained to critical thinking that is other or outward

directed. However, this also might be a good screen for applicants for overly sensitive or narcissist potential research mentors. Thus, this proposed task might allow all to more clearly see how well some professors can check their narcissism (if any). I would also argue that this is a good start to address the insularity of research lab: all too often there is a lack of perspective on the limitations of the labs or professor's research. To paraphrase Cicero (excusing the sexism), "He cannot be strict in judging, who does not wish others to be strict judges of himself."

As in any proposal, the merits and problems will be revealed in implementation. It seems worthy to continually question how can graduate admissions be improved. In general, more empirical approaches need to be taken and only those subtasks that actually show predictive validity ought to be included. If other components are eliminated this would also allow more resources to go to this task—if, again, it is shown empirically to be predictive. This proposal is advanced in this spirit.

## Reference

Meehl, P.E. (1954). *Clinical versus statistical prediction*. Minneapolis: University of Minnesota Press.

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1. The list serve is tied to the email you use as your main email with ABCT; when posting via the list serve, be sure you're using the email associated with your membership account. Many people, either because of COVID restrictions or the summer displacement, will use personal accounts rather than their listed institutional email accounts. The system won't recognize you, and you won't be able to send (you can receive, however).
2. The list serve has a posting limit of 100kb. If you send a message with larger content, it won't go through.
3. Many institutions reject attachments; for higher delivery success rate, include text only in the body of the message.



## OBITUARY

# Remembering Jack Newman

Ricks Warren, *University of Michigan Medical School*

THOSE OF US WHO ARE FRIENDS and colleagues of Jack Newman are very sad to hear of his passing May 30, 2020. Jack was a devoted member of ABCT and the ACT community. Jack and I roomed together at ABCT conventions for over 30 years. Jack was a native Californian and had a master's degree in counseling and marital therapy from California State University, Chico. He was in practice for over 40 years. When Jack was in graduate school and the predominant therapeutic orientation was humanistic and Rogerian, he became an avid behaviorist, though he never lost his humanistic view of human beings. Jack and I first met at an ABCT convention and found out we had both been trained in REBT by Albert Ellis. As ACT became a more prominent part of ABCT, Jack found a supportive home within the ABCT community.

Jack regretted not having a Ph.D., though his command of theory and practice was superb. Jack was always evidence based in his work at the mental health clinic and in his private practice. Jack cherished the ABCT conferences and our time together. At the end of a full day attending presentations, we greatly enjoyed staying up late discussing what we had attended and enjoying some fine whiskey that Jack always brought for us. Jack's sense of

humor would come alive when he showed us his favorite Monty Python scenes on YouTube, such as *The Meaning of Life* and Mr. Creosote having a wafer thin mint (<https://www.youtube.com/watch?v=uRpt4a6H99c>) and "Look on the Bright Side" (<https://www.youtube.com/watch?v=L2Wx230gYJw>).

In addition to Jack's excellent clinical expertise, he had many other interests. He enjoyed Japanese language and culture and spent many hours learning to speak, read, and write the language. He occasionally would meet up with Japanese colleagues at the conferences and practice their languages. He also enjoyed fine wine, travel, golf, and much more.

When we were attending ABCT conventions, I would compulsively attend sessions all day, without stopping for lunch, while Jack was more selective, attending sessions of interest, but also exploring the cities we were in. When Jack retired a few years ago, he still came to ABCT, his professional home, to enjoy our friendship and hear about my experiences of the day. At ABCT 2019, we attended the Jimmy Carter Presidential Library and Museum where I took the above picture of Jack.

I admired Jack's marital relationship with Anne. It was obvious when I heard him talking to her on the phone that there

was deep love and respect in the relationship. I sent a draft of this obituary to Anne to review. When she wrote back, she added that Jack "loved a string of rescue cats and dogs that we pampered for more than 35 years. He was skeptical, but spiritual at the same time. The bonds of friendship were extremely important to him, and he kept up with friends for decades."

In the last few years Jack was in poor health. He suffered from COPD (despite the fact that he had never smoked), asthma, and, most recently, melanoma, which eventually spread to his brain and left him wheelchair bound.

When I talked with his wife Anne after Jack's death, she told me, with no surprise to me, that Jack "believed strongly in the precepts of ACT, and that they helped him deal with his own terminal illness." In our many talks, I could see the acceptance that he got from ACT and originally from REBT, as he accepted his forthcoming death with equanimity and gratefulness.

Our last convention together was in 2019 in Atlanta, when Jack was very emotional as he told me how much our friendship meant to him and how grateful he was. He talked of how grateful he was to have Anne as his wife and to be living in a wonderful retirement community in Medford, Oregon, where he loved to play golf. Jack's golf buddies plan to have a memorial service on the golf course and spread his ashes there. Jack was a generous, sensitive, loving friend. I cherished our relationship, and will especially miss him at ABCT.

...

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