

the Behavior Therapist

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PRESIDENT'S MESSAGE

Going to New Orleans: Facing the Challenges and Consequences

David F. Tolin, *The Institute of Living*



LAST YEAR, in response to the COVID pandemic, ABCT held its first-ever virtual convention. By all accounts, the convention was highly successful, thanks to the efforts of 2020 Program Chair Shannon Wiltsey Stirman and Associate Program Chair Daniel Cheron, 2020 President Martin Antony, and our Convention Manager, Stephen Crane. Still, I missed attending in person. ABCT's convention is not just about the presentations and posters (which are wonderful); it's about catching up with old friends, colleagues, and meeting new people who share our passion for CBT practice and research. It's about networking, sharing ideas, and developing new collaborations. And that's just really difficult to manage in a virtual environment.

And here we are again, facing a similar dilemma, to meet in person or not. Any decision we make has consequences. 2021 Program Chair Dr. Gregory Chasson and Associate Program Chair Dr. Elizabeth Katz have worked diligently to ensure that the convention will be rich with scientific and clinical information. They are working with a first-rate Convention and Education Issues Coordinator, Katharina Kircanski, and committee chairs Drs. Brian Baucom (AMASS), Christina Boisseau (Workshops), Samantha Farris (Institutes), Cole Hooley (Research & Professional Development), Tajal Jakatdar (Master Clinician Semi-

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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. 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.

nars), Shireen Rizvi (Representative-at-Large), Patrick McGrath (Sponsorship), Rosaura Orengo-Aguayo (2022 Program Chair), and Emily Kroska (2022 Associate Program Chair). Last, but certainly not least, Local Arrangements Chair Dr. Amanda Raines is working to make sure that attendees have access to all that this diverse city has to offer.

This year's convention theme is "Championing CBT: Promoting Cognitive and Behavioral Practice and Science in the Context of Public Health, Social Justice, Policy, Research, Practice, and Training." Be sure to look for invited addresses related to this topic by Drs. Kelly Brownell, Monica Williams, and Lynn Bufka; an invited panel sponsored by ABCT's Neurocognitive Methods for the Clinic Think Tank and the Neurocognitive Therapies and Translational Research SIG; and a Lifetime Achievement Award address by past ABCT president Dr. Richard Heimberg. There's also a special panel and networking event, sponsored by ABCT's Minority SIGs.

We recognize that some ABCT members and other prospective attendees might not be comfortable with an in-person convention. We further understand that not all employers will allow travel at that time. As of this writing (I'm writing this article in July), there are lots of news stories informing of us the rise of the Delta variant and the fact that Louisiana is one of the states with the highest population of unvaccinated citizens. As is no surprise, the City of New Orleans is addressing this issue in terms of compliance with city/state regulations and guidance regarding the current state of the pandemic. As of this writing, over 71% of all adults in New Orleans have received at least one shot of the COVID-19 vaccine and more than 51% of New Orleansians have been fully vaccinated. Staff is monitoring the New Orleans website, which outlines current cases and protocols: <https://ready.nola.gov/incident/coronavirus/safe-reopening/#phase>

Staff is working to determine the options available to us to meet in person, hybrid, or virtual. There are a lot of variables to address (including the cost in terms of direct dollars and people power) and it takes some time to do the research and know the options that would work for us. The Board then will decide what we will do, taking the personal safety of members, attendees, staff, and their families into consideration.

Of course, November is still several months away and we do not know how

COVID and its variants will progress between now and then. Your health and safety are at the top of our priority list, and we will adjust our procedures according to trends in COVID infection and local, state, and federal safety guidelines. There will be hand sanitizing stations placed in the meeting space. At all Hyatt hotels in the U.S., guests who are unvaccinated are required to wear face masks or coverings in hotel indoor public areas, as well as outdoors where social distancing is not feasible. Staff are researching companies that require attendees to either scan their vaccination proof in advance of our meeting or take a Covid test within 72 hours of their convention arrival. A representative would be on-site to check each attendee's record.

We will, of course, keep you posted as things progress.

Our new website (www.abct.org) is now open for your membership renewal and to register for the convention. Soon, the convention program will be available in the convention itinerary planner. As a member-driven organization, ABCT has paid a great deal of attention over the past two years addressing member benefits and services. We have expanded our webinar offerings, added free webisodes to our YouTube Channel, expanded our library of Fact Sheets, and increased our journal rankings for both *Behavior Therapy* and *Cognitive and Behavioral Practice*.

I strongly urge you to renew your ABCT membership and continue to be an active participant in the Association. This would be a great time for you to consider joining one of our many Special Interest Groups (see www.abct.org/membership/special-interest-groups-sig).

And please remember to vote. November is ABCT officer election month. Be sure you cast your ballot.

As always, I invite your comments and questions. Please feel free to email me at david.tolin@hhchealth.org.

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No conflicts of interest or funding to disclose.

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Find a CBT Therapist



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

We urge you to sign up for the Expanded Find a CBT Therapist (an extra \$50 per year). With this addition, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars. The expanded Find a Therapist listing will have a unique style and come first in any searches that capture the member's listing.

→ To sign up for the Expanded Find a CBT Therapist, visit abct.org/membership
For further questions, contact the ABCT central office at 212-647-1890 or membership@abct.org

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

Mary Jane Eimer, *Executive Director*



2021 has been a year of flux and pivoting. We offered you more opportunities to earn continuing education credits through our online webinars. We introduced a discounted rate to make webinars more accessible to our students. Our Student Membership Committee continues to produce free webinars on career opportunities. In fact, this year, the panel “Predoctoral and Early Career Training Grants: The What, Who, Why, and How,” usually presented at the Annual Convention, will be presented online in October.

The biggest change is how you interact with ABCT online. As many of you have already experienced, we have transitioned to a new database and website. Staff, our web editors and associate editors, along with many members, held countless meetings to look at all aspects of how we do business. They looked closely at the time members spend on our database and how easy it is to find what you are looking for on our website. We simplified our taxonomy from 150 topics to 40. Big changes include

single sign-on, allowing you to register for the convention directly from our site, updating our subdirectories (membership directory, Find a CBT Therapist directory, Mentorship Directory, Medical Educators Directory, and Speakers Bureau) directly from the main membership database, in real time. You can access our journals via Elsevier’s ScienceDirect directly from our website. We rearranged features on the website to make them easier to access. Our donation page provides clear opportunities for members to support our awards program and other work of the association. And we added Forums, which for the moment is in addition to the list serve, but which will soon replace it.

Changing our database and website also has ABCT staff paying close attention to cyber security. It is a never-ending assault on our server and email server by hackers and phishers. Switching to a new system will help but it is not enough. We aim to keep our data safe, your information private, and keep ABCT running smoothly.

Please join me in congratulating Denise Sloan, Editor of *Behavior Therapy*, and Brian Chu, who recently ended his term as Editor of *Cognitive and Behavioral Prac-*

tice, and their editorial team. Under their term as editor, our JIF increased in *BT* to 4.183 with a 5-year IF of 5.425; and *C&BP*’s increased to 2.946 and 3.271.

President Tolin addressed the New Orleans Convention preparations in his column. All hands are on deck to offer an opportunity for members to network in person in a safe environment. New information, changes in protocols, and options for social distancing are being closely monitored. The traditional program offers a wide variety of topics and the ability to earn new skill sets and continuing education credits. You will note in this issue of *tBT* that we are offering some sessions virtually with a special rate.

ABCT leadership and staff continue to work to offer you a variety of outlets to learn, share, and network. We know many of you consider ABCT your professional home. Your home needs you. Please renew your membership. Please take time to look at the new website and give us feedback. It isn’t just membership numbers that matter, it is involvement. Take a moment to see if there is an opportunity for you to give back to ABCT by becoming a member of a committee, become a member of the program committee to review abstracts, submit an article, join a SIG, run for office, and vote this November.

If you have questions or want to get involved in an ABCT committee, please contact me at mjeimer@abct.org. There is plenty to do!

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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



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The New Frontier of Mental Health Apps: A Multidisciplinary Approach to Managing the Risks

Susan Longley, *Texas A & M University–Corpus Christi*

THOUSANDS OF MENTAL health applications (MH apps) are available to consumers through a variety of digital devices (Fairburn & Rothwell, 2015). A vital sector of this market is made up of the privately funded data-collecting devices within self-contained programs used on smartphones or tablets (Fairburn & Rothwell). The number of available MH apps is growing exponentially as consumer mental health startups attract capital from private market investors with an appetite for innovative businesses in the mental health sector (Shah & Berry, 2020). These devices have the potential to increase access to high-quality treatments for common and costly mental disorders (Torous & Roberts, 2017). This promise, however, is increasingly overshadowed by controversies about the lack of oversight for their development and use. Rapid expansion of the number and type of these devices make this a critical time that requires advocates for mental health to understand the multidisciplinary nature of issues that put app users at risk for unknowingly making personal information public, and for exposure to low-quality treatments. The following is a timely review of these unresolved issues and their partial solutions, as well as a call for a dialogue between the Association for Behavioral and Cognitive Therapies (ABCT) and other disciplines involved, such as law and the behavioral and computer sciences.

There is agreement across disciplines that mobile devices for behavioral health hold the promise of scalable access to evidence-based treatments for common mental disorders (Chandrashekar, 2018; National Institute of Mental Health, 2017). Mental disorders are highly prevalent and have a negative impact on the life of affected individuals (Eaton et al., 2008). One in four individuals will have a diagnosable mental illness in their lifetime, but less than 30% of those will receive or have access to the array of available evidence-based treatments (Wainberg et al., 2017). The reach of mobile MH apps has the

potential to vastly expand access to behavioral health treatments. This expanded access can reduce the disparity between the need and availability of evidence-based treatments. The availability of digital access in a place and time of one's own choosing may further reduce treatment barriers to traditional mental health treatment, such as stigma, scheduling, scarcity of local resources, and cost (Munoz et al., 2018). For these reasons, it is easy to imagine the potential positive changes of this technology for mental health treatment.

Scholars from the disciplines of computer science, law, and mental health suggest that the future promise of MH apps is currently overshadowed by the potential harms of these largely untested and unregulated devices. For example, the MH app treatment programs presented, and the personal information gathered by the apps, are not formally regulated by government agencies or external organizations. In the absence of proper oversight, this technology represents a potential threat to consumers that is without benefit of traditional scientific, ethical, and safety guidelines. For the most part, these devices are developed by an unregulated high-tech industry, ranging from well-established, large companies to small startup entrepreneurship. These new technologies do not clearly fall under the auspices of a particular agency or scope of authority, and the devices are being created at a rate that outpaces the capacity of any agency to adequately regulate this industry (U.S. Department of Health and Human Services [HHS], 2016).

Privacy

Concerns about the lack of privacy for the personal health information collected by mobile devices were summarized in a report to the United States Congress that was issued by the Office of the National Coordinator for Health Information Technology (ONC) in coordination with the Office for Civil Rights (OCR) and the U.S. Federal Trade Commission (FTC; U.S.

Department of Health and Human Services, 2016). The report indicated the inadequacy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to address privacy issues with digital technology. HIPAA is a federal law that ensures safeguards for sensitive personal and health information, but only for covered entities such as health plans, health care clearinghouses, and health care providers who electronically transmit health information. The report pointed out that HIPAA dictates the security of protected health information (PHI; e.g., name, location, and mental health condition), and that this is the same information that MH apps collect. Developers of MH apps do not fall under the covered entities specified by HIPAA and therefore have no legal obligation to protect these data. Although smartphone app technology did not exist when HIPAA became law, the protection of PHI data should be uniform across all entities that collect this data.

The lack of digital privacy that endangers personal information while using apps on a computer or personal device has alarmed professionals in law, cybersecurity, and mental health. A common business model for commercial MH apps is to consider the collected personal and health data as a commodity to be bought and sold, often without the user's awareness (Parker et al., 2019). For example, a "first party" mobile app can obtain sensitive health data. It is notable that the data can be linked to a particular user through the Global Positioning System (GPS) receiver installed in most cell phones. In a study of GPS data from the phones of 1.5 million Europeans, it took only four GPS points accumulated over a 15-hour time-period to identify 95% of individuals (de Montjoye et al., 2013). The collection of this data is not limited to the app itself.

The 2016 report to Congress that was cited previously mentions the additional problem of "third" parties (U.S. Department of Health and Human Services, 2016). To defray the cost of developing and hosting the app, "third party" trackers are permitted to follow users with the source code of the "first-party" mobile application (Binns et al., 2018). The "third party" trackers not only have access to the data collected by "first party" app, but also collect additional data to construct aggregated profiles of individuals. The trackers can link a single user's activity across multiple apps to the user's activities on other devices or mediums. For example, Moodpath, a widely available MH app for depression,

shares user data with two of the most robust “third party” consumers of user data—Facebook and Google (Binns et al.).

Typically, smartphone apps use click-through privacy policies that are difficult to read and sometimes intentionally obscure. A recent study of 36 top downloaded apps for depression and smoking cessation revealed that the transmission of data to third-party entities occurred in 92% of the apps, and that most apps failed to provide transparent disclosure of that fact (Huckvale et al., 2019). Similarly, a review of apps for dementia care found that only 4% offered written assurances that user data would not be sold (Rosenfeld et al., 2017). These practices raise questions about the adequacy of (a) disclosure regarding generation and use of the individuals’ information, (b) informed consent that uses a click-through agreement to download mental health apps, and (c) safeguards for the confidentiality of sensitive mental health information. For a more in-depth discussion of informed consent provided by digital apps see Palmer and Burrow (2020).

Treatment

Mental health professionals have noted the risk to consumers and the lack of federal oversight for the therapeutic treatments offered by MH apps (Larsen et al., 2019; Marshall et al., 2019). One agency seems to be the logical choice for safeguarding the public from these risks, namely, the U.S. Food and Drug Administration (FDA; 2019). The FDA has the mission to protect public health by ensuring the safety, efficacy, and security of mobile medical devices (e.g., smartphone apps). Medical devices are those that perform “diagnosis, cure, mitigation, prevention, or treatment of a disease or condition.” MH apps that provide treatment or assessment certainly fall within the agency’s purview by meeting the definition of a medical device. The policy of the FDA, however, is that the developer, and not the agency, is responsible for labeling their app as a medical device—a label that makes it eligible for the agency’s review (Rothstein et al., 2020). Predictably, this self-policing policy has resulted in only a handful of MH apps being declared as a medical device. The FDA also has the authority to establish a product’s intended use based on evidence of a known misuse and has indicated its willingness to pursue false claims about these devices. The FDA, however, has given MH apps a low priority and it has been rare

for it to assert this authority (FDA, 2019; Rothstein et al., 2020).

Consumers often have little guidance in selecting an MH app other than descriptions they find on the hosting website. The therapeutic variations in widely available MH apps often range from those that are pseudoscientific to others that could best be described as unstudied efforts to utilize empirically supported techniques. Portrayals of the therapeutic virtues of MH apps, however, are more likely to use superficial scientific claims rather than provide empirical support for treatment efficacy (Larsen et al., 2019). Indeed, one study investigated the largely unsupported therapeutic claims of 293 widely available MH apps that offered treatment for depression and anxiety (Marshall et al., 2019). Less than 4% of the apps had research to justify their claims, and most of the research was not from independent sources. Of that 4%, only one-third of these MH apps claimed to have been developed with expert input, and only one-fifth were developed in affiliation with a government body, academic institution, or medical facility. In other words, it appears that the majority of MH apps were not developed with a scientific approach that would provide empirical evidence to support the treatment’s efficacy. Conclusions from investigations regarding the evidence base for the effectiveness of MH apps varies significantly, however, and such investigations are limited by inconsistent operationalizations, varied methods of study, and the fact that so many MH apps are emerging it is impossible to assess them all (or even a truly representative sample).

For example, MH apps that have published empirical data to support the treatments offered comprise only a small fraction of those available, but meta-analyses of these have increased to over 50 within the last 3 years (Linardon et al., 2019). The results from these meta-analyses can be inconsistent regarding treatment efficacy of MH apps (e.g., Firth et al., 2017; Weisel et al., 2019). Some of the variations that make comparisons of studies difficult are the result of differences in the selection criteria (e.g., sample type, download availability, control condition, type(s) of mental disorder, etc.). Another difficulty with interpretation is that the number of eligible studies (e.g., randomized control trials, or RCTs) in the meta-analyses are often relatively small. This limits both the power of the analyses and the conclusions that can be drawn. A synthesis of data across the numerous individual meta-analyses could provide needed clarity about critical ques-

tions, like how well the MH apps perform compared to more traditional methods of treatment, and for which groups they provide benefit.

Privacy and Treatment

Privacy and treatment are intertwined when considering the rise of MH apps. The American Psychiatric Association (APA) has taken another approach to the quality of therapeutic treatments by announcing a plan that has wide application for the evaluation of many MH apps. The APA has recently announced the development of a centralized database that allows users to make informed decisions about the quality of various MH apps (Lagan et al., 2020). The database applies a four-stage hierarchical model (Torous et al., 2018) that prioritizes MH app characteristics as follows: (1) safety and privacy, (2) evidence and benefit, (3) engagement, and (4) interoperability (e.g., operating on both iOS and Android platforms). Judging the quality of MH apps, however, is a formidable task; collectively, the MH apps have heterogeneous characteristics that make them complex to categorize and evaluate (Wisniewski et al., 2019). Consequently, the proposed tool rates the apps on no less than 150 different characteristics. As this tool is developed further it is expected to become more scalable.

A group of legal scholars have recently voiced concerns about the risks for MH app users, suggesting that the process of MH app development and the data collected falls under the umbrella of nonregulated health research (Rothstein et al., 2020). This nonregulated and nontraditional health research lacks the oversight given to traditional research involving research with humans. The development and testing of MH apps does, however, meet the definition of human research outlined in the Federal Policy for Protection of Human Subjects (i.e., The Common Rule). MH app research involves studies of living individuals from whom private information is obtained that is used, studied, analyzed, or generated (1991). This official policy for traditional research identifies the necessity of an Institutional Review Board (IRB) to review all research with human subjects. The IRB plays a critical role in the protection of the privacy, rights, and welfare of human research subjects and ensures the soundness of research studies.

This oversight, however, only applies to government bodies, academic institutions, and medical facilities that receive federal

funds, or when there is an FDA review. Although MH app development and the data gathered meets the definition of human research, the private companies that launch them generally do not require FDA review, nor are they the recipients of government funding, which is a qualification for IRB oversight. It is understandable that without this oversight, the developers of MH apps have had no obligation to protect the privacy, rights, and welfare of human users from which data is collected. The industry producing commercial apps can disregard the privacy of personal health information and perpetuate potentially fraudulent claims about therapeutic treatments. Lacking an IRB review, the development and marketing of MH apps fail to adhere to generally recognized ethical norms for the treatment of participant-users. Without guiding principles, users experience violations of privacy and rights, as well as exposure to potential harms (Rothstein et al., 2020). Hard lessons since the Tuskegee Syphilis Study ought to be kept in mind; it is highly questionable that some organizations doing human research and potentially exposing humans to harm are exempt from independent oversight.

Some attempts at the federal level have been made to reduce such exposure to harm. Consistent with its mission to address “unfair or deceptive acts or practices,” the Federal Trade Commission (FTC) has pursued digital privacy violations of the Children’s Online Privacy Protection Act (COPPA). The FTC settled this precedent-setting case against a manufacturer of stalking apps for violation of consumers’ digital privacy and exposing the users’ devices and data to cyber-attacks. The agency alleged that Retina-X Studios marketed spyware apps that allowed purchasers to covertly monitor data from users’ smartphones by circumventing the mobile device’s security restrictions. Whether the FTC’s review may extend to other vulnerable populations, such as those who use MH apps, is unknown, as the legislation on which it can build a legal case is either newly implemented, nonexistent, or pending.

The FTC may take future cases based on recent legislation at the state and federal levels to protect digital privacy of data collected by smartphone apps. The California Consumer Privacy Act of 2018 (CCPA) is a landmark law that secures new digital privacy rights for California consumers. CCPA gives consumers controls over the personal information collected about them by giving them the right to: (a) know what

is collected and its use, (b) delete the information, (c) opt out of its sale, and (d) ensure nondiscrimination for exercising their rights (<https://oag.ca.gov/privacy/ccpa>). This is a trend in emerging legislation at the federal and state levels that address the security and privacy of digital personal information.

More Comprehensive Approaches

Others suggest that only a comprehensive bill of rights that delineates broad principles will guard users’ digital privacy and safeguard the data collected by MH apps (Kerry, 2018). A Digital Privacy Bill of Rights was proposed during the Obama administration, but it was not implemented (Obama, 2013). The proposed approach was to have the FTC review potential violations of the principles on a case-by-case basis. The cases were to establish precedents to guide organizations outside of government in the development of best practices, standards, and codes of conduct that would, in turn, be vetted by the FTC. It was believed that the pace of technological change and the variety of circumstances involved would soon make traditional legislations outmoded. For example, MH apps that use artificial intelligence and virtual reality are becoming more common (Terry & Gunter, 2018). It was also believed that only a bill of rights would address the power differential between the unaware users and the knowledgeable collectors of their data. It may be time to revisit such a comprehensive method to protect digital data.

In the same comprehensive vein, a potential exemplar for MH apps is the suite of tools developed by the U.S. Department of Veterans Affairs, Veterans Administration (VA)/Department of Defense (DOD). These digital tools were developed with a different model than the majority of commercially available MH apps (Gould et al., 2019). The VA/DoD suite of mobile apps is distinct because of the following characteristics: (a) it was developed for noncommercial purposes by a multidisciplinary team of clinical psychologists, including sociologists, app designers, and software engineers; (b) it is available on iOS and Android platforms; and (c) it has accessibility features to accommodate physical challenges (e.g., for visual challenges the apps have appropriate color contrast and do not use color as the sole means of communicating information).

The VA’S suite of apps also incorporates digital privacy and evidence-based

treatment. Although these digital tools are hosted on commercial websites, the apps are free, and the users have anonymity. No identifiers or data that could be linked to individual users are collected (J. Owen, personal communication, May 4, 2021). The informed consent used by the VA/DOD suite of MH apps has been lauded because it summarizes privacy issues in simple and straight-forward language. Although only one of these apps has completed a formal efficacy study, there are ongoing empirical studies of the suite. A partial list of the studies can be found at this website <https://myvaapps.com/mhealth-research>. These apps have differences in their key features, intended use, and presentations, but all are grounded in a strong theoretical evidence base. The accountability, transparency, and multidisciplinary team approach are critical elements that have contributed to the trustworthiness and quality of these digital interventions.

Conclusion

MH apps have posed unprecedented challenges to the privacy of users and to the treatments delivered to them. To date, attempts to address these challenges have proven inadequate. A more comprehensive approach to regulation is required because of the magnitude of the reach of these devices, the multidisciplinary nature of the issues involved, and the possibility of harm to a large number of consumers (Armontrout et al., 2018; Terry & Gunther, 2018). MH apps are being downloaded at a phenomenal rate by consumers who trust them (Elias, 2015). New technologies are rapidly evolving that will be transformative. The current and next generation of MH apps that offer treatment (e.g., monitoring, psychotherapy, and coaching) may augment or even replace trained professionals in some circumstances. MH apps have enormous potential to address the disparity between the need for and availability of mental health services, but this is undermined by the issues of the invasion of digital privacy, a lack of transparency in consent, and potentially fraudulent treatment claims (HHS, 2016).

Trusted regulatory agencies have been reticent or slow to develop strategies to protect the public from the risks of MH app technology (HHS, 2016; Lewis & Wyatt, 2014). In part, this is because traditional privacy and security regulations do not apply to the interactions between apps and users. The complex issues presented by

technology exceed the federal government's limited resources. The FDA has taken a laissez-faire approach to regulation; meanwhile, HIPAA and The Common Rule (i.e., IRB) have narrowly defined jurisdictions, and although the FTC has taken a more active role, it has yet to address mental health directly. These deficiencies in the regulatory frameworks are troubling but unsurprising in light of both the volume and novelty of the emerging app technologies.

The issue of the lack of empirical evidence for the interventions offered by MH apps has been less explored than privacy but also has troubling implications. Psychologists have long campaigned for evidence-based, psychological interventions to be a gold-standard for treatment. Most of the app-delivered interventions, however, are developed with no scientific support and lack expert input. These deficiencies make the treatments questionable and the users vulnerable. Users who download these apps in the absence of accurate descriptions have a good chance of selecting those that are ineffective or harmful.

Mental health professionals share a duty to protect those they work with, and this extends to the use of MH apps. For this reason, practitioners should recommend these devices with extreme caution (Terry & Gunter, 2018). In the absence of oversight, the mental health professionals may be completely responsible for the privacy, health, and safety of clients who use the apps within a therapeutic relationship (Palmer & Burrow, 2020). Despite these cautions, and as noted above, there are some efforts to address the therapeutic value of MH apps and to ensure the digital privacy of users, but these so far have been partial or inadequate. In addition to the need to develop those efforts, there is an urgent need to broadly influence policy. Current policies and laws remain too outdated for MH apps, or are not efficiently enforced for the risk management of these apps; this poses a risk to the health, safety, and privacy of those who use them.

A multidisciplinary approach could integrate the legal, digital security, and mental health issues to determine the appropriate regulatory framework to manage these devices. This must be a collaborative and collective process that involves multiple disciplines and incorporates diverse perspectives. Rather than remaining on the periphery of this discussion, ABCT must actively commit to offering its expertise to this multifaceted problem. An example of this could be playing a

key role in influencing public policy in collaboration with colleagues in law and computer science. Another related example would be to take a leadership role in the coordination of academic and public responses to this problem. This might include clearly worded policy reports and position papers with input from multidisciplinary teams. To empower the membership in this discussion, an educational campaign is required that will enhance understanding the impact of these powerful technologies. As evidenced in all of these examples, a sensible next step would be to invite an interdisciplinary panel of knowledgeable experts to the Annual Convention.

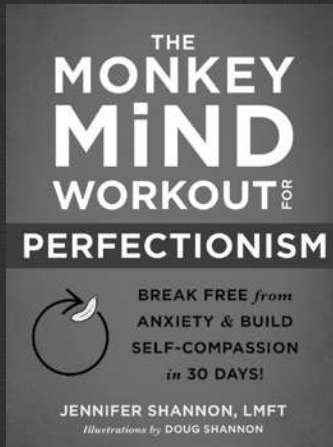
In closing, advocates for a safe and scientific approach to treating mental health now have a unique opportunity to work with colleagues in law and computer science to guide the development of MH apps. It should be stressed that the objective is to improve these apps and not to eliminate them.

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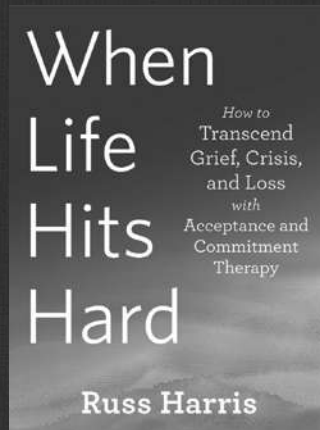
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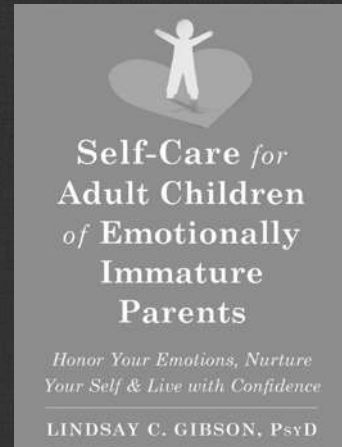
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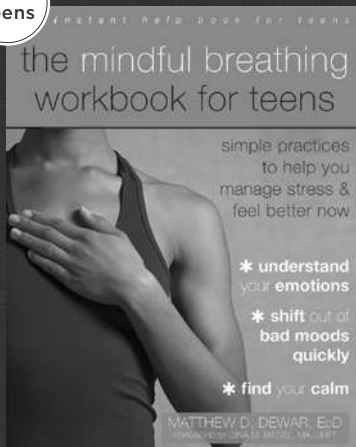


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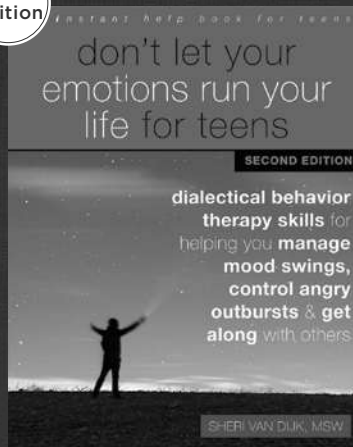
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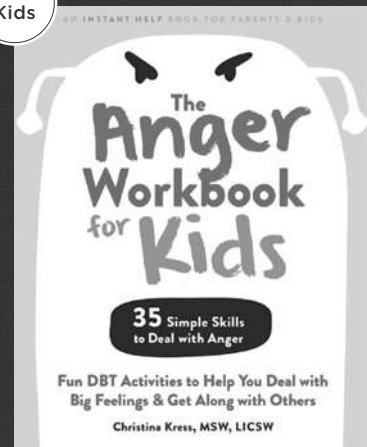
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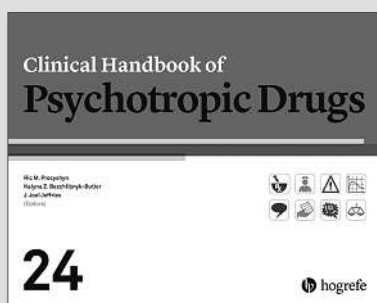


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Unicorns, Leprechauns, and White Allies: Exploring the Space Between Intent and Action

Monnica T. Williams, Noor Sharif, Dana Strauss, Sophia Gran-Ruaz,
Amy Bartlett, *University of Ottawa*

Matthew D. Skinta, *Roosevelt University*

IN THE WAKE of a resurgence of the Black Lives Matter movement and the unjust killing of many Black Americans at the hands of police, there has been increased awareness of the concept of racial justice allyship. Specifically, what does it mean for someone to act as a “White ally,” and what is their role in the social justice movements centered around anti-Black racism? Unfortunately, when trying to answer this question, there seems to be a disconnect between how people see themselves versus how they practice allyship in the real world. For example, White people frequently report themselves as allies and are in verbal agreement with necessary behaviors to ensure that we are moving towards a more equitable society. However, when real-life opportunities arise to act on these convictions and dismantle systems of oppression, many White people do not end up engaging (e.g., Buchanan, 2020; Reed, 2019). We are therefore left wondering, in the midst of the current climate of social upheaval and calls for racial justice: Is it really enough for one to simply claim to be an ally? And what characteristics of allyship make one a meaningful ally?

Allies are members of a dominant social group, or ingroup, who work towards fairness for people in a nondominant group, or outgroup. Ingroup and outgroup terminology draws from social identity theory, and offers a helpful frame for considering intergroup dynamics—particularly when an ingroup, such as Whiteness, is defined through exclusion and exclusionary practices (e.g., Hogg et al., 1995). According to Brown and Ostrove (2013), allyship consists of supporting nondominant groups through meaningful relationships and taking concrete action to dismantle inequitable colonial systems. Ally behaviors can include calling out discrimination and fighting for inclusion of outgroup members, and allyship consists of both public and private behaviors. When it comes to tackling racism, White allies can

use their privilege as part of the ingroup and play an important role in helping to reduce incidents of individual or systemic racism against people of color. Smith et al. (2016) clarify some key points about racial justice allyship. First, allyship is about support, not leadership. Second, allyship is a continuous process that cannot be “achieved,” but to which one aspires. Last, one cannot self-prescribe the label “ally”; it is a designation given by members of the nondominant group with which one aspires to ally themselves. White allyship, in this way, diverges from other forms of allyship, as popular “Safe Zone” programs in the 1990s and onward encouraged faculty and individuals in higher education to self-declare themselves as allies (e.g., Draughn et al., 2002). Such identifications do come with their own expectations, however, as queer and trans students still expect active engagement on the part of self-declared allies (Forbes & Ueno, 2020). Spanierman and Smith (2017) further clarify White allies are those who: “(a) demonstrate nuanced understanding of institutional racism and White privilege, (b) enact a continual process of self-reflection about their own racism and positionality, (c) express a sense of responsibility and commitment to using their racial privilege in ways that promote equity, (d) engage in actions to disrupt racism and the status quo on micro and macro levels, (e) participate in coalition building and work in solidarity with people of color, and (f) encounter resistance from other White individuals.” Unfortunately, many confuse White allyship with White saviorship—engaging in performative acts of helping others for benefit, self-image, or recognition (Williams & Sharif, 2021). White saviors espouse more of a charity model or paternalistic view of helping those they consider “less fortunate” while still maintaining notions of White superiority and social/emotional distance. Genuine allyship requires identifying and decentering Whiteness, empowering

others even when this involves peer conflict, and engaging in reciprocal vulnerability (e.g., confronting uncomfortable or shameful race-based topics; Haeny et al., in press; Printz Pereira & George, 2020).

There are currently not many tools for assessing and quantifying the allyship of ingroup members, and, as such, there is a need to develop new methods for assessing allyship that can be used in this moment of social change to better understand the most important characteristics of allies and determine if interventions designed to reduce prejudice can improve allyship in the service of equity and equality. Furthermore, research has shown that White people frequently label themselves as allies, yet most of this research is based on self-report. Very little research exists within the academic literature examining people's real-life behaviors and objectively rating it as in line with allyship or not. For example, a study by Mekawi and Todd (2018) sought to measure allyship using self-report measures. University students were presented with a variety of microaggressive situations, to which the majority (93%) reported they would behave in an allied manner by openly disagreeing if met with such a situation in the real world. However, there was no follow-up behavioral assessment to verify whether these allied intentions actually predicted allied behavior. In fact, based on reports from people of color, who often feel abandoned by would-be allies (e.g., Buchanan, 2020; Williams, 2020), and the persistence of microaggressions since they were first identified by Pierce (1970; Williams, 2020), it is highly unlikely that these self-reported allied intentions are acted upon with the same frequency with which they are endorsed by participants in research studies. Rather, it seems that, more often than not, microaggressions against people of color go unchallenged by self-proclaimed “White allies.”

This disconnect between intention and action is also documented by Suárez-Orozco and colleagues (2015), who noted instances of microaggressions in approximately 30% of college classrooms they observed, which went largely unchallenged. One possible explanation for the lack of allied behavior in that study might relate to the issue of power, since professors were usually the microaggressors. However, it is important to note that an attempt at allied behavior that is unsuccessful (due to power imbalance, counterattacks by the perpetrator, social anxiety, etc.) could result in anger and frustration in the potential ally, which may lead to counterproduc-

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tive reactions in would-be allies such as giving up the effort of allyship altogether. The negative effects of a roadblock on White allies may be particularly strong for those who highly value antiracist ideals, yet hold those only in the abstract. As this study reveals, relationships and connection may be at the heart of effective allyship, and the endorsement of strongly held moral convictions in the absence of those relationships or desires for intergroup connection may ultimately express a dead end in understanding the development of an antiracist mindset.

So how can we better understand the connection between intention and action when it comes to White allyship? In terms of what types of developmental characteristics are best predictors of increased allyship behavior, previous research found that enthusiasm (feeling impressed, inspired, and enthusiastic about people of color) and engagement (a desire to know people of color and learn about their experiences) seem to be vital (Williams & Sharif, 2021). This is consistent with reports in the literature describing the origins of antiracist White allies, which is predicated by opportunities for intergroup contact, mentorship, belonging to a socially active organization, and being part of an experience that challenges ideas previously held (Smith, 2007).

The objective of this study is to ascertain the degree to which White individuals behave in an allied manner when provided the opportunity to do so. Authors previously developed the Interpersonal Racial Allyship Scale (IRAS) that is correlated to allied behaviors (Williams & Sharif, 2021), using a behavioral experiment to establish predictive validity. Using the data from this behavioral experiment, we now aim to ascertain (1) what percentage of individuals demonstrate allied behaviors in the laboratory experiment, (2) how aligned are people's intentions to be allies when contrasting their thoughts to their actions, and (3) what score on the IRAS reliably corresponds to participants behaving as an ally consistently.

Methods

Participants

Participants were derived from a larger study. The original participants were 987 non-Hispanic White undergraduate students (M age = 19.19, SD = 1.85) and 61 Black undergraduate students (M age = 19.61, SD = 2.48) at a university in the Pacific Northwest who participated for

extra credit in their introductory psychology courses. The university's Institutional Review Board had approved this study, and participants signed an online consent form prior to accessing the survey. The majority of participants identified as female (63.6% and 67.2% for White and Black samples, respectively). A subset of the White participants (n = 31) participated in a laboratory behavioral task; the majority of these participants identified as female (51.6%) and had a mean age of 20.29 (SD = 4.07). The participants for this study consist of the 31 White individuals who participated in the behavioral task of the larger study.

Measures

The Interpersonal Racial Allyship Scale (IRAS; Williams & Sharif, 2021) is a 10-item measure designed to quantify actionable and behavioral components of interpersonal racial allyship based on responses to hypothetical racially charged scenarios. After each scenario, participants are provided a series of potential statements one might make in that situation, including statements that would be considered microaggressive (e.g., "What is your favorite basketball team?") and supportive (e.g., inviting the Black student to a future group social engagement). The 10 supportive items demonstrate inclusion, advocacy, concern, and assistance toward Black people in various situations. Respondents were asked to report how likely they would be to do or say each response (or something similar) on a 5-point scale with anchors 1 ("Very unlikely"), 2 ("Unlikely"), 3 ("Neither likely or unlikely"), 4 ("Likely"), and 5 ("Very Likely"). For the purposes of study, participants were also asked (a) how likely they were to think the supportive response, as well as (b) whether or not they would carry it out. A separate total was computed for the allyship "thought" items versus the allyship anticipated "actions."

The IRAS (action items) have demonstrated strong fit across several indices in factor analyses, good convergent validity across several well-validated measures of racism and feelings about people of color, good divergent validity against social desirability, and strong predictive validity with observed supportive behavior of individuals in the laboratory task. Internal consistency was good in the current subsample (α = .82).

Procedure

In this study, we wanted to determine the extent to which self-reported allyship

corresponds with real-life allyship. To do this, we designed a laboratory behavioral task that we used as a behavioral ("real-life") measure of allyship. As noted, a subset of the participants who completed the self-report allyship measure, IRAS, completed the behavioral lab task. We then compared participants' scores on each measure to determine the cut-off score on the IRAS that corresponds with "real-life" allyship as demonstrated in our laboratory behavioral task.

• Behavioral Lab Task

Participants took part in a laboratory behavioral task wherein they engaged in three 5-minute discussions with another research participant (who was actually a confederate research assistant [RA]) about racially charged news stories in the United States. Each participant was greeted by a Black RA, who obtained informed consent, introduced the participant to the confederate who was White, and informed them that the RA would be watching the interactions in the other room via live video-recording. The researchers of the study did not want to expose the Black RA to microaggressions directly. However, the participant knew the interactions were being watched and recorded by a Black peer. All participants were debriefed once the study was complete. The interactions were subsequently coded and scored to arrive at a numerical rating for each vignette for each participant, based on the number and quality of supportive statements made by the participant toward outgroup members.

Development of the behavioral test.

News stories used as the subject of discussion were selected based on their ability to provoke racial microaggressions. These were types of news stories that had generated discussions about racial issues in the popular press. The first story ("Monument") described the fight between activists and the city government concerning the removal of a Confederate monument in Kentucky, a painful reminder of slavery and an example of an environmental microaggression (Williams, 2019). Support for keeping the monument in place would be microaggressive, whereas denouncing it would be a supportive behavior. Similarly, the second story ("Police") described the killing of an unarmed Black male college student by police after a car accident, the type of problem that has sparked the Black Lives Matter movement. Support for the killing of the

Black man would be microaggressive, whereas denouncing would be supportive behavior. The third (“Party”) described a fraternity party that involved members employing Black stereotypes, resulting in their suspension and a campus-wide debate about free speech. Support for the fraternity party-goers employing Black stereotypes and against their suspension would be microaggressive whereas denouncing both would be an indication of supportive behavior. (The full text of the three vignettes is available in Kanter et al., 2020.) The discussion generated by these news items provided ample opportunity for participants to express microaggressions or allyship behaviors.

Coding and scoring procedure for behavioral task. The recording of the behavioral task was coded by a team of trained and supervised undergraduate research assistants. The group was intentionally diverse: five identified as female, three as Asian, two as Black, and two as White. The coding system was developed by a researcher and a graduate student who met with the coders weekly for 1.5 hours over 2 months for the provision of training. Two criterion coders—both Black female graduate students—randomly coded 10 videotapes for a reliability check.

Coders rated each recording (three discussions per participant) on two dimensions: overall racist microaggressions and overall supportive nonracist statements. For the development of the IRAS, only the supportive statements were examined. The coders were asked to consider everything the participant said and rate how they believed a person of color (non-White person) would feel interacting with that participant using a 4-point Likert scale: 0 (*absence of any supportive comments*); 1 (*at least one specific positive supportive comment*); 2 (*consistently supportive throughout the interaction*); 3 (*very explicit, unwavering support for nonracist and equity values and behavior*). While coders were encouraged to consider this process holistically, considering tone and other noncontent features of speech and communication, this was factored into the assigned scale and not separately tracked. The scores were then averaged between the two coders. More information about this task and the methodology is described elsewhere (Kanter et al., 2020; Williams & Sharif, 2021).

Results

Research Question 1: What Percentage of Individuals Demonstrated Allied Behaviors in the Laboratory Experiment?

Descriptive statistics are presented in Table 1, which indicates the degree to which participants displayed allyship behaviors in each of the scenarios in the behavioral lab task. Table 1 describes the outcomes (low, moderate, or high allyship) for each scenario (“Party,” “Police,” and “Monument”) as determined by the team of coders based on the number and quality of supportive statements made by the participants toward outgroup members.

When using a minimum mean cut-off score of 2 as an indicator of allyship for each scenario (consistently supportive throughout the interaction), participant mean ally scores for the three scenarios combined was a low 2.79 ($SD = 1.56$) out of 9. Moreover, only 3.2% of the participants were allies in all three scenarios, 9.7% were allies in two scenarios, and 16.1% were allies in one scenario. Participants showed the highest allyship in the Black stereotyping “Party” scenario, followed by the unarmed “Police” killing scenario, and, finally, the Confederate “Monument” scenario.

Research Question 2: Are People More Likely to Think About Allied Behaviors Than Do Them?

Paired t -tests were conducted on the IRAS total scores for allyship thoughts versus anticipated actions, with the expectation that thoughts would be significantly greater than anticipated actions, which is consistent with our theory that people may have more allied intentions than actions. The thoughts scale means ($M = 37.32$, $SD = 5.79$) were significantly greater than the actions scale ($M = 33.84$, $SD = 6.37$), with $t(30) = 4.68$, $p < .001$. This indicated that more participants had more thoughts about saying or doing something support-

ive than beliefs that they would actually carry it out.

Research Question 3: What IRAS Score Corresponds to Participants Behaving as an Ally Consistently?

For each item in the IRAS, participants rated how likely they were to say or do each response (or something similar) on a 5-point scale. Only scores of 4 or 5 (likely or very likely, respectively) were considered to be responses demonstrating allied intentions as determined by a diversity expert sample. We report the descriptive statistics for each item on the IRAS, as illustrated in Table 2. As shown in Table 2, there were three items that the majority of participants reported they would be likely or very likely to say or do. Notably, none of those items require much interpersonal risk.

In examining IRAS scores, 43/50 would appear to be the best cut-off as it coincides with a score of 2 or greater (high allyship) on all of the three behavioral lab tasks. Although it seems as if, for most IRAS items, a majority of participants responded in a way that would indicate allied intentions, in fact, only 3.2% of participants were observed to engage in an allied manner in all three situations on the behavioral tasks ($N = 1$). Because there was only one person that we could classify as an ally, we were unable to perform a valid receiver operating characteristic (ROC) analysis for the IRAS to determine a cut-off score. These results indicate that meaningful White allyship is low.

Discussion

This study sought to better understand racial justice allyship by investigating observed allyship behavior versus self-reported intentions of allyship in White participants. Though allies are defined as people in the dominant group who support members of nondominant groups and take concrete actions to end their oppression (Brown & Ostrove, 2013; Washington & Evans, 1991), to our knowledge there have not been any prior studies that quantita-

Table 1. Frequency of Participant Allyship in Laboratory Behavioral Tasks

Scenario	% Low Allyship (N) (score 0-.99)	% Moderate Allyship (N) (score 1-1.99)	% High Allyship (N) (score 2-3)	Mean Allyship Rating (0-3) (SD)
Party	41.9% (13)	41.9% (13)	16.1% (5)	1.21 (0.62)
Police	61.3% (19)	35.5% (11)	3.2% (1)	0.89 (0.56)
Monument	74.2 % (23)	16.1% (5)	9.7% (3)	0.70 (0.73)

tively measure these actions. Most of the literature has been focused on the theory of allyship, rather than the practical components or real-life application of allyship intention. Previous research on allyship has examined the qualities that self-reported allies possess (i.e., out-group empathy, attitudes, exposure, etc.) with the goal of cultivating more allies (i.e., Fingerhut, 2011; Gonzalez et al., 2015). The current study is among the first to quantitatively measure the behavioral components of allyship and compare it against self-reported intention. This was accomplished through the use of a self-report scenario-based measure of allyship combined with a behavioral task. The results indicate that White people consistently do not act as racial justice allies towards Black people in the real world, despite their intentions of allyship or their view of themselves as allies. For example, although over half of participants indicated that they would speak out against the shooting of an unarmed Black man (based on responses to the item “No law enforcement officer should shoot an unarmed person under any circumstances”), only 39% actually did during the “Police” behavioral task, and of these only 3% provided a robust supportive response. This indicates that people engage in allyship behavior less often than they say they would, or such behaviors may not be as supportive as respondents believe. Further, more people thought about acting as an ally than those who said they would do allied behaviors.

The outcomes in our study also indicate that White people show different levels of allyship behavior depending on the form of racism presented. More specifically, the scenario concerning stereotyping Black people (“Party”) generated comparatively more allyship behavior than that of police killings (“Police”) or removing Confederate monuments (“Monument”), with the latter generating the least allyship behavior of all three scenarios. One possible explanation for the increased allyship behavior in the “Party” scenario might be that stereotyping and other overt forms of racism are more widely understood to be racist, whereas institutional or structural racism, such as Confederate monuments and racial profiling in law enforcement, is not. This is consistent with findings in the developmental literature that White children learn at a young age that race is a meaningful cue for sorting ingroup and outgroup members, and then acquire outgroup stereotypes earlier than ingroup stereotypes (Pauker et al., 2010; Stangor, 2016). It could also be that there is more racial awareness around inappropriate behaviors at fraternity parties on college campuses (which is the context from where participants for this study were drawn). Or, perhaps White people feel more comfortable and are less fearful of failure when engaging in ally-like behaviors towards perpetrators who occupy a similar plane or position of power as them (e.g., peer against peer, as is the case of the “Party”

scenario), whereas with racism from perpetrators in positions of power, allies may feel fear, uncertainty, or hopelessness in being able to make a difference (e.g., citizen against police officer, as in the case of the “Police” scenario, or citizen against State, as is the case with the “Monument” scenario).

Allyship behavior in White people may be infrequent because maintaining society’s status quo serves to benefit White people the most (Guess, 2006; Moore-Berg & Karpinski, 2019). Therefore, perhaps on a visceral level many do not, in actuality, want to address the racism that exists in order to maintain the status of “most privileged.” Nevertheless, they may want to maintain the image of being an ally and behaving in ways that seem allied performatively but, in fact, do not authentically address the issues that need to change to create an antiracist society (e.g., joining groups, committees or task forces to address these issues but not making meaningful structural or personal change). Furthermore, behaving as an ally means potentially being rejected by the ingroup or facing other social or career consequences for being a White ally. Indeed, White allies and people of color who push for meaningful change face negative consequences in their lives for doing so by those who do not want to dismantle oppressive structures; Spanierman and Smith (2017) underscore the reality of negative social consequences as a result of allied behaviors. Finally, low

Table 2. Ratings of IRAS Items of Allied Behaviors

Item	Scenario	<i>M</i>	<i>SD</i>	% Likely or Very Likely to Do/Say
1. “I’m glad I got a partner who knows this stuff.”	7	4.03	0.71	83.9
2. “Racism is a major issue in our country.”	3	3.81	0.98	71.0
3. Invite the Black student to a future social engagement, like a lecture, group lunch, or party.	8	3.74	0.77	71.0
4. “White supremacy needs to be addressed for our country to move forward.”	3	3.26	1.21	51.6
5. “It’s not fair, but I’ve gotten lots of advantages from being White.”	2	3.29	1.24	51.6
6. “No law enforcement officer should shoot an unarmed person under any circumstances.”	6	3.32	1.11	51.6
7. “I am upset about the unfair treatment minorities get.”	3	3.35	0.88	51.6
8. Say that you object to the song because it bothers your friend.	5	3.13	1.02	35.5
9. “Too many White people have a hard time talking about race, and that’s a problem.”	2	3.03	0.98	35.5
10. “I’m sure race was a big factor in that shooting”	6	2.87	1.23	29.0

Note. Scenarios: (1) Interacting with a young, Black female with African-style dress and braided hair; (2) taking a diversity training workshop; (3) talking about current events with racially diverse friends, (4) responding to a Black man lost in the neighborhood, (5) listening and singing along to rap music with racially diverse friends, (6) watching news at a sports bar about a police shooting, (7) doing a project with a racially ambiguous female, and (8) meeting a Black male law student at a party.

ally behavior may be a result of a lack of adequate education and training around these issues. Many institutions do not educate and discuss issues around racism in depth to their students, staff, etc., and so it may be that many people simply do not know how to behave in allied ways since they lack the necessary knowledge and sensitization to issues of race. Bystander training could be utilized to help people act in allied ways in the moment (e.g., Santacrose et al., 2020).

Poor allyship behavior by White people has implications for both the would-be allies and the marginalized groups they have failed. White people may experience cognitive dissonance between their ideals or values and their behaviors, resulting in negative outcomes, such as anger, sadness, and giving up their allied ambitions altogether. Marginalized groups may feel abandoned, disappointed, more distrustful of White people, or even experience more serious clinical implications (impacts on mental health, everyday life, relationships, work, school, or parenting; Gopalkrishnan 2018).

So, how can we improve the connection between allyship intention and behavior? Unfortunately, traditional diversity training cannot be assumed to improve allyship. One intervention specifically designed to improve constructs related to allyship resulted in maintained gains of positive attitudes towards outgroup members (i.e., allophilia), but eventually saw reduced allyship after just 1 month (e.g., Williams et al., 2020). Based on previous literature, interventions to improve allyship should be carefully designed to maximize enthusiasm, engagement, and intergroup communication and connection. As was previously mentioned, research has shown that allophilia is linked to allyship (Ostrove & Brown, 2018; Pittinsky et al., 2011). Of the five components of allophilia (affection, comfort, kinship, engagement, and enthusiasm; Pittinsky & Maruskin, 2008), enthusiasm and engagement have been found to best predict allyship (Williams & Sharif, 2021). Consistent with these findings, the origins of antiracist White allies have been attributed to opportunities for intergroup communication, mentorship, involvement in socially active organizations, and challenging stereotypes (O'Brien, 2001; Smith, 2007). As such, more opportunities for cross-racial connections may be important.

Other exercises that can be used in interventions include role-play around responding to microaggressions, celebrat-

Table 3. White Allies vs. White Saviors

	White Allies	White Saviors
<i>Attitudes</i>	<p>Are passionate about disrupting and correcting patterns of injustice.</p> <p>Recognize and value racial, ethnic, and cultural differences.</p> <p>Are willing to be vulnerable and challenge own internal racism.</p> <p>Examples: <i>Realizing that automatic assumptions about who is most qualified to run a research study have been shaped by a lifetime of racist messages and treating these attitudes with skepticism.</i> <i>Developing a mindful stance of noticing and observing anti-Black thoughts without assuming such thoughts are true.</i> <i>Challenging thoughts derived from guilt, shame, and anger that comes with reckoning with one's own White privilege.</i></p>	<p>Believe White people have the unique power to uplift and edify others.</p> <p>Have paternalistic attitudes toward people of colour.</p> <p>See themselves as uniquely qualified to bring necessary change.</p> <p>Examples: <i>Assuming that a White research team leader is best for everyone rather than considering that a team leader of colour may possess relevant insight that may be preferable.</i> <i>Uncritically accepting the perspective of a White person over a Black person.</i> <i>Adopting a Chinese baby with no effort to expose the child their ancestral language or culture, believing White American culture is adequate or superior.</i></p>
<i>Motivation</i>	<p>Are motivated by values surrounding equity, inclusion, and diversity.</p> <p>Act out of genuine care and concern for the wellbeing of BIPOC in their lives.</p> <p>Examples: <i>Conducting research that could uncover racism at one's own institution in order to address it.</i> <i>Giving money to an anti-racism cause one believes in for the purpose of empowering Black people who have been oppressed.</i></p>	<p>Are seeking reputational benefits or personal glorification.</p> <p>Are motivated by White guilt to feel like a "good person" or that they have "done their part."</p> <p>Examples: <i>Going to a Black Lives Matter protest and posting the selfies on social media to broadcast one's presumed allyship.</i> <i>Giving money to a charity to feed starving children in Africa to feel like they have done well to support Black people.</i></p>
<i>Action</i>	<p>Transform White dominated systems such that they are equitable, fair, and just.</p> <p>Maintain cultural humility and freely apologize for missteps.</p> <p>Step back, avoid centering themselves in situations, and create opportunities for people of colour to be centered.</p> <p>Examples: <i>Advocating for system-level reform in the workplace through the development of anti-racist office policies.</i></p>	<p>Help people of colour navigate a system of White dominance without trying to change it.</p> <p>Broadcast allyship behaviours and sentiments, without accepting criticism.</p> <p>Center themselves and overstate their own relevance.</p> <p>Examples: <i>Offering to bring up issues relating to BIPOC with other White colleagues at the next meeting rather than inviting BIPOC to the meeting to voice concerns.</i></p>

Continued on p. 279

ing cultural differences, and sharing excitement over stories of antiracism victories that include allies (Steketee et al., in press; Sue et al., 2019). Sue et al. also focus on the importance of actually doing antiracist actions, and self-identified White allies taking the concrete step of exposing oneself to lived experiences of allyship. In order to combat the divergence between ally intention and behavior in potential allies, including the risks of White saviorship (Spanierman & Smith, 2017), future interventions should address allyship with more intentionality, providing specific instructions and guidance on actionable steps that allies can take. Some of these concrete steps may include initiating conversations with family and friends about racism, donating to BIPOC (Black, Indigenous, People of Color) organizations and movements, advocating to policymakers around issues facing BIPOC people, amplifying BIPOC voices, increasing support of BIPOC businesses, or calling out microaggressions one encounters in public settings (e.g., Sue et al., 2019; Thurber & DiAngelo, 2018). In addition, including mentors and clearly structured goals that extend after the intervention may help to increase allyship longevity. In that spirit, in Table 3 we highlight some characteristics and actions that can help orient White allies towards more meaningful allyship behaviors, as opposed to White saviorship (Edwards, 2006; Printz Pereira & George, 2020; Smith et al., 2016; Spanierman & Smith, 2017; Straubhaar, 2015; Sue et al., 2019). Concrete examples are provided to help instantiate concepts that can often seem abstract.

There are some limitations of this study that should be noted. First, this study was an exploratory analysis comparing allyship intention and behavior; given this, the sample size is small and therefore more work is needed to make broader conclusions. Second, the study sample was entirely university students. Research has shown that allyship is a developmental process that happens in stages (Waters, 2010) and therefore university students may be in an earlier stage of development than others, as university is frequently the first place in which young adults engage with situations that require critical thinking. This work should be extended with a larger sample that represents people from different age groups, communities, and geographic areas. Further, debates on whether attitudes and bias toward people of color is the same as specific, anti-Black bias, and how best to capture that distinction in exploring White allyship, is outside

the scope of this study (e.g., Sears & Savalei, 2006).

Our study suggests that the problem with meaningful White allyship is perhaps not a lack of intent, but rather a lack of follow-through and meaningful action. Self-proclaimed allies seem to understand the basic idea behind allyship but fall short when tasked with transforming these ideals into actions. With this knowledge, future research might focus on how to promote allyship behavior among those who either believe they are allies or aspire to be allies. One potential way to promote allyship behavior might be through allyship workshops in which allies receive practical experiences, tests, and training (e.g., Metinyurt et al., 2020). And to prevent potential burnout and/or harm to people of color, allies should train future allies. By better understanding this gap and encouraging people to transform their allyship from intention to action, it is hoped that White allies will move farther from the imaginary realm of unicorns and leprechauns, and closer to having a more concrete and positive impact on equity and social justice in our communities and profession.

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Table 3 continued

	White Allies	White Saviors
Action	<p>Directing questions about specific or technical topics to BIPOC colleagues with subject-matter expertise instead of answering them themselves.</p> <p>Talking to friends and family about the problem of racism.</p> <p>Stepping down from a leadership role to allow it to be filled by a person of colour who would benefit professionally.</p> <p>Encouraging Black women to set the goals and agenda for a feminist organization traditionally controlled by White women.</p>	<p>Creating a diversity vision statement for an organization about getting BIPOC to support existing organizational goals rather than creating a shared organizational vision with BIPOC.</p> <p>Organizing a panel presentation about Hispanic mental health without any Hispanic people on the panel.</p> <p>A feminist organization using stories of oppressed Black women to garner donations without addressing the different needs of Black women.</p>
Expectations	<p>Anticipate that anti-racism work is an ongoing effort to dismantle individual and institutional beliefs, practices, and policies.</p> <p>Expect that their education about diversity issues will be a continual process of hard work and self-reflection</p> <p>Understand they will receive disapproval / punishment from dominant group members.</p> <p>Examples:</p> <p>Offering support to a BIPOC person without expecting acknowledgement or thanks.</p> <p>Speaking up if they witness behaviour or speech that is degrading or offensive.</p> <p>Anticipating losing some friends when talking to them about their racist behaviours.</p>	<p>Expect acknowledgement, credit and/or glory for efforts.</p> <p>Expect everyone to agree when they refer to themselves as allies.</p> <p>Expect BIPOC to be grateful for their good intentions, even if they accidentally cause harm.</p> <p>Examples:</p> <p>Expecting praise and support for writing anti-racism posts on social media.</p> <p>Expecting credit for chairing a diversity committee at their workplace.</p> <p>Stopping efforts to recruit BIPOC graduate students after receiving unexpected criticism from higher-ups.</p>
Connection	<p>Build meaningful relationships with members of the groups with which they aspire to ally themselves.</p> <p>Having several BIPOC as close friends whom one would reach out to if in need.</p> <p>Examples:</p> <p>Checking in with therapy clients of colour when something racist has happened in the media, and showing care and support.</p> <p>Avoiding sharing potentially traumatizing material, such as videos depicting the murder of Black individuals</p>	<p>Maintain hierarchical or distant relationships with members of the groups with which they wish to ally themselves.</p> <p>Having no BIPOC as close friends.</p> <p>Examples:</p> <p>Pathologizing a BIPOC therapy client over an emotional reaction to racism in the media, advising the person to be calm and rational instead of justifiably distressed.</p> <p>Psychology researchers looking for diversity in their participant pool but not in their own research team.</p>

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2021 Student Research Grant Winner and Honorable Mention

Every year, ABCT's Research Facilitation committee awards a Graduate Student Research Grant to provide financial support for a student whose research shows great innovation, creativity, and broader significance. Our 2021 Winner is Quyen A. Do, M.Ed., a doctoral student at the University of Texas at San Antonio and a member of Dr. Shelby Scott's Promoting Resilience in DiversE (PRIDE) Family Studies Lab (<https://www.pridefamilystudies.com>). Our 2021 Honorable Mention is Kathryn Coniglio, a doctoral student at Rutgers, The State University of New Jersey and a member of the Dr. Selby's Emotional and Psychopathology Lab. We sat down with our awardees to learn more about their projects.



2021 Student Research Grant Winner: Quyen A. Do, M.Ed.

Tell us about the project the SRG is funding: The project is a dissertation project investigating intimate partner violence (IPV) among sexual minority individuals in consensual nonmonogamous relationships. IPV is a serious public health issue that is becoming increasingly prevalent

due to the indirect effects of COVID-19. Research has established that IPV is a complex issue with negative effects on the health of individuals, families, and society. Unfortunately, IPV is often overlooked in marginalized populations such as individuals who practice consensual nonmonogamy (CNM), a practice in which all partners consent to having romantic and/or sexual relations with other people outside of their dyads. Despite the increasingly common practice of CNM among sexual minorities, there remains a dearth of research on the CNM population and how IPV manifests in these relationships. Thus, the current project seeks to investigate the manifestation of intimate partner violence (IPV) among sexual minority individuals in non-monogamous (CNM) relationships. Study aims will focus on (1) understanding the prevalence and frequency of IPV among sexual minorities in CNM relationships, (2) examining anticipated risk factors such as sexual minority stress and jealousy for IPV in said population, (3) examining the moderating effects of communication and social support on the relationships between proposed risk factors and IPV, and (4) evaluating mental health implications of IPV in CNM partners, including associations with depression, anxiety, and PTSD symptoms. Findings from the project will provide insight into the manifestation of IPV among sexual minority individuals in CNM relationships, which will in turn provide clinical guidelines for the development of effective IPV assessments and interventions for this underrepresented population.

What does receiving this award mean to you?

I am extremely honored to be the recipient of the 2021 ABCT Graduate Student Research award. The award provides the necessary funding for my dissertation project which examines intimate partner violence among sexual minority individuals

who practice consensual nonmonogamy, which in turn may inform the development of clinical interventions for this underserved community.

How has ABCT contributed to your development as a researcher and clinician? I first learned about the association in 2020 through my faculty advisor, Dr. Shelby Scott, who is a long-term member of ABCT. Since then, I have had the opportunity to present my research at the 2020 ABCT convention which helped me gain valuable skills and experiences. I have also had the opportunity to meet and learn from other ABCT researchers/clinicians. This year, I will be presenting a poster and moderating a clinical roundtable at the 2021 ABCT convention.



2021 Student Research Grant Honorable Mention: Kathryn Coniglio

Tell us about the project the SRG is funding: This longitudinal study will examine whether shape- and weight-focused cognitions during exercise predict future eating disorder behaviors, and whether this

relationship varies across different exercise types and settings. This is important because pathological exercise is a dangerous behavior with a range of negative health consequences and treatments for those who engage in pathological exercise are minimally effective. Findings will inform the specificity of future interventions so that individuals with eating disorders can engage in healthy, safe exercise during and after treatment while avoiding specific forms of exercise that may lead to a relapse.

What does receiving this award mean to you? I have been a proud student member of the Association for Behavioral and Cognitive Therapies since 2017. I have great respect for the pioneers of the ABCT and believe deeply in its mission. I'm so honored to receive acknowledgement from this organization for my project.

How has ABCT contributed to your development as a researcher and clinician? ABCT has contributed to my professional development in two important ways. First, as an eating disorders researcher, participation in ABCT has allowed me to stay up to date on current trends in the field more broadly and prevent the drift towards being siloed into what many describe as a "niche" or ultra-specialty area. Second, participation in the Public Education and Media Dissemination Committee has allowed me to continue to nurture my love of science communication. I have enjoyed interfacing with media and journalists to help spread the word that #CBTworks!

Please join us in congratulating these fabulous student researchers at the 2021 ABCT Convention Award Ceremony.

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Table 3 continued

	White Allies	White Saviors
Connection	<p>or Black bodies lying on the street, out of respect and caring.</p> <p>Listening and asking questions when someone describes an experience of racism, without inserting own personal stories or attempting to link a racist experience to a White experience.</p> <p>A church that offers bilingual services to better connect with locals from immigrant communities.</p>	<p>Partnering with Black trainees as coauthors but not collaborating with Black scholars of equal rank that might be empowered to disagree.</p> <p>A church sending missionaries to Africa with no effort to bring Black people from the local community into the congregation.</p>
Accountability	<p>Work to understand the needs of the groups to which they hope to ally themselves and hold themselves accountable to those groups.</p> <p>Examples:</p> <p>Asking people of colour (colleagues, community stakeholders, friends) for constructive criticism of anti-racist efforts.</p> <p>Accepting the label of "ally" only from recognized members of the non-dominant groups with which they wish to ally themselves</p> <p>Conducting participatory research with a community of colour, where BIPOC share equal or greater power in decision making.</p>	<p>Do not hold themselves accountable to the groups with which they claim to ally themselves, but only to their own goals.</p> <p>Examples:</p> <p>Requesting more funding for EDI initiatives without getting feedback from BIPOC on the relevance or success of those initiatives.</p> <p>Making misleading claims about an indigenous heritage in order to create credibility when discussing Native American issues.</p> <p>Implementing a substance abuse intervention in a community of colour without permission from the community leaders.</p>

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Improving Support for Parents During Professional Psychology Training

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COMPLETING A DOCTORAL degree in psychology is a long process. The median age for receiving a doctorate is 31, and trainees spend about 7 years obtaining their degrees. Following completion of graduate school, around 40% of graduates continue their training, mostly by pursuing postdoctoral fellowships (National Center for Science and Engineering Statistics, 2019). As trainees spend many of their childbearing years attending graduate school, a quarter to a third of students in doctoral programs have dependent children (Mason et al., 2006; National Center for Educational Statistics, 2019).

Research and policy efforts have focused mostly on supporting faculty members who are parents, with much less attention paid to the needs of graduate student parents (GSPs). GSPs and faculty members face similar challenges, including balancing research and teaching responsibilities, but GSPs have less power than faculty members within their departments and encounter more structural barriers to their success. For example, graduate students struggle to afford childcare on a graduate student budget, adhere to inflexible schedules like classes with attendance policies, and complete their degrees within their programs' standard timeframes (Mason et al., 2013; Theisen et al., 2018). GSPs also often do not have access to the institutional and legal protections afforded to long-term employees like paid parental leave, unpaid medical leave provided by the Family and Medical Leave Act (FMLA), or access to university-affiliated daycares, which usually offer discounts only to faculty and staff members (Lynch, 2008).

The clinical training in professional psychology programs presents GSPs with additional barriers to success, including fulfilling requirements for clinical work

that tend to be less flexible than research requirements, as well as balancing mentorship relationships with both research and clinical supervisors. Studies of medical, nursing, and social work students highlight concerns that GSPs face related to clinical responsibilities, including difficulties reconciling childcare and clinical schedules, challenges meeting clinical requirements within the required timeframe after taking parental leave, and needing to acclimate to different policies and cultures at various clinical sites (Arhin & Cormier, 2008; Bye et al., 2017; Wladkowski & Mirick, 2020).

In addition to doctoral programs' policies related to GSPs, another important aspect of a GSP's experience is their relationship with supervisors. Research has highlighted the importance of mentorship to doctoral students' success (Bagaka et al., 2015). GSPs perceive mentors as helpful when they serve as role models, supports, and advocates for GSPs' needs, but less so when they are unable to help them manage their roles as both parents and academics (Grasseti et al., 2019; Mirick & Wladkowski, 2020; Wladkowski & Mirick, 2019). Having limited support from mentors and other role models during graduate school can contribute to graduate students leaving their doctoral programs (Rockinson-Szapkiw et al., 2017).

Concerns about balancing work and family impact not only the experiences of GSPs during their training, but also their ability to complete their training and their career decisions. Female GSPs leave their programs at higher rates than students without children, and women leave academia in greater numbers during graduate school than at any other time during their careers (Mason et al., 2013; Wladkowski & Mirick, 2020). Many doctoral students who complete their programs consider the field

of academic research not friendly to families and therefore choose alternative careers, and women and underrepresented minorities are particularly likely to opt out of careers in academia due to these concerns (Goulden et al., 2009; Mason et al., 2009). There is growing recognition that improving support for GSPs is particularly important to encouraging women and individuals from diverse backgrounds to attend and complete graduate training, as well as to pursue successful careers.

Little work has focused on the experiences of GSPs in professional psychology programs. Two qualitative studies (Holm et al., 2015; Trepal et al., 2014) investigated the experiences of mothers in counseling education graduate programs and found that many reported experiencing delays in their progress and difficulties managing resources. GSPs also noted the logistical and emotional support provided by mentors and family members. A qualitative study of psychology trainees found that GSPs reported a lack of resources, gender discrimination, and a desire for greater advocacy (Wilhelmi et al., 2019). Another paper described the challenge of balancing parenthood with the intensive clinical training required during internship (Grasseti et al., 2019).

Previous research leaves questions unanswered. Studies have not quantitatively assessed GSPs' perceptions of parenting-related policies and institutional support in professional psychology programs, nor their experiences with research and clinical supervisors. Research showing that experiences of parenting-related policies and mentorship vary by demographic factors suggests that it is important to examine differences in experiences based on these factors. It would also be helpful to understand the relationships between perceptions of parenting-related policies, institutional support, and supervisory experiences, as well as the specific supervisory behaviors perceived to be helpful and unhelpful. To address these gaps, we conducted a survey of GSPs in professional psychology doctoral programs aiming to (1) describe GSPs' experiences with parenting-related policies, institutional support, and support received from clinical and research supervisors; (2) test the ways in which these experiences differ based on GSPs' demographic characteristics; (3) examine associations among perceptions of parenting-related policies, institutional and supervisory support, and adjustment to parenthood; and (4) describe supervi-

sory behaviors perceived by GSPs as helpful and unhelpful.

Materials and Methods

Participants

We recruited participants by posting on the Association for Behavioral and Cognitive Therapies (ABCT) list serve, sending emails to training directors in psychology graduate programs and to internship and postdoctoral program coordinators, and posting on Facebook and Twitter. We requested that program coordinators forward the survey link to current and past trainees identifying as a parent at any time during their graduate training. All parents (biological, step, adoptive, etc.) were invited to participate, and no compensation was offered.

Procedure

IRB approval was obtained from West Chester University of Pennsylvania. Participants provided informed consent before completing a 15-minute-long survey hosted on Qualtrics. The first item screened participants to ensure that they were pursuing a doctoral degree in psy-

chology and currently considered themselves parents (i.e., were not currently expecting their first child). Participants were also excluded if they were currently on parental leave as they had not yet experienced parenting during graduate training. Subsequent items assessed participants' demographic information and their perceptions of parental leave policies, institutional support for parents, and support received from clinical and research supervisors. Participants also responded to two open-ended questions asking them to "describe the supervisory behaviors (what your research or clinical supervisor did or said) that were most/least helpful to you in balancing training with parenthood" (two separate questions).

Analyses

For questions about perceptions of parental leave policies and institutional support, prompts and response options are presented in Table 2. For questions about support received from clinical and research supervisors, participants responded on a 5-point Likert scale ranging from *not at all* to *extremely*. To assess demographic differences across parenting and training experi-

ences, we examined differences by gender (female vs. male), race/ethnicity (White, non-Hispanic vs. racial/ethnic minority), number of children (one vs. more than one), timing of becoming a new parent (during vs. before graduate school), and type of program (Ph.D. vs. Psy.D.; Table 3). We evaluated differences among categorical and continuous responses using chi-square tests and independent-samples *t*-tests, respectively. Associations among accessibility of parental leave policies (an ordinal variable) and institutional and supervisory support were analyzed with Spearman's Rho. Associations among all other variables were tested with Pearson's *R* (Table 4).

For open-ended questions about helpful and unhelpful supervisory behaviors, we utilized Moustakas' (1994) phenomenological analysis method for qualitative data. Phenomenological methods are particularly well-suited to understanding individuals' experiences and feelings from their own perspectives (Yuksel & Yildirim, 2015). We first pulled meaning units from responses that were each considered equally valuable to the overall understand-



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ing of themes (horizontalization). We then chunked meaning units into groups of significant statements that were used to identify themes. Each step was conducted separately and subsequently discussed by two authors in order to ensure consistency across coders.

Results

Participants

Participants ($N = 163$) were primarily female (84%) with one (52%) or two (34%) children, who were pursuing Ph.D.s (63%) or Psy.D.s (37%) in clinical or counseling psychology (see Table 1). The majority of participants (82%) became parents for the first time during graduate training and 90% had or adopted a child during training. Most participants were White (79%), with some identifying as Asian (7%), African American (5%), Hispanic, nonidentified (5%), and Biracial/Other (4%). No participants identified as gender minorities (transgender or gender queer/nonbinary). The racial and ethnic backgrounds of participants accurately reflect the profiles of psychology Ph.D. students, whereas our sample consisted of a slightly higher proportion of females than official estimates (around 72%; Cope et al., 2016).

Perceptions of Policies, Institutional Support, and Supervisory Support

Only 18% of GSPs reported that their training sites had accessible, written poli-

cies about parental leave that pertained to them as trainees, and almost half (42%) reported having no accessible policies at all (see Table 2). Even for GSPs at sites with accessible parental leave policies, 36% reported that it was difficult to understand these policies. Only 30% of GSPs said that they knew “exactly where to go” to ask questions about leave policies. The vast majority of GSPs (81%) reported having under 1 month of paid leave, and most GSPs (57%) also reported not taking more than 1 month of unpaid leave. During their leaves, the majority of GSPs (65%) reported being required to complete some type of research, clinical, or academic work.

About half of GSPs reported that parenthood did not delay their progress towards degree completion (55%), with the other half (45%) reporting that they took or expected to take additional time to complete their training. On average, GSPs reported that their adjustment to parenthood was not impacted by the support they received from their training site ($M = 3.13$, $SD = 1.25$; 3 = Not at all impacted), with equal proportions reporting that their adjustment to parenthood was slightly or very positively (42%) versus slightly or very negatively (38%) impacted by the support they received from their site. Most GSPs (66%) reported that their site did not have counseling services to help them navigate leave or adjustment to parenthood.

Overall, GSPs reported feeling “very” comfortable initiating conversations about

parenthood with their clinical ($M = 4.00$, $SD = 1.19$) and research mentors/supervisors ($M = 4.16$, $SD = 1.28$). They also reported feeling “very” supported by their clinical ($M = 4.37$, $SD = 1.18$) and research mentors/supervisors ($M = 4.36$, $SD = 1.19$) before, during, and immediately after taking parental leave.

Demographic Differences Across Parenting and Training Experiences

We examined differences across parenting and training experiences by gender (female versus male), race/ethnicity (white non-Hispanic versus minority), number of children (one versus more than one), timing of becoming a new parent (during versus before graduate school) and type of program (Ph.D. versus Psy.D.; see Table 3). Women reported taking more paid ($\chi^2 = 4.44$, $p = .035$) and unpaid time off ($\chi^2 = 21.04$, $p < .001$) than men. GSPs with one child reported taking more paid time off ($\chi^2 = 7.14$, $p = .008$), but not more unpaid time off ($\chi^2 = 0.43$, $p = .510$), than those with more than one child. GSPs with one child (versus more than one child), those who became new parents during graduate training (versus before graduate training), and those in Ph.D. (versus Psy.D.) programs also reported feeling more supported by their clinical supervisors (all $t > 2.07$, both $p < .040$).

Associations Among Policies, Institutional Support, and Supervisory Support

GSPs who reported that their training sites had more accessible parental leave policies and that these policies were easier to understand also reported that their adjustment to parenthood was impacted more positively by the support they received ($rs = .34-.35$; see Table 4). Accessibility of parental leave policies was also associated with greater comfort initiating conversations about parenthood with clinical supervisors ($r = .28$) and feeling more supported by clinical and research supervisors ($rs = .26-.37$). Similarly, ease of understanding parental leave policies was associated with greater comfort initiating conversations with research and clinical supervisors ($rs = .24-.30$) and feeling more supported by research supervisors ($r = .28$). Finally, GSPs who reported that their adjustment to parenthood was impacted more positively by the support they received also felt more comfortable initiating conversations with research and clinical supervisors ($rs = .31-.47$) and more supported by them ($rs = .43-.67$).

Table 1. Demographic Characteristics of Sample and Type of Degree ($N = 163$)

Sample Characteristic	Percent of Sample
Demographic	
Female	84.0
Race/Ethnicity	
White non-Hispanic	75.5
White Hispanic	3.1
African American non-Hispanic	3.7
African American Hispanic	1.2
Hispanic non-specified	4.9
Asian	7.4
Biracial/Other	4.2
Number of children	
One	51.5
Two	34.4
Three or more	14.1
Timing of becoming a new parent	
Before graduate training	17.8
During graduate training	82.2
Had or adopted a child during training	
Yes	89.6
No	10.4
Type of Degree	
PhD in clinical psychology	49.7
PhD in counseling psychology	13.5
PsyD in clinical psychology	34.3
PsyD in counseling psychology	2.5

Table 2. Perceptions of Policies, Institutional Support, and Supervisory Support

Survey question	Responses (percent)				
Accessible, written parental leave policies for trainees (<i>n</i> = 163)	No accessible policies 42.3	General guidelines, no specific policies 26.4	Specific policies that were followed 17.9	Do not know 6.7	Other 6.7
Ease of understanding parental leave policies (<i>n</i> = 85)	Extremely easy 11.8	Somewhat easy 25.9	Neither easy nor difficult 25.9	Somewhat difficult 28.2	Extremely difficult 8.2
How well informed was the person/office addressing questions about leave policies (<i>n</i> = 152)	I knew exactly where to go 30.3	I had some idea, but was unsure where to go 40.8		I had no idea where to go 28.9	
Paid time off (<i>n</i> = 152)	None 61.8	Under 1 month 19.1	1-2 months 11.2	2-3 months 3.9	>3 months 4.0
Unpaid time off (<i>n</i> = 152)	None 32.2	Under 1 month 25.0	1-2 months 16.4	2-3 months 11.2	>3 months 15.2
Required to complete work during time off (<i>n</i> = 149)	Yes 31.5	Some, but not as much as usual 33.6		No 34.9	
Parenthood impacting progress towards completion of training (<i>n</i> = 152)	Completed/expect to complete earlier than expected 2.6	Completed/expect to complete within the expected time limits 52.0		Took or expect to take additional time or complete training 45.4	
Adjustment to parenthood impacted by support received from training site (<i>n</i> = 152)	Very negatively 7.9	Slightly negatively 30.2	Not at all impacted 20.4	Slightly positively 23.7	Very positively 17.8
Experience with site's counseling services during leave (<i>n</i> = 149)	No services available 55.0	No services available; sought external counseling 11.4	Did not use available services 32.9	Utilized services and found them helpful 0.7	

Supervisory Behaviors: Helpful and Unhelpful

Themes and examples from GSPs' open-ended responses about helpful and unhelpful supervisory behaviors are presented in Table 5. GSPs considered it most helpful when their supervisors (1) showed interest in their lives outside of school and in the well-being of GSPs and their families; (2) shared their personal experiences with parenthood and work/life balance; (3) expressed empathy and support for GSPs' needs; (4) allowed for flexibility in GSPs' clinical and/or course schedules; (5) were accommodating of GSPs taking parental leave; (6) provided support and scheduling accommodations for breastfeeding and pumping; and (7) highlighted the clinical advantages of being a parent. GSPs considered it unhelpful when their supervisors (1) were unaccommodating of GSPs taking parental leave; (2) expected GSPs to maintain a higher workload or make up for time "lost" due to family leave; (3) did not express or provide support; and/or (4) made discriminatory remarks about their parenting status.

Overall, GSPs were appreciative of genuine expressions of interest, empathy and emotional support, as well as help navigating the logistical challenges of parental leave, breastfeeding, and childcare. As stated by one GSP, "I literally chose my internship site because they were the only ones who mentioned creating time and space for breastfeeding/pumping mothers at the internship interview." GSPs also found it helpful when supervisors shared their personal experiences. GSPs found it unhelpful when supervisors were inflexible about parental leave and treated their parenting role as a burden; in addition, they felt the absence, as well as the presence, of supervisors' emotional and logistical support. As summarized by another GSP: "My clinical supervisor did nothing, and that in itself was isolating."

Discussion

We surveyed 163 GSPs pursuing doctoral degrees in professional psychology using both quantitatively scaled and open-ended survey questions. Few GSPs reported that their training sites had accessible parental leave policies. GSPs who

reported having accessible policies often felt that these policies were difficult to understand and that they were unsure where to go to have their questions answered. The majority of GSPs reported having under a month of both paid and unpaid parental leave, and about half reported that they took or expected to take additional time to complete their training due to their roles as parents. On average, however, GSPs reported that their adjustment to parenthood was not negatively impacted by the support they received from their training site, and that they felt supported by their clinical and research supervisors.

When examining demographic differences across these experiences, we found that women reported taking more paid and unpaid time off than men and GSPs with one child reported taking more paid time off than those with more than one child. GSPs with one child (versus more than one child), those who became new parents during graduate training (versus before graduate training), and those in Ph.D. (versus Psy.D.) programs also reported feeling more supported by their clinical supervisors. Accessibility of parental leave

Table 3. Demographic Differences Across Parenting and Training Experiences

	Gender		Race /Ethnicity		Number of children		Timing of new parenthood		Type of program	
	Women	Men	White non-Hispanic	Minority	One	More than one	During training	Before training	Ph.D.	Psy.D.
Paid time off (More vs. less than 1 month)	22%	5%	18%	24%	28%	10%	21%	8%	22%	16%
	$X^2 = 4.44^*, p = .035$		$X^2 = 0.47, p = .093$		$X^2 = 7.14^*, p = .008$		$X^2 = 1.56, p = .212$		$X^2 = 0.65, p = .421$	
Unpaid time off (More vs. less than 1 month)	54%	5%	43%	59%	44%	49%	48%	31%	48%	44%
	$X^2 = 21.04^{**}, p < .001$		$X^2 = 2.21, p = .137$		$X^2 = 0.43, p = .510$		$X^2 = 1.45, p = .229$		$X^2 = 0.18, p = .673$	
Progress towards completion of training (Early or on time vs. additional time)	54%	60%	57%	47%	56%	53%	52%	67%	57%	51%
	$X^2 = 0.35, p = .552$		$X^2 = 0.97, p = .324$		$X^2 = 0.12, p = .733$		$X^2 = 1.97, p = .161$		$X^2 = 0.51, p = .475$	
	M(SD)		M(SD)		M(SD)		M(SD)		M(SD)	
Adjustment to parenthood	2.43(0.56)	2.40(0.50)	2.40(0.56)	2.53(0.51)	2.41(0.55)	2.44(0.33)	2.46 (0.53)	2.26(0.59)	2.40(0.55)	2.47(0.54)
	$t(150) = 0.28, p = .783$		$t(150) = 1.21, p = .229$		$t(150) = 0.32, p = .752$		$t(150) = 1.78, p = .078$		$t(150) = 0.80, p = .423$	
Comfort initiating conversations with clinical supervisors	3.94 (1.19)	4.28 (1.14)	4.04(1.16)	3.84(1.30)	4.04(1.23)	3.96(1.11)	4.08(1.15)	3.63(1.28)	4.07(1.18)	3.88(1.20)
	$t(150) = 1.30, p = .197$		$t(150) = 0.84, p = .403$		$t(150) = 0.41, p = .683$		$t(150) = 1.80, p = .073$		$t(150) = 0.99, p = .324$	
Supported by clinical supervisors	4.34(1.19)	4.54(1.14)	4.35(1.21)	4.45(1.09)	4.63(1.22)	4.12(1.10)	4.46(1.20)	3.92(0.97)	4.53(1.15)	4.09(1.19)
	$t(144) = 0.78, p = .437$		$t(144) = 0.43, p = .665$		$t(144) = 2.63^*, p = .010$		$t(144) = 2.08^*, p = .039$		$t(144) = 2.20^*, p = .029$	
Comfort initiating conversations with research supervisors	4.15(1.29)	4.21(1.25)	4.21(1.29)	3.97(1.24)	4.00(1.35)	4.28(1.21)	4.23(1.26)	3.88(1.31)	4.05(1.26)	4.37(1.29)
	$t(125) = 0.22, p = .829$		$t(125) = 0.92, p = .358$		$t(125) = 1.24, p = .218$		$t(125) = 1.23, p = .222$		$t(125) = 1.36, p = .176$	
Supported by research supervisors	4.40(1.20)	4.11(1.15)	4.39(1.16)	4.25(1.30)	4.36(1.30)	4.35(1.10)	4.44(1.19)	3.95(1.10)	4.38(1.21)	4.30(1.16)
	$t(116) = 1.00, p = .317$		$t(116) = 0.54, p = .591$		$t(102) = 0.02, p = .984$		$t(116) = 1.69, p = .094$		$t(116) = 0.37, p = .716$	

Note. We ran chi-square tests for categorical responses and between-samples t-tests for continuous responses. We excluded participants who did not report having or adopting a child during graduate training ($n = 17$) from analyses of paid and unpaid time off.

* $p < .05$

policies and ease of understanding them were associated with more positive perceptions of the adjustment to parenthood, as well as greater comfort initiating conversations with supervisors about parenthood and feeling more supported by them. GSPs found expressions of interest, empathy, and logistical and emotional support from their supervisors helpful, as well as supervisors sharing their personal experiences. By contrast, they perceived supervisors' inflexibility about leave and the absence of support as unhelpful.

Possible Explanations for Findings

There are several explanations for the demographic differences presented in this study. Our finding that women take more paid and unpaid time off than men is a pattern that has been observed in other contexts; it may suggest that men are more concerned about taking leave because it implies that they are less committed to their work (Evertsson, 2016). Alternatively, it may indicate that men were offered less leave time or felt less of a need to take leave due to their female partners taking on more childcare responsibilities. Research has

confirmed that women often serve as their children's primary caregiver, particularly when children are very young (Gjerdingen & Center, 2005).

We did not find differences in responding based on participants' racial/ethnic backgrounds and no participants identified as gender minorities. Nonetheless, GSPs from traditionally underrepresented demographic groups face unique challenges when navigating parenthood, such as having few mentors with whom they identify and greater financial burdens (Anaya, 2011; Belasco et al., 2014). While we did not measure differences among participants' access to outside financial or logistical (e.g., childcare) support, the financial and logistical challenges faced by GSPs suggest that lacking access to these forms of support would make the transition to parenthood more difficult.

We also found that GSPs with one child reported taking more paid time off than those with more than one child. Perhaps GSPs with more than one child had less access to paid time off because they had exhausted these resources or felt less enti-

tled to paid time off than GSPs with only one child. Alternatively, GSPs with more than one child may have had preexisting childcare arrangements that they were able to take advantage of more quickly than GSPs with one child.

Additionally, we found that GSPs with one child (versus more than one child), those who became new parents during graduate training (versus before graduate training), and those in Ph.D. (versus Psy.D.) programs reported feeling more supported by their clinical supervisors. Lower levels of support reported by GSPs with more than one child further highlights the perceived disadvantages that may result from parenting multiple children as a doctoral student. As becoming a parent for the first time is associated with unique challenges like an increase in housework and greater relational conflict for some couples, perhaps GSPs who became new parents during their graduate training requested and/or received more support from their supervisors than GSPs who were already parents (Nomaguchi & Milkie, 2003). Ph.D. students feeling more supported by

Table 4. Relationships Among Perceptions of Parenting-Related Policies, Institutional and Supervisory Support, and Adjustment to Parenthood

Variable	1	2	3	4	5	6
1. Accessibility of parental leave policies						
2. Ease of understanding policies	.44**					
3. Adjustment to parenthood impacted by support received	.34**	.35**				
4. Comfort initiating conversations with clinical supervisors	.28**	.30**	.47**			
5. Supported by clinical supervisors	.37**	.21	.67**	.67**		
6. Comfort initiating conversations with research supervisors	.17	.24*	.31**	.52**	.46**	
7. Supported by research supervisors	.26**	.28*	.43**	.46**	.58**	.79**

Note. Correlations between Accessibility of parental leave policies (1) and other variables are in Spearman's rho because Accessibility of parental leave policies is ordinal. All other relationships are in Pearson's *r*.

* $p < .05$, ** $p < .01$

their clinical supervisors may be due to Psy.D. programs' greater emphasis on clinical training, higher yearly clinical hour requirements, or greater reliance on clinical supervisors (Norcross et al., 2004). While we did not measure the extent to which Ph.D. programs were research or clinically oriented, this program characteristic may impact GSPs' experiences as well.

Finally, we found positive associations between accessibility of parental leave policies and ease of understanding them on the one hand and perceptions of adjustment to parenthood and support received from supervisors on the other hand. These results may indicate that accessible and comprehensible parental leave policies improve GSPs' overall training experiences in multiple ways, perhaps because of the challenges of navigating leave policies that are unavailable or difficult to understand. Alternatively, programs with more accessible policies may have more supportive supervisors due to greater resources or more organized administrators. These findings suggest that clarifying leave poli-

cies in professional psychology programs could improve GSPs' training experiences.

Existing Policies and Recommended Changes

Current policies surrounding parental leave and accommodations for parents in professional psychology programs are vague. The American Psychological Association (APA) guidelines recommend that supervisors appropriately attend to identity-related dimensions, which should extend to the identity of "parent" (American Psychological Association, 2015), but details regarding how to attend to this identity are lacking. Additionally, APA requires that accredited programs make any leave policies publicly available, but they do not mandate the development of parental leave policies or require a minimum amount of paid or unpaid leave (Mizock & Ameen, 2018). Similarly, the Association of Psychology Postdoctoral and Internship Centers (APPIC) guidelines recommend that internship programs accommodate parental leave (Ponce et al., 2015), but do not offer any specific guidelines or policies.

The results of this study were presented at a panel on improving support for GSPs at the ABCT Annual Convention in 2019; panelists included directors of graduate, internship, and postdoctoral programs. Based on our results and the discussion at this panel, we recommend that APA and APPIC develop more specific policies about parental leave that would ideally include a requirement for paid leave and that would apply to GSPs in graduate schools, internships, and postdoctoral fellowships. Given the need for flexibility among programs and trainees, it would be most useful for these societies to establish minimally acceptable policies with room for additional accommodation of GSPs.

The panelists made several other recommendations as well. First, training sites can offer need-based financial aid to GSPs and extend daycare subsidies currently available only to faculty to graduate students as well. Second, training sites can increase the flexibility of their start and end dates so that GSPs on parental leave can "stop the clock" like faculty members and fulfill program requirements upon their

Table 5. Themes Describing Supportive and Unsupportive Supervisory Behaviors

	Theme	Description	Example
Positive	Showing interest	Supervisors showed interest in GSPs' lives outside of school, including an interest in their own well-being and the well-being of their child(ren).	'Checking in often with me and another trainee who were young mothers; asking about my child; normalizing feelings of overwhelm...'
	Sharing personal experience and advice	Supervisors shared their own experiences with parenthood and work/life balance and gave advice.	'My research advisor was also a mom and an early career professor, and hearing her experience helped me feel validated.'
	Supporting and validating	Supervisors expressed empathy and support for the needs of GSPs.	'They expressed their utmost support and empathy with my needs.'
	Allowing for flexibility	Supervisors allowed GSPs to make adjustments to their clinical and/or course schedules.	'Allowed additional time for or modification to assignments; assured that I could leave early enough to pick child up from daycare on time'
	Accommodating leave	Supervisors were accommodating of GSPs taking parental leave; Students experienced leave policies as personalized, unlimited, or otherwise beneficial.	'My clinical supervisor said that I could be flexible about the timing of my return to work. He understood when I was no longer able to regularly attend evening meetings. He also supported me in bringing my baby to meetings and trainings when necessary.'
Negative	Prioritizing breastfeeding	Supervisors provided support and scheduling accommodations for breastfeeding and pumping.	'I literally chose my internship site because they were the only ones who mentioned creating time and space for breastfeeding/pumping mothers at the internship interview. All my supervisors with both of my children were very supportive of me making my own schedule in order to create time for pumping...'
	Highlighting clinical advantages	Supervisors discussed with GSPs how parenting may benefit their clinical work.	'...Some have treated my role as a parent as a clinical advantage and encouraged me to use it with clients...'
	Not accommodating leave	Supervisors were unaccommodating of GSPs' parental leave; Students experienced leave policies as strict, inflexible, and restrictive.	'Only allowed me to take 2 weeks off from school after my first baby, which totaled to 4 weeks off after he was born.'
	Pressuring to overcompensate	GSPs were expected to maintain a higher workload or make up for time 'lost' due to family leave.	'Asking me to stay late at work, working evenings and weekends at home - put extra hours and not have a balanced life'
	Not providing support	Supervisors did not express or provide support for GSPs.	My clinical supervisor did nothing, and that in itself, was isolating. I had to advocate for myself, and had to push the issue about accommodations on my own...'
	Discriminating against parents	Some GSPs were subjected to discriminatory treatment by their supervisors as a result of their parenting status.	'Shaming me for deciding to get pregnant when I did ("this is an issue of professional development; you really should have spoken to us before you decided to get pregnant to make sure we could coordinate your clinical work around this timeline")...'

return. Third, the constraints of the internship match system and clinical hour requirements are a particular challenge for both GSPs and internship programs. While APPIC does not currently allow trainees to defer their internship match if they anticipate being on parental leave, this option would allow internship programs more flexibility to accommodate GSPs. The addition of half-time internships and postdoctoral fellowships would also increase trainee's options.

In formulating these policies, APA and APPIC may improve GSPs' training experiences and the extent to which they feel supported by their programs and supervisors. Additionally, these policies may impact GSPs' perceptions of their field as family friendly and ultimately their career opportunities and choices. Importantly, graduate students may have caretaking responsibilities unrelated to parenting (e.g., for parents or spouses) that impact their graduate training in similar ways. Ideally, policy changes would address the needs of graduate students with caretaking responsibilities broadly defined.

Strengths, Limitations, and Future Directions

Limitations of this study include its reliance on self-report, the self-selected nature of the sample that is not necessarily representative of all GSPs in professional psychology programs, and the lack of verification of training sites' policies and practices. Additionally, the sample was limited to those willing to complete the survey without compensation, and not all GSPs in professional psychology programs had access to the survey. Finally, as our sample included a higher percentage of women than those enrolled in psychology doctoral programs, our conclusions regarding the experiences of male GSPs were limited.

Notwithstanding these limitations, this is the first study to quantitatively assess the experiences of GSPs in professional psychology programs. We describe GSPs' perceptions of policies, institutional support, and supervisory support in professional psychology programs and highlight associations among these variables, demographic differences across parenting and training experiences, and the supervisory behaviors that GSPs consider helpful and unhelpful.

It is important for future research to further investigate the needs of GSPs in professional psychology programs and the extent to which shifts in training policies improve their experiences. Mixed methods studies that compare the experiences of

GSPs to trainees who are not parents would help clarify the common and unique experiences of these groups. Studies of clinical and research supervisors would also allow for greater understanding of the perceived benefits and challenges of mentoring GSPs and ways for training programs to strengthen relationships between supervisors and students. Finally, tracking GSPs' and supervisors' experiences before and after the initiation of policy changes at specific training sites would shed light on the impact of these policies such that the most effective ones could be implemented across sites. While GSP-led initiatives like the Families in Psychology Project (<https://www.familiesinpsych.org/>) are spearheading research efforts in this area, research collaborations among GSPs, training sites, and governing bodies like APA and APPIC would be particularly fruitful.

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ORIGINAL RESEARCH

Psychological and Professional Repercussions of the COVID-19 Pandemic in Female Faculty With Children: An Investigation of Outcomes Across Different Academic Career Stages

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MANDATED LOCKDOWNS during the coronavirus disease 2019 (COVID-19) pandemic profoundly altered many professionals' work dynamics, and women appear uniquely impacted by the transition to remote work because of COVID-19. With schools, daycares, and similar supports no longer easily accessible for many, childcare responsibilities appear to be a major driver of these inequities. In the U.S., compared to 10% of working fathers, 33% of working mothers reported that they were the only provider of care for their children (Zamarro et al., 2020) and women were three times more likely to have left their job because of childcare issues amidst the pandemic (Heggeness & Fields, 2020). As many as 2 million women are considering taking a leave of absence or leaving the workforce altogether, and many cite child-

care concerns as a main reason (Thomas et al., 2020). Although the increasing availability of COVID-19 vaccinations is paving the way towards the end of the pandemic, the resulting wedge driven between male and female faculty is likely to have adverse effects on the representation of women in the academy long after a return to "normal" life.

A large body of research documents that childcare and household chores stereotypically fall on women (Brescoll & Uhlmann, 2005; Rudman et al., 2012; Rudman & Glick, 2008). Conflicts between professional and personal responsibilities in conjunction with a lack of clear boundaries between work and non-work, specifically in the "up or out" field of academia, contribute to the disproportionate disadvantage that female faculty have experi-

enced even before the arrival of COVID-19. The tenure system in the U.S. involves a probationary period of several years, followed by an invitation to join the permanent faculty or the direction to leave the institution (Jacobs & Winslow, 2004). The tremendous challenge of reconciling the time and effort needed to become a competitive tenure applicant with the disproportionate burdens women face at home is evidenced by the overrepresentation of women in contingent, as opposed to tenure-track, faculty positions and a tendency for female academics to delay childbirth until after promotion (Park & Rim, 2020; Winslow & Davis, 2016).

For academics, remote work during the pandemic may have alleviated time commitments to in-person responsibilities such as teaching and service. Given the nature of careers in academia and the fact that women faculty were already disproportionately burdened with responsibilities at home before the pandemic, we expect that academic mothers of young children may be particularly impacted by the shift to remote work due to the COVID-19 pandemic. To the extent that these effects may adversely impact women's chances for success in their tenure review, the pandemic will likely have both short- and long-term implications for individual careers and for the retention and representation of women in the academy in general. As is the case in most academic fields, the representation of

women in academic psychology decreases with each successive career stage (Hormes, 2016). As clinical psychologists, we are uniquely positioned to appreciate the fact that professional success is driven not only by objective indicators such as measurable research outputs, but also impacted by sustained satisfaction in professional and personal domains. This study was designed to identify factors that put women at increased risk of leaving academic careers in the wake of the COVID-19 pandemic as a crucial first step in developing evidence-based strategies to provide effective support and facilitate their retention.

Gender Inequality in Academia Before COVID-19

Social role theory suggests that people tend to automatically and oftentimes implicitly attribute distinct traits and beliefs to each gender (Eagly & Wood, 2016). For example, men are typically associated with agentic traits such as ambition and assertiveness, whereas women are typically linked with communal traits such as compassion and nurture (Eagly & Karau, 2002). These gender stereotypes strongly influence how people believe men and women should act (Moss-Racusin, 2014), and pressures to act in concordance with gender stereotypes adversely impact female faculty's success in academia (Blau & Kahn, 2017; Cuddy et al., 2004). For example, women are expected to prioritize caregiving, resulting in greater work-life conflict compared to their male counterparts (Catano et al., 2010; Dorenkamp & Süß, 2017; Tausig & Fenwick, 2001), particularly in the early career stage when family planning milestones such as marriage and children typically occur and account for the largest loss of women in the academic pipeline (Cech & Blair-Loy, 2019). Women are less likely to pursue and be hired for tenure-track positions in academia if they are married or have children, even in the absence of any adverse impact on their productivity; however, men actually experience a boost in hireability as a result of these factors (Ginther & Kahn, 2006; Misra et al., 2012). Even if available, academics describe difficulty taking advantage of formal breaks (e.g., parental leave): the "lock step" nature of academia makes reentry following extended absences seemingly impossible (Corley et al., 2003; Goulden et al., 2011).

The adverse impact of motherhood on research productivity that occurs when children are very young is compounded by other barriers unique to women in acad-

mia, including unequal service expectations and biases in evaluations of teaching effectiveness (Stack, 2004). Women are disproportionately assigned service roles that are time-consuming and yet generally devalued in tenure evaluations (Misra et al., 2011). Consistent with social role theory and the impact of gender stereotypes on interpersonal behavior, female faculty typically also spend more time and expend more emotional energy mentoring and supporting students compared to male faculty (Alayli et al., 2018; Sprague & Massoni, 2005). Students' judgments of female faculty in their teaching evaluations appear influenced by the extent to which they display gendered traits such as warmth, support, and empathy, more so than evaluations of male professors (Kierstead et al., 1988). However, if women do exhibit these traits, they are also seen as less competent, creating an impossible bind (Burnell et al., 2018; Lazos, 2012). Taken together, these findings suggest that women in academia face unique challenges compared to their male counterparts and these challenges appear exacerbated by motherhood. There is reason to assume that the COVID-19 pandemic has further worsened these issues.

Gender Inequality in Academia During COVID-19

Recently published studies support the notion that women in academia experience more challenges during the COVID-19 pandemic than their male counterparts. Women with very young children reported significant decreases in hours worked and academic productivity during the lockdown compared to when they were not working remotely (Cardel et al., 2020). This is consistent with prepandemic research suggesting women with young children, burdened by gendered childcare responsibilities, report a dip in research productivity (Stack, 2004). Even though overall research productivity by faculty increased by 35% in the 10 weeks after the initial U.S. lockdown, this increase was driven exclusively by male faculty; female academics' productivity actually dropped by 13.9% (Andersen et al., 2020; Cui et al., 2020). A study of over 3,000 Brazilian academics similarly documents decreased academic productivity specifically in women with children as measured by the ability to submit papers and meet overall deadlines (Stanislauski et al., 2020). Male academics without children were the group least affected by the COVID-19 pandemic in

terms of academic productivity (Stanislauski et al., 2020).

While it is evident from emerging studies that women, in particular women with younger children, are less productive during the COVID-19 pandemic than men, little is known about whether this pattern applies across different career stages. Further, less is known about the impact these effects have on factors other than objective indices of productivity that may predict dropout from academic careers. These factors may include psychological health and fulfilling social relationships. Previous research suggests that, in general, mothers experience more work-family guilt than fathers, which adversely affects their overall psychological well-being (Borelli et al., 2016). Importantly, work-family conflict is the most common reason why women drop out of academic careers (Deutsch & Yao, 2014). Anecdotally, female scientists have expressed significant sadness and frustration in the midst of balancing work and home roles in the pandemic lockdown (Buckee et al., 2020; Scheiber, 2020). However, considerably less empirical research has examined the impact of COVID-19 of female faculty's psychological well-being.

A study of almost 6 million academics concluded that women submitted fewer manuscripts than men during lockdown, and found this gap to be especially pronounced among women in more advanced stages of their career (Squazzoni et al., 2020). This result is concerning insofar as it suggests that women in the early stages of their careers may continue to prioritize productivity during lockdown due to the pressures of the tenure review process, but potentially at a great cost to their psychological well-being. A recent large-scale survey found that among partnered women with children, 49% reported at least mild symptoms of psychological distress during the pandemic compared to 40% of partnered women without children (corresponding prevalence rates in men were 33% versus 28%; Zamarro et al., 2020). While these data suggest a potential gender difference in psychological distress experienced as a result of COVID-19, this study did not survey working parents specifically.

The current study aimed to expand on the growing body of literature that suggests that women in the academy are disproportionately harmed by the impact of COVID-19 because it exacerbates preexisting gender inequalities. We explore the impact of the COVID-19 pandemic on personal and professional activities, satisfaction with

life, and indices of well-being in women faculty with children across different academic career stages. We specifically sought to examine how the added burdens and barriers to research productivity imposed by the pandemic impact women's mental health and quality of life in ways that may make them more likely to drop out of academic careers altogether. Because childrearing responsibilities often coincide with earlier career stages, we also expect female faculty on the tenure track and pretenure review to be more adversely impacted by the COVID-19 lockdown than tenured female faculty. Given that women in academia report substantial work-family guilt, we hypothesize that the adverse impact of the pandemic on the professional activities of women in the early career stages negatively impacts their well-being and satisfaction with their personal lives.

Materials and Methods

Participants and Procedures

This study was approved by the local Institutional Review Board. Respondents were recruited via Facebook groups specifically targeting mothers in academia. Data were collected between May 6 and May 17, 2020, via a survey hosted on the secure server Qualtrics. Participants were consented prior to completion of questionnaires. The first three survey questions assessed eligibility for participation as defined by the following inclusion criteria: age 18 or older, currently identifies as female, and currently holds a position in academia.

Measures

• Demographics

Participants provided information on age, race/ethnicity, sexual orientation, relationship status, income, and household composition, including the number and ages of children currently living in the household. They also reported their current country and (if in the U.S.) state of residence.

• Work and Household Responsibilities

Participants were asked to indicate their current role in academia, work location, and percentage of time (out of 100%) allocated towards various professional responsibilities (i.e., research, teaching, service, and, if applicable, clinical and administrative responsibilities) before and during the pandemic. They were asked to indicate past and current availability of help with childcare and various other household responsibilities and reported on the percentage of

childcare duties and household chores they completed, compared to their partner, before versus during the pandemic (out of a total 100%, with the remaining proportion referring to the amount of work completed by their partner, and not considering any outside help they may still be receiving).

• Satisfaction with Personal and Professional Activities

Using a Likert scale ranging from 1 = *strongly agree* to 5 = *strongly disagree*, participants rated the extent to which the pandemic had adversely impacted their work productivity and satisfaction and the perceived quality of and satisfaction with their relationship and parenting. They completed the same items again to reflect their impressions of the adverse impact of the pandemic on their partners' work productivity and satisfaction and satisfaction with and perceived quality of their relationship and parenting.

• Satisfaction With Life Scale

Participants completed this widely used and well-validated five-item measure of subjective well-being and global life satisfaction (Diener et al., 1985), once retrospectively reflecting their life satisfaction before the start of the pandemic (Cronbach's $\alpha = .88$) and again to indicate their current agreement with the scale items (Cronbach's $\alpha = .87$). Items are rated on a seven-point Likert scale, ranging from 1 = *strongly disagree* to 7 = *strongly agree*, and summed for a total score, which can then be categorized to represent degree of current life satisfaction (ranging from *extremely satisfied* to *extremely dissatisfied*).

• Quality of Life

Participants rated their perceived quality of life retrospectively prior to and again during the pandemic via visual analogue scales, ranging from 0 (worst) to 100 (best).

• Depression Anxiety and Stress Scales-21

Participants completed this widely used and well-validated measure of general mental health, quantifying depression (Cronbach's $\alpha = .88$), anxiety (Cronbach's $\alpha = .72$), and stress (Cronbach's $\alpha = .84$) over the course of the past week via 21 items rated on a four-point Likert scale, ranging from 0 = *did not apply to me at all* to 3 = *applied to me very much, or most of the time* (Lovibond & Lovibond, 1995).

Statistical Analyses

A total of 196 respondents started the survey. Since our hypotheses are specific to women faculty with children working in the American tenure system, we focused analyses reported here on those who resided in the U.S. with a partner and any children under the age of 18 at the time of survey completion ($n = 153$). Except for items assessing eligibility to participate in the research, participants were able to skip any question for any reason. As a result, sample sizes underlying the analyses reported here vary. All percentages reported are valid percent (out of the n of completed responses).

Results

Participant Demographics

Participants were on average 40 years old ($M = 39.59$ years, $SD = 4.70$, range: 29–57) and overwhelmingly identified as White (90.2%, $n = 138$) and heterosexual/straight (95.4%, $n = 146$). The majority was married (96.1%, $n = 147$) and reported living in households with two adults ($M = 2.09$ adults, $SD = .40$, range: 1–4) and one to two children ($M = 1.80$ children, $SD = .74$, range: 1–5). Half of respondents indicated living with a child under the age of 3 (51.6%, $n = 79$). At the time of survey completion, 27.9% of respondents ($n = 41$) were tenured, 39.5% ($n = 58$) were on the tenure track and pretenure review, and 27.9% ($n = 41$) were not on the tenure track, with 4.8% ($n = 7$) reporting some “other” current employment in academia. The respondents not on the tenure track or tenured reported a wide range of professional roles, including doctoral student ($n = 1$), postdoctoral fellow ($n = 4$), adjunct ($n = 4$) and visiting professor ($n = 2$), and assistant ($n = 21$) and associate professor ($n = 7$) in non-tenure-track positions. As expected, compared to tenured respondents, participants on the tenure-track and pretenure were on average significantly younger [$M = 38.14$ years, $SD = 3.66$ vs. $M = 42.39$, $SD = 5.12$; $t(97) = 4.56$, $p < .001$, $d = .95$] and significantly more likely to live with children under the age of three (63.8%, $n = 37$ vs. 24.4%, $n = 10$; $\chi^2 = 14.96$, $p < .001$, $\phi = .39$). Half of respondents reported a current household income over \$200,000 (51.0%, $n = 78$) and 11.1% ($n = 17$) had a household income below \$100,000. Most respondents indicated no change in their household income as a result of the pandemic (75.2%, $n = 115$).

Time Spent on Personal and Professional Responsibilities

Respondents on average were responsible for more than half of chores in most household domains (compared to their partner) prior to the pandemic (see Table 1). During the pandemic, the proportion of participants' chores related to children's schooling and other care, pet care, cleaning, laundry, and cooking/ meal preparation increased significantly (see Table 1). Women pretenure reported significant increases in the relative amount of time spent on childcare related to schooling and other childcare, cleaning, laundry, cooking/meal preparation, and yard work (all $p < .05$), though these increases were not significantly different from those reported by women with tenure. Prior to the pandemic, a majority of respondents (76.5%, $n = 117$) reported having some form of help with childcare. That number decreased to 27.5% ($n = 42$) during the pandemic. Women on the tenure track and pretenure were especially reliant on help with childcare prior to the pandemic (82.8%, $n = 48$), and markedly fewer reported still having access to help during the pandemic (31.0%, $n = 18$).

All respondents reported a significant decrease in proportion of time spent on research during the pandemic, with simultaneous increases in time allocated towards teaching, administrative obligations, and "other" tasks (including training and professional development; see Table 2). There were no differ-

Table 1. Percentage of Time Spent on Chores, Out of 100% Relative to Partner, Prior to Versus During the Pandemic

	Prior to the Pandemic Mean % (SD)	During the Pandemic Mean % (SD)	Differences in Mean % Prior vs. During Pandemic	Statistic
<i>Childcare – Schooling</i>	61.83 (23.39)	71.17 (21.93)	+9.34	$t(80) = 3.69, p < .001, d = .41$
<i>Childcare – Other</i>	59.75 (19.65)	66.16 (19.61)	+6.41	$t(128) = 3.67, p < .001, d = .33$
<i>Caring for Family Members</i>	59.46 (29.62)	63.31 (30.79)	+3.85	$t(12) = 1.42, p = .18, d = .13$
<i>Pet Care</i>	48.24 (26.47)	51.44 (28.19)	+3.20	$t(79) = 2.52, p = .01, d = .12$
<i>Cleaning</i>	57.12 (19.61)	66.26 (20.58)	+9.14	$t(129) = 6.26, p < .001, d = .45$
<i>Laundry</i>	64.91 (26.43)	68.56 (27.84)	+3.65	$t(128) = 2.87, p = .01, d = .13$
<i>Grocery Shopping</i>	62.21 (29.32)	59.85 (34.89)	-2.36	$t(80) = 3.69, p < .001, d = .07$
<i>Cooking/ Meal Preparation</i>	57.45 (27.81)	60.64 (28.41)	+3.19	$t(129) = 2.28, p = .02, d = .11$
<i>Schedules/ Appointments/ Planning</i>	86.76 (15.52)	85.86 (18.81)	-0.90	$t(131) = .67, p = .50, d = .05$
<i>Finances</i>	56.35 (33.05)	57.89 (34.98)	+1.54	$t(120) = 1.90, p = .06, d = .05$
<i>Home Maintenance</i>	32.77 (25.32)	33.60 (28.09)	+0.83	$t(99) = .54, p = .59, d = .03$
<i>Yard Work</i>	31.44 (27.21)	33.06 (29.72)	+1.62	$t(83) = .99, p = .33, d = .06$

Table 2. Allocation of Time Spent (out of 100%) on Various Professional Obligations Before Versus During the Pandemic

	Prior to the Pandemic Mean % (SD)	During the Pandemic Mean % (SD)	Differences in Mean % Prior vs. During Pandemic	Statistic
<i>Research</i>	52.84 (30.89)	43.08 (34.43)	-9.76	$t(144) = 8.06, p < .001, d = .30$
<i>Teaching</i>	23.70 (25.22)	28.65 (31.65)	+4.95	$t(144) = 4.88, p < .001, d = .17$
<i>Clinical</i>	10.05 (18.25)	11.21 (20.42)	+1.16	$t(144) = 1.72, p = .09, d = .06$
<i>Administrative</i>	5.17 (11.32)	7.26 (13.52)	+2.09	$t(144) = 3.20, p = .002, d = .17$
<i>Service</i>	6.82 (8.56)	6.28 (9.53)	-0.54	$t(144) = 1.01, p = .32, d = .06$
<i>Other</i>	1.41 (9.77)	3.53 (15.05)	+2.12	$t(144) = 2.18, p = .03, d = .17$

ences between tenured respondents and participants on the tenure-track and pre-tenure in reported changes in time spent on various professional responsibilities. Tenure status, number of children, the presence of young children (i.e., under the age of 3) in the house, or the availability of childcare during the pandemic did not impact time spent on research during the pandemic or change in time allocated to research as a result of the pandemic.

Work Productivity and Satisfaction

Respondents on average indicated that they “strongly agree” that the pandemic has adversely impacted their work-related productivity and “agree” that it adversely impacted their satisfaction with their work (Figure 1). Agreement with perceived adverse impact on partners’ productivity and work satisfaction was significantly lower [$t(128) = 9.27, p < .001, d = 1.08$ and $t(128) = 4.35, p < .001, d = .47$, respectively; see Figure 1 for means and standard deviations]. There were no significant differences, by tenure status, in reported agreement with the adverse impact on respondents’ own or their partners’ work productivity or satisfaction. Those living with children under the age of three reported a significantly greater adverse impact of the pandemic on their work productivity, compared to respondents with older children regardless of the availability of help with childcare [$M = 4.86, SD = .35$

vs. $M = 4.54, SD = .90; F(1,133) = 7.50, p = .01, \eta_p^2 = .05$], with no effect of the age of respondents’ children or access to childcare on reported work satisfaction.

Satisfaction with and Perceived Quality of the Relationship and Parenting

Respondents on average “neither agreed nor disagreed” that the pandemic had a significant adverse impact on their own or their partner’s perception of the quality of or their satisfaction with their relationship [$t(132) = 1.12, p = 2.66, d = .06$; Figure 1]. Respondents generally “agreed” that the pandemic had a significant adverse impact on the quality of and their satisfaction with their parenting and also perceived that impact to be significantly less adverse for their partner [$t(133) = 5.22, p < .001, d = .45$; Figure 1]. Examining differences in these factors by tenure status, participants on the tenure track and pre-tenure endorsed significantly greater agreement with statements regarding the adverse impact of the pandemic on the perceived quality of and their satisfaction with their relationship [$t(89) = 2.56, p = .01, d = .53$] and their parenting [$t(89) = 2.11, p = .04, d = .46$; Figure 1] compared to tenured respondents. They also felt that their partners’ perception of the quality of and their satisfaction of the relationship had been impacted more adversely by the pandemic, compared to tenured respondents [$M =$

$2.79, SD = 1.21$ vs. $M = 2.08, SD = .97; t(87) = 2.93, p = .004, d = .65$].

Well-Being and Mental Health

Participants reported a statistically significant decrease in their perceived quality of life as a result of the pandemic [$M = 78.39, SD = 10.77$ vs. $M = 60.29, SD = 16.51; t(133) = 14.17, p < .001, d = 1.30$]. Similarly, participants endorsed a significant drop in their satisfaction with life as a result of the pandemic [$M = 26.87, SD = 5.85$ vs. $M = 21.79, SD = 6.87; t(127) = 10.88, p < .001, d = .80$]. Prior to the pandemic, a majority of respondents reported being “extremely satisfied” (28.7%, $n = 37$) or “satisfied” with their life (36.4%, $n = 47$); during the pandemic, those percentages dropped to 8.3% ($n = 11$) and 24.8% ($n = 33$), respectively at the time of survey completion.

Compared to respondents with tenure, participants on the tenure track and pre-tenure endorsed a significantly greater drop in quality of life as a result of the pandemic [$M = -21.87, SD = 15.35$ vs. $M = -15.18, SD = 14.63; t(89) = 2.09, p = .04, d = .45$]. There were no significant between-group differences in total scores on the Satisfaction with Life Scale [$M = 6.17, SD = 5.07$ vs. $M = 3.91, SD = 6.35; t(84) = 1.83, p = .07, d = .39$]. Before the pandemic, 28.8% ($n = 15$) of respondents pretenure reported being “extremely satisfied” with their lives and another 32.7% ($n = 17$) endorsed being “satisfied;” these percentages dropped to 7.5% ($n = 4$) and 20.5% ($n = 11$), respectively during the pandemic. In comparison, 48.6% ($n = 18$) tenured participants remained “extremely satisfied” or “satisfied” with their life during the pandemic.

In women on the tenure track and pre- or posttenure, there was a significant multivariate main effect of the age of the youngest child on combined DASS-21 scores [$F(3,78) = 3.30, \text{Wilks' } \lambda = .89, p = .03, \eta_p^2 = .11$], with significantly greater levels of anxiety [$M = 3.72, SD = 3.43$ vs. $M = 2.07, SD = 2.31; F(1,80) = 8.28, p = .01, \eta_p^2 = .09$] and stress [$M = 11.31, SD = 4.59$ vs. $M = 9.58, SD = 3.96; F(1,80) = 4.81, p = .03, \eta_p^2 = .06$] reported by women with very young children (under the age of three). There were no significant differences in reported depression, anxiety, or stress by tenure status and no interaction.

Discussion

Women continue to face inequities in the workplace, in particular when they are mothers to young children and need to balance demands at work and at home. Acad-

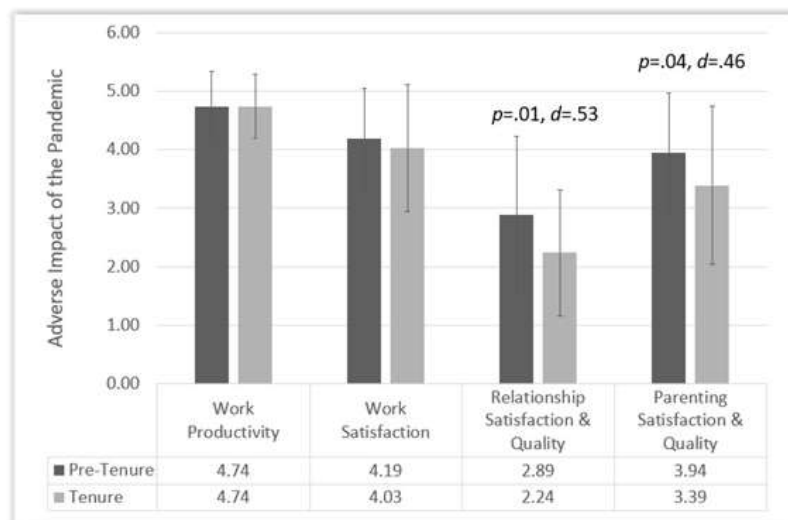


Figure 1. Impact of the pandemic on work productivity and satisfaction and satisfaction with and perceived quality of the relationship and parenting in respondents pre- versus posttenure. Note. 1 = “strongly disagree” and 5 = “strongly agree” that the pandemic had a significant adverse effect. Error bars = standard deviation of the mean. Significance level and effect sized indicated for statistically significant between-group differences.

emia presents unique challenges to women due to its “up or out” nature and the often-times blurred boundaries between the professional and personal domains. Emerging evidence suggests that these existing challenges are significantly exacerbated during the COVID-19 pandemic when access to usual supports, in particular help with childcare, is limited.

This is the first study, to our knowledge, to quantify the professional and psychological repercussions of the COVID-19 pandemic in female faculty with children with a focus on women in the early career stages. We specifically examine the impact of the pandemic on the way mothers in academic positions allocate time towards professional and personal responsibilities and on indicators of life satisfaction and well-being. Briefly, our findings point to few differences between women pre- and posttenure in the effects of the COVID-19 pandemic on time spent on various professional and personal pursuits. All women reported an increase in the proportion of chores they are responsible for at home during the pandemic, and a decrease in time spent on research due to competing demands at home and at work, including the burden of shifting to online teaching. Women pre- and posttenure did differ significantly in the extent to which these changes appear to impact their reported satisfaction with life and with their relationships with their partners and children. To the extent that the negative psychological effects of heightened work-family conflict increase the likelihood that women drop out of academic careers, these findings highlight the fact that the COVID-19 pandemic could have long-lasting adverse repercussions for the retention and representation of women in academia.

Pre- Versus Posttenure Differences

Reports from our participants point to marked differences by career stage in the impacts of pandemic-related shifts in time allocated towards various obligations at work and at home on their personal lives and well-being. Pretenure respondents' ability to continue to dedicate time and effort towards their research endeavors, presumably in pursuit of the goal of obtaining tenure and promotion in the future, appears to come at a relatively greater personal cost. Compared to women with tenure, women pretenure reported substantially greater decreases in quality of life and satisfaction with life as a result of the pandemic, and more adverse impacts on their perceived relationship and parenting

quality and satisfaction. They also believed the satisfaction with and quality of their parenting to have suffered relatively more than it did for their partners. This is consistent with prior work suggesting that women experience more guilt related to their careers interfering with their family, compared to men (Borelli et al., 2016; Ward & Wolf-Wendel, 2004; Young & Wright, 2001), and indicates that these disparities may be further exacerbated by the current pandemic specifically in women in the earliest career stages.

Pre- Versus Postpandemic Differences

Compared to their partners, respondents on average reported being responsible for more than half of most household chores prior to the pandemic. COVID-19 appears to have significantly exacerbated these inequities, with women reportedly taking on an even greater share of responsibilities during the pandemic. The most marked increases were in women's share of traditionally gendered chores such as childcare, cleaning, laundry, and meal preparation. Participants also reported a significant decrease in proportion of work time dedicated towards research and endorsed a marked adverse impact of the pandemic on their work productivity and satisfaction. This shift appears attributable to both increased demands at home and more time spent on other work-related tasks, most notably shifting teaching to novel online formats. Women on average perceived their partners' work productivity and satisfaction to be significantly less adversely impacted than their own.

These findings are consistent with the tenets of social role theory, which predicts that disadvantages women suffer in the workplace are in large part due to conscious and unconscious expectations regarding gender roles that still relegate women disproportionately into caretaker and homemaker roles. Our data support this hypothesis and furthermore suggest that the COVID-19 pandemic exacerbates existing inequities related to traditionally gendered household and family chores. Findings are also in line with recent research suggesting lowered research productivity in female scientists, in particular those with children, during the pandemic (Andersen et al., 2020; Staniscuaski et al., 2020). Our data point to reasons for these discrepancies—namely, that women disproportionately take on extra work at home.

Our data did not reveal significant differences by career stage in the impact of the

pandemic on the way women allocated their time at work and at home. The same pattern of increased burdens at home and less time spent on research-related activities was reported by women pre- and posttenure. Women pre- and posttenure also did not differ significantly in the reported adverse impact of the pandemic on their work productivity or satisfaction.

It is worth noting that there were overall few differences by age of children in how respondents allocated their time at home or at work prior to and during COVID-19. Our data thus suggest that the challenges women face are not limited to those with very young children but impact women broadly, perhaps due to the new responsibilities related to home-schooling older children being placed disproportionately on mothers during the pandemic. These findings expand upon previous literature suggesting women with very young kids experience a dip in research productivity and draw attention to the unique burdens posed by COVID-19 that impact mothers of children of any age, with potentially devastating effects on their individual career trajectories and the representation of women in the academy in general.

Implications and Future Directions

Our data, along with a growing body of related research, anticipate long-term adverse consequences of the COVID-19 pandemic for the status of women in academia. Before the arrival of COVID-19, women were already dropping out of academic careers at disproportionately high rates (Khan et al., 2019; Misra et al., 2011). The added burden on female academics during the pandemic identified here, in conjunction with a lack of support and resources, has the potential to drastically increase this already disproportionate dropout rate. A decrease in time spent on research-related activities due to competing obligations at home and at work will likely put women at a disadvantage in decisions about tenure and promotion for years to come. Furthermore, reports of significant adverse effects of the pandemic on the personal lives of women pre-tenure raises the possibility that these faculty members may elect to leave academia even if they managed to remain competitive for tenure and promotion in an attempt to resolve perceived work-family conflicts.

In other words, the end of the pandemic will not undo the disadvantages that threaten women's future representation in the academic workforce. Instead, thoughtful, evidence-based intervention is needed

to proactively counter any long-term adverse effects. Prior research shows that even well-intentioned interventions, such as “pausing the tenure clock” or giving pre-tenured faculty more time to develop their portfolio before they are evaluated for tenure, can have the opposite of their intended effects. These interventions may further disadvantage women faculty because they inadvertently perpetuate biased expectations for how women versus men spend time off from formal work obligations (Antecol et al., 2016). These types of interventions are also ineffective in helping women successfully resolve the work-family conflicts that prompt a disproportionate number of female faculty to drop out of academic careers (Deutsch & Yao, 2014). As we move forward with vaccinations and a return to prepandemic life, the academy must focus on practical solutions to promote both policy and cultural changes to retain and promote female faculty.

Malisch et al. (2020) provides several suggestions to protect the pipeline of women faculty in the wake of COVID-19, such as a mandatory intervention that acknowledges gender biases related to the pandemic before faculty return to “normal” institutional operations, as well as the creation of “COVID committees” to address the numerous ways the pandemic has impacted institutions. A lack of specific criteria for academic promotion beyond tenure has been posited to contribute to the lack of female representation in full professorships even before the arrival of COVID-19 (Fox & Colatrella, 2006), as it opens the door for subtle discrimination that is difficult to identify. Even more pertinent now is the need for explicit guidelines on how to quantify impacts of COVID-19 on faculty in order to decrease bias in promotion decisions postpandemic. For example, universities and funding agencies should give faculty the option of submitting COVID-19 impact statements that broadly describe how the pandemic impeded their work (Langin, 2021).

At a cultural level, the postpandemic landscape provides academia with the unique opportunity to restructure the status quo in the academy. Professional success in academia is often contingent upon a willingness to be geographically flexible and adhere to fairly rigid sequential deadlines (Hormes, 2016). This antiquated and largely male model for academic careers does not promote a sustainable academic environment for everyone. For example, women are more likely to pass on

optimal opportunities that would advance their career in favor of jobs that are geographically advantageous (Leeman et al., 2010). In order to retain and encourage female faculty, particularly at the pretenure level where competing work and family demands elicit burdensome feelings of guilt and a lower quality of life, institutional action needs to confront the inherent gender bias in academic culture. Further, larger scale interventions that go beyond the scope of interventions within institutions and instead target problematic U.S. norms and policies, such as mandating federal childcare and adequate parental leave time, ensuring pay equity, and implementing basic social safety are needed. These interventions would not only set an egalitarian example by providing guaranteed and equivalent resources and supports to both male and female faculty, but also alleviate the work-family guilt imposed on female faculty with children by gender stereotypic societal norms.

Some important limitations of the research must be noted. First, the generalizability of our findings is limited due to the fact that the sample was comprised of mainly affluent, married White women. However, given that COVID-19 brought on significant professional and personal challenges even to a financially privileged sample with spousal support, it is reasonable to assume that women who are less affluent and single mothers may be suffering even more. More research and evidence-based strategies are needed to address these issues. Another noteworthy limitation of our sample was the lack of racial and ethnic diversity. Research conducted before COVID-19 suggests there are both gender-related and race/ethnicity-related barriers to success in academic positions (Khan et al., 2019). COVID-19 has disproportionately impacted communities of color at a time when racial injustices have also been at the center of public discourse. The extent to which the COVID-19 pandemic may have dual effects on racial and ethnic minorities, due to higher rates of COVID-19 infection and mortality (Egbert et al., 2020) and potential indirect adverse effects on career advancement, are not captured in our data and must be examined in future research. To reach a more diversified sample, future studies need to expand beyond social media recruitment methods and utilize community and other online (e.g., Mechanical Turk) samples.

Our sample included a large and very heterogeneous group of women in non-

tenure-track academic positions who were excluded in the analyses comparing women pre- and posttenure to facilitate interpretation of our results. In doing so, we were unable to capture the unique challenges affecting a large group of women in the academy who do not benefit from the relative security and stability of the tenure track. More work is needed to document the adverse effects of the pandemic on women in postdoctoral, adjunct, and comparable positions and to advocate for support tailored specifically to their situation. We elected to inquire about changes in the proportion of time respondents spend engaged in various professional and personal pursuits as a result of the pandemic, rather than absolute hours. Given our interest in exploring the impact of the COVID-19 pandemic specifically on women pre-tenure and through a social role theory lens, we were primarily interested in the hypothesized disproportionate impact of the resulting changes on women, especially those at earlier career stages, compared to those post-tenure, and relative to their partners. It is, however, reasonable to assume that the total number of hours engaged in tasks such as childcare increased across the sample and our data are unable to speak to these changes, which is a noteworthy limitation of the study. Finally, many of our analyses are based on retrospective reports of behaviors and attitudes prior to the pandemic as well as participants’ ratings of the feelings and attitudes of their significant others, which may be subject to biases. That being said, these biases likely apply equally across all participants and are therefore not assumed to have impacted our comparisons of relative effects of the pandemic on women at various career stages. Nevertheless, data should be interpreted with this issue in mind.

Conclusion

Our findings suggest that female academics, in particular those in the early career stages, are suffering both professionally and psychologically as a result of the COVID-19 pandemic. The implications of this suffering have the potential to extend far beyond the end of the pandemic, creating barriers and further decreasing representation of women in academia for years to come. To combat this pressing issue, institutions must actively address and develop evidence-based solutions for the gender disparities in academia that have been exacerbated by COVID-19.

Recommended Reading List for Intervention Strategies

Members of the Association for Behavioral and Cognitive Therapies are uniquely positioned to appreciate the complex factors that impact the successful retention of women in academic careers and to develop empirically supported strategies to counter the adverse effects of COVID-19 on the status of women faculty in the academy. Below, we list a brief set of resources to inform and guide those efforts:

Cohen Miller, A. (2020). *Promoting equity and inclusion for mothers in academe*. Inside Higher Ed (<https://www.inside-highered.com/blogs/university-venus/promoting-equity-and-inclusion-mothers-academe>).

Flaherty, C. (2021). *Where caregiving and gender intersect*. Inside Higher Ed (<https://www.insidehighered.com/news/2021/03/31/where-and-how-gender-and-caregiving-intersect-professors-during-covid-19>).

Gonzalez, L.D., & Griffin, K.A. (2020). Supporting faculty during and after COVID-19: Don't let go of equity. (<https://www.mtu.edu/advance/resources/articles-books/supporting-faculty-during-and-after-covid.pdf>).

Malisch, J.L., Harris, B.N., Sherrer, S.M., Lewis, K.A., Shepherd, S.L., McCarthy, P.C., Spott, J.L., Karam, E.P., Moustaid-Moussa, N., Calarco, J.M., Ramalingam, L., Talley, A.E., Canas-Carrell, J.E., Ardon-Dryer, K., Weiser, D.A., Bernal, X.E., & Deitloff, J. (2020). Opinion: In the wake of COVID-19, academia needs new solutions to ensure gender equity. *PNAS*, 117(27), 15378-15381.

McKinley, M., & Stephen, L. (2020). *Labor Inequities for Faculty and GE Caregivers during COVID-19: A Call to Action*. University of Oregon Centre for the Study of Women in Society (<https://csws.uoregon.edu/labor-inequities-covid-19/>).

Misra, J., Clark, D., & Mickey, E.L. (2021). *Keeping COVID-19 from sidelining equity*. Inside Higher Ed (<https://www.insidehighered.com/views/2021/02/10/without-intentional-interventions-pandemic-will-make-higher-education-less-diverse>).

National Academies of Sciences, Engineering, and Medicine. (2021). *The Impact of COVID-19 on the Careers of Women in Academic Sciences, Engineering, and Medicine*. The National Academies Press. <https://doi.org/10.17226/26061>.

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ABCT 2021

November 18–21, 2021 | New Orleans

Hyatt Regency
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Hotel

CHAMPIONING CBT

Promoting Cognitive and Behavioral
Practice and Science in the Context
of Public Health, Social Justice,
Policy, Research, Practice,
and Training

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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.

Welcome From the Program Chairs



Gregory S. Chasson, Ph.D., *Program Chair*, Illinois Institute of Technology

Elizabeth C. Katz, Ph.D., *Associate Program Chair*, Towson University

Welcome (back)! The 2021 ABCT convention in New Orleans is not a mirage. We repeat, the 2021 ABCT convention in New Orleans is not a mirage. Come November, ABCT will resume in-person convention activities. We are planning for a hybrid-based convention that provides a rich and full array of in-person events plus limited remote broadcasting of content for those who wish to stay distant. ABCT is diligently examining the evolving COVID trends, as well as local, state, and federal safety guidelines. We are prepared to shift the content delivery as needed. That being said, based on current trends, we are optimistically mapping out the liveliest walking path from the Hyatt Regency to Bourbon Street and Café Du Monde (after all, beignets = primary reinforcer). By the way, keep an eye out for some truly exceptional New Orleans tips from the 2021 Local Arrangements Chair, Dr. Amanda Raines.

The theme of the 55th ABCT Annual Convention in New Orleans is “Championing CBT: Promoting Cognitive and Behavioral Practice and Science in the Context of Public Health, Social Justice, Policy, Research, Practice, and Training.” To highlight aspects of the theme, we are pleased to welcome three esteemed speakers and an invited panel for the convention. First, past ABCT president (1988–89) and Director of the World Food Policy Center, Dr. Kelly Brownell from Duke University’s Sanford School of Public Policy will highlight the policy and research component of the convention theme. Second, Canada Research Chair for Mental Health Disparities at the University of Ottawa’s School of Psychology, Dr. Monnica Williams will target the social justice part of the convention theme by highlighting ways to reduce racism in cognitive-behavioral interventions and training. Third, the Senior Director of Practice Transformation and Quality for the American Psychological Association (APA), Dr. Lynn Bufka will provide insights on the APA practice and policy elements of the convention theme. Last, the three addresses will be complemented by an invited panel sponsored by the Neurocognitive Therapies and Translational Research SIG, chaired by Dr. Angela Fang, and moderated by Dr. Judy Illes. Among other objectives, the panel aims to (1) “describe historical and ongoing barriers that have limited the application of neuroscientific techniques to study mental health disparities in minoritized populations,” and (2) “develop an up-to-date conceptualization of how

translational neuroscience could serve minoritized stakeholders from bench to bedside.” Rounding out the scientific program is an address on the nature and treatment of emotion dysregulation in social anxiety from this year’s recipient of the ABCT Lifetime Achievement Award, past ABCT president (2001–02) Dr. Richard Heimberg.

Completing the scientific program for the convention was a considerable challenge in large part because of the substantial number of high-quality submissions. There is clearly no shortage of innovative and impactful work being done in our field. Indeed, it has been a tremendous privilege to learn about all of the creative and significant projects being carried out. Alas, not all submissions could be accepted into the program given space and time limitations. Our decisions for the program were guided by the peer review process, fit with the convention theme, and balance of various topics and their representation. For example, no doubt because of the timing of the submission process, we received such a large pool of COVID-related submissions that we could have assembled an entire second convention just on this topic alone. We balanced the need for COVID programming with the need for including non-COVID content. Additionally, continuing the trend from previous ABCT conventions—and in line with ongoing societal shifts pertaining to social justice and ABCT’s growing effort to enhance diversity, inclusion, and equity—the scientific program for this year is replete with content intended to facilitate this critical dialogue and action.

We feel honored to serve as your Program Chairs for the 2021 convention. Many thanks to current President Dr. David Tolin and the ABCT Board of Directors for giving us this opportunity. ABCT central office staff, especially Mary Jane Eimer and Stephen Crane, have been indispensable throughout this process; we literally could not have done this without you—thank you! Thanks to Grayson Highfield for her assistance with administrative support. We also extend our appreciation to past Program Chairs for their wisdom and resources (Drs. Shannon Wiltsey Stirman, Dan Cheron, Alyssa Ward, Kiara Timpano, Jordana Muroff, and Katharina Kircanski). Dr. Katharina Kircanski gets an extra note of appreciation because of her [often thankless] role as the ABCT Coordinator of Convention and Education Issues, or, in other words, the glue that binds the entirety of the convention each

year. We would also like to acknowledge the many Chairs and participants of the Convention and Education Issues Committee for the insights, meeting laughs, and hard work shaping this convention: Drs. Brian Baucom (AMASS), Christina Boisseau (Workshops), Samantha Farris (Institutes), Cole Hooley (Research & Professional Development), Tajal Jakatdar (Master Clinician Seminars), Amanda Raines (Local Arrangements Chair), Shireen Rizvi (Representative-at-Large), Patrick McGrath (Exhibit), Rosaura Orengo-Aguayo (2022 Program Chair), and Emily Kroska (2022 Associate Program Chair). Last, but certainly not least, we extend our deepest thanks to the hundreds of Program Committee members who served as scientific reviewers for the convention, with an extra thanks to those who stepped up as super reviewers. The scientific program was shaped by your critical contribution.

We're excited to see everyone at the convention! Enjoy the scientific program, see familiar faces (hopefully in person!!!), energize the soul at the legendary Preservation Hall (arguably, traditional New Orleans jazz = primary reinforcer), and take a little time to experience The Big Easy.

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 2021 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 <https://www.abct.org/2021-convention/>. 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 2021 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

www.abct.org/convention-ce/

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. *Continuing education applications are currently under review for both psychologists and social workers by the New York State Board of Education, Office of the Professions.*

Psychology

American Psychological Association to sponsor continuing education for psychologists for 28 continuing education contact hours. ABCT maintains responsibility for this program and its content.

Social Work

National Association of Social Workers (Approval # 886427222) for 28 continuing education contact hours.

Counseling

NBCC (National Board for Certified Counselors) as an Approved Continuing Education Provider, ACEP No. 5797, for 28 continuing education contact hours. 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 | **Creating a Relational Frame in the Context of Youth Substance Use: Foundations of Family Engagement**

♦ Participants earn 7 continuing education credits

Molly Bobek, LCSW, *Partnership to End Addiction*
Aaron Hogue, Ph.D., *Partnership to End Addiction*

Although family therapy has the largest base of empirical support for treating adolescent substance use (ASU), there are several significant barriers to its widespread adoption. Informed by research and clinical practice in real world settings, this training will provide an introduction to techniques for therapists to build a relational frame with youth and their families. The techniques featured emerge from an empirical distillation of the core elements of family therapy across the three most prominent evidence based manualized treatments for adolescent substance use (Brief Strategic Family Therapy, Functional Family Therapy, Multidimensional Family Therapy). Participants will be invited to learn and practice a relational and systemic set of interventions that are socio-culturally attuned, pragmatic, and accessible. Techniques include Parent Collaboration, Enhancing Parental Love and Commitment, Parent Ecosystem, Family Goal Collaboration, and Relational Reframing. The training will be experiential, with opportunities for participants to observe the techniques via video demonstrations, practice with co-trainees, and engage in reflective processes related to self of the therapist.

CIT 2 | **Culturally Responsive, Anti-Racist Cognitive Behavioral Therapeutic Practice: Awareness, Knowledge, and Skills**

♦ Participants earn 7 continuing education credits

Jessica LoPresti, Ph.D., *Co-Founder, BARE Mental Health and Wellness, LLC, Suffolk University*
Tahirah Abdullah, Ph.D., *Co-Founder, BARE Mental Health and Wellness, LLC, University of Massachusetts, Boston*

While racial diversity grows in the U.S., stark disparities in access to quality, effective mental healthcare grow in tandem, debilitating people and communities of color. Even after surmounting barriers to accessing mental healthcare, people of color frequently experience negative outcomes related to mental health treatment experiences. Research has suggested several reasons for the decreased likelihood of receiving quality, effective mental health services for people of color, including lack of culturally responsive mental health care. Further, racism has been and continues to be pervasive in U.S. society, contributing to increased racism-related stress, psychological distress, anxiety, depression, and trauma symptoms. Cognitive behavioral therapy has long been considered a gold standard, evidence-based best practice for the treatment of many psychological challenges. Therefore, it is imperative that CBT clinicians are antiracist in their work and workplaces and are trained in the provision of culturally responsive CBT. This workshop will present some background knowledge and foundational skills for being an antiracist therapist and implementing culturally responsive cognitive behavioral interventions.

President's Address



Hoarding: Chasing a New Diagnosis Through Brain, Body, and Behavior

David F. Tolin, Ph.D., ABPP, *Director, Anxiety Disorders Center, The Institute of Living, Yale University School of Medicine*

♦ Participants earn 1 CE credit

Hoarding disorder (HD) is a relatively new diagnosis in DSM-5. Characterized by excessive clutter and difficulty discarding objects, this condition is both common and potentially debilitating. Cognitive-behavioral therapy has been demonstrated to be efficacious, but most patients remain clinically symptomatic after treatment. I suggest that current CBT faces an “efficacy ceiling” due to our currently fragmented understanding of the disorder. I will discuss a body of research aimed at increasing our understanding of central and peripheral nervous system correlates of HD and will describe how those correlates are reflected in behavior. We will also examine current research on neural moderators and mediators of CBT treatment. The ultimate aim of this research is to develop a working model of HD that will inform specific, targeted intervention efforts. To this end, we will review novel interventions that might more specifically target dysfunctional brain mechanisms and provide greater symptom relief.

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

Institute 1

◆ Participants earn 7 continuing education credits.

Organization and Executive Function Skills Interventions for Children and Adolescents with ADHD

Margaret H. Sibley, Ph.D., *University of Washington School of Medicine*
Richard Gallagher, Ph.D., *New York University School of Medicine*

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

Nicole Little, Ph.D., *Radically Open DBT Canada*
Kristen Fritsinger, LICSW, MSW, *DBT Associates*

Institute 3

◆ Participants earn 5 continuing education credits.

Treating Transdiagnostic Sleep and Circadian Problems in Clinical Practice: Basics and Beyond

Allison G. Harvey, Ph.D., *UC-Berkeley*
Emma Agnew, LCSW, LCSW, *UC-Berkeley*
Marlen Diaz, B.A., *UC-Berkeley*

Institute 4

◆ Participants earn 5 continuing education credits.

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

Terri L. Messman, Ph.D., *Miami University*
Noga Zerubavel, Ph.D., *Duke University Medical Center*

Institute 5

◆ Participants earn 5 continuing education credits.

Health Improvement Practitioners: Using Focused ACT in the Primary Care Behavioral Health Model

Patti J. Robinson, Ph.D., *Mountainview Consulting Group*
Kirk D. Strosahl, Ph.D., *Heart Matters Consulting*

Institute 6

◆ Participants earn 5 continuing education credits.

Motivational Interviewing in Diverse Health Care Settings

Daniel W. McNeil, Ph.D., *West Virginia University*
Trevor A. Hart, Ph.D., *CPSych, Ryerson University*

Institute 7

◆ Participants earn 5 continuing education credits.

The CALM Program: Treating Early Childhood Anxiety Using PCIT

Anthony Puliafico, Ph.D., *Columbia University Irving Medical Center*
Jami M. Furr, Ph.D., *Florida International University*
Jonathan S. Comer, Ph.D., *Florida International University*

Advanced Methodology and Statistics Seminars

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

→ Virtual Only

AMASS 1 | 12:00 PM - 4:00 PM | Thursday, Oct. 14

◆ Participants earn 4 continuing education credits.

Introduction to Clinical Digital Phenotyping

Laura Thornton, Ph.D., *University of North Carolina School of Medicine*
Jonathan Butner, Ph.D., *University of Utah*
Robyn Kilshaw, M.S., *University of Utah*
Colin Adamo, M.S., *University of Utah*

→ Virtual Only

AMASS 2 | 12:00 PM - 4:00 PM | Thursday, Oct. 21

◆ Participants earn 4 continuing education credits.

Community-Based Participatory Research in Psychology: An Overview of Emerging Best Practices, Challenges, and Ethical Considerations

Eleanor Gil-Kashiwabara, Psy.D., *Founder and CEO, Luminosa Psychological Services, LLC*
Patricia Rodriguez Espinosa, Ph.D., MPH, *University of New Mexico School of Medicine*

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

Within Six Feet: Treating Childhood Anxiety Disorders During the COVID Pandemic

Deborah Roth Ledley, Ph.D., *Children's and Adult Center for OCD and Anxiety*

MCS 2

♦ Participants earn 2 continuing education credits

Values Clarification and Action in Acceptance-based Behavioral Therapy: Helping Anxious Clients Reclaim Their Lives

Lizabeth Roemer, Ph.D., *University of Massachusetts Boston*
Sue Orsillo, Ph.D., *American Psychological Association*

MCS 3

♦ Participants earn 2 continuing education credits

Shaping Bravery: A Clinical Demonstration of Shared Processes Across ACT and CBT That Target Youth Anxiety and Avoidance

Jill Ehrenreich-May, Ph.D., *University of Miami*
Lisa W. Coyne, Ph.D., *Harvard Medical School*

MCS 4

♦ Participants earn 2 continuing education credits

Developing a Case Formulation and Using It to Guide CBT

Jacqueline B. Persons, Ph.D., *Oakland Cognitive Behavior Therapy Center*

→ Virtual Only

MCS 5 | 1:00 PM - 3:00 PM | Thursday, November 4

♦ Participants earn 2 continuing education credits

Using Virtual Reality to Treat Anxiety Disorders

Elizabeth McMahon, Ph.D., *Independent Practice*

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., *University of Pennsylvania*

MCS 7

♦ Participants earn 2 continuing education credits

Treating OCD in Children and Adolescents: A Cognitive-behavioral Approach

Martin E. Franklin, Ph.D., *Rogers Behavioral Health*

MCS 8

♦ Participants earn 2 continuing education credits

OCD and Comorbidity: When Does Treatment Need to Be Modified Because of Other Problems and How Do You Do It?

Jonathan B. Grayson, Ph.D., *University of Southern California*

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

ACT for Life: Using Acceptance and Commitment Therapy to Prevent Suicide and Build Meaningful Lives

Sean M. Barnes, Ph.D., *Rocky Mountain MIRECC*
Lauren M. Borges, Ph.D., *Rocky Mountain MIRECC*
Nazanin H. Bahraini, Ph.D., *Rocky Mountain MIRECC*
Robyn D. Walser, Ph.D., *National Center for PTSD*

Workshop 2

♦ Participants earn 3 continuing education credits

Advanced Training in Trauma Focused CBT: Applications to Developmental Disabilities

Peter J. D'Amico, ABPP, Ph.D., *Northwell Health Long Island Jewish Medical Center*
Daniel Hoover, ABPP, Ph.D., *Center for Child and Family Traumatic Stress, Kennedy Krieger Institute*

Workshop 3

♦ Participants earn 3 continuing education credits

Comprehensive Behavioral Intervention for Tic Disorders

Douglas W. Woods, Ph.D., *Marquette University*
Michael B. Himle, Ph.D., *University of Utah*

Workshop 4

♦ Participants earn 3 continuing education credits

Family Based Interpersonal Psychotherapy (FB-IPT) for Preadolescent Depression

Laura J. Dietz, Ph.D., *University of Pittsburgh*

Workshop 5

♦ Participants earn 3 continuing education credits

Healing Interpersonal and Racial Trauma: Cultural Considerations for Integrating Racial Socialization in TF-CBT for Black Children and Families

Isha W. Metzger, Ph.D., *University of Georgia*

Workshop 6

♦ Participants earn 3 continuing education credits

How to Apply Dialectical Behavior Therapy When Treating Emotion Dysregulation Complicated by Sexual and Gender Minority Stress

Colleen A. Sloan, Ph.D., *VA Boston HCS & Boston University School of Medicine*

Jeffrey M. Cohen, Psy.D., *Columbia University*

Workshop 7

♦ Participants earn 3 continuing education credits

Supporting Caregivers of Children with ADHD: An Integrated Parenting Program

Christina Danko, Ph.D., *University of Maryland, College Park*

Andrea M. Chronis-Tuscano, Ph.D., *University of Maryland*

Workshop 8

♦ Participants earn 3 continuing education credits

Upgrading Our Toolkit for Assessment and Treatment of Mood Problems and Bipolar Disorder

Eric A. Youngstrom, Ph.D., *UNC Chapel Hill/Helping Give Away Psychological Science*

Workshop 9

♦ Participants earn 3 continuing education credits

What to Do When Therapy Isn't Working: A Transdiagnostic Model for Assessing Progress, Changing Course, and Improving Outcomes in the Treatment of Anxiety and Its Related Problems

Rochelle I. Frank, Ph.D., *U.C. Berkeley & The Wright Institute*

Joan Davidson, Ph.D., *S.F. Bay Area Center for Cognitive Therapy*

Lifetime Achievement Award Address



Social Anxiety Disorder: The Role of Emotion (Dys)Regulation in Its Nature and Treatment

Richard G. Heimberg, Ph.D., *Thaddeus L. Bolton Professor Emeritus, Department of Psychology, Temple University*

♦ Participants earn 1 CE credit

Rick Heimberg received his Ph.D. from Florida State University in 1977. He was, until his recent retirement, Thaddeus L. Bolton Professor of Psychology at Temple University, where he also directed the Adult Anxiety Clinic of Temple. For the past four decades, he has been one of the world's most prominent researchers in the study of the nature and treatment of social anxiety disorder and his Managing Social Anxiety program (coauthored with Debra Hope and Cynthia Turk) is a one of the leading approaches to its treatment. Dr. Heimberg has also made contributions to the study of generalized anxiety disorder and anxiety about going to the dentist. Together with his several collaborators, postdoctoral fellows, and doctoral students at Temple University and the University at Albany, SUNY, he has published 14 books and nearly 500 articles and chapters on these topics. His work has been cited more than 60,000 times. His research accomplishments have been recognized by Lifetime Achievement Awards from the Academy of Cognitive and Behavioral Therapies and the Philadelphia Behavior Therapy Association, as well as awards from the American Society for Group Work and Temple and Florida State Universities. He also received the Jerilyn Ross Clinician Advocate Award from the Anxiety and Depression Association of America.

Social anxiety disorder (SAD) is highly prevalent and associated with significant impairment. It is, by definition, associated with an excess of anxiety, but it is also associated with other difficulties in the regulation of emotion, which have received much less attention. Primarily using data from two randomized controlled trials evaluating Cognitive Behavioral Therapy for the treatment of SAD (one versus Waiting List and the other versus Mindfulness-Based Stress Reduction and Waiting List), Dr. Heimberg will describe the relationships of several emotion variables, including cognitive reappraisal, expressive suppression, emotion theory, empathy, and anger to SAD and its treatment.

Invited Panel



Sponsored by: ABCT's Neurocognitive Methods for the Clinic Think Tank and the Neurocognitive Therapies/Translational Research Special Interest Group

♦ *Participants earn 1.5 CE credits*

Toward an Intersectional Model of Translational Neuroscience: Engaging Marginalized Community Partners to Adopt Neuroscience in Psychology Clinics

Chair: Angela Fang, Ph.D., University of Washington

Moderator: Judy Illes, Ph.D., University of British Columbia

Presenters:

Riana Anderson, Ph.D., *University of Michigan*

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

Kristen Eckstrand, M.D., Ph.D., *University of Pittsburgh*

Kean Hsu, Ph.D., *Georgetown University*

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

Shawn Jones, Ph.D., MHS, *Virginia Commonwealth University*

Maria Kryza-Lacombe, Ph.D., *San Diego State University*

Andrew Peckham, Ph.D., *McLean Hospital, Harvard Medical School*

Greg Siegle, Ph.D., *University of Pittsburgh*

Lucina Uddin, Ph.D., *University of Miami*

Mariann Weierich, Ph.D., *University of Nevada, Reno*

Mary Woody, Ph.D., *University of Pittsburgh*

The COVID-19 pandemic and Black Lives Matter movement together have brought our collective attention to widespread disparities in the access, provision, and outcomes of healthcare services, as well as the lack of research participant and workforce representation and inclusivity of minoritized populations within clinical psychological science. Clinical translational neuroscience is an emerging field that is at even greater risk of excluding the voices of minoritized researchers, clinicians, and patients, given that it requires the integration of two disciplines (clinical psychology and neuroscience) that each often lack appropriate representation and inclusivity of Black, Indigenous, People of Color (BIPOC), and additionally marginalized voices. At the same time, this interdisciplinary field is also well-positioned to question basic assumptions about emotions, cognitions, behavior, and brain development due to strong cross-fertilization between different scientific disciplines. In line with this year's conference theme, in this invited panel, we aim to assess the basic assumptions and practices of relevant stakeholders in choosing to adopt or not adopt neuroscientific principles into clinical practice, through an intersectional framework.

Invited Talk 1

Harnessing Research for Social and Policy Change: Thinking Differently About Impact

Kelly D. Brownell, Ph.D., *Professor of Psychology and Neuroscience,
Director of the World Food Policy Center, Duke University*



Kelly Brownell is Robert L. Flowers Professor of Public Policy, Professor of Psychology and Neuroscience, and Director of the World Food Policy Center at Duke University. From 2013-2018 he served as Dean of the Sanford School of Public Policy at Duke. Dr. Brownell has published 15 books and more than 350 scientific articles and chapters. He has served as President of several national organizations and has advised the White House, members of congress, governors, state attorneys general, world health and nutrition organizations, and media leaders on issues of nutrition, obesity, and public policy.

People in research careers hope their work has impact on the world, yet models of training and criteria for career advancement can impede this ambition. This is especially true given how the academic community conceptualizes inward-looking definitions and measures of impact that do not account for what the world might view as a more sensible definition—whether lives improve, problems get prevented, and social and policy changes occur. This traditional academic approach leads to programmatic research, which produces useful but typically incremental information. A “strategic science” model might be considered as a companion to programmatic research and might broaden how the field conceptualizes impact. The model involves the identification of change agents, designing research to address strategic gaps in information, and communication of the research back to the change agents. A model for harnessing science to create social and policy change will be presented with a number of concrete examples.

Invited Talk 2

Civil Courage for Racial Justice: A Behavioral Prescription for Change

Monnica T. Williams, Ph.D., *Canada Research Chair in Mental Health Disparities, Associate Professor, Clinical Psychology Program, School of Psychology, University of Ottawa*



Dr. Monnica T. Williams is a board-certified licensed clinical psychologist and Associate Professor at the University of Ottawa, in the School of Psychology, where she is the Canada Research Chair in Mental Health Disparities. She is also the Clinical Director of the Behavioral Wellness Clinic in Connecticut, where she provides supervision and training to clinicians for empirically-supported treatments. Prior to her move to Canada, Dr. Williams was on the faculty of the University of Pennsylvania Medical School (2007-2011), the University of Louisville in Psychological and Brain Sciences (2011-2016), where she served as the Director of the Center for Mental Health Disparities, and the University of Connecticut (2016-2019) where she had appointments in both Psychological Science and Psychiatry. Dr. Williams' research focuses on BIPOC mental health, culture, and psychopathology, and she has published over 100 scientific articles on these topics. Current projects include the assessment of race-based trauma, unacceptable thoughts in OCD, improving cultural competence in the delivery of mental health care services, and interventions to reduce racism. This includes her work as a PI in a multisite study of MDMA-assisted psychotherapy for PTSD for people of color. She also gives diversity trainings nationally for clinical psychology programs, scientific conferences, and community organizations.

In racialized societies, race divides people, prioritizes some groups over others, and directly impacts opportunities and outcomes in life. Racial problems cannot be corrected merely by good wishes of individuals—purposeful actions and interventions are required. To create equitable systems, civil courage is vital. Civil courage differs from other forms of courage, as it is directed at social change. People who demonstrate civil courage are aware of the negative consequences and social costs but choose to persist based on a moral imperative. After defining allyship and providing contemporary and historical examples of civil courage, this presentation explains the difficulties and impediments inherent in implementing racial justice. Dr. Williams with describe exercises based on cognitive and behavioral approaches to help individuals increase their awareness and ability to demonstrate racial justice allyship in alignment with valued behaviors. She explains how these approaches can be utilized, how they can help individuals grow, why they can be difficult, and how psychologists might make use of them.

Invited Talk 3

Translating Psychological Science for Public Action: Lessons, Assumptions and Moving Forward

Lynn F. Bufka, Ph.D., Senior Director, Practice Transformation and Quality,
American Psychological Association



Lynn F. Bufka, Ph.D., is Senior Director, Practice Transformation and Quality, at the American Psychological Association. The Practice Transformation and Quality Department focuses on the development and implementation of programs and policies related to supporting and expanding opportunities for professional psychology. Current areas of emphasis are evidence-based practice, clinical practice guideline development and defining the direction of the future of psychology education and practice. Dr. Bufka is an advocate for science to support practice and practice-based evidence to inform research and policy. Dr. Bufka frequently serves as a media spokesperson for APA on these topics as well as clinical topics, stress, telepsychology and other policy matters relevant to professional practice. Prior to coming to APA, she was affiliated with Boston University and the Center for Anxiety and Related Disorders (CARD) (1996-2002), serving as Associate Director of the doctoral clinical training program and Director of Practice Training at CARD. Additionally, Dr. Bufka is a Maryland licensed psychologist and continues to provide treatment and clinical consultation on a limited basis. Dr. Bufka received her PhD in psychology from Boston University. She is a Fellow of APA's Division 12 (Society of Clinical Psychology) and a Fellow of the Association for Behavioral and Cognitive Therapies.

Many of us started graduate school with a desire to “do good” and a fascination for our discipline and the science. Upon graduation, we often follow one of two paths—we deliver great services or we develop an area of research. Both paths are important—society needs talented providers of behavioral health services and, at the same time, many pressing questions can be addressed by psychological science. Yet, too often, our science is used primarily within psychology and never makes it out of our circles. Societal challenges could be significantly informed by psychological science yet a disconnect exists between what the science can tell us and the decisions that are made. We need to find and create opportunities to engage and educate the public and decision makers. To be successful in this domain, several key communication lessons need to be applied. Additionally, assumptions need to be questioned in order to identify missing knowledge and appropriately address pressing societal problems. Finally, clear priorities can help us to focus our message and effectively address significant societal challenges.

Special Interest Groups

Attendance at an ABCT Special Interest Group meeting is a wonderful networking opportunity. The SIGs focus on a diverse range of topics, including treatment approaches, specific disorders or unique populations. SIGs are open to ABCT members only, so be sure to join or renew your membership. The Friday-night Cocktail Party/SIG Exposition, 6:30 PM – 8:30 PM, is a fabulous chance to get an overview of ABCT's SIG Program in a friendly, networking atmosphere.

Please note that all SIG meetings will take place in the Hyatt Regency New Orleans Hotel.

As a reminder, the SIG Leaders Meeting is scheduled for Saturday, November 20th, 8:00 AM – 9:00 AM in Foster 1, Level 2, Hyatt Regency New Orleans.

For dates, times, & locations of SIG meetings, visit <https://www.abct.org/2021-convention/>

Addictive Behaviors
Anxiety Disorders
Asian American Issues in Behavior Therapy and Research
Attention- Deficit/Hyperactivity Disorder
Autism Spectrum and Developmental Disabilities
Behavior Analysis
Bipolar Disorders
Child and Adolescent Anxiety
Child and Adolescent Depression
Clinical Psychology at Liberal Arts Colleges
Clinical Psychological Science
Clinical Research Methods and Statistics
Couples Research and Treatment
Dissemination and Implementation Science
Forensic Issues and Externalizing Behaviors
Latinx

Mindfulness and Acceptance
Native American Issues in Behavior Therapy and Research
Neurocognitive Therapies & Translational Research
Obesity and Eating Disorders
Oppression and Resilience: Minority Mental Health
Parenting and Families
Psychedelic Research and Therapies
Psychosis and Schizophrenia Spectrum
Research in Clinical Practice
Sexual and Gender Minority
Spiritual and Religious Issues in Behavior Change
Student
Suicide and Self-Injury
Technology and Behavior Change
TIC and Impulse Control Disorders
Women's Issues in Behavior Therapy

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 for a complete listing of general sessions.*

■ PANEL DISCUSSIONS

♦ *Participants earn 1.5 continuing education credits*

Advocating for and Supporting Emerging Adults with Autism: needs, Challenges, Clinical Considerations, and Approaches

Moderator: Susan W. White, ABPP, Ph.D.,

Panelists: Ashleigh Hillier, Ph.D., University of Massachusetts Lowell

Laura G. Klinger, Ph.D., University of North Carolina at Chapel Hill

Brenna Maddox, Ph.D., University of North Carolina at Chapel Hill

Cara Pugliese, Ph.D., Children's National Hospital, George Washington University

Carol Schall, Ph.D., Virginia Commonwealth University

♦ *Participants earn 1.5 continuing education credits*

Beyond the Day Job: Championing CBT with Meaningful Side Projects

Moderators: Ilyse Dobrow DiMarco, Ph.D., North Jersey

Center for Anxiety and Stress Management

Amelia Aldao, Ph.D., Together CBT

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

Amelia Aldao, Ph.D., Together CBT

Jelena Kecmanovic, Ph.D., Arlington/DC Behavior Therapy Institute

Stephanie Zerwas, Ph.D., Zerwas

Kathryn H. Gordon, Ph.D., Sanford Health

♦ *Participants earn 1.5 continuing education credits*

Bridging the Gap Between Research and Practice: Improving Implementation of EBI Through the Use of Transdiagnostic and Principles-based Interventions

Moderators: Michael Friedman, PsyM, Rutgers University

Melissa Pedroza, PsyM, Rutgers University

Discussant: Todd Farchione, Ph.D., Boston University

Panelists: Sarah Kate Bearman, Ph.D., The University of Texas at Austin

Brian C. Chu, Ph.D., Rutgers University

Jill Ehrenreich-May, Ph.D., University of Miami

Melanie Harned, Ph.D., VA Puget Sound Health Care System and University of Washington

♦ *Participants earn 1.5 continuing education credits*

Bringing Evidence-based Practices to the Community: An Implementation Science Approach

Moderators: Erica A. Mitchell, Ph.D., The University of Tennessee, Knoxville

Panelists: Kristina Gordon, Ph.D., University of Tennessee, Knoxville

Timothy A. Cavell, Ph.D., University of Arkansas

Erika Lawrence, Ph.D., The Family Institute at Northwestern University

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

♦ *Participants earn 1.5 continuing education credits*

Climate Change, Mental Health and Evidence-Based Practice

Moderator: Katherine Crowe, Ph.D., Home for Anxiety, Repetitive Behaviors, OCD, and Related Disorders (HARBOR)

Panelists: R. Eric Lewandowski, Ph.D., NYU Langone Health

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

Jura Augustinavicius, Ph.D., Johns Hopkins Bloomberg School of Public Health

Sarah Lowe, Ph.D., Yale School of Public Health

Sarah Schwartz, Ph.D., Suffolk University

Lena Verdelli, Ph.D., Teachers College, Columbia University

♦ *Participants earn 1.5 continuing education credits*

Copecolumbia: Rapid Development and Deployment of an Evidence-based Program of Support for Health Care Workers During COVID-19

Moderator: Deborah R. Glasofer, Ph.D., NY State Psychiatric Institute/Columbia

Panelists: Anne Marie Albano, ABPP, Ph.D., Modern Minds

Colleen C. Cullen, Psy.D., Columbia University Medical Center

Patrice K. Malone, M.D., Ph.D., Columbia University

Medical Center

Laurel Mayer, M.D., Columbia University/New York State Psychiatric Institute

Claude A. Mellins, Ph.D., Columbia University/New York State Psychiatric Institute

♦ *Participants earn 1.5 continuing education credits*

Developing Culturally Inclusive Digital Tools in Partnership with Stakeholders to Promote Emotional Well-being in Children and Youth

Moderators: Angela W. Chiu, Ph.D., Weill Cornell Medicine/New York Presbyterian Hospital

Jennifer Kaminski, Ph.D., Centers for Disease Control and Prevention

Panelists: Angela W. Chiu, Ph.D., Weill Cornell Medicine/New York Presbyterian Hospital

Ricardo F. Munoz, Ph.D., Palo Alto University

Nicole F. Kahn, Ph.D., Seattle Children's Hospital

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

Sonya Mathies Dinizulu, Ph.D., University of Chicago Medicine

◆ *Participants earn 1.5 continuing education credits*

Family Involvement in the Treatment of Youth Opioid Use Disorders

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

Panelists: Craig Henderson, Ph.D., Sam Houston State University

Aaron Hogue, Ph.D., Partnership to End Addiction
Sara Becker, Ph.D., Brown University School of Public Health
Marc Fishman, M.D., Maryland Treatment Centers
Kevin Wenzel, Ph.D., Maryland Treatment Centers
Nicole P. Porter, M.A., Partnership to End Addiction

◆ *Participants earn 1.5 continuing education credits*

How to Discuss and Promote CBT With Different Constituencies: Lessons Learned From Engaging With the Medical Staff, Parents, and the General Public

Moderator: Jelena Kecmanovic, Ph.D., Arlington/DC Behavior Therapy Institute

Panelists: Anne Marie Albano, ABPP, Ph.D., Modern Minds
Sandra Pimentel, Ph.D., Montefiore Medical Center/Albert Einstein College of Medicine

Deborah Roth Ledley, Ph.D., Children's and Adult Center for OCD and Anxiety

Jill Stoddard, Ph.D., The Center for Stress and Anxiety Management

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

Amelia Aldao, Ph.D., Together CBT

◆ *Participants earn 1.5 continuing education credits*

How to Translate Mental Health Research into Policy: A Discussion with International Policy Advocates

Moderator: Margaret Crane, M.A., Temple University

Panelists: Lynn F. Bufka, Ph.D., American Psychological Association

Matthew Sanders, Ph.D., School of Psychology, University of Queensland

Roz Shafran, Ph.D., University College London, Great Ormond Street Institute of Child Health

Sarah Walker, Ph.D., University of Washington School of Medicine

Casey Trupin, Raikes Foundation

Jonathan Purtle, D.Phil., Dornsife School of Public Health

◆ *Participants earn 1.5 continuing education credits*

If Not Now, When?: Trainee and Supervisor Experiences Providing Treatment for Suicidal Populations

Moderators: Katharine Bailey, PsyM - Rutgers University - GSAPP

Maria C. Alba, PsyM, Rutgers University

Panelists: Shireen L. Rizvi, ABPP, Rutgers University

David A. Jobs, Ph.D., Catholic University of America

Marjan G. Holloway, Ph.D., Uniformed Services University of the Health Sciences

Mariam Gregorian, Ph.D., American University

Matthew Thompson, M.S., Uniformed Services University of the Health Sciences

◆ *Participants earn 1.5 continuing education credits*

Is There a Yellow Brick Road?: Lessons Learned from Mid-career Women in Academic Medicine

Moderator: Victoria E. Cosgrove, Ph.D., Stanford University School of Medicine

Panelists: Victoria E. Cosgrove, Ph.D., Stanford University School of Medicine

Amy E. West, Ph.D., Children's Hospital Los Angeles/University of Southern California

Louisa G. Sylvia, Ph.D., Massachusetts General Hospital

Caryn R.R. Rodgers, Ph.D., Albert Einstein College of Medicine

Lori Eisner, Ph.D., Needham Psychotherapy Associates, LLC

◆ *Participants earn 1.5 continuing education credits*

Let's Talk: Managing Microaggressions at Work, in Our Work, and in Our Lives!

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

Jessica Floyd Alexander, Psy.D., Mind Works

Panelists: Jessica Floyd Alexander, Psy.D., Mind Works

Ryan C. DeLapp, Ph.D., Montefiore Medical Center

Yash Bhambhani, Ph.D., Montefiore Medical Center

Patricia A. Resick, Ph.D., ABPP, Ph.D., Duke University Medical Center

Sabine Wilhelm, Ph.D., Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

Looking Forward to Liberation: Creating Inclusive Environments for Diverse Professionals

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

Panelists: Alexandria N. Miller, M.S., Suffolk University

Broderick Sawyer, Ph.D., Genesee Valley Psychology

Lorraine U. Alire, B.S., M.A., University of Massachusetts Boston

Jacqueline M. Carmines, B.A., Virginia Wesleyan University

Charlie A. Davidson, Ph.D., Atlanta Center for Cognitive Therapy; Emory University

Ilana Seager van Dyk, Ph.D., Yale School of Public Health

Darlene M. Davis, Ph.D., Parents Zone, LLC

◆ *Participants earn 1.5 continuing education credits*

Masters-level Clinical Training as an Avenue to Championing CBT: Opportunities Rewards, and Challenges

Moderators: Georganna R. Sedlar, Ph.D., University of Washington School of Medicine

Matthew Capriotti, Ph.D., San Jose State University

Panelists: Georganna R. Sedlar, Ph.D., University of Washington School of Medicine

Matthew Capriotti, Ph.D., San Jose State University

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

Bitu Ghafouri, Ph.D., California State University Long Beach

Caleb W. Lack, Ph.D., University of Central Oklahoma

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

◆ *Participants earn 1.5 continuing education credits*

Maximizing the Societal Value of CBT: How Economic Evaluations Can Improve the Implementation and Dissemination of Cognitive and Behavioral Therapies

Moderators: Corinne N. Kacmarek, M.A., American University

Akash Wasil, M.A., University of Pennsylvania

Panelists: Zuleyha Cidav, Ph.D., University of Pennsylvania

Alex R. Dopp, Ph.D., RAND

Alessandro S. De Nadai, Ph.D., Texas State University

Brian T. Yates, Ph.D., American University

◆ *Participants earn 1.5 continuing education credits*

Money Makes the World Go Round: Creating and Implementing Equitable Policies Within Your CBT Practice

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

Panelists: Jeffrey M. Cohen, Psy.D., Columbia University

Kevin Chapman, Ph.D., The Kentucky Center for Anxiety and Related Disorders

Amber Calloway, Ph.D., Center for Anxiety and Behavior Therapy

Lauren P. Wadsworth, Ph.D., Genesee Valley Psychology

Monica Shah, Psy.D., Center for Anxiety

Colleen C. Cullen, Psy.D., Columbia University Medical Center

◆ *Participants earn 1.5 continuing education credits*

Moving from Awareness to Action: Building an Intentionally Anti-racist Clinical Training Program in an Academic Medical Center

Moderator: Courtney A. Smith, Ph.D., University of Louisville School of Medicine

Panelists: Kristie V. Schultz, Ph.D., University of Louisville School of Medicine

Jennifer F. Le, M.D., University of Louisville School of Medicine

Kelly E. Slaughter, M.S., University of Louisville School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Multicultural Considerations for Integrating Positive Psychology and Strengths-based Approaches into Mental Health Treatment

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

Panelists: Katherine A. Lenger, Ph.D., Alpert Medical School of Brown University

Marianna Graziosi, M.A., Hofstra University

Chardée Galán, Ph.D., University of Southern California

Broderick Sawyer, Ph.D., Genesee Valley Psychology

Sarah W. Whitton, Ph.D., University of Cincinnati

Cameron L. Gordon, Ph.D., Vancouver Island University

◆ *Participants earn 1.5 continuing education credits*

Now Streaming: Disseminating CBT Through Public-Facing Platforms

Moderators: Tommy Chou, Ph.D., Alpert Medical School of Brown University

Xin Zhao, M.S., Florida International University

Panelists: Tommy Chou, Ph.D., Alpert Medical School of Brown University

Riana Anderson, Ph.D., University of Michigan

Maya M. Boustani, Ph.D., Loma Linda University

Anne S. Morrow, Ph.D., South Florida Integrative Medicine

Eric A. Youngstrom, Ph.D., UNC Chapel Hill/Helping Give Away Psychological Science

◆ *Participants earn 1.5 continuing education credits*

One Community at a Time: Trainee-led Activism That Harnesses Evidence-based Approaches in Partnering With Community Organizations for Positive Social Change

Moderator: Laura G. McKee, Ph.D., Ph.D., University of Georgia

Panelists: Nada M. Goodrum, Ph.D., Medical University of South Carolina

Meghan S. Goyer, M.A., Georgia State University

April Highlander, M.A., University of North Carolina at Chapel Hill

Sarah E. Moran, B.A., Georgia State University

Jacqueline O. Moses, M.S., University of California, San Francisco

Ifrah Sheikh, M.S., Georgia State University

◆ *Participants earn 1.5 continuing education credits*

Parent Training for Children with Autism and Disruptive Behavior: Adaptations and Innovations to Enhance Dissemination, Training, and Access to Care

Moderator: Elisabeth H. Sheridan, Ph.D., Drexel University/A.J. Drexel Autism Institute

Panelists: Andrea T. Wieckowski, Ph.D., A.J. Drexel Autism Institute

Stewart Pisecco, Ph.D., Attend Behavior, Inc.

Eric M. Butter, Ph.D., Nationwide Children's Hospital, The Ohio State University College of Medicine

Cy Nadler, Ph.D., Children's Mercy Kansas City

Teresa Burrell, Ph.D., Emory University School of Medicine

Karen Elizabeth Bearss, Ph.D., University of Washington, Seattle

◆ *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

Panelists: Anne Marie Albano, ABPP, Ph.D., Modern Minds

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

Michelle Craske, Ph.D., University of California Los Angeles

Linda C. Sobell, ABPP, Ph.D., Nova Southeastern University

G. Terence Wilson, Ph.D., Rutgers University

◆ *Participants earn 1.5 continuing education credits*

Predicting Suicide Risk Using Nonobvious/Indirect Methods

Moderator: Christopher D. Hughes, Ph.D., Alpert Medical School of Brown University

Panelists: Michael F. Arney, Ph.D., The Alpert Medical School of Brown University
 Heather Schatten, Ph.D., Butler Hospital & Brown Medical School
 Nicole Nugent, Ph.D., Brown Med School
 Tony T. Wells, Ph.D., Oklahoma State University
 Jennifer Barredo, Ph.D., Alpert Medical School of Brown University
 Taylor Burke, Ph.D., Rhode Island Hospital/Alpert Medical School of Brown University

♦ *Participants earn 1.5 continuing education credits*

Preparing Future Psychologists: Centering the Experience of Underrepresented Groups in Graduate and Undergraduate Clinical Training Opportunities

Moderator: CJ Fleming, Ph.D., Elon University

Panelists: CJ Fleming, Ph.D., Elon University

Patti A. Timmons. Fritz, Ph.D., University of Windsor
 Tamara Del Vecchio, Ph.D., St. John's University
 Shelby B. Scott, Ph.D., University of Texas at San Antonio
 Miguel T. Villodas, Ph.D., San Diego State University
 Aleja Parsons, Ph.D., New York University

♦ *Participants earn 1.5 continuing education credits*

Prioritizing Underserved and Marginalized Communities in the Design of Digital Mental Health Interventions

Moderator: Ashley A. Knapp, M.A., Ph.D., Northwestern University Feinberg School of Medicine

Panelists: Heather Davis, Ph.D., University of Chicago Medicine

Jennifer Duffecy, Ph.D., University of Illinois, Chicago
 Ashley A. Knapp, M.A., Ph.D., Northwestern University Feinberg School of Medicine
 Emily G. Lattie, Ph.D., Northwestern University
 Terika McCall, M.P.H., Ph.D., Yale University School of Medicine
 Kofoworola Williams, M.P.H., Ph.D., Northeastern University

♦ *Participants earn 1.5 continuing education credits*

Promoting CBT Principles and Interdisciplinary Collaboration Through Multidisciplinary Learning and Supervisory Experiences

Moderator: Kristin S. Vickers, ABPP, Ph.D., Mayo Clinic

Panelists: Elle Brennan, Ph.D., Mayo Clinic

Olivia E. Bogucki, Ph.D., Mayo Clinic
 Jarrod M. Leffler, ABPP, Ph.D., Mayo Clinic
 Craig N. Sawchuk, ABPP, Ph.D., Mayo Clinic
 Eleshia J. Morrison, ABPP, Ph.D., Mayo Clinic

♦ *Participants earn 1.5 continuing education credits*

Promoting Health and Wellness Among Psychology Graduate Students: Considerations and Paths Forward

Moderator: Natalie Hong, M.S., Florida International University

Panelists: Mary Fernandes, M.A., Georgia State University
 Molly Bowdring, B.S., M.S., University of Pittsburgh and VA Palo Alto Health Care System

Jacqueline O. Moses, M.S., University of California, San Francisco
 Nabil H. El-Ghoroury, Ph.D., California Association of Marriage and Family Therapists

♦ *Participants earn 1.5 continuing education credits*

Recovery-Oriented Cognitive Therapy as a Game Changer for Municipal and State Forensic Systems: Lessons Learned and Future Directions

Moderator: Paul M. Grant, Ph.D., Beck Institute

Panelists: Shelby Arnold, Ph.D., Beck Institute

Joe Keifer, Psy.D., Beck Institute
 Christy Giallella, Ph.D., Philadelphia Department of Behavioral Health and Intellectual disAbility Services
 Chris von Zuben, Ph.D., Philadelphia Department of Behavioral Health and Intellectual disAbility Services
 James Beacher, Psy.D., New York Office of Mental Health
 Stella Keitel, Psy.D., New York Office of Mental Health

♦ *Participants earn 1.5 continuing education credits*

Representation Matters: Diversity, Equity, and Inclusion in ADHD Research and Practice

Moderator: Phylcia F. Fleming, Ph.D., Children's Hospital of Philadelphia

Panelist: Heather A. Jones, Ph.D., Virginia Commonwealth University

Yamalis Diaz, Ph.D., NYU School of Medicine
 Amori Y. Mikami, Ph.D., University of British Columbia

♦ *Participants earn 1.5 continuing education credits*

Seeking Diversity, Equity and Inclusion: Perspectives and Concerns of ABCT's Minority Special Interest Groups

Moderator: Janie J. Hong, Ph.D., Stanford University School of Medicine and Redwood Center for CBT and Research

Panelists: Janie J. Hong, Ph.D., Stanford University School of Medicine and Redwood Center for CBT and Research
 Ashleigh Coser, Ph.D., Cherokee Nation of OK
 Jeffrey M. Cohen, Psy.D., Columbia University
 Alexandria N. Miller, M.S., Suffolk University
 Juventino Hernandez Rodriguez, Ph.D., The University of Texas Rio Grande Valley
 Destiny Printz Pereira, M.S., University of Connecticut

♦ *Participants earn 1.5 continuing education credits*

Spreading the Word: How Graduate Students Can Leverage Social Media for #scicomm and Professional Development

Moderator: Stephanie Y. Wells, Ph.D., Durham VA Health Care System

Panelists: Gabriella T. Ponzini, M.S., West Virginia University
 Karen T. Tang, B.A., Dalhousie University
 Eve A. Rosenfeld, M.A., Stony Brook University Renaissance School of Medicine
 Margaret Crane, M.A., Temple University
 Perri Tutelman, B.S., Dalhousie University
 Kathryn A. Coniglio, M.S., Rutgers University

◆ *Participants earn 1.5 continuing education credits*

**Stepping out on Your Own and into the Community:
Launching a Community-Engaged Research Program**

Moderator: Blanche Wright, M.A., University of California Los Angeles

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

Kelsie H. Okamura, Ph.D., Hawaii Pacific University

Maya M. Boustani, Ph.D., Loma Linda University

Davielle Lakind, Ph.D., Mercer University

Alayna Park, Ph.D., Palo Alto University

◆ *Participants earn 1.5 continuing education credits*

Successful Mentorship for Women and Underrepresented Groups

Moderators: Larissa A. McGarrity, Ph.D., University of Utah School of Medicine

Lane L. Ritchie, Ph.D., VA Greater Los Angeles Healthcare System

Panelists: David A. Haaga, Ph.D., American University

Khiela J. Holmes, Ph.D., Shalom Wellness Services, LLC

Ricardo F. Munoz, Ph.D., Palo Alto University

Bethany A. Teachman, Ph.D., University of Virginia

◆ *Participants earn 1.5 continuing education credits*

Towards Creating an Inclusive, Equitable, and Culturally Responsive Clinical Environment for Doctoral Trainees of Color

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

Panelists: Jessica LoPresti, Ph.D., Suffolk University

Jennifer Martinez, Ph.D., Northwestern University Feinberg School of Medicine

Christian N. Adames, M.A., Columbia University

Lauren Toben, Ph.D., Miami University

Jamilah R. George, M.S., University of Connecticut

Anu Asnaani, Ph.D., University of Utah

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Technology-based Interventions for Black, Indigenous, and People of Color: A Strategy to Reduce Disparities and Promote Mental Health Equity

Moderator: Giovanni Ramos, M.A., University of California Los Angeles

Panelists: Adrian Aguilera, Ph.D., UC Berkeley

Jonathan S. Comer, Ph.D., Florida International University

Tatiana M. Davidson, Ph.D., Medical University of South Carolina

Armando A. Pina, Ph.D., Arizona State University

Jessica L. Schleider, Ph.D., Stony Brook University

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

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

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

Kiara R. Timpano, Ph.D., University of Miami

Panelists: Joanna J. Arch, Ph.D., University of Colorado Boulder

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

Jonathan D. Huppert, Ph.D., The Hebrew University of Jerusalem

Jurgen Margraf, Ph.D., Ruhr University-bochum

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The Perfect Storm: Experiences of Racism, Political Strife, and Public Health Stressors During the COVID-19 Pandemic in Asian American and Pacific Islander Communities

Moderator: Janie J. Hong, Ph.D., Stanford University School of Medicine and Redwood Center for CBT and Research

Panelists: Vaishali V. Raval, Ph.D., Miami University

Adriana Miu, Ph.D., University of Texas Southwestern Medical Center

Lorraine U. Alire, B.S., M.A., University of Massachusetts Boston

Charles Liu, Ph.D., Wheaton College

Anu Asnaani, Ph.D., University of Utah

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Towards a More Inclusive Clinical Science: How to Fight for Systemic Changes to Increase the Impact of Behavioral and Cognitive Therapies

Moderator: Allura L. Ralston, M.A., University of Nebraska-Lincoln

Panelists: Allura L. Ralston, M.A., University of Nebraska-Lincoln

Todd J. Caze, II, Ph.D., UTSW/Children's Health Andrew's Institute

Broderick Sawyer, Ph.D., Genesee Valley Psychology

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

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Training and Implementation of CBT for Psychosis in Clinical Services to Improve Equity and Quality of Care for Veterans

Moderators: Dimitri G. Perivoliotis, Ph.D., VA San Diego Healthcare System/University of California, San Diego

Yuliana Gallegos Rodriguez, Ph.D., VA San Diego Healthcare System; University of California, San Diego

Panelists: Colin J. Carey, Ph.D., VA San Diego Healthcare System; University of California, San Diego

Samantha J. Reznik, Ph.D., VA San Diego Healthcare System/University of California, San Diego

Yulia Landa, M.S., Psy.D., Icahn School of Medicine at Mount Sinai; Veteran's Affairs VISN 2 Mental Illness Research Education and Clinical Center

Joseph Deluca, Ph.D., Icahn School of Medicine at Mount Sinai; Veteran's Affairs VISN 2 Mental Illness Research Education and Clinical Center

Shirley M. Glynn, Ph.D., UCLA

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What Are We Missing? Carving a Path Forward to Improve Health Disparities That Impact CBT Approaches to Research and Treatment for Eating Disorders

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

Kathryn M. Huryk, Ph.D., University of California, San Francisco

Panelists: Carolyn Becker, Ph.D., Trinity University

Natasha L. Burke, Ph.D., Fordham University

Amy H. Egbert, Ph.D., The Miriam Hospital/Alpert Medical School of Brown University

Neha J. Goel, M.S., Virginia Commonwealth University

Colleen Stiles-Shields, Ph.D., Rush University Medical Center

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Working Effectively with Criminal Legal System Partners to Conduct Research and Implement CBT and Other Empirically Supported Treatments

Moderator: Mandy Owens, Ph.D., University of Washington

Panelists: Jeffrey Gepner, SCORE Jail

Elizabeth L. Jeglic, Ph.D., John Jay College

Kelly E. Moore, Ph.D., East Tennessee State University

Catalina Ordorica, University of California, San Francisco

Brittany A. Soto, Psy.D., South Carolina Department of Corrections

Lauren Weinstock, Ph.D., Alpert Medical School of Brown University

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Working with Minoritized Veterans: The Intersection of Military Culture with Racial, Ethnic, Sexual, and Gender Identity

Moderator: Alexandra M. King, M.S., Rutgers University

Panelists: Juliette McClendon, Ph.D., Boston University School of Medicine

Jessica Stern, Ph.D., NYU Langone Health

Colleen A. Sloan, Ph.D., VA Boston HCS & Boston University School of Medicine

Maurice Endsley, Jr., Ph.D., U.S. Department of Veterans Affairs

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◆ *Participants earn 1.5 continuing education credits*

Addressing Gaps in Clinical Science for Sexual and Gender Minority Behavioral Health: Lessons from the Translational Research Spectrum

Chair: Craig Rodriguez-Seijas, Ph.D., University of Michigan

Co-Chair: Alex R. Dopp, Ph.D., RAND

Discussant: Steven A. Safren, Ph.D., ABPP, University of Miami

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Addressing Interpersonal and Systemic Experiences of Minority Stress in Cognitive Behavioral Therapy with Sexual and Gender Minority Clients

Chair: Jae A. Puckett, Ph.D., Michigan State University

Discussant: Ethan H. Mereish, Ph.D., American University

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Addressing Limitations of PTSD Treatments with Innovative, Evidence-based Approaches

Chair: Erika M. Roberge, Ph.D., Salt Lake City VA Healthcare System & The University of Utah

Discussant: Deborah Beidel, ABPP, Ph.D., University of Central Florida & UCF RESTORES

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Addressing Social Determinants of Health in Cognitive and Behavioral Treatments for Trauma Survivors

Chair: Joah Williams, Ph.D., University of Missouri-Kansas City

Discussant: Alyssa A. Rheingold, Ph.D., Medical University of South Carolina

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Addressing the Real-world Complexity of Mental Illness: Cognitive Behavioral Approaches to Comorbidity and Transdiagnostic Treatments

Chair: Laurel Sarfan, Ph.D., University of California at Berkeley

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

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Adolescent Suicide, Self-injury, and Rdoc: Advancing Understanding of Adolescents' Self-injurious Thoughts and Behaviors Across Multiple Rdoc Domains

Chair: Olivia H. Pollak, B.S., University of North Carolina at Chapel Hill

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

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Advancements in Understanding Disruptions in Sleep and Circadian Rhythms for Individuals with Obsessive Compulsive Disorder

Chair: Meredith E. Coles, Ph.D., Binghamton University

Discussant: Katherine Sharkey, M.D., Warren Alpert Medical School of Brown University

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Advances in the Assessment and Treatment of Hoarding Disorder

Chair: Caitlin A. Stamatis, M.S., New York-Presbyterian Hospital/Weill Cornell Medical College

Discussant: Jordana Muroff, Ph.D., Boston University School of Social Work

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Advances in the Assessment and Treatment of Suicidal Adolescents During and After Psychiatric Hospitalization

Chair: Hannah R. Lawrence, Ph.D., McLean Hospital/Harvard Medical School

Discussant: Regina Miranda, Ph.D., Hunter College

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Advances in the Understanding and Treatment of Cannabis Use Disorder: Co-use, Comorbidities, and Transdiagnostic Mechanisms

Chair: Kate Wolitzky-Taylor, Ph.D., UCLA School of Medicine
Discussant: Michael J. Zvolensky, Ph.D., University of Houston

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Advancing Knowledge About Intimate Partner Violence Among Sexual and Gender Minorities: Prevalence, Risk Factors, and Barriers to Care

Chair: Sarah W. Whitton, Ph.D., University of Cincinnati
Discussant: Jennifer Langhinrichsen-Rohling, Ph.D., University of North Carolina at Charlotte

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Advancing Relationship Science and Countering Stigma: Understanding Relationship Diversity Through the Study of Consensual Nonmonogamy

Co-chairs: Ellora Vilkin, M.A., Stony Brook University
Cara Herbitter, M.P.H., Ph.D., VA Boston Healthcare System
Discussant: Rhonda N. Balzarini, Ph.D., Texas State University

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Applications and Considerations for Data-driven Personalized Treatments Across Forms of Psychopathology

Chair: Caroline Christian, M.S., University of Louisville
Discussant: Matthew K. Nock, Ph.D., Harvard University

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Applying Minority Stress Theory to Community-Based Approaches to Prevent and Respond to Sexual Violence Among SGM Communities

Co-chairs: Daniel W. Oesterle, B.S., Purdue University
Allyson Blackburn, B.A., University of Illinois, Urbana-Champaign
Discussant: Lindsay Orchowski, Ph.D., Rhode Island Hospital/Alpert Medical School of Brown University

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Anxiety in Children with Autism Spectrum Disorder: Enhancing Treatment Effects by Targeting Neural and Behavioral Mechanisms

Chair: Denis Sukhodolsky, Ph.D., Yale University School of Medicine
Discussant: Matthew D. Lerner, Ph.D., Stony Brook University

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Assessing and Understanding Fidelity to Interventions for Individuals with PTSD or Trauma Exposure in Public Mental Health Settings

Chair: Shannon Wiltsey-Stirman, Ph.D., VA National Center for PTSD and Stanford University
Discussant: Cassidy A. Gutner, Ph.D., BU School of Medicine/ViiV Healthcare

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“An Unprecedented Time”: Understanding the Public Health Consequences of the COVID-19 Pandemic

Co-chairs: Brianna J. Turner, Ph.D., University of Victoria
Katherine Dixon-Gordon, Ph.D., University of Massachusetts Amherst
Discussant: Bunmi Olatunji, Ph.D., Vanderbilt University

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Behavioral Economics for Suicide Prevention Public Health Initiatives and Clinical Practice

Chair: Brian W. Bauer, M.S., University of Southern Mississippi
Discussant: Craig Bryan, ABPP, Psy.D., The Ohio State University Wexner Medical Center

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Behavioral Interventions to Support Healthy Early Childhood: Home, Classroom, and Zoom-room

Chair: Katherine E. Hess, B.A., The University of Texas at Austin
Discussant: Alice S. Carter, Ph.D., Ph.D., University of Massachusetts, Boston

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Behavioral, Social and Emotional Consequences of COVID-19 Stress

Chair: Dean McKay, ABPP, Ph.D., Fordham University
Discussant: Gordon Asmundson, Ph.D., University of Regina

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Beyond Retrospective Self-report Questionnaires: Novel Methods for Assessing Affect

Chair: Christopher D. Hughes, Ph.D., Alpert Medical School of Brown University
Discussant: Heather Schatten, Ph.D., Butler Hospital & Brown Medical School

◆ *Participants earn 1.5 continuing education credits*

Body Image and Eating Pathology in Sexual and Gender Minority Individuals: Risk and Protective Factors

Chair: Alexandra D. Convertino, M.S., SDSU/UC San Diego Joint Doctoral Program in Clinical Psychology
Discussant: Aaron J. J. Blashill, Ph.D., San Diego State University

◆ *Participants earn 1.5 continuing education credits*

Building Community Capacity for Evidence-based Trauma Services: Processes and Outcomes of a Trauma-focused Learning Collaborative

Chair: Elizabeth Casline, M.S., University of Miami
Discussant: Michael A. de Arellano, Ph.D., Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

Busting Myths and Addressing Suicidality Across PTSD Treatments and Populations

Chair: Kathy Benhamou, M.A. - Case Western Reserve University

Discussant: Craig Bryan, ABPP, Psy.D., The Ohio State University Wexner Medical Center

◆ *Participants earn 1 continuing education credit*

Breaking the Cycle: Behavioral Health Prevention and Treatment in the Juvenile Justice System

Chair: Sarah Helseth, Ph.D., Brown University School of Public Health

Discussant: Kathleen Kemp, Ph.D., Rhode Island Hospital/Alpert Medical School of Brown University

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CBT in Context: Exploring the Role of Social and Environmental Contextual Factors in the Course and Outcome of Youth Depression Treatment and Prevention

Chair: Rachel A. Vaughn-Coaxum, Ph.D., University of Pittsburgh School of Medicine

Discussant: Laura G. McKee, Ph.D., Ph.D., University of Georgia

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Championing the Science of CBT: Identifying Which Treatments Work and Which Treatments Harm

Chair: Yevgeny Botanov, Ph.D., The Pennsylvania State University - York

Discussant: Shireen L. Rizvi, ABPP, Ph.D., Rutgers University

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Cognitive Behavioral and Acceptance and Commitment Based Therapy Approaches in the Context of Integrated Health Models: Addressing Multidimensional Health Outcomes

Co-chairs: Naomi Ennis, Ph.D., Medical University of South Carolina

Anne Marie Albano, ABPP, Ph.D., Modern Minds

Discussant: Steven C. Hayes, Ph.D., University of Nevada, Reno

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Cognitive Behavioral Couple Focused Interventions to Prevent Suicide

Chair: Feea Leifker, M.P.H., Ph.D., University of Utah

Discussant: Brian R. Baucom, Ph.D., University of Utah

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Cognitive Behavioral Therapy for Obsessive-Compulsive and Related Disorders: How, When, and Why It Works

Chair: Emily E. Bernstein, Ph.D., Massachusetts General Hospital

Discussant: Sabine Wilhelm, Ph.D., Harvard Medical School

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Comprehensive Behavioral Intervention for Tics: Exploring the Mechanisms, Longitudinal Outcomes, and the Potential Benefit of Early Intervention

Chair: Flint M. Espil, Ph.D., Stanford University School of Medicine

Discussant: Alan L. Peterson, ABPP, Ph.D., University of Texas Health Science Center at San Antonio

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COVID Risk and Protective Factors in Latinx Communities: From Infections to Vaccination

Chair: Ana Bridges, Ph.D., University of Arkansas

Discussant: Cristina Lopez, Ph.D., Medical University of South Carolina

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Cultivating Religiosity and Spirituality (R/S): Spiritual Bypass and External Locus of Control as Barriers to Better Mental Health

Chair: Salman S. Ahmad, M.S., University of Miami

Discussant: Stevan L. Nielsen, Ph.D., Brigham Young University

◆ *Participants earn 1.5 continuing education credits*

Cultural Factors Affecting Individuals' Health Across the Illness Trajectory

Chair: Daisy Lopez, M.S., University of Miami

Discussant: Shirley M. Glynn, Ph.D., UCLA

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Cyber Dating Violence Perpetration: Implications for Policy, Prevention, and Intervention in the Changing Landscape of Intimate Partner Violence

Chair: Tara L. Cornelius, Ph.D., Grand Valley State University

Discussant: Jeff Temple, Ph.D., University of Texas Medical Branch

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Dating in the Online Era: Implications for Mental Health and Relational Outcomes

Chair: Ariella P. Lenton-Brym, M.A., Ryerson University

Discussant: Jeff Temple, Ph.D., University of Texas Medical Branch

◆ *Participants earn 1 continuing education credit*

Delivering Complementary and Integrative Therapies Alongside CBT for PTSD in Military Samples: Research and Clinical Implications

Chair: Elizabeth M. Goetter, Ph.D., Massachusetts General Hospital

Discussant: Rachel A. Millstein, Ph.D., MGH/Home Base

◆ *Participants earn 1 continuing education credit*

Designing Digital Mental Health Interventions for Suicide and Self-injurious Thoughts and Behavior: Incorporating Lived Experience and Multiple Stakeholder Perspectives

Co-chairs: Kaylee P. Kruzan, Ph.D., Northwestern University
Jonah Meyerhoff, Ph.D., Northwestern University Feinberg School of Medicine

Discussant: Sarah E. Victor, Ph.D., Texas Tech University

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Designing Personalized Cognitive-behavioral Treatments for Youth: Approaches to Guide Clinical Decision Making Across Various Stages of Intervention

Co-chairs: Natalie Hong, M.S., Florida International University
Lesley A. Norris, M.A., Temple University

Discussant: Jill Ehrenreich-May, Ph.D., University of Miami

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Disseminating CBT Principles Through Mobile Mental Health Apps: An Evaluation of Self-management Apps from Va's National Center for PTSD

Chair: Haijing W. Hallenbeck, Ph.D., National Center for PTSD
Discussant: Eric Kuhn, Ph.D., VA Palo Alto Health Care System/Stanford

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Diversifying Well-established Frameworks for Suicide: Applications to Sexual and Gender Minority Populations and the Importance of Intersectionality

Co-Chairs: Cindy J. Chang, PsyM, Rutgers University
Benjamin F. Shepherd, Nova Southeastern University

Discussant: Raymond Tucker, Ph.D., Louisiana State University

◆ *Participants earn 1.5 continuing education credits*

Does Stigma Moderate the Efficacy of Mental Health Interventions Among Marginalized Groups? A Multi-group, Multi-level Perspective

Chair: Mark L. Hatzenbuehler, Ph.D., Harvard University
Discussant: Anna S. Lau, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

Doing What Works: Predictors, Correlates, and Outcomes of Skills Use Across Transdiagnostic CBTs

Chair: Matthew W. Southward, Ph.D., University of Kentucky
Discussant: Shireen L. Rizvi, ABPP, Ph.D., Rutgers University

◆ *Participants earn 1.5 continuing education credits*

Drivers of Substance Use Among Populations of Sexual Minority Men and Women: Social Determinants of Substance Use Disparities and Indications for Culturally Informed Practice

Co-chairs: Graham W. Berlin, B.A., Ryerson University
Trevor A A. Hart, Ph.D., CPsych, Ryerson University

Discussant: David Pantalone, Ph.D., University of Massachusetts Boston

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Emotion Dysregulation in Repetitive-negative Thinking: Investigating the Role of Emotional Contrast Avoidance

Co-chairs: Sandra Llera, Ph.D, Towson University
Hanjoo Kim, Ph.D., Michigan Medicine

Discussant: Thane Erickson, Ph.D., Seattle Pacific University

◆ *Participants earn 1.5 continuing education credits*

Emphasizing the “Cultural” in Sociocultural: Western Values of Appearance and Eating Pathology in Ethnic Minority Women and Men

Co-chairs: Liya M. Akoury, Ph.D., Aviva Psychology Services
Cortney S. Warren, ABPP, Ph.D., Choose Honesty, LLC
Discussant: Marisol Perez, Ph.D., Arizona State University

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Engagement, Skills Practice, and Response to Smartphone and Internet CBT

Chair: Hilary Weingarden, Ph.D., Massachusetts General Hospital
Discussant: Jonathan S. Comer, Ph.D., Florida International University

◆ *Participants earn 1.5 continuing education credits*

Engaging “Hard-to-Reach” Populations in Psychological Research and Intervention

Chair: Crystal X. Wang, M.A., University of Southern California
Discussant: Stanley J. Huey, Jr., Ph.D., University of Southern California

◆ *Participants earn 1.5 continuing education credits*

Enhancing the Precision and Impact of CBTs with Neuroscience: New Predictors and New Approaches

Chair: Andrada D. Neacsu, Ph.D., Duke University Medical Center
Discussant: Stefan G. Hoffman, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

Examination of Implementation Processes, Intervention Adaptation and Outcomes for Children with Autism

Chair: Kelsey S. Dickson, Ph.D., San Diego State University
Discussant: Brenna Maddox, Ph.D., University of North Carolina at Chapel Hill

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Examining the Effect of ADHD on Parent and Adolescent Mental Health Outcomes and the Parent-Adolescent Relationship

Chair: Nellie Shippen, B.S., M.A., University of Illinois, Chicago
Discussant: Erin Schoenfelder Gonzalez, Ph.D., University of Washington School of Medicine

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Examining the Public Health Impact of COVID-19 on College Student Health

Co-chairs: Emily G. Lattie, Ph.D., Northwestern University
Emily Hersch, B.A., Northwestern University Feinberg School of Medicine
Discussant: Emily G. Lattie, Ph.D., Northwestern University

◆ *Participants earn 1.5 continuing education credits*

Expanding Access to Care for Individuals with Autism: Understanding Clinician Attitudes, Support Needs, and Treatment Decision Making

Chair: Teresa Burrell, Ph.D., Emory University School of Medicine
Discussant: Lauren Brookman-Frazee, Ph.D., University of California San Diego

◆ *Participants earn 1.5 continuing education credits*

Expanding the Evidence Base: Transdiagnostic Treatments Across the Lifespan

Chair: Laurel Sarfan, Ph.D., University of California, Berkeley
Discussant: Allison G. Harvey, Ph.D., University of California Berkeley

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Expanding the Implementation of Evidence-Based Diagnostic Assessment: Methods to Enhance the Feasibility and Applicability of the Evidence-Based Assessment Model

Chair: Amanda Jensen-Doss, Ph.D., University of Miami
Co-Chair: Elizabeth Casline, M.S., University of Miami
Discussant: Bryce McLeod, Ph.D., Virginia Commonwealth University

◆ *Participants earn 1.5 continuing education credits*

Eye Tracking Without the Eyes: A Mouse-based Measure of Attentional Bias Inspired by the COVID-19 Pandemic

Chair: Thomas R. Armstrong, Ph.D., Whitman College
Discussant: Yair Bar-Haim, Ph.D., Tel Aviv University

◆ *Participants earn 1.5 continuing education credits*

Father Engagement: Understanding and Overcoming Barriers in Multiple Treatment Settings

Chair: Juan Carlos Gonzalez, M.A., University of California, Santa Barbara
Discussant: Gregory A. Fabiano, Ph.D., Florida International University

◆ *Participants earn 1.5 continuing education credits*

Features of Misophonia (Selective Sound Sensitivity): Psychopathology Bases and Treatment Developments

Chair: Dean McKay, ABPP, Ph.D., Fordham University
Discussant: Martha Falkenstein, Ph.D., McLean Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

From Minority Stress to Minority Strengths: The Role of Identity Pride, Community, and Social Support on LGBTQ+ Mental Health

Co-chairs: Cindy J. Chang, PsyM, Rutgers University
Nicole D. Cardona, M.A., Boston University
Discussant: Michael E. Newcomb, Ph.D., Northwestern University

◆ *Participants earn 1.5 continuing education credits*

From Neurological Processes to Implementation: Targets and Strategies for Adaptations Across the Translational Spectrum to Advance the Reach of Effective Treatment for Anxiety

Chairs: Emily M. Haimes, Ph.D., Perelman School of Medicine at the University of Pennsylvania
Hannah E. Frank, Ph.D., Alpert Medical School of Brown University
Discussant: Kristen Benito, Ph.D., The Warren Alpert Medical School of Brown University

◆ *Participants earn 1.5 continuing education credits*

From Trauma to Resilience

Chair: Richard J. McNally, Ph.D., Harvard University
Discussant: Richard J. McNally, Ph.D., Harvard University

◆ *Participants earn 1.5 continuing education credits*

Geographical Disparities in Mental Health Information and Care

Co-chairs: Xin Zhao, M.S., Florida International University
Adela Timmons, Ph.D., Florida International University
Discussant: Jessica L. Schleider, Ph.D., Stony Brook University

◆ *Participants earn 1.5 continuing education credits*

Here a Fear, There a Fear, Everywhere an Eating Disorder Fear: Heterogeneity and Treatment of Eating Disorder Fears

Chair: Mackenzie L. Brown, B.A., University of Louisville
Discussant: Cheri A. A. Levinson, Ph.D., University of Louisville

◆ *Participants earn 1.5 continuing education credits*

High-risk, yet Understudied: Disordered Eating and Body Dysmorphic Symptoms in Asian American Women

Chair: Liya M. Akoury, Ph.D., Aviva Psychology Services
Discussant: Janie J. Hong, Ph.D., Stanford University School of Medicine and Redwood Center for CBT and Research

◆ *Participants earn 1.5 continuing education credits*

Identifying and Addressing Psychological and Behavioral Risk Factors for Cardiovascular Disease in Underserved Women: Implications for Cognitive and Behavioral Intervention Development

Co-chairs: Jacklyn D. Foley, Ph.D., Massachusetts General Hospital

Amelia M. Stanton, Ph.D., Massachusetts General Hospital/Harvard Medical School
Discussant: Christina Psaros, Ph.D., Harvard Medical School, Massachusetts General Hospital

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Identifying and Mitigating the Effects of Stigma on the Health of Marginalized and Underserved Populations: Implications for Developing Cognitive Behavioral Interventions in Local and Global Contexts

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

Discussant: Abigail W. Batchelder, M.P.H., Ph.D., Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

Identifying Mechanisms of Effective Treatment: Transparency and Experimental Therapeutics in Intervention Research

Chair: Susan W. White, ABPP, Ph.D., University of Arizona

Discussant: Joel Sherrill, Ph.D., National Institute of Mental Health

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Identifying Strengths for Better Health: Resilience Factors in Borderline Personality Disorder and Non-suicidal Self-injury

Chair: Matthew W. Southward, Ph.D., University of Kentucky

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

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Implementing Dialectical Behavior Therapy in the Department of Veterans Affairs: Challenges and Successes

Chair: Melanie Harned, Ph.D., VA Puget Sound Health Care System and University of Washington

Discussant: Shannon Wiltsey-Stirman, Ph.D., VA National Center for PTSD and Stanford University

◆ *Participants earn 1.5 continuing education credits*

Implementation of Evidence-based Treatment at Acute Levels of Pediatric Psychiatric Care

Chair: Rebecca E. Ford-Paz, Ph.D., Northwestern University Feinberg School of Medicine, Ann & Robert H. Lurie Children's Hospital of Chicago

Discussant: Jill Ehrenreich-May, Ph.D., University of Miami

◆ *Participants earn 1.5 continuing education credits*

Implementing Evidence-based Treatment for PTSD in Non-traditional Mental Health Settings

Chair: Rebecca K. Sripada, Ph.D., University of Michigan

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

◆ *Participants earn 1.5 continuing education credits*

Impact of the Covid-19 Crisis on Individuals with OCD and the Providers Who Treat Them: Challenging Assumptions About How, for Whom, and Why Effects Exist

Chair: Jennie M. Kuckertz, Ph.D., McLean Hospital/Harvard Medical School

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

◆ *Participants earn 1.5 continuing education credits*

Incorporating Underexplored Emotions and Bodily Experiences into Eating Disorder Research and Treatment

Co-chairs: Tiffany A. Brown, Ph.D., University of California, San Diego, Eating Disorders Center for Treatment & Research

Christina Ralph-Nearman, M.S., Ph.D., University of Louisville

Discussant: Cheri A. A. Levinson, Ph.D., University of Louisville

◆ *Participants earn 1.5 continuing education credits*

Increasing Access and Equity Through Innovation: preliminary Groundwork from the Weissman Children's Foundation Equity and Effectiveness Scientific Council

Chair: Adam S. Weissman, Ph.D., The Child & Family Institute and Weissman Children's Foundation

Discussant: Brian C. Chu, Ph.D., Rutgers University

◆ *Participants earn 1.5 continuing education credits*

Increasing Engagement in Evidence-based Suicide Prevention Interventions: Considering Patients, Providers, and Organizations

Co-chairs: Gabriela K. Khazanov, Ph.D., Corporal Michael J. Crescenzo VA Medical Center

Courtney N. Forbes, M.A., University of Toledo

Discussant: Sara Landes, Ph.D., Central Arkansas Veterans Healthcare System

◆ *Participants earn 1.5 continuing education credits*

Innovations and Updates to Early Intervention Treatment in Psychosis

Chair: Alia R. Warner, ABPP, Ph.D., University of Texas Health Science Center at Houston

Discussant: David Penn, Ph.D., University of North Carolina at Chapel Hill

◆ *Participants earn 1.5 continuing education credits*

Innovations in Emotion Regulation Research: Examining Understudied Emotion Regulation-related Factors

Chair: Tara L. Spitz, M.A., University of Toledo

Discussant: Jennifer S. Cheavens, Ph.D., Professor, Ohio State University

◆ *Participants earn 1.5 continuing education credits*

Innovations in the Role of Hormones in Exposure-based Therapy for Anxiety Disorders

Chair: Hannah Levy, Ph.D., The Institute of Living

Discussant: Stefan G. Hoffman, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

Innovations in the Study and Treatment of OCD

Chair: Richard J. McNally, Ph.D., Harvard University

Discussant: Richard J. McNally, Ph.D., Harvard University

◆ *Participants earn 1.5 continuing education credits*

Innovations in Service Delivery to Promote Health Equity for Children with ADHD

Co-chairs: Jennifer A. Mautone, ABPP, Ph.D., Children's Hospital of Philadelphia/Perelman School of Medicine at University of Pennsylvania

Thomas J. Power, ABPP, Ph.D., Children's Hospital of Philadelphia, Perelman School of Medicine at University of Pennsylvania

Discussant: Heather A. Jones, Ph.D., Virginia Commonwealth University

◆ *Participants earn 1.5 continuing education credits*

Innovative and Accessible Mobile Apps Addressing the Effects of Trauma in Unique Populations: Approaches and Outcomes

Chair: Kevin O. Narine, B.A., William James College

Discussant: Josef I. Ruzek, Ph.D., Palo Alto University

◆ *Participants earn 1.5 continuing education credits*

Innovative Cognitive Behavioral Treatment Approaches for ARFID

Chair: Cate Morales, B.A., Hofstra University

Discussant: Erin E. Reilly, Ph.D., Hofstra University

◆ *Participants earn 1.5 continuing education credits*

Innovative Multimethod Approaches to Disentangling the Interplay of Emotions and Impulsive Behaviors in BPD: Fine-Tuning Treatment Targets

Chair: Elinor E. Waite, B.A., University of Massachusetts Amherst

Chair: Katherine Dixon-Gordon, Ph.D., University of Massachusetts Amherst

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

◆ *Participants earn 1.5 continuing education credits*

Integrating Longitudinal Designs Across Multiple Timescales and Demographics to Improve the Prediction and Prevention of Suicidal Ideation

Co-chairs: Gemma T. Wallace, M.S., Colorado State University

Kimberly L. Henry, Ph.D., Colorado State University

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

◆ *Participants earn 1.5 continuing education credits*

In the Here and Now: Using Smartphones and Wearable Sensor Technology to Study Anxiety and Emotion Regulation in Daily Life

Co-chairs: Katharine E. Daniel, M.A., University of Virginia

Allison E. Meyer, Ph.D., Michigan Medicine

Discussant: Michelle G. Newman, Ph.D., The Pennsylvania State University

◆ *Participants earn 1.5 continuing education credits*

Internalizing Symptoms in Latinx Families: Identifying Treatment Targets Through Translational and Intervention Research

Co-chairs: Giovanni Ramos, M.A., UCLA

Carolyn Ponting, M.A., UCLA

Discussant: Denise Chavira, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

Invisible, yet Stigmatized: Conceptual and Methodological Innovations in Research on Bisexual Stigma and Mental Health

Chair: Brian Feinstein, Ph.D., Rosalind Franklin University of Medicine and Science

Discussant: Christina Dyar, Ph.D., Ohio State University

◆ *Participants earn 1.5 continuing education credits*

Leveraging Digital Single-session Interventions for Public Mental Health: Innovations from Large-scale Clinical Trials

Co-chairs: Jessica L. Schleider, Ph.D., Stony Brook University

Michael Mullarkey, Ph.D., Stony Brook University

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

◆ *Participants earn 1.5 continuing education credits*

Leveraging Human Support for the Dissemination of Cognitive-behavioral Skills Through Technology-delivered Interventions

Chair: Maya Hareli, B.A., Loyola University Chicago

Discussant: Emily G. Lattie, Ph.D., Northwestern University

◆ *Participants earn 1.5 continuing education credits*

Leveraging Mindfulness, Acceptance, and Values-based Strategies to Promote Adherence to Health Behaviors

Chair: Joanna J. Arch, Ph.D., University of Colorado Boulder

Discussant: Evan Forman, Ph.D., Drexel University

◆ *Participants earn 1.5 continuing education credits*

LGBTQ-affirmative CBT: From Theory to Trial to Community Dissemination and Implementation

Co-chairs: Mark L. Hatzenbuehler, Ph.D., Harvard University

John Pachankis, Ph.D., Yale School of Public Health

Discussant: Joanne Davila, Ph.D., Stony Brook University

◆ *Participants earn 1.5 continuing education credits*

Looking Beyond the End of Treatment: Examining Maintenance and Predictors of Maintenance Following Treatment with the Unified Protocol

Chair: Elizabeth H. Eustis, Ph.D., Boston University

Discussant: Todd Farchione, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

Loving from a Distance: An Examination of Unique Challenges and Coping Strategies in Long-distance Relationships

Chair: Emily A. Carrino, B.A., University of North Carolina at Chapel Hill

Discussant: Tamara Sher, Ph.D., Rosalind Franklin University of Medicine and Science

◆ *Participants earn 1.5 continuing education credits*

Mental Health Disparities Experienced by Sexual and Gender Minority (SGM) Individuals

Chair: Trevor A. Hart, Ph.D., CPsych, Ryerson University

Co-Chair: Audrey Harkness, Ph.D., University of Miami

Discussant: Christopher Martell, Ph.D., University of Massachusetts Amherst

◆ *Participants earn 1.5 continuing education credits*

Military Couple Health Across the Deployment Cycle

Chair: Christina Balderrama-Durbin, Ph.D., Binghamton University

Discussant: David S. Riggs, Ph.D., Professor, Uniformed Services University of the Health Sciences

◆ *Participants earn 1.5 continuing education credits*

Mind-body-behavior: Cognitive-behavioral and Related Processes at the Intersection of Medical and Mental Health

Chair: Shannon M. Blakey, Ph.D., Durham VA Health Care System/VA Mid-Atlantic MIRECC

Discussant: Alicia E. Meuret, Ph.D., Southern Methodist University

◆ *Participants earn 1.5 continuing education credits*

Mind-Body Interventions for Emotional and Behavioral Disorders

Chair: Stefan G. Hoffman, Ph.D., Boston University

Discussant: Stefan G. Hoffman, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

Mobile Apps for Depression and Anxiety Disorders: Promises and Pitfalls

Co-Chairs: Nur Hani Zainal, M.S., The Pennsylvania State University

Michelle G. Newman, Ph.D., The Pennsylvania State University

Discussant: Sabine Wilhelm, Ph.D., Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

Models of Risk and Resilience Applied to Children, Adolescents, Emerging Adults, and Caregivers During COVID-19: Identification of Components for Preventive Interventions

Chair: Elissa Brown, Ph.D., St. John's University, Child HELP Partnership

Discussant: Michael A. de Arellano, Ph.D., Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

More Frequent Assessments, More Problems? Methodological and Ethical Considerations in Ecological Momentary Assessment Research

Chair: Daniel Coppersmith, M.A., Harvard University

Co-Chair: Kate H. Bentley, Ph.D., Massachusetts General Hospital

Discussant: Aidan Wright, Ph.D., University of Pittsburgh

◆ *Participants earn 1.5 continuing education credits*

Moving Beyond the Therapy Room to Examine Internal and External Influences in Tourette Syndrome

Chair: Brianna Wellen, M.S., The University of Utah

Discussant: Michael B. Himle, Ph.D., University of Utah

◆ *Participants earn 1.5 continuing education credits*

Not Just a Young Girl's Struggle: Body Image and Eating Disorders in Midlife and Older Women

Co-chairs: Lisa S. Kilpela, Ph.D., UT Health San Antonio Barshop Institute for Longevity and Aging Studies

Kerstin K. Blomquist, Ph.D., Furman University

Discussant: Pamela Keel, Ph.D., Florida State University

◆ *Participants earn 1.5 continuing education credits*

Novel Analytic Approaches to Clinical Science: Integrating Recent Advances to Statistical Methodology

Co-chairs: Duncan G. Jordan, Ph.D., Murray State University

Gemma T. Wallace, M.S., Colorado State University

Discussant: Craig Henderson, Ph.D., Sam Houston State University

◆ *Participants earn 1.5 continuing education credits*

Novel Approaches to Implementing Evidence-based Practices in Schools

Co-chairs: Jacqueline R. Anderson, Ph.D., UT Southwestern Medical Center

Jennifer Hughes, M.P.H., Ph.D., UT Southwestern Medical Center

Discussant: Courtney Benjamin Wolk, Ph.D., University of Pennsylvania

◆ *Participants earn 1.5 continuing education credits*

Nuanced Mechanisms Underlying Developmental Psychopathology: How Vicarious Learning, Irritability, Culture, and Interpretation Bias Influence the Emergence of Anxiety Disorders

Chair: Tomer Shechner, Ph.D., University of Haifa
Discussant: Tomer Shechner, Ph.D., University of Haifa

◆ *Participants earn 1.5 continuing education credits*

Out of the Laboratory, and into the Clinic: Measuring and Testing Novel Mechanistic Theories of Exposure

Chair: Jennie M. Kuckertz, Ph.D., McLean Hospital/Harvard Medical School

Discussant: Eric A. A. Storch, Ph.D., Baylor College of Medicine

◆ *Participants earn 1.5 continuing education credits*

Overcoming Barriers to Care for LGBTQA+ Communities: Successes and Opportunities

Chair: Debra A. Hope, Ph.D., University of Nebraska-Lincoln

Discussant: Jae A. Puckett, Ph.D., Michigan State University

Positive Body Image as Social Justice: Cognitive Behavioral Applications to Socioculturally Diverse Groups

Chair: Zachary A. Soulliar, Ph.D., Yale School of Public Health

Discussant: Tracy L. Tylka, Ph.D., Department of Psychology, The Ohio State University

◆ *Participants earn 1.5 continuing education credits*

Predicting, Preventing and Addressing Perinatal Mental Health Concerns

Co-Chairs: Mira Snider, M.S., West Virginia University

Shari A. Steinman, Ph.D., West Virginia University

Discussant: Amy Wenzel, ABPP, Ph.D., Main Line Center for Evidence-Based Psychotherapy

◆ *Participants earn 1.5 continuing education credits*

Predictors of Observed Community Provider Fidelity to Evidence-based Interventions for Children and Associations with Child Outcomes

Chair: Barbara Caplan, Ph.D. - UC San Diego, Child and Adolescent Services Research Center

Discussant: Ann Garland, Ph.D., University of San Diego

◆ *Participants earn 1.5 continuing education credits*

Promoting the Use of Evidence-based Practices Through Provider Training

Chair: Nicole P. Porter, M.A., Partnership to End Addiction

Discussant: Shannon Wiltsey-Stirman, Ph.D., VA National Center for PTSD and Stanford University

◆ *Participants earn 1.5 continuing education credits*

Protecting the Most Vulnerable: Suicide Prevention in the Justice System

Chair: Brittany Rudd, Ph.D., University of Illinois at Chicago

Discussant: Jennifer Johnson, Ph.D., Michigan State University

◆ *Participants earn 1 continuing education credit*

Provider Attitudes Toward Rapid Telemental Health Implementation During the COVID-19 Pandemic: Lessons Learned and Paths Forward

Co-chairs: Jessica M. Lipschitz, Ph.D., Brigham and Women's Hospital / Harvard Medical School

Samantha L. Connolly, Ph.D., VA Boston Healthcare System/Harvard Medical School

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

◆ *Participants earn 1.5 continuing education credits*

Psychopathology in College Students: Implications for Research, Theory, and Public Health Policies

Co-chairs: Kiara R. Timpano, Ph.D., University of Miami

Amitai Abramovitch, Ph.D., Texas State University

Discussant: Richard J. McNally, Ph.D., Harvard University

◆ *Participants earn 1.5 continuing education credits*

Psychophysiology of Emotion Regulation: Leveraging Multiple Units of Analysis to Advance Cognitive and Behavioral Science

Chair: Akanksha Das, B.S., Miami University

Discussant: Sheila Crowell, Ph.D., University of Utah

◆ *Participants earn 1.5 continuing education credits*

Public Attitudes, Beliefs and Knowledge About Evidence-based Treatments

Chair: Alexandra L. Silverman, M.A., University of Virginia

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

◆ *Participants earn 1.5 continuing education credits*

Racial/ethnic Disparities in Mental Health Services for Youth at Risk for Suicide: Findings from Across the Continuum of Care

Chair: Belinda Chen, B.A., UCLA

Co-Chair: Tamar Kodish, M.A., UCLA

Discussant: Kiara Alvarez, Ph.D., Massachusetts General Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

Recent Advances in Decision-making as a Factor in Hoarding Disorder Symptoms

Co-chairs: Michael G. Wheaton, Ph.D., Barnard College

Kiara R. Timpano, Ph.D., University of Miami

Discussant: Randy O. Frost, Ph.D., Smith College

◆ *Participants earn 1.5 continuing education credits*

Recent Developments in Studying Fear and Avoidance Learning as Mechanisms for Understanding and Treating Anxiety Disorders

Chair: Tomer Shechner, Ph.D., University of Haifa

Discussant: Tomer Shechner, Ph.D., University of Haifa

◆ *Participants earn 1.5 continuing education credits*

Refining Exposure Therapy in the Clinic and the Laboratory: Underlying Neural Mechanisms

Chair: Lily Brown, Ph.D., University of Pennsylvania

Discussant: Sheila Rauch, ABPP, Ph.D., Emory University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Relationship Health and COVID-19: Identifying and Reducing Maladaptive Relationship Behaviors Across Diverse and Underserved Populations During a Public Health Emergency

Chair: Judith Biesen, Ph.D., University of New Mexico Health Sciences Center

Discussant: Brandi C. Fink, Ph.D., University of New Mexico

◆ *Participants earn 1 continuing education credit*

Relevance, Training, and Feasibility of Virtual Dialectical Behavior Therapy Skills Groups to Support Mental Health of Emerging Adults in India During COVID-19

Co-chairs: Vaishali V. Raval, Ph.D., Miami University

Elizabeth Thomas, Ph.D., Christ University

Discussant: Linda Dimeff, Ph.D., Jaspr Health, Inc.

◆ *Participants earn 1.5 continuing education credits*

Results of a Randomized Controlled Trial of the Cannabis Echeckup TO GO Intervention

Chair: Mark A. Prince, Ph.D., Colorado State University

Discussant: Kara Thompson, Ph.D., St. Francis Xavier University

◆ *Participants earn 1.5 continuing education credits*

Risk, Resilience, or Both? Towards a More Nuanced Understanding of Stress and Relationship Functioning Among Sexual Minorities to Facilitate Strengths-Based Approaches

Chair: Timothy J. Sullivan, M.A., Stony Brook University

Discussant: Sarah W. Whitton, Ph.D., University of Cincinnati

◆ *Participants earn 1.5 continuing education credits*

Seeking Help While Being Othered: The Effect of Islamophobia and Discrimination on Muslims Living in the United States

Chair: Merranda McLaughlin, B.A., University of Miami

Discussant: Ayse S. Ikizler, Ph.D., St. Mary's College of Maryland

◆ *Participants earn 1.5 continuing education credits*

Self-advocacy as an Essential Tool for Recovery for People with Psychosis in the Clinic and in the Community

Chair: Emily Treichler, Ph.D., University of California, San Diego and Veterans Affairs San Diego Healthcare System

Discussant: Shirley M. Glynn, Ph.D., UCLA

◆ *Participants earn 1.5 continuing education credits*

Sexual Assault Among College Students: From Risk Factors to Post-assault Outcomes

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

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

Discussant: Patricia A. Resick, Ph.D., ABPP, Ph.D., Duke University Medical Center

◆ *Participants earn 1.5 continuing education credits*

Situational Vulnerabilities and Their Impact on Treatment Uptake and Adherence Among Marginalized Groups: Implications for Cognitive and Behavioral Practice and Science in the Context of Social Justice

Chair: Samantha M. McKetchnie, LCSW, Massachusetts General Hospital

Discussant: Trevor A. Hart, PhD, CPsych, Ryerson University

◆ *Participants earn 1.5 continuing education credits*

Sociocultural Considerations for Assessment and Treatment of OCD Among Diverse Groups

Chair: Jennifer Buchholz, M.A., University of North Carolina at Chapel Hill

Co-Chair: Henry A. Willis, Ph.D., University of North Carolina at Chapel Hill

Discussant: Monnica Williams, ABPP, Ph.D., University of Ottawa

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Sociocultural Factors in PTSD: Improving Treatment Outcomes and Dissemination

Chair: Katherina Arteaga, B.S., Texas State University

Discussant: Dean G. Kilpatrick, Ph.D., Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

Substance Misuse and Suicidal Thoughts and Behaviors: Understanding Shared Risk

Co-chairs: Margaret Baer, M.A., University of Toledo

Matthew T. Tull, Ph.D., University of Toledo

Discussant: Paul Nestadt, M.D., Johns Hopkins School of Medicine

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Supporting Providers Who Support Kids: Exploring the Roles of Training, Supervision, Secondary Traumatic Stress, and Financial Strain

Chair: Corinna C. Klein, LCSW, University of California, Santa Barbara

Discussant: Tara Mehta, Ph.D., University of Illinois at Chicago

◆ *Participants earn 1.5 continuing education credits*

Task-shifting as an Implementation Strategy to Improve Access and Enhance Engagement with Cognitive and Behavioral Interventions

Chair: Robert E. Brady, Ph.D., Geisel School of Medicine at Dartmouth

Discussant: Laura K. Murray, Ph.D., Johns Hopkins University School of Public Health

◆ *Participants earn 1.5 continuing education credits*

The Effectiveness of Youth Psychotherapy over the past 50 Years: Results from Four Specialized Meta-analyses on Depression, Autism, and Remotely Delivered Therapies

Chair: Ana M. M. Ugueto, PhD, ABPP, UT Health Science Center, McGovern Medical School

Discussant: V. Robin Weersing, Ph.D., SDSU-UC San Diego JDP in Clinical Psychology

◆ *Participants earn 1.5 continuing education credits*

The Impact of Multi-level Implementation Factors on School-based ASD Evidence-based Interventions

Chair: Allison Jobin, Ph.D., California State University, San Marcos

Discussant: Jill Locke, Ph.D., University of Washington School of Medicine

◆ *Participants earn 1.5 continuing education credits*

The Importance of Parenting During the COVID-19 Pandemic for Child and Adolescent Well-being

Chair: Rosanna Breau, Ph.D., Virginia Polytechnic Institute and State University

Discussant: Thomas Ollendick, Ph.D., Virginia Polytechnic Institute and State University

◆ *Participants earn 1.5 continuing education credits*

The Kids Are Not Alright: The Emergence and Treatment of Sexual and Gender Minority Mental Health Disparities in Children and Adolescents

Co-Chairs: Ilana Seager van Dyk, Ph.D., Yale School of Public Health

Kirsty A. Clark, M.P.H., Ph.D., Yale School of Public Health

Discussant: Michael E. Newcomb, Ph.D., Northwestern University

◆ *Participants earn 1.5 continuing education credits*

The Potential of Machine Learning and Artificial Intelligence in the Delivery of Cognitive Behavioral Therapy

Chairs: Steven Hollon, Ph.D., Vanderbilt University

Shiri Sadeh-Sharvit, Ph.D., Center for m2Health, Palo Alto University and Eleos health

◆ *Participants earn 1.5 continuing education credits*

The Role of Machine Learning in Evaluating, Refining, and Scaling Evidence-based Mental Health Practices

Chair: Torrey A. Creed, Ph.D., University of Pennsylvania

Discussant: David C. Atkins, Ph.D., University of Washington

◆ *Participants earn 1.5 continuing education credits*

The Role of Repetitive Thinking in Depression Within the Autistic Community

Chair: Katherine O. Gotham, Ph.D., Rowan University

Discussant: Greg J. Siegle, Ph.D., University of Pittsburgh School of Medicine

◆ *Participants earn 1.5 continuing education credits*

The Value of Targeting Mechanisms: The Science of Behavior Change (SOBC) Method and Recent Mechanistic Wins for Sleep, Pain, and Smoking Cessation

Chair: Michael W. Otto, Ph.D., Boston University

Discussant: Lisa Onken, Ph.D., National Institute on Aging, NIH

◆ *Participants earn 1.5 continuing education credits*

Ties That Bind: Addressing the Needs of Siblings of Chronically Suicidal and Emotionally Dysregulated Clients

Chair: Lauren B. Yadlosky, Ph.D., McLean Hospital/Harvard Medical School

Discussant: Alan E. Fruzzetti, Ph.D., McLean Hospital/Harvard Medical School

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Toward Streamlined Psychotherapies: Understanding the Role of Specific Youth Psychotherapy Elements in Clinical Practice and Outcomes

Co-chairs: Katherine E. Venturo-Conerly, B.A., Harvard University

Olivia M Fitzpatrick, B.A., Harvard University

Discussant: Christian Webb, Ph.D., Harvard Medical School & McLean Hospital

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Treatments That Work for Childhood ADHD: Diversity in the Evidence-base and Strategies to Improve Treatment Equity, Inclusion, and Cultural Fit

Co-chairs: Brittany M. Merrill, Ph.D., Florida International University

Jennifer Piscitello, Ph.D., Florida International University

Discussant: Heather A. Jones, Ph.D., Virginia Commonwealth University

◆ *Participants earn 1.5 continuing education credits*

Understanding and Treating Trauma-related Guilt and Shame in PTSD

Chair: Jesse McCann, B.S., University of Kentucky

Discussant: Christal Badour, Ph.D., University of Kentucky

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Understanding Links Between Trauma, PTSD, and OCD: From Conceptualization to Treatment

Co-chairs: Heidi J. Ojalehto, B.S., UNC Chapel Hill

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

Discussant: Jesse Cougle, Ph.D., Florida State University

◆ *Participants earn 1.5 continuing education credits*

Understanding Mechanisms That Underlie Disparities Among Black Americans with Schizophrenia Spectrum Disorders

Chair: Bryan J. Stiles, B.A., University of North Carolina at Chapel Hill

Discussant: Donte Bernard, Ph.D., Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

Unified Protocol for Transdiagnostic Treatment and Prevention of Emotional Disorders in Health Conditions

Co-chairs: Jorge Osma, Ph.D., Universidad de Zaragoza

Todd Farchione, Ph.D., Boston University

Discussant: Elizabeth H. Eustis, Ph.D., Boston University

◆ *Participants earn 1.5 continuing education credits*

Utilizing Stakeholder Input to Improve Quality of and Access to Evidence-based Practices

Co-chairs: Amber Calloway, Ph.D., Center for Anxiety and Behavior Therapy

Amanda Sanchez, Ph.D., University of Pennsylvania School of Medicine

Discussant: Torrey A. Creed, Ph.D., University of Pennsylvania

◆ *Participants earn 1.5 continuing education credits*

We'll Keep This Short: The Developing and Testing of Brief Interventions for Borderline Personality Disorder

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

Discussant: Jennifer S. Cheavens, Ph.D., Ohio State University

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What Happens After People Leave Treatment? Examining Transdiagnostic Illness Trajectories and Transitions During Critical Periods

Co-chairs: Rowan A. Hunt, B.A., University of Louisville

Shirley B. Wang, M.A., Harvard University

Discussant: Matthew K. Nock, Ph.D., Harvard University

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What Is Psychological Pain? A Transdiagnostic Examination of the Nature and Correlates of Pain Affect Arising from Psychological or Social Stimuli

Chair: Madelyn Frumkin, M.A., Washington University in St. Louis

Discussant: Matthew K. Nock, Ph.D., Harvard University

■ **CLINICAL ROUND TABLES**

◆ *Participants earn 1.5 continuing education credits*

Adapting Interventions for Individuals with Intellectual Disability: Considerations and Challenges

Moderator: Jonathan Weiss, Ph.D., York University

Presenters: Caitlin M. Conner, Ph.D., University of Pittsburgh School of Medicine

Audrey Blakeley-Smith, Ph.D., University of Colorado School of Medicine

Andrew Jahoda, Ph.D., University of Glasgow

Kelly Vinquist, Ph.D., University of Iowa

◆ *Participants earn 1.5 continuing education credits*

Advancing Couple Therapy for Low-income Relationships: A Discussion of Intervention and Policy

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

Presenters: McKenzie K. Roddy, Ph.D., VA Tennessee Valley Healthcare System

Kristina Gordon, Ph.D. University of Tennessee, Knoxville

Anthony L. Chambers, ABPP, Ph.D., The Family Institute at Northwestern University

Shalonda Kelly, Ph.D., Rutgers University

Mariana K. Falconier, Ph.D., University of Maryland

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Approaching the Conversation of Race and Diversity in the Therapy Room: What to Say and How to Say It

Moderators: Hollie Granato, Ph.D., UCLA

Jamie Schumpf, Psy.D., Yeshiva University, Ferkauf Graduate School of Psychology

Presenters: Mudita Bahadur, Ph.D., Private Practice

Lizbeth Gaona, Ph.D., LCSW, California Baptist University

Lisa Bolden, M.A., Psy.D., UCLA School of Medicine

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CBT and ACT for the People: Adapting Group Treatments for a True Clinical Population

Moderators: Lynn M. McFarr, Ph.D., Harbor-UCLA Medical Center; Anne Marie Albano, ABPP, Ph.D., Modern Minds

Presenters: Zachary Blumkin, Psy.D., Columbia University Medical Center

Erica Gottlieb, Ph.D., Columbia University Medical Center

Elizabeth Ellman, Psy.D., Columbia University Medical Center

Jared O'Garro-Moore, Ph.D., Columbia University Medical Center

Constance Abruzzese, Ph.D., Columbia University Medical Center

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Challenges and Opportunities in Promoting Cognitive Behavioral Therapies for Social Anxiety Disorder

Moderator: Daniel Chazin, Ph.D., Center for Anxiety, OCD, and Cognitive Behavioral Therapy & National Social Anxiety Center Philadelphia Clinic

Presenters: David M. Clark, D. Phil., University of Oxford

Richard G. Heimberg, Ph.D., Temple University

Torrey A. Creed, Ph.D., University of Pennsylvania

Stefan G. Hoffman, Ph.D., Boston University
Anu Asnaani, Ph.D., University of Utah

♦ *Participants earn 1.5 continuing education credits*

Clinical Considerations for Engaging African American Couples and Families in Practice

Moderator: Aleja Parsons, Ph.D., New York University
Presenters: Shalonda Kelly, N/A, Ph.D., Rutgers University
Gihane Jeremie-Brink, Ph.D., William Patterson University
Shawn Jones, Ph.D., Virginia Commonwealth University
Anthony L. Chambers, ABPP, Ph.D., The Family Institute at Northwestern University

♦ *Participants earn 1.5 continuing education credits*

Covid Crises and CBT: Mobilizing Cognitive Behavioral Interventions to Meet the Psychological Needs of Hospital Patients, Staff, and Health Workers During COVID-19

Moderator: Andrea B. Temkin, Psy.D., Weill Cornell Medicine
Presenters: Shannon M. Bennett, Ph.D., Weill Cornell Medical School
JoAnn Difede, Ph.D., Weill Cornell Medicine
Corinne Catarozoli, Ph.D., Weill Cornell Medicine
Victoria M. Wilkins, Ph.D., Weill Cornell Medicine/New York -Presbyterian Hospital
Abhishek Jaywant, Ph.D., Weill Cornell Medicine
Dora Kanellopoulos, Ph.D., Weill Cornell Medicine

♦ *Participants earn 1.5 continuing education credits*

Expanding Access to Care for Youth with ASD: Supervision and Treatment Considerations for the “non-asd Expert” CBT Provider

Moderator: Rebecca Sachs, ABPP, Ph.D., CBT Spectrum
Presenters: Anne Marie Albano, ABPP, Ph.D., Modern Minds
Dena Gassner, MSW, Adelphi University
Matthew D. Lerner, Ph.D., Stony Brook University
Lauren Moskowitz, Ph.D., St. John’s University
Sandra Pimentel, Ph.D., Montefiore Medical Center/Albert Einstein College of Medicine
Tamara Rosen, Ph.D., JFK Partners, Section of Developmental Pediatrics

♦ *Participants earn 1.5 continuing education credits*

Family Feud: A Clinician’s Guide to Navigating Challenging Family Dynamics and Awkward Conversations in Youth-focused Treatment

Moderator: Andrea B. Temkin, Psy.D., Weill Cornell Medicine
Presenters: Shannon M. Bennett, Ph.D., Weill Cornell Medical School
Anthony Puliafico, Ph.D., Columbia University Irving Medical Center
Samuel Fasulo, Ph.D., New York University School of Medicine

♦ *Participants earn 1.5 continuing education credits*

Group Telehealth CBT and DBT Treatments for Adolescents: Benefits, Challenges, and Special Considerations for Implementation

Moderators: Laura Cyran, M.S. - Cognitive & Behavioral Consultants

Lata K. McGinn, Ph.D., Yeshiva University/Cognitive & Behavioral Consultants

Presenters: Magdalena Buczek, Psy.D., Cognitive & Behavioral Consultants

Tali Wigod, Psy.D., Cognitive Behavioral Consultants
Anthony Puliafico, Ph.D., Columbia University Irving Medical Center

Sandra Pimentel, Ph.D., Montefiore Medical Center/
Albert Einstein College of Medicine
Jill Ehrenreich-May, Ph.D., University of Miami

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How Does CBT Translate to Real-world Settings? A Discussion on Implementing CBT Online, in Community Mental Health Clinics, and in Prison

Moderator: Louisa G. Sylvia, Ph.D., Massachusetts General Hospital
Presenters: Douglas Katz, Ph.D., Dauten Family Center for Bipolar Treatment Innovation, Massachusetts General Hospital
Aaron Katz, Ph.D., Eliot Community Health Services
Lauren Weinstock, Ph.D., Alpert Medical School of Brown University

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How to Apply Dialectical Behavior Therapy When Working with Minoritized People

Moderator: Cindy J. Chang, PsyM, Rutgers University
Presenters: Colleen A. Sloan, Ph.D., VA Boston HCS & Boston University School of Medicine
Kelci C. Flowers, Ph.D., Atlanta VA Health Care System
Alexandra Canetti, M.D., Columbia University Medical Center
Jeffrey M. Cohen, Psy.D., Columbia University
Vinushini Arunagiri, Ph.D., McLean Hospital

♦ *Participants earn 1.5 continuing education credits*

Increasing Access to Evidence-based Treatments for Underserved and Diverse Populations: creative, Innovative, Real-world Solutions

Moderators: Janie J. Hong, Ph.D., Stanford University School of Medicine and Redwood Center for CBT and Research
Quyen A. Do, University of Texas at San Antonio
Presenters: Adrian Aguilera, Ph.D., UC Berkeley
Tara Mehta, Ph.D., University of Illinois at Chicago
Kevin O. Narine, B.A., William James College
Nadine A. Chang, Ph.D., Gracie Square Hospital

♦ *Participants earn 1.5 continuing education credits*

Is It Working? Routine Outcome Monitoring in Practice, Supervision and Training

Moderator: Julie L. Ryan, Ph.D., William James College, Boston Child Study Center
Presenters: Julie L. Ryan, Ph.D., William James College, Boston Child Study Center
Ilana Luft-Barrett, Ph.D., Saint Louis Children’s Hospital, Washington University School of Medicine
Jennifer Malatras, Ph.D., University at Albany, State University of New York
Lyndsey Moran, Ph.D., Boston Child Study Center

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Moving Towards Culturally Informed and Anti-oppressive, Trauma-focused Care

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

Casey D. Calhoun, Ph.D., University of North Carolina at Chapel Hill

Presenters: Molly Cevasco, Ph.D., Seattle Children's Hospital

Isha W. Metzger, Ph.D., University of Georgia

Kimberly E. Dean, Ph.D., Massachusetts General Hospital; Harvard Medical School

Jillian Shipherd, Ph.D., Veterans Health Administration Central Office; National Center for PTSD Women's Health Sciences Division at VA Boston Healthcare System; Boston University

Rosaura Orengo-Aguayo, Ph.D., Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

Using Technology to Improve Access, Engagement, Research, and Outcomes with Cognitive Behavioral Therapy

Moderators: J. Ryan Fuller, Ph.D., New York Behavioral Health

Jacqueline B. Persons, Ph.D., Oakland Cognitive Behavior Therapy Center

Presenters: Lindsay A. Bornheimer, Ph.D., University of Michigan

Douglas W. Woods, Ph.D., Marquette University

Nicole A. Stadnick, Ph.D., University of California San Diego

Alex R. Dopp, Ph.D., RAND

Andrea K. Graham, Ph.D., Northwestern University Feinberg School of Medicine

■ **SPOTLIGHT RESEARCH**

◆ *Participants earn 1.5 continuing education credits*

Championing CBT with a Research Framework for Investigating the Cost-effectiveness and Cost-benefit of Different Delivery Systems for CBTs

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

Panelists: Corinne N. Kacmarek, M.A., American University

Brian D. Kiluk, Ph.D., Yale University

◆ *Participants earn 1.5 continuing education credits*

Early Phases of the Acceptance Based Coping (ABaCo) Skills Program: A Community Health Worker-delivered Intervention for Hispanic/Latinx Patients with Type 2 Diabetes

Chair: Kathryn E. Kanzler, ABPP, Psy.D., University of Texas Health Science Center San Antonio

Panelist: Patti J. Robinson, Ph.D., Mountainview Consulting Group, Inc.

■ **MINI WORKSHOPS**

◆ *Participants earn 1.5 continuing education credits*

A Clinician's Guide to Sexual Assault Disclosure

Amie R. Newins, Ph.D., University of Central Florida

Laura C. Wilson, Ph.D., University of Mary Washington

◆ *Participants earn 1.5 continuing education credits*

A Transdiagnostic Approach to Caregiver Intervention Using the Unified Protocols for Children and Adolescents

Sarah M. Kennedy, Ph.D., University of Colorado School of Medicine

Jill Ehrenreich-May, Ph.D., University of Miami

◆ *Participants earn 1.5 continuing education credits*

Adapting Motivational Interviewing Training to Different Trainee and Provider Types

Julie A. Schumacher, Ph.D., University of Mississippi Medical Center

Michael B. Madson, Ph.D., University of Southern Mississippi

◆ *Participants earn 1.5 continuing education credits*

Adding a Recovery Orientation to Cognitive Behavior Therapy for Depression

Judith S. Beck, Ph.D., Beck Institute for Cognitive Behavior Therapy

◆ *Participants earn 1.5 continuing education credits*

Culturally Responsive CBT for Later-life Depression

Ann M. Steffen, ABPP, Ph.D., University of Missouri-St. Louis

◆ *Participants earn 1.5 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, Seattle

◆ *Participants earn 1.5 continuing education credits*

Evidence-based Strategies to Increase Substance Use Treatment Engagement with Limited Resources

Adam Rubenis, Psy.D., Turning Point, Eastern Health, Victoria, Australia

Shalini Arunogiri, M.D., Ph.D., Turning Point; Monash University

Jennifer A. Nation, Psy.D., LaTrobe University

Elizabeth Katz, Ph.D., Towson University

◆ *Participants earn 1.5 continuing education credits*

Flexible Applications of CBT for Emerging Adults in Crisis: Lessons Learned from a Multimodal Approach to Outreach, Training, and Treatment for Emerging Adults During COVID-19

Andrea B. Temkin, Psy.D., Weill Cornell Medicine

Shannon M. Bennett, Ph.D., Weill Cornell Medical School
Lauren Hoffman, Psy.D., Columbia University College of
Physicians and Surgeons
Anne Marie Albano, ABPP, Ph.D., Modern Minds

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Got a Client Afraid of Puke? This Workshop Is for You!

David Yusko, Psy.D., Center for Anxiety & Behavior Therapy
Dara Lovitz

◆ *Participants earn 1.5 continuing education credits*

Implementing Cognitive-behavioral Therapy for Adults and College Students with ADHD

Mary V. Solanto, Ph.D., Zucker School of Medicine at
Hofstra/Northwell

◆ *Participants earn 1.5 continuing education credits*

Improving Treatment for Hoarding Disorder

Gail Steketee, Ph.D., MSW, Boston University
Randy O. Frost, Ph.D., Smith College

◆ *Participants earn 1.5 continuing education credits*

Integrating the Menstrual Cycle into Assessment and Treatment: A Practical Overview

Jessica R. Peters, Ph.D., Alpert Medical School of Brown University

Tory Eisenlohr-Moul, Ph.D., University of Illinois at Chicago
Katja Schmalenberger, M.A., Heidelberg University

◆ *Participants earn 1.5 continuing education credits*

Intensive Exposure-based Therapy in Acute Care Settings for Children and Adolescents

Rachel L. Goldman, Ph.D., Weill Cornell Medicine
Abby Bailin, Ph.D., Weill Cornell Medical College
Avital Falk, Ph.D., Weill Cornell Medicine
Jessica Simberlund, M.D., New York Presbyterian/
Weill Cornell Medicine

◆ *Participants earn 1.5 continuing education credits*

Mindfulness Techniques for Distress Reduction and Emotion Regulation

Lynn C. Waelde, Ph.D., Palo Alto University
Sarah M. DeLuca, Ph.D., Kaiser Permanente

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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., McClean Hospital & Harvard Medical School
Alison Yaeger, Psy.D., McLean Hospital
Esme A L. Shaller, Ph.D., University of California San Francisco

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Navigating Queer Spaces with LGBTQ+ Therapist and/or Clients

Debra A. Hope, Ph.D., University of Nebraska-Lincoln
Christopher Martell, Ph.D., University of Massachusetts Amherst

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One in Fifty-four: Supervision Considerations for Utilizing CBT in Cases Involving Autism and Co-morbid Anxiety and OCD

Rebecca Sachs, ABPP, Ph.D., CBT Spectrum
Lauren Moskowitz, Ph.D., St. John's University

◆ *Participants earn 1.5 continuing education credits*

Screens, School, and Suicidality: Borrowing Strategies from Acute Care Settings to Help Parents of Anxious Teens Avoid Landmines

Arielle Claire V. Linsky, Ph.D., Weill Cornell Medicine
Paul Sullivan, Ph.D., NYU Langone Medical Center/Bellevue Hospital Center
Stephanie N. Rohrig, Ph.D., Weill Cornell Medicine/New York Presbyterian Hospital
Angela W. Chiu, Ph.D., Weill Cornell Medicine / New York Presbyterian Hospital

◆ *Participants earn 1.5 continuing education credits*

The New Normal: Coping with Uncertainty and Mitigating Anxiety in an Age of “unprecedented” Local, National, and Global Challenges and Crises

Rochelle I. Frank, Ph.D., U. C. Berkeley & The Wright Institute
Joan Davidson, Ph.D., S. F. Bay Area Center for Cognitive Therapy

◆ *Participants earn 1.5 continuing education credits*

Treating Existential and Spiritual Struggles with CBT

David H. Rosmarin, ABPP, Ph.D., Harvard Medical School

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Using a Standardized Supervisee Framework for Experiential Training in Competent Clinical Supervision

Jennifer C. Veilleux, Ph.D., University of Arkansas
Rebecca A. Schwartz-Mette, Ph.D., University of Maine
Samantha Gregus, Ph.D., Wichita State University

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Yo Graduate Students!! Yeah, You Over There. Come Learn How to Actually Apply What You Just Learned: Helping Your Anxious Patients Without Being Totally Anxious While Doing It

Patrick B. McGrath, Ph.D., NOCD

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Youth Opioid Recovery Support Intervention: Combining Family Involvement, Assertive Outreach, Home Delivery of Medications, and Contingency Management for Young Adults with Opioid Use Disorder

Kevin Wenzel, Ph.D., Maryland Treatment Centers

Marc Fishman, M.D., Maryland Treatment Centers

■ RESEARCH AND PROFESSIONAL DEVELOPMENT

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Assembling a Dream Team: Innovative Approaches to Improving Quality, Access, and Impact of Mentorship in Clinical Psychology

Kathryn A. Coniglio, M.S., Rutgers University

Shirley B. Wang, M.A., Harvard University

Bethany A. Teachman, Ph.D., University of Virginia

Ann F. Haynos, Ph.D., University of Minnesota

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Careers in Clinical Psychology: Which Path Makes Sense for Me?

Jedidiah Siev, Ph.D., Swarthmore College

Sabine Wilhelm, Ph.D., Harvard Medical School

Matthew K. Nock, Ph.D., Harvard University

Jonathan B. Grayson, Ph.D., University of Southern California

Barbara W. Kamholz, ABPP, Ph.D., VA Boston HCS/ BU School of Medicine

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Developing an Evidence-based Specialization and Private Practice: Practical Tools and Insights into Building and Growing a Private Practice from Master's Level Clinicians

Loren E. Prado, Center for Dialectical and Cognitive Behavioral Therapies

Sarah Nadeau, MFT, Private Practice & San Jose State University

Kelly Turner, LCSW, Tampa Bay DBT Counseling Center

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How to Build an Infrastructure to Support Research in Your Clinical Practice

Jacqueline B. Persons, Ph.D., Oakland Cognitive Behavior Therapy Center

Rebecca A. Courry, LCSW, Oakland Cognitive Behavior Therapy Center

Travis L. Osborne, ABPP, Ph.D., Evidence Based Treatment Centers of Seattle (EBTCS)

Mary K. Alvord, Ph.D., Alvord, Baker & Associates, LLC

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Practice-Based Research Methods Bootcamp: Learn How to Conduct and Publish Research in a Private Practice Setting

Scott H. Waltman, ABPP, Psy.D., Center for Dialectical and Cognitive Behavior Therapies

John Lothes, II, University of North Carolina Wilmington

Kirk D. Mochrie, Ph.D., Triangle Area Psychology Clinic

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Sharing Our Psychological Science Better: How to Use Creative Commons Licensing, Social Media, Open Science, and Wiki to Reach the Biggest Audience

Eric A. Youngstrom, Ph.D., UNC Chapel Hill/Helping Give Away Psychological Science

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Using Media as a Tool for Social Good: Disseminating Cognitive Behavioral Science and Practice Online with a Social Justice Lens

Ilana Seager van Dyk, Ph.D., Yale School of Public Health

Kevin Chapman, Ph.D., The Kentucky Center for Anxiety and Related Disorders

Juliette McClendon, Ph.D., Boston University School of Medicine

Jessica L. Schleider, Ph.D., Stony Brook University

Jeffrey M. Cohen, Psy.D., Columbia University

Broderick Sawyer, Ph.D., Genesee Valley Psychology

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What Does It Mean to Dress “Professionally” as a Therapist?

Jennifer C. Veilleux, Ph.D., University of Arkansas

Rebecca A. Schwartz-Mette, Ph.D., University of Maine

Hotel

The special ABCT Convention rates will be offered, based on mutual agreement with the Hotel, 3 days before and 3 days after the official Convention dates of November 18 – 21, 2021. The block is limited and available on a first-come basis until the block is depleted. If you are interested in upgrading your hotel accommodations, there are limited options available, at an increased rate. Contact the hotel directly.

All ABCT Convention scientific sessions will take place at the Hyatt Regency New Orleans Hotel. General registration includes panel discussions, clinical round tables, symposia, mini-workshops, and over a dozen poster sessions. Remember to check out the limited-attendance CE events – both on Thursday and throughout the Convention on Friday and Saturday. One complimentary beverage ticket will be provided for use at the Welcoming Reception/SIG Exposition on Friday night from 6:30 p.m. to 8:30 p.m.

Stay at the Hyatt Regency New Orleans to meet your friends and colleagues on the elevator, in the coffee shop, as well as in the meeting rooms. Your support of the convention hotels also helps to keep the overall expenses to a minimum. Rooms and rates are subject to rate and room availability. Please be sure to book your reservation early!

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All reservations must be accompanied by a first night room deposit or guaranteed with a major credit card.

Registration

Preregister on-line at www.abct.org/2021-convention/.

To pay by check, complete the registration form available in PDF format on the ABCT website. Participants are encouraged to register by the **preregistration deadline of September 30**. Beginning October 1 all registrations will be processed at the on-site rates.

Please note: A PDF of the program book will be available and posted to the ABCT convention page. Please visit the online Cadmium itinerary planner to view and create your own personalized schedule.

► **To receive the member-discounted convention registration rate, members must renew for 2022 before completing the registration process or they must join as a new member of ABCT.**

The general registration fee entitles the registrant to attend all events on November 18–November 21 except for ticketed sessions. Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. Email confirmations will be sent within 1 week for faxed and mailed registrations. If you do not receive an email confirmation in the time specified, please call the ABCT central office, (212) 647-1890, or email Tonya Childers at tchilders@abct.org.

All presenters (except for the first two presenters of ticketed CE sessions) must pay the general registration fee. Leaders of ticketed session will receive information regarding their registration procedure from the ABCT Central Office.

Admission to all ticketed sessions is by ticket only. Preregistration is strongly advised as ticketed sessions are sold on a first-come, first-served basis.

Please note: **NO PURCHASE ORDERS ACCEPTED.**

All fees must be paid in U.S. currency on a U.S. bank. Any bank fees charged to the Association will be passed along to the attendee. Please make checks payable to ABCT.

To get member rates at this conference, your ABCT dues must be paid through October 31, 2022.

The ABCT membership year is November 1, 2021–October 31, 2022. To renew, go to abct.org.

You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method please **DO NOT** send a follow-up hard copy. This will cause double payment. For preregistration rates, please register **BEFORE** the deadline date of September 30.

All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, 16th Floor, New York, NY, 10001. For preregistration rates, forms must be postmarked by the deadline date of Thursday, September 30. Forms postmarked beginning Friday, October 1 will be processed at on-site rates. There will be no exceptions. Refund Policy Cancellation refund requests must be in writing. Refunds will be made until the October 15 deadline, and a \$50 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 15.

SHARE Strategies: Using Acronyms to Disseminate the Science of Clinical Child Psychology

Stephen Hupp, *Southern Illinois University Edwardsville*

DURING EVERY YEAR of graduate school, I attended AABT, now known as ABCT (a much better acronym), and one symposium about parent-child interaction therapy (PCIT) stuck with me over the years. The PCIT folks were using an acronym to teach parents about child-directed interactions. Specifically, *Describe, Reflect, Imitate*, and *Praise* could be remembered with the acronym DRIP. Unfortunately, DRIP was a downer in terms of being an acronym. Luckily, they figured out how to morph DRIP into PRIDE by rearranging the letters and adding a little bit of Enthusiasm.

In addition to PCIT (McNeil & Hembree-Kigin, 2011), examples of other evidence-based parenting programs include the Helping the Noncompliant Child program (McMahon & Forehand, 2005), the Positive Parenting Program (Sanders & Mazzucchelli, 2018), and the Incredible Years program (Webster-Stratton, 2006). All of these programs focus on increasing both positive attention and effective parental control strategies. In recent years, Bruce Chorpita and colleagues have been advocating for the identification of common elements between these evidence-based treatment packages through the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC; Chorpita & Weisz, 2009).

One advantage of the common elements approach is that, when compared to name brand treatment packages, it provides greater flexibility for clinicians to tailor treatments to family needs. Chorpita (2018) further describes ways that the common elements approach addresses the limitations of name brand treatment packages. For example, the common elements approach cuts across the research silos that have developed for each of the packages. Overall, the uptake of evidence-based practices in the community has been slow, and the common elements approach has the potential to increase the dissemination of the science of clinical child psychology.

In the consulting work my team provides in the East St. Louis Head Start program, we use the common elements of multiple variations of parent behavior therapy as well as other evidence-based treatments for children. We also teach these same elements to teachers and the college students who help out in the classrooms (e.g., graduate assistants, practicum students, field study students). We use these elements across all three tiers of universal prevention, targeted supports, and intervention.

In our setting, we use acronyms to teach the common elements and other strategies. For example, to teach the common element of positive attention we started using the FAN acronym (i.e., Follow, Appreciate, Narrate). Parents, teachers, and college students all learned the information quickly, sometimes asking for more tricks to help them remember other concepts. In fact, Stalder (2005) provides some evidence that acronyms helped students in introductory psychology courses learn material better, partly because the acronyms reportedly increased the students' motivation for studying.

With the goal of helping everyone in our setting remember the additional strate-

gies, over the past 20 years as a professor and Mental Health Consultant, I have developed several more acronyms, mostly derived from the common elements used in clinical child psychology. To be clear, our team did not develop the actual strategies; however, the acronyms are unique to the work we have been doing in the Clinical Child and School Psychology Master's program at Southern Illinois University Edwardsville. We call these concepts the Social Health & Academic Readiness Enrichment Strategies (i.e., SHARE Strategies). These strategies are all described below.

Social-Emotional Basics

The social-emotional basics comprise the first set of strategies. First, we FAN Interactions by increasing positive attention (e.g., similar to PCIT's child-directed interactions). Then, we SING Altruism by setting the stage for prosocial behaviors (e.g., empathy). Last, we HEART Emotions to promote emotional competence (e.g., reflecting emotions).

Academic Development

The next set of strategies focuses on core aspects of early academic development. First, we DRESS Language to help build language skills (e.g., expanding on children's words). Then, we TAP Literacy to promote reading acquisition (e.g., print referencing). Last, we CAN Math by interacting in ways that promote learning about numbers (e.g., math talk).

Emotion Coaching

The next set of strategies, focused on emotion coaching, expands on the earlier

FAN Interactions

- Follow Follow the child's lead by doing **similar activities**.
- Appreciate Appreciate aspects of the child with **positive attention** such as praise.
- Narrate Narrate the child's actions like a **play-by-play**.

SING Altruism

- Struggle Struggle with a task, and **see if the child will help** independently.
- Inquire Inquire for help by **directly asking** if the child doesn't help independently.
- Notice Notice times when the child helps by saying **thank you** or using praise.
- Give Give help overtly to the child and point out that **you like helping**.

HEART Emotions

- Hear Hear emotions within the **child's words**.
- Express Express your own **milder emotions** from time to time.
- Accept Accept that it's okay for the child to have **strong emotions**.
- Reflect Reflect the **specific emotions** that you hear a child expressing.
- Teach Teach emotion **coping skills**.

DRESS Language

- Describe** Describe appropriate **behaviors** of the child.
- Recommend** Recommend **communication ideas** for expressing wants.
- Expand** Expand on what the child says.
- Self-talk** Self-talk about situations as a way to **model language** (and emotion expression)
- Sing** Sing songs as part of the child's **routine**.

TAP Literacy

- Track** Track words with your finger while **reading together**.
- Ask** Ask **questions** about the letters, words, and other aspects of the book.
- Point** Point out **aspects** of the letters, words, and other aspects of the book.

CAN Math

- Count** Count objects and people during **play** and other interactions.
- Add** Add **numbers together** during activities.
- Number** Number items (and identify numbers) during **shared reading** and other times.

VIBE Serenity

- Vent** Vent your feelings and encourage children to **express their feelings** too.
- Imagine** Imagine peaceful scenes together using **visual imagery**.
- Breath** Breathe **together slowly and deeply** when feeling anxious or frustrated.
- Exercise** Exercise together and engage in other **physical activities**.

READ Thoughts

- Recognize** Recognize extreme **negative thoughts** together.
- Evaluate** Evaluate the **accuracy** of extreme negative thoughts together.
- Activate** Activate **behaviors** that diminish extreme negative thoughts.
- Dispute** Dispute extreme negative thoughts together with **rational thoughts**.

PURE Activation

- Plan** Plan ahead together fun things to do **later** in the day or on a later day.
- Unite** Unite the child with a bigger group of others to **promote belonging**.
- Recall** Recall together **fun events** from each of your pasts.
- Enjoy** Enjoy **daily activities** in new ways.

SPIN Engagement

- Suggest** Suggest ideas for how the child can **participate** in group activities.
- Prepare** Prepare the child for **events** that are about to happen.
- Identify** Identify specific **opportunities** for participation.
- Nudge** Nudge participation with **encouragement** and praise.

STAR Skills

- Show** Show the child a new skill by **modeling** the behavior.
- Tell** Tell the child specifically how to do the new skill by giving **instructions**.
- Attempt** Attempt the new skill together during multiple **practice** scenarios.
- Review** Review each practice attempt with specific **feedback, praise, and rewards**.

CAST Resolution

- Calm** Calm everyone by describing their feelings and giving some **time** to cool down.
- Allow** Allow each child the opportunity to **describe their view** of the problem.
- Solve** Solve the conflict together by having everyone come up with a **possible solution**.
- Try** Try a solution together and then **evaluate** together how well it works.

strategies that are aimed at improving emotional competence. First, we VIBE Serenity by teaching relaxation skills (e.g., deep breathing). Then, we READ Thoughts by using cognitive restructuring for extreme thoughts (e.g., recognizing distortions). Last, we use PURE Activation to proactively promote joy (e.g., behavioral activation).

Increasing Skills

The next set of strategies focuses on increasing skills that can help replace challenging behaviors. First, we SPIN Engagement by prompting ways to participate (e.g., suggesting ideas). Then, we STAR Skills by using a better acronym than the one created by the concepts of Modeling, Instructions, Rehearsal, and Feedback (e.g., behavioral skills training). Last, we CAST Resolution by teaching ways to deal with disagreements (e.g., conflict resolution).

Decreasing Behaviors

The last set of strategies focuses on decreasing challenging behaviors. First, we MAP Challenges by helping caregivers consider the factors that strengthen challenging behaviors (e.g., motivating operations). Next, we CARD Prevention by setting up an environment that minimizes the likelihood that challenging behaviors will occur (e.g., antecedent interventions). Last, we HELP Behavior by setting up consequences to weaken challenging behaviors (e.g., operant conditioning).

Conclusion

Most of the strategies described above have considerable empirical support when used as part of a treatment package (McMahon & Forehand, 2005; McNeil & Hembree-Kigin, 2011; Sanders & Mazzuchelli, 2018; Webster-Stratton, 2006). Evidence continues to emerge regarding each of the individual strategies as used as part of a common elements approach (Chorpita & Weisz, 2009; Hupp et al., 2018). These programs and strategies, along with other evidence-based programs for children, are also described in more detail in a 10-volume reference work called *The Encyclopedia of Child and Adolescent Development* (Hupp & Jewell, 2020), the book *Child and Adolescent Psychotherapy: Component of Evidence-Based Treatments* (Hupp, 2018), and my dissertation in which we developed the Parent Instruction-Giving Game with Youngsters (Hupp et al., 2008), also known

as the PIGGY (the briefer version is called the “Little PIGGY”).

The acronyms for the SHARE Strategies were developed to help parents, teachers, and college students learn the common elements of evidence-based treatments for children. Whether or not these specific acronyms really help everyone learn the strategies is an empirical question that still needs to be examined. In our program, we have frequently used one-page handouts for each acronym. These handouts are shared during center-wide parent meetings, individual parent-child sessions, teacher trainings, and during instruction for the college students (i.e., field study students, practicum students, graduate assistants). Whenever possible, behavioral skills training (i.e., Show, Tell, Attempt, Review) was also used to help teach the information, and most recently we have added many of the handouts on the classroom walls as reminders. The corresponding handouts (which also include examples for each strategy) are available upon request (sthupp@siue.edu). We have also found it valuable to show parents a list of the strategies and let them pick the ones they would most like to learn. Anecdotally, parents, teachers, and students have all been positive about the acronyms and the strategies they describe.

The dissemination of the science of clinical child psychology has been slow, despite decades of research. Much progress has been made, but we must continue to push forward to find ways to increase the adoption of evidence-based practices. Recent developments in working with families remotely have made it possible for therapists to reach more people in new ways. For example, these days it is easier for families in rural areas, single parents, and working parents to overcome practical obstacles by receiving mental health support via the internet. At the same time, some skills may be harder to teach remotely, so we need every tool possible to facilitate learning, even a good acronym.

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MAP Challenges

- Motivation?** Consider the existing motivation that the challenging behavior is **likely filling**.
- Antecedent?** Consider the existing antecedents that **prompt** the challenging behavior.
- Payoff?** Consider the existing payoffs the child **receives** from the challenging behavior.

CARD Prevention

- Coach** Coach behavioral skills to help **prevent** challenging behaviors.
- Arrange** Arrange the **environment** so that is favorable to rule-following.
- Remove** Remove **antecedents** for challenging behaviors.
- Distract** Distract challenging behaviors by providing a sudden new **interruption**.

HELP Behavior

- Halt** Halt **access to payoffs** for challenging behaviors.
- Exaggerate** Exaggerate **natural consequences** for challenging behaviors.
- Logical** Logical **consequences** can be added that directly relate to challenging behaviors.
- Propose** Propose more appropriate ways to get **similar payoffs**.

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Erasing Distance: Interstate Graduate-Student-Led Undergraduate Mentorship During COVID-19

Alexandra D. W. Sullivan, *University of Vermont*

Kat L. Wright, *University of Kentucky*

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MENTORSHIP IS INSTRUMENTAL in training rising psychology researchers. Donahue and colleagues (2021) recently published an excellent article in *the Behavior Therapist* on mentoring undergraduate students. Among the important topics covered were remote mentorship and graduate students serving as mentors, particularly during COVID-19. Technology provides the foundation for a novel training relationship—matching willing mentors with eager mentees regardless of location. Recent scholarship defines mentorship as “an endeavor of villages” (Gruber et al., 2020, p. 78), emphasizing the growing reliance on networks, in which multiple professionals advise trainees. Here, we illustrate a contemporary twist on traditional one-on-one mentorship arising in response to the social distancing demands of COVID-19: a collaboration between a fifth-year clinical psychology Ph.D. student (the first author) and undergraduate student (the second author) situated at universities in states 900 miles apart. A faculty member (the third author), who was acquainted with the other two authors, both facilitated and supervised this collaboration. We provide a template through which advanced undergraduate students can connect with external researchers, in our case a graduate student, to access structured, attentive mentorship regardless of geographic and economic constraints. Finally, this example depicts a path through which graduate students can receive training in mentorship, a cornerstone of psychological research.

Using both synchronous and asynchronous tools, the mentor and mentee collaborated on a specific goal: developing a manuscript (Chaney, 2014). Participating in all aspects of manuscript development (i.e., from conceptualization through responding to editorial reviews) supports the development of critical research skills

(e.g., Forehand, 1993). In our case, the mentor leveraged an existing dataset, evaluating a parenting intervention for young children from low-income families, and assigned readings supporting the development and evaluation of research questions that these data could answer. The mentor emphasized skill development in identifying, reviewing, and summarizing manuscripts; scientific writing; and data analyses (Gruber et al., 2020). Screenshare features scaffolded learning; for example, the mentee observed data analyses, followed by the mentor providing audio support while the mentee attempted tasks independently. This iterative and transactional process resulted in pragmatic, project-based research method training above and beyond that provided in a traditional college course.

In addition to the importance of project-based learning, intentionality is another key characteristic of the mentor-mentee relationship (e.g., Johnson, 2007). Perhaps more so than traditional mentor-mentee relationships, long-distance relationships require intentional face-to-face time and benefit from increased structure (e.g., Forehand, 2008), as they lack the spontaneous interactions in-person work affords (Pfund et al., 2021). Accordingly, the mentor and mentee teleconferenced weekly. The mentor collaboratively set clear goals and deadlines on intermediate steps to enhance structure, given the remote format (Pfund et al.). As providing psychosocial support is a primary responsibility of mentors (e.g., Gruber et al., 2020; Johnson, 2007), particularly during times of stress (Pfund et al.), the mentor and mentee developed rapport during these meetings, an essential foundation preceding the provision of support in difficult contexts. These meetings provided casual opportunities for the mentee to gain insight into potential career trajectories

(e.g., the day-to-day of a Ph.D. student), a critical developmental task of undergraduate education (Gruber et al., 2020).

The graduate-student mentor used a developmentally informed approach (Forehand, 2008), tailoring her guidance to align with the undergraduate mentee's educational background and current competency, to provide structured training in how to write a manuscript, using selected readings (e.g., Bem, 2004), examples, and written feedback. They openly discussed authorship, with both the graduate and undergraduate student serving as lead authors on the final product (Sullivan et al., in press). The graduate student drafted the body of the paper; the undergraduate student read and provided feedback on each section, assembled and formatted references, and wrote the Abstract. Mentee feedback supported this approach, indicating that first learning about the construction of a manuscript and then applying that knowledge to the development and evaluation of a research question supported her learning. Not only did the mentee experience the repeated revision of a manuscript required to bring it to its final form, but also observed the submission of the article and subsequent response to editorial comments. The paper is in press at a peer-reviewed outlet. Subsequently, the mentee continued to evidence increasing autonomy in crafting and presenting a poster presentation from the project at the National Conference for Undergraduate Research (Wright et al., 2021).

The supervising faculty member, with extensive experience in mentorship, supported the graduate-undergraduate mentorship pair. Indeed, evidence suggests this triadic structure, in which undergraduates interact primarily with graduate and secondarily with faculty mentors, is particularly beneficial in supporting undergraduate scientific learning (Aikens et al., 2016). The supervising faculty member commented on drafts and attended the mentor and mentee's weekly research meetings, providing ample opportunity for the undergraduate to both ask questions and observe the graduate student's critical thinking and problem-solving. Separately, the mentor teleconferenced weekly with the faculty supervisor, receiving supervision on how best to support the undergraduate and direct the research experience. This meta-supervision supported the graduate student's training goals and professional development, allowing her to gain competency in clinical science research mentorship. Aligning with research sug-

gesting the impact of formalized training in mentorship (Pfund et al., 2014), integrating an experienced faculty member into a graduate-undergraduate mentorship dyad promoted learning among all parties.

This experience sparked continued engagement in research. Currently, the mentee is continuing her research training at her home university, developing critical research skills including data collection and participating in team-based lab experiences with other undergraduates. These experiences, as well as the manuscript preparation and dissemination skills developed in her long-distance research experience, are all critical aspects of preparing a student for a potential research career.

Technology can circumnavigate many COVID-19-instigated barriers, allowing cost-efficient long-distance learning relationships to develop. Further, it supports flexible, multiple mentorship models, enhancing not only the undergraduate's research training but also the graduate student's professional competencies (Gruber et al., 2020). Going forward, such relationships may be particularly beneficial for research-ambitious low-income, underrepresented, and/or remotely situated undergraduates, a topic Donahue and colleagues (2021) expand on in their description of University at Albany's Psychology Undergraduate Mentorship Program. Skilled research mentorship is the foundation upon which junior scholars are built. To continue training high-quality scientists, it is paramount for faculty members to mentor a graduate student so that they, in turn, can mentor an undergraduate. By leveraging existing data (an increasingly frequent phenomenon in psychology) and a skilled graduate student who is dedicated to mentoring, learning opportunities can

occur for undergraduates—even when separated by 900 miles from their mentor.

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Interview Series: Clinical Psychology Careers “Off the Beaten Path”

Samantha Moshier, *Emmanuel College*

DOCTORAL TRAINING in clinical psychology provides trainees with a broad skill set encompassing rigorous analytical and quantitative skills, expertise in psychological assessment and intervention, and skills related to communication, problem-solving, and leadership. Surveys show that the average psychologist is engaged in a diverse set of activities on the job and reports generally high levels of satisfaction with their work (Norcross & Karpiak, 2012).

Although early career psychologists are equipped to work in a wide range of roles and settings, many are exposed to a limited set of professional models during their training. Doctoral students do not need to look far to find examples of the tenure track academic career path; often, their closest advisors and mentors are principal investigators whose primary roles involve running a research lab and mentoring students. As students complete practica and predoctoral internships, they become familiar with career paths that focus on delivery of clinical services. But what about careers outside of the tenure track or clinic? Increased awareness of these options may help students find the paths that best fit their skills, values, and interests.

The next three issues of *the Behavior Therapist* will feature interviews with six psychologists whose career trajectories represent a departure from the dichotomy of tenure-track academia and full-time clinician. Their roles span the research consulting, pharmaceutical, technology start-up, and public sectors, and illustrate the diverse ways that training in clinical psychology can be utilized. It is our hope that this series will provide ABCT student members with a broader picture of the possibilities that their training provides.

Thank you to the psychologists who generously gave their time to share their advice and experience. Interviews with Drs. Sarah Kleiman and Michelle Davis appear below. Interviews with Drs. Cassidy Gutner, Lisa Benson, Ellen Healy, and Andrea Niles will appear in the forthcoming October and December issues of *the Behavior Therapist*.

■ Sarah Kleiman, Ph.D.

Kleiman Consulting and Psychological Services, PC

What type of degree do you have and where did you receive it from?

I graduated from George Mason University's Clinical Psychology Ph.D. program in 2014.

What is your current position?

I am self-employed full-time through the professional corporation I founded: Kleiman Consulting and Psychological Services, PC. As a research consultant, I have contracts with nonprofit organizations, university-affiliated research groups, VA hospital research groups, pharmaceutical companies, and other organizations who conduct research studies on Posttraumatic Stress Disorder (PTSD). My primary role on these contracts is providing clinical supervision, training, and oversight of diagnostic assessors who assess participants on the studies. I also occasionally provide forensic PTSD assessments through contracts with law firms. In addition, I am employed part-time as an adjunct instructor through Harvard University's Division of Continuing Education.

Describe your job. What does a typical day or week look like for you?

On a typical week, my consulting work involves providing diagnostic assessment supervision to psychologists, psychiatrists, social workers, psychiatric nurses, and other professionals across 4 to 6 different studies. This involves reviewing recordings of their assessments and providing written feedback, providing remediation or ongoing supervision through weekly phone calls or Zoom meetings, presenting didactic sessions on specific diagnostic instruments or clinical interviewing skills to groups of new diagnostic assessors, and creating and delivering ongoing training activities to maintain and deepen assessors' skills. I am also in frequent contact with study sponsors and Principal Investigators to answer

their methodological design questions, provide consultation for managing participant risk, discuss enrollment considerations for complicated participant presentations, and communicate the skill level of diagnostic assessors working on their studies and my recommendations for hiring and continuing contracts with assessors. Each day is a combination of phone and video meetings, as well as video or audio reviews of assessments, and preparation for upcoming presentations or training activities. Since the vast majority of my work in this capacity has always been remote, COVID-19 did not cause any major disruptions to this workflow. I continue to primarily work from home.

Once per year I also teach an undergraduate and graduate course on PTSD, which meets weekly. During the semesters I teach, I am preparing for lectures, presenting lectures, answering students' questions, meeting with students for professional development and mentoring, and grading assignments.

What attracted you to your current position?

I have always had a passion for assessment and clinical supervision, and also enjoyed working within research settings with research-oriented clinical psychologists. Therefore, focusing on clinical supervision in the context of research studies is a perfect combination of my areas of interest. While I love working on teams and the camaraderie and support that comes from having coworkers, I have an independent spirit, enjoy having a flexible schedule, and value being able to have autonomy and control over my work life; therefore, being self-employed is a good fit for my preferences and personality.

What prior experiences or positions made this career path possible for you?

Throughout my graduate training, internship, and postdoctoral fellowship, I specialized in diagnostic assessment. During my postdoctoral fellowship, I was able to deepen my content area expertise in PTSD assessment specifically. I developed a few small-scale contracts as a research consultant in graduate school, but pursued this much more intentionally during my postdoctoral fellowship. I expressed my interest in consulting to my mentors during postdoc and they were integral to expanding my work in this area. They repeatedly sent opportunities my way that allowed me to build a wide-ranging portfolio of research consultant experiences

focused on PTSD assessment. These part-time contracts increased in number and scope the course of over several years, through word of mouth and continued referrals from mentors and other colleagues, until it reached a full-time workload about 2.5 years ago.

What skills from your graduate training do you use most often?

Diagnostic assessment, clinical interviewing, clinical supervision, and research design.

What do you enjoy about your work?

I love ensuring that the assessment data collected within a PTSD study is of the highest quality, knowing that this gives the study the best chance for success. I find it very rewarding to guide diagnostic assessors to achieve a high level of validity and reliability on a study, knowing that the noise within the data is being minimized and the chance for finding significant results is being maximized. When studies I work on result in the successful development of new treatments for PTSD, for example, my efforts to ensure the outcome data is scientifically sound feel particularly meaningful. I also love seeing improvement in the skills of diagnostic assessors I supervise and find it very rewarding to listen to a high-quality assessment knowing that I had a hand in shaping the skills and diagnostic knowledge needed to conduct it well.

What do you find most challenging about your work?

One of the biggest challenges of being self-employed and working across so many different contracts is work-life balance and avoiding overcommitting myself. It's often difficult to predict the exact timelines of when my effort will be needed on each contract, which further complicates the challenging of committing to the appropriate number of studies. Another challenge has been negotiating contracts, since this was not a skill set I received formal training on and have had to learn over time, primarily through trial and error.

As a graduate student, what was your intended career path?

I knew that I wanted a career that primarily involved clinically oriented work, but as my passion for teaching and research grew, I had hoped I would be able to have a career that involved a variety of my skills. While I didn't predict I would be able to do so in a self-employed way, I'm so thankful that this has turned out to be the case!

What advice would you give to a graduate student who is interested in pursuing a similar line of work?

My advice is that while it's important to develop some content area of expertise, it's also reasonable to pursue a career that involves a variety of professional roles and activities. Although many psychologist careers involve solely clinical positions, research positions, or teaching positions, it is possible to enjoy a combination. You don't have to just pick one!

■ Michelle Davis, Ph.D.

Big Health

What type of degree do you have and where did you receive it from?

I have a Ph.D. in clinical psychology from the University of Texas at Austin.

What is your current position?

Clinical Innovation Lead for Anxiety at Big Health.

Describe your job. What does a typical day or week look like for you?

I work at a company that creates digital (i.e., fully automated) cognitive and behavioral interventions for common mental health problems, like insomnia and anxiety. I lead the clinical activities related to our anxiety program, called Daylight. The primary aspect of my role involves working closely with the product team to design, test, and make improvements to Daylight. In a typical day, I might participate in a brainstorming session to develop a concept for a new piece of content for Daylight (e.g., an animated video or interactive technique), review marketing materials to ensure they are clinically appropriate and relevant, participate in user experience (UX) testing to get feedback and input from users, and plan upcoming research experiments.

What attracted you to your current position?

My background is in the research and treatment of anxiety disorders. It's always upset me that evidence-based treatments for anxiety disorders can be so highly effective, yet few people have access (or even know about them). I wanted a career where I could help make information about anxiety disorders and their treatment more widely accessible. While I was on internship, I kept seeing misinformation about

anxiety disorders on social media. It was frustrating, knowing how people spend so much time and energy trying different things for anxiety that just don't work. I started my own Instagram account (@know.fear) intended to provide information and dispel myths about anxiety. At one point, I even started trying to create my own online anxiety treatment program, but soon realized that I lacked the engineering, design, and marketing skills required for it to make a big impact. I was passionate about technology as a means to increase mental health knowledge and treatment access, but never thought to seek out a role in an industry setting. All of the psychologists I knew did research, clinical work, or some combination of the two. Luckily, my former graduate school mentor, who knew that this was an interest of mine, learned from one of his colleagues that Big Health was looking for a psychologist to help design digital interventions for anxiety. He put me in contact with them and I quickly got excited about the opportunity to create effective, scalable anxiety interventions.

What skills from your graduate training do you use most often?

I use my clinical knowledge and experience with providing treatment for anxiety disorders most often. For example, when helping with the development of marketing materials, I'll try to think about the daily experience of someone with an anxiety disorder and what messaging might speak to them. If I'm thinking about how to describe a behavioral technique in Daylight, I can draw from rationales that have resonated with others in the past, or examples from previous clients. I try to take what I know works in face-to-face therapy and apply that to a digital format. Most often this is not just knowledge about the specific techniques to use, but rather how to apply them in a way that is engaging and rewarding (in other words, how to get people to try out new behaviors that may be difficult for them, and stick with them long enough to see a benefit).

What do you enjoy about your work?

I love working with a cross-functional team with a diverse set of skills and expertise. I work closely with engineers, UX designers, animators, illustrators—all of whom have different ideas and unique approaches to solving tricky problems. This makes the day-to-day at work really fun and exciting. It's also really rewarding to see parts of our programs come to life. I get to be involved all the way from the ini-

tial concept design of a product to its release and testing in the real world.

What do you find most challenging about your work?

One of the aspects that is most challenging (but also most fun!) is to try to take what we know works in face-to-face therapy and translate it into a digital format that is both engaging and effective. Both in-person and digital therapy face a huge barrier that is often overlooked—if someone does not feel that treatment is going to work for them (e.g., if they don't relate to the examples given in the rationale, if they don't believe the therapist or treatment is credible, or if they don't "buy-in" to information about the treatment's efficacy), they are not going to prioritize adherence. Directly translating a treatment manual into an app format just doesn't work because it isn't engaging. We're able to use technology to develop innovative ways to foster engagement, which requires out-of-the-box thinking and creativity.

As a graduate student, what was your intended career path?

I initially wanted to conduct research in an academic setting, then (after enjoying my clinical experiences as a graduate student) I thought I would eventually end up in a role where I could split my time 50-50 between research and clinical work. I never imagined ending up in the setting I'm in currently because I wasn't aware of other psychologists doing similar things.

What advice would you give to a graduate student who is interested in pursuing a similar line of work?

Reach out to clinical psychologists who are working in industry settings. You can find them on LinkedIn (look for titles like "Clinical Lead," "Research Lead," "Clinical Researcher," "Director of Medical Affairs," or "User Research") or by searching online for technology companies focusing on mental health. Ask them questions about their work to try to get a sense of their day-to-day and whether it would be of interest

to you. Some companies may have contract work available (i.e., conducting user assessments via phone, content writing for blogs and social media, etc.), which could be a good way to get a foot in the door. This area is relatively new, but rapidly growing, so there are a lot of opportunities to get involved.

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STUDENT FORUM

Exploring Mental Health Career Pathways: Mental Health Counseling and Social Work

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PER OUR MISSION statement, ABCT is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles. ABCT serves professionals, students, mental health care consumers, and the general public. But at its core, ABCT is a membership organization. Accordingly, ABCT strives to support its professional and trainee members across several disciplines, including counseling, psychiatry, psychiatric nursing, psychology, public health, and social work. ABCT does not currently have data on the distribution of its membership across professional degrees or settings, though the new membership database implemented with the updated website launch will provide this critical

information to the organization moving forward.

As 2018–2021 Chair of the ABCT Student Membership Committee, I have worked carefully with my committee members to ensure that our efforts benefit all ABCT students and trainees. Upon initial review of our professional development resources, we noticed that most of our committee's offerings focused on getting into and succeeding in clinical psychology Ph.D. programs. Consequently, we have worked hard in recent years to develop and promote content relevant to other degrees (e.g., Psy.D., M.A.) and disciplines (e.g., counseling, social work). As part of those efforts, we have generated digital content for current and prospective students across multiple disciplines/degree programs, and we will continue to upload new resources online as they are finalized (monitor <https://www.abct.org/for-students/>).

As part of our committee's efforts to engage and showcase ABCT members outside of clinical psychology, I had the pleasure of speaking individually with Velizar Nikiforov, M.A., L.C.P.C., and Gwilym Roddick, D.S.W., L.C.S.W. Both Velizar and Gwilym generously donated their time to discuss why (and how) they entered the fields of counseling and social work, respectively; the degree to which they perceived their disciplines were represented by ABCT, both at the Annual Convention and during the other 361 days of the year; and how they recommended the ABCT Student Membership Committee educate and empower prospective mental health professionals to pursue advanced training in disciplines other than clinical psychology. Those productive conversations led to a recorded professional development interview (<https://youtu.be/-BaYMshEzVo>) and the two articles that follow in this issue of *the Behavior Therapist*.

In this issue, I encourage you to read (and share with undergraduate students and postbaccalaureate staff!) these articles on careers and training in mental health counseling and social work. First, Velizar Nikiforov provides a practical orientation to counseling, generally, and mental health counseling, specifically. He describes degree training and licensure requirements, differentiates mental health counseling from other psychotherapy profes-

sions, and shares his personal experiences becoming a licensed mental health counselor. Second, Kathy Benhamou, M.A., Marilyn L. Piccirillo, Ph.D., and Rafi Jakubovic, B.S., provide a summary of ABCT's recorded professional development interview with Gwilym Roddick. It is *the Behavior Therapist's* and the ABCT Student Membership Committee's hopes that these articles will generate excitement and future conversations about how students can pursue a wide range of mental health career pathways—and how ABCT will always be here to support them.

I am deeply thankful to Velizar Nikiforov, Gwilym Roddick, Dan Beck (who also donated an hour of his time to talk with me about social work degrees), Kathy Benhamou, Marilyn Piccirillo, Rafi Jakubovic, the ABCT Student Membership Committee, Mary Jane Eimer, and Dakota McPherson for their contributions to helping ABCT broaden its reach to all of its members. It has been an honor to serve ABCT in this capacity and I look forward to seeing the Student Membership Committee continue these efforts in the upcoming years.

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STUDENT FORUM

Professional Careers and Training in Counseling: An Orientation for Prospective Mental Health Counselors

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INDIVIDUALS INTERESTED in the practice of psychotherapy can pursue several different career paths. Although ABCT has generated a wide array of resources related to entering and succeeding in the field of clinical psychology, fewer resources exist for other mental-health-related disciplines. In this article (and in collaboration with the ABCT Student Membership Committee), I provide an introduction to the field of counseling, focusing primarily on the educational/training requirements and common postgraduate career paths. As many community providers (e.g., in social work, marriage and family therapy, and counseling) practice with a terminal master's degree, this article is meant to complement ABCT's existing doctoral training resources in the hopes it can be of use to budding mental health trainees and practitioners interested in a counseling career.

What is counseling? What are the different types of counseling?

According to a definition developed by a consortium of counseling organizations led by the American Counseling Association, "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan et al., 2014). Within that broader definition, counseling encompasses numerous job roles performed in a variety of settings. In addition to mental health counseling, counseling organizations accredit programs that train graduate students for professions including career counseling, clinical rehabilitation counseling, and school counseling, among others. In each of these, the counseling relationship is focused on a different set of client goals and concerns. For example, school counselors specialize in providing educational support in K-12 schools, while career counselors focus on helping clients of all ages determine and accomplish their vocational goals and may provide this service in settings like career resource centers, col-

leges and universities, or community non-profit organizations.

Among the counseling specialties, mental health counseling is the pathway toward a career in delivering psychotherapy. Accordingly, I focus on the specialty field of mental health counseling in the present article.

What is a mental health counselor?

What are the requirements to become one?

Mental health counselors are primary mental health care providers who work with individuals, couples, families, and groups to diagnose and treat psychological disorders and enhance client strengths and wellness (American Mental Health Counselors Association, n.d.). Counselors work in any setting that provides mental health care and support. This may include hospitals, specialized settings such as IOP/PHP programs, community mental health centers, employee assistance programs, K-12 schools, colleges or universities, group or individual private practices, and others. Depending on setting or role, counselors provide a full range of mental health services, including assessment and diagnosis, psychotherapy, treatment planning and utilization review, crisis management, and development of psychoeducational and prevention programs (American Mental Health Counselors Association, n.d.).

Obtaining a state license is a prerequisite to working as a mental health counselor. "Mental health counselor" is a professional title that is licensed by all 50 states. There is no national licensure, so exact licensure titles vary by state and include licensed professional counselor (LPC), licensed clinical professional counselor (LCPC), licensed clinical mental health counselor (LCMHC), and others. While titles vary, the requirements for becoming a counselor are similar across states and include earning a master's degree in counseling or mental health counseling, completing a state-defined number of supervised postgraduate clinical hours

(frequently 2,000 to 4,000 hours), and passing the National Counselor Examination (NCE), the National Clinical Mental Health Counseling Examination (NCMHCE), or both, depending on their state. Once fully licensed, counselors must satisfy continuing education and other periodic renewal requirements (e.g., fees, record of ethical practice) to maintain an active license.

What are the differences between mental health counseling and other psychotherapy career pathways? What are the distinguishing values of the counseling field?

Given the diversity of specializations within mental health counseling and the variety of contexts in which counselors work, it can be difficult to define characteristics that universally apply to all counselors. However, there are certain values that the profession holds and inculcates in new counselors through training and education. Among these are an emphasis on client strengths and enhancing wellness. Similar to a positive psychology perspective, counselors look to promote their clients' health and well-being in a variety of life dimensions, rather than simply addressing disorders or problems in living.

Another value is an emphasis on counseling the "whole person"—viewing individuals in the systemic context of their social setting, as well as their spirituality, family, and occupation. Relatedly, counselors are committed to social justice, a commitment they bring to their work with clients by helping them identify and challenge environmental factors that limit their growth, and to challenge systemic oppression. The counseling profession also considers advocacy a key part of its work. This may include working within systems to facilitate changes that will promote client growth or advocating for public policy or other systemic changes towards greater equity.

The values of counseling are reflected in the educational emphases of its training programs. Reflecting the "whole person" perspective, core courses in master's programs in counseling include career counseling, multicultural counseling, and lifespan development courses, providing counselors with the foundational knowledge to help address different dimensions of their clients' identities.

What education and post-graduate training do mental health counselors receive?

A master's degree in counseling is considered a terminal degree for those intending to deliver clinical services. Most master's programs in counseling can be completed in 2 years of full-time study. During the course of study, students can expect to learn about developing and maintaining effective helping relationships, assessment and testing, the counseling profession and ethical counseling practice, human growth and development, career development, social and cultural diversity, and research and program evaluation. Different programs may have different courses that address these topic areas, but the focus is on giving students practical and applicable knowledge to be mental health care providers.

Students develop and practice their skills in the required practicum and internship components of their master's program. During these supervised training activities, counseling students gain hands-on experience with clinical work and its related activities (e.g., effective use of supervision, session and client documentation, managing schedules, and other professional skills). Practicum takes place during the first program year. Although the exact requirements (e.g., number of hours, eligible clinical settings) vary, many programs require 100 hours of counseling activities, 40 of which must be direct counseling work with clients. The practicum provides students with foundational counseling skills, which are extended during the internship, in the second year of the program. Frequently, students are placed at an internship site that provides them with experience related to their intended area of specialization. Students typically complete 600 hours of counseling activities during internship, 240 hours of which involve direct client work. This training may take place within a private practice, community mental health center, an intensive outpatient or partial hospitalization program (IOP/PHP), or other settings. Of note, some states have specific limiting requirements on what sites are acceptable for an internship placement.

After successful graduation from a counseling master's program, paths to licensure vary by state. For example, in my home state of Illinois, the process includes the following: first, future counselors must take an initial licensure exam. With successful passage, they are credentialed as a

"licensed professional counselor" (LPC) and allowed to practice under supervision. The supervised practice period lasts no less than 2 years, during which the new counselor is required to accrue 3,360 practice hours, including 1,920 hours of face-to-face client service. During this time, counselors further hone their clinical skills and may begin to develop clinical specializations or further develop their expertise in a particular therapeutic approach or modality. Once the required hours are accrued, the counselor is eligible to sit for the second licensure exam. If successfully passed, and if all other state requirements are met, the counselor receives a title of "licensed clinical professional counselor" (LCPC) and can practice independently in the state of Illinois. In other states, the specific licensure requirements and titles vary, but they generally include at least one examination and between 2,000 and 4,000 hours of post-graduate supervised clinical practice. Specific state requirements can be found at <https://www.counseling.org/knowledge-center/licensure-requirements/state-professional-counselor-licensure-boards>. Once licensed, mental health counselors may pursue specialized clinical interests through their work experiences, supervision and training, and self-study.

Can master's-level counselors pursue additional academic training in counseling?

While the master's degree is considered the terminal degree for mental health counselors and allows for independent practice, some counselors choose to further their education by pursuing a doctorate in counselor education and supervision. Doctoral-level counselors develop advanced expertise in supervision and apply these skills in their clinical settings. In addition, this advanced degree provides opportunities to teach or lead counseling graduate programs, conduct research and program evaluations, or take on leadership roles within professional organizations and the field of counseling at large.

What was your personal experience becoming a counselor?

My own path to counseling was somewhat circuitous. I studied psychology as an undergraduate but did not immediately continue on to postgraduate studies. After working in a variety of roles, including educational development and corporate communications, by my mid-30s, I was looking to return to work that better fit with my values, which involved working in

a helping profession. My primary interest was in conducting psychotherapy with adults, and I was lucky enough to live in Chicago, which has a number of institutions of higher learning offering various pathways into the profession. I considered doctoral studies but was not certain I could commit the time required to complete those programs. I attended several informational sessions on both social work and counseling programs. Ultimately, the program in counseling seemed to have a greater focus on clinical work, so this was the path I chose.

Based on my experience in my program, my personal career path is not uncommon. My fellow students ranged in age from their 20s through their 50s. The counseling field is welcoming of returning students and career changers; in fact, the program I attended had a special track for individuals without previous experience in psychology and counseling. During my program, I recognized I was most interested in treating people with anxiety and mood disorders. Additionally, the way in which CBT conceptualized these experiences resonated most with me. My counseling program allowed considerable latitude in pursuing specializations, and the faculty facilitated finding placements and supervision that allowed students to learn more about the approaches they were most interested in. Some of my peers opted for internships in our dialectical behavioral therapy (DBT) program; others, in the anxiety and obsessive-compulsive disorder specialty intensive treatment centers in our area. After graduation, I was hired into a postgraduate fellowship where I was trained and supervised by ABCT Fellow Dr. Paula Young. After completing the fellowship, I have continued to develop my CBT skills by pursuing further supervision and attending conferences and trainings, such as at ABCT. My clinical focus has been on working with anxiety, mood, and OCD and related disorders using empirically supported treatments.

What are the requirements for applying to a counseling graduate program?

What considerations should a prospective student take into account when choosing a program?

One of the values of the counseling profession is diversity, so many programs seek to lower barriers to qualified candidates' entry so as to make counseling careers available to students of various backgrounds and life stage. For many programs, this means that the GRE is not required. An undergraduate

degree is required, but an academic background in psychology is not. A more important prerequisite is some real-world counseling or advising experience, whether work experience in the field or volunteering experiences with a crisis line or similar organization. Along with a CV, a candidate's undergraduate record (i.e., transcript), letter of interest, and letters of recommendation are the most important requirements in an application.

When assessing program fit, there are several factors to take into consideration. First, prospective students should learn about the program's accreditation status. Some, but not all, counseling programs are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the organization responsible for developing educational standards for the profession. Licensure is easier in most states when the licensure candidate has graduated from a CACREP accredited program. Nonaccredited programs may also allow for licensure, but the process might be more time-consuming, as the licensing board will have to determine whether the applicant's program meets requirements for covered program content (students are usually advised to keep copies of their syllabi for this purpose).

Beyond accreditation, the format and setting of counseling programs can vary. In recent years, many counseling programs have begun offering online and part-time options. This can lower some barriers to entry into the field, allowing more nontraditional students the flexibility to pursue a degree while balancing other priorities. Many online programs are CACREP accredited, so the prospective student can decide which experience is more appealing without having to forego the advantages of graduating from a CACREP accredited program.

Finally, the prospective student should consider their own interests and goals: Would they prefer to work with children and adolescents or with adults? Do they want to specialize in any particular disorders or issues? Is there a theoretical orientation they are particularly drawn to—some programs have an overall theoretical orientation (e.g., psychodynamic or cognitive-behavioral) that informs their curriculum, while others might offer a variety of perspectives. If a student has a particular interest in these or other factors, it will be important for them to review information beforehand (e.g., on the program's website).

Conclusion

Counseling represents an important, diverse field dedicated to improving the wellness and empowerment of individuals, families, and other groups (Kaplan et al., 2014). Mental health counseling in particular focuses on the provision of mental health services to individuals through a social-justice-informed, "whole-person" lens. For individuals interested in the clinical work of psychotherapy, the mental health counseling field provides a well-defined but flexible path.

For more information about counseling programs, visit:

<https://www.cacrep.org/>
<https://thebestschools.org/rankings/best-online-masters-counseling/>
<https://www.humanservicesedu.org/most-affordable-masters-in-counseling-programs-by-state-2019-20/>

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Professional Careers and Training in Social Work: An ABCT Primer With Gwilym Roddick, D.S.W., L.C.S.W.

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ABCT MEMBER and licensed clinical social worker Gwilym Roddick, D.S.W., L.C.S.W., spoke with ABCT Student Membership Committee Chair, Shannon Blakey, Ph.D., to share his perspective on careers and professional training in social work. In this article, we summarize Dr. Roddick's interview, which can be viewed in full at <https://www.youtube.com/watch?v=-BaYMshEzVo>.

ABCT: *Could you share how and why you entered the field of social work generally, and clinical social work specifically?*

GR: I had a previous career in the arts and, after several years, I thought about shifting to something in the helping professions. I talked with some people who suggested I could get an M.S.W. (master in social work), become a therapist, and go back to school afterward to further education, if I wanted. Clinical social work was something I hadn't heard about. I always assumed most therapists were clinical psychologists or psychiatrists. I had some very helpful people who spoke with me about what being a social worker entailed, what graduate social work education entailed, and how they loved the field and how I might be a good fit for it. I wanted to pay that forward by participating in this ABCT interview.

Generally speaking, how does an M.S.W. program differ from other programs and related disciplines, such as clinical psychology or mental health counseling?

Social workers operate in a variety of different settings, including hospitals, community mental health settings, government-based programs, and schools, and are often involved in things like case management and program leadership. They

work with kids, adults, older adults, underserved populations, and those who are often marginalized. The focus in social work is on the person-and-environment perspective, as opposed to a diagnosis alone. I think that contextual emphasis represents a significant difference [from other disciplines]. The courses in a social work program center around human behavior and the social environment, policy, direct practice, and issues of power and privilege. When someone comes into your office, you're trying to look at a much broader picture of why they're coming in than simply their diagnostic symptoms.

For those interested in a clinical social work career, what sort of clinical training is involved during graduate school or postgraduate training?

In a 2-year social work program, you start an applied placement within the first 6 weeks, which might not necessarily be a clinical placement. Some examples of placements are doing case management, crisis intervention, or assessments at schools, community health centers, behavioral medicine units in a hospital, child and adolescent work in a variety of different hospital settings, a DBT (Dialectical Behavior Therapy) program—it varies. During a social work master's program, you will get an introduction to a lot of topics you might seek out additional education or experience in post-master's training, which is what I did. I had clinical supervisors who were experts in the field, and I also studied on my own. You also just learn by doing and having peer supervision. It's a different curriculum and level of psychiatric clinical training than what you might get [in a longer program, such as a doctoral program].

Are there any other program milestones that are common to social work programs?

Different programs have different Capstone or thesis projects. At Columbia (where I received my M.S.W.), we had a group Capstone project where we completed an interdisciplinary case study, and presented on how we would approach the case from micro-, mezzo-, and macro-perspectives, which was evaluated by the faculty. M.S.W.s don't have a dissertation; there's just not enough time, and a social work master's-level degree is commonly the terminal degree for the social work profession. You can go back to school, as I did, for a doctorate in social work (D.S.W.) or Ph.D., but you don't need to.

What does postgraduate supervised experience toward clinical licensure look like? Is there a period of continued supervised clinical work before you get licensed?

If you want to become a therapist who can work independently, you need to get your clinical license. When you finish your social work graduate degree, you first need to take your L.M.S.W. [Licensed Masters in Social Work] exam. Different states have different criteria [for licensure as a licensed clinical social worker]. In New York State, you have to complete the licensure process within 3 to 6 years [of graduation], which entails completing 2,000 client contact hours and 100 hours of registered supervision (among other requirements). Sometimes, it's hard to find a job postgraduate school that will give you that type of supervision and training that you're looking for [or that is required for state licensures]. In these cases, you can complete CBT training and supervision under other licensed providers, such as under a clinical social worker, psychologist, or psychiatrist.

You mentioned not all social work graduates pursue clinical careers. What are some typical social work career paths?

It varies. Some of the main positions social work graduates obtain are related to counseling and intervention, such as in schools, hospitals, or they work in administrative or director roles in settings like these or at nonprofits. Social workers commonly work with veterans, LGBTQ+ individuals, children in the foster care system, incarcerated individuals, and people in community health clinics. Social work careers in these settings can also include policy development, and even international social work

practice. For example, someone with an M.S.W. or D.S.W. could teach at a social work program and also conduct research about how poverty affects educational outcomes. Someone else could work in a school setting throughout their social work career, then transition to private practice. A peer of mine ran a home for new mothers recovering from substance use, for almost a decade. She then got her D.S.W., taught, and went into private practice. There are many social work career paths.

Are there any other major considerations you would recommend for people considering pursuing social work over other mental health-related disciplines?

It depends on the candidate's ultimate career goal. If your goal is to become a therapist, then you have different paths, hurdles, or milestones to get through to get that degree. Are you wanting to complete your training in a consecutive 5-year program? Do you prefer to complete a 2-year program and then subsequently obtain post-master's training and supervision? If you're interested in working with vulnerable, marginalized populations and taking a broader perspective into the treatment experience, factor that into your decision-making. Other important considerations are your stage of life, cost of the program/cost of living, limitations on your time influenced by family life and other personal responsibilities, and your educational background. I didn't have an academic background in psychology, remember, so it was easier for me to begin a social work program than to study for the GRE, apply to doctoral programs, and make the big commitment to relocate, which can be part of a psychology degree, especially with your internship. I wanted to relocate to New York, so I focused my applications

geographically and chose to enroll at Columbia.

What advice would you give to individuals applying or considering social work programs?

There are so many great social work programs across different states, and you don't have to necessarily move to another city to get into a good program. Most social work programs do not require the GRE. You also don't necessarily need a psychology or sociology background to be a competitive applicant. Tuition varies (state schools are typically more affordable than private schools). Most programs are looking for applicants who have some sort of being-of-service experience. They're also looking for people who have a personal interest in the field that they can talk about in a narrative way: Why do you want to do this? What interests you in this field?

If someone was to pursue a Doctorate in Social Work (D.S.W.), are there additional considerations on top of what are required for masters-level programs?

The Ph.D. and D.S.W. programs generally, though less so for Ph.D. programs, require you to be in the field for a few years. For the D.S.W., they want you to have a clinical license. Your time and experiences in the field can serve you as you complete your dissertation or qualitative research study. As a general guideline, the D.S.W. is a practice-focused doctorate, like a Psy.D. in clinical psychology, whereas the Ph.D. is more focused on becoming a professor in social work and conducting research.

Do you have any final recommendations, comments, or words of advice?

If you can find current social workers to learn about what they do in their position

and setting, that might be helpful in making an informed decision about whether to pursue social work. I would also like to acknowledge that I don't speak for the whole of social work profession. I am also a cis-gendered, White, heterosexual male and I can only speak to my experience. What I like about the field of social work is that you're constantly learning, and the field aligns with my personal values around being of service to others. I work in a private practice right now and I also do some pro-bono work. I wanted to be invested in certain communities that I know are not going to get access to evidence-based care. I have learned so much from my peers in the field who have opened my eyes to my own personal experiences in this country, and in this world. They have helped me grow and develop as a human being in a way that I couldn't have anticipated, and I am grateful.

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About Dr. Roddick: Dr. Gwilym Roddick received his M.S.W. from Columbia University and his D.S.W. from Rutgers University. He specializes in delivering CBT and Acceptance and Commitment Therapy for anxiety disorders and substance use disorders. In addition to his practice at The Ross Center in New York City, Dr. Roddick provides psychotherapy to United States military veterans through the nonprofit Headstrong Project and also trains and supervises junior psychologists and psychotherapists.

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The Use of Profanity in Cognitive Behavior Therapy

Frank M. Dattilio, *University of Pennsylvania School of Medicine*

THERE IS PROBABLY a special place in heaven for those who haven't used the "f word." I'll never see it! Although, I would certainly be in good company with many of my friends, relatives, and esteemed colleagues, including the late Albert Ellis. Ellis worked profanities into his presentations like many artists work in oils or pastels. I once invited Ellis to present a keynote address for a summer seminar that I conducted at Lehigh University in the early 90s. One of my graduate students had kept track of the number of times Ellis dropped the "f bomb," which equated to 26 during a 60-minute keynote. I also happened to notice that there was an elderly nun seated in the front row of the audience. I never did learn whether she was hearing impaired or just decided to ignore Ellis's flatulence of obscenities, but she never flinched once. In fact, much to my astonishment, she joined the audience in giving him a standing ovation at the end of his presentation.

While such verbiage may be acceptable in some modern-day presentations, in my experience it has usually fallen flat during the delivery of treatment. Or so I thought.

Odd Request in Therapy

This issue surfaced recently during one of my therapy sessions with a middle-aged woman I was treating for anxiety and problems with her four male children. I have always encouraged clients to feel free to express themselves in whatever manner they desire, short of punching the doctor. Many of the sessions that I conducted over the course of my 40-plus years in the field had their share of clients expressing their anger and resentment via obscenities. Often, they wanted to spew and get something off their chest, including being ticked off at me. In fact, many therapists regard it as "cathartic" to exercise that freedom of expression. But I was startled by this client who interrupted me one day with an odd request, "Can I ask you a personal question?"

"Sure," I replied.

She asked, "Why is it that I've never heard you curse?"

"What a question," I thought to myself. My mind instantly shot back to a day decades prior when our oldest daughter brought her college roommate home to spend the holiday vacation with us. This young woman happened to be a psychology major, of all things. Every year in our household, I was given the daunting task of fitting a grossly overgrown Christmas tree into a small, flimsy stand. This task was similar to forcing a heavy square peg into a round hole. During my struggle, I started spewing a barrage of obscenities, only later to be mortified when I learned that my daughter and her roommate had been within earshot. Quite an embarrassing moment it was for me, not to mention when I later heard her roommate ask her, "Does your father have Tourette's Syndrome?" So, as one who has never been a stranger to using choice words during a trying moment, it took me aback to be asked about cursing. However, it was true that I always avoided using foul language during the course of my treatment sessions, except on rare occasions when I was attempting to draw out anger from an inhibited client. For us clinicians, it is de rigueur to maintain an air of professionalism and pride with our demeanor and at the very least, use appropriate language. Not to do so may be considered a breach of decorum, usually frowned upon. So, when I inquired as to why she would ask such an unusual question, she replied, "I don't know. I just noticed that unlike many of my former therapists, you never seem to curse."

Review of the Literature

This got me thinking about whether foul language was actually common with other therapists, at least those this woman had consulted previously. I also wondered what the professional literature had to say about the art and science of using obscenities from both an ethical and therapeutic perspective. After conducting a quick literature search, I discovered that, surprisingly, there have been a number of empirical studies conducted on the topic over the past 50 years. While the late psychiatrist Fritz Perls, M.D.,

developed the term "mind f***ing" in his gestalt therapy approach with groups during the 1960s, it was said that he used the term to "describe and deride, deliberately confusing or misleading double-talk" (Perls, 1969). On the other hand, while Albert Ellis had certainly showed no reserve in using foul language during his many presentations, there was nothing in any of his early writings in the 1960s, nor during his famous session with the Gloria tapes, in which he used foul language. One of the first empirical articles to address the use of profanity in counseling was published by Heubusch and Horan (1977). In their study, they referred to profanity as "non-standard English" and they questioned the consequence of the use of such language on clients. The researchers recruited 30 males and 30 females ranging in age from 24 to 50 who were randomly selected, and then randomly assigned to one of three male counselors and one of two treatment conditions. In the "non-standard English" treatment condition, the counselors were instructed to use (only once in a session) each of the following words: "f**k," "s**t," "hell," and "damn." The words were not to be used in any manner which could be construed as intimidating to the clients; rather, they were to be employed in a passive sense (e.g., "Some clients take longer to get their s**t together"). Interestingly, the results of the study clearly indicated that the casual use of "non-standard English," namely profanity, in initial interviews by male counselors with adult clients of both sexes, had a generally detrimental effect on counseling as perceived by the client. On all of the self-report and behavioral measures, clients judged counselors who used such language as significantly less effective and satisfying. Notably, the results did not show that negative client evaluations in turn reflected fewer adaptive changes in the actual lives of the clients. Also, the researchers were unable to generalize that younger age clients and/or clients involved in long-term counseling would be similarly displeased. The results raise the question of whether counselor profanity might have had a less deleterious effect if it had been used in response to more intensive levels of client affect. Nevertheless, the authors of this study recommended at that time that the use of "non-standard English" by counselors doing therapy should be avoided.

In subsequent years most research has focused on the client's language instead of the therapist's. Very little has addressed professionals' use of foul language in therapy settings (Stone et al., 2010). Jay (2000) posits that cursing provides for both emotional

expression about and emotional reactions to the world that creates an aspect of self-awareness that noncurse words fail to capture. Therefore, understanding more fully the way that using profanity in therapy affects the therapeutic relationship will help therapists to make more educated choices when speaking to clients. Research also demonstrates that swearing has been used in therapy when the need to get the listener's attention was more vital, such as in group treatment for illicit drug and alcohol use, sex offenders, and other criminal populations (Gittin, 2016). In general, there is less research that investigates how swearing specifically affects the therapeutic relationship.

Another interesting study was conducted by Kottke and MacLeod (1989). Their investigation had test subjects listen to an audio recording of a therapist and client, with several different testing groups: in one, the therapist swore and the client did not; in the second, the client swore and the therapist did not; and in the third, both parties swore. In the end, "the counselor who swore was viewed as being insensitive to the needs of the client, disrespectful and unprofessional" regardless of whether the client swore. When the client swore and the therapist didn't, the therapist was perceived in a more favorable light. Interactions wherein both the counselor and client swore were viewed as neutral. However, again this particular research did not investigate the therapeutic relationship, but instead people's perceptions of swearing in therapy. A later study conducted by Maier and Miller (1993) involved the clinical review of the impact of obscene language in psychotherapy settings describing how profanity can be both effective and detrimental to quality therapeutic care. Their one definitive conclusion was that racialized slurs are never appropriate. Their other conclusions were less than absolute. The authors ultimately determined, "It is the contention of the authors that under the right circumstances, obscene language can be used by mental health professionals." Additional research (Jay, 2000; Ljung, 2007; O'Callaghan, 2013) found that swearing in mental health settings can sometimes be very powerful in making a point.

More recently, Giffin (2016) conducted a master's thesis at Smith College in which she addressed clients' perceptions of therapists' swearing. This study was conducted via an exploratory, mixed methods research design. Individuals whose therapist had used swear words during their individual therapy were surveyed about their own per-

sonal swearing habits, their opinions of swearing and of therapists' swearing in general, their specific experiences and perceptions of their therapists swearing, as well as demographic information. The majority of the study's respondents reported that the therapists' use of swear words had helped their therapeutic relationship. While participants reported that they were happy with the frequency and context of their therapist's swearing, they also preferred that in general therapists swear in moderation.

Of course, many other factors need to be considered that may affect acceptance of profanity, such as gender, culture, or age match or mismatch between therapist and client. In addition, the use of profanity has become more prevalent with modern media, including television, movies, and music, since some of the earlier studies were conducted.

Conclusions

So, I guess according to the literature, if obscenities are used too early in the treatment process and without tact and diplomacy, they go over like a skunk at a picnic and contribute to clients' view of it being displeasing. On the other hand, after a therapeutic relationship has been established, if such choice language is used tactfully and in a way that is helpful, then it may be better accepted by clients and even helpful with the therapeutic process.

The interesting issue with my client is that, in time, the question she asked helped us to uncover some of her underlying schemas, which pertained to her struggle with morality and growing up in an environment that was rigid and stalwart against the use of profanity. At the same time, she felt the urge to let a few expletives fly on occasion in helping her express her anger and frustration and was inadvertently looking for me to endorse that by using such language myself. After a lengthy discussion about why she needed my approval to use foul language and providing her with support to make her own decision, I took advantage of using my modeling skills and offered to help her become more comfortable with the use of obscenities. We initially started out with some of the smaller, less onerous words (i.e., "damn," "sh*t") and slowly graduated to more advanced language. However, she never reached the pinnacle of using the "f word." As for me, obscenities continue to find their way into some of my sessions selectively when necessary, but only to make a point. It's still uncomfortable for me to curse in session

and feels awkward. I guess it depends on the individual's comfort level. In the meantime, I can't help to think that ole Al Ellis must be grinning from ear to ear wherever he is!

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ABCT Governance: Looking Behind the Curtain

Rebecca B. Skolnick, *MindWell NYC*

Shannon M. Blakey, *Durham VA Health Care System; Durham VA Mid-Atlantic Mental Illness Research, Education and Clinical Center*

EVERY YEAR we look forward to ABCT's Annual Convention. We are all familiar with the symposia, clinical roundtables, workshops, and other sessions that introduce us to new theories, findings, and colleagues (and reunite us with established ones). However, many of us attendees are unfamiliar with the team of ABCT members and staff organizing and overseeing the convention. Furthermore, who keeps ABCT running the rest of the year? Surprisingly (or maybe not), many ABCT members are unfamiliar with how ABCT Governance is structured. Accordingly, the purpose of this article is to pull back the curtain and showcase the many individuals and suborganizations who keep ABCT thriving, growing, and disseminating behavioral and cognitive science and practice.

ABCT governance consists of the Board of Directors, committees, and ABCT Central Office staff, who report to the Board through designated coordinators. The

organization's staff is headed by Executive Director Mary Jane Eimer. You may be familiar with ABCT's Board of Directors, who are decided by ABCT's annual elections. The Board of Directors includes the President, Immediate Past President, President-Elect, Secretary-Treasurer, and three Representatives-at-Large. The President nominates individual coordinators, who are then approved by the Board of Directors. The coordinators oversee committees related to Convention and Continuing Education Issues, Academic and Professional Issues, Publications, and Membership Issues. Under the leadership of these coordinators, there are currently 28 committees. Each committee has one committee chair and multiple members. The committee chairs serve in their roles for 1 to 3 years, depending on the rules of that committee. The members are typically recruited by committee chairs, though some committees accept volunteers. Of course, there are procedures in place for

expanding, condensing, and restructuring components of ABCT governance as needed. A simplified illustration of how the committees, coordinators, and Central Office staff are currently organized in relation to the elected Board of Directors is shown in Figure 1.

As you can see, there are numerous ABCT members working hard behind the scenes to support, develop, and empower the organization. While each committee has distinct roles and responsibilities, many of the committees regularly collaborate. Moreover, certain committee chairs have standing monthly cross-committee conference calls with ABCT Central Office staff liaisons. For example, the Membership Committee Chair, Student Membership Committee Chair, and Ambassadors Program Chair jointly meet with members of ABCT Central Office staff to coordinate initiatives, provide updates on activities, and ensure all requirements and membership benefits generated by these committees converge to support the overall mission and priorities of ABCT as an organization.

Volunteer participation in an ABCT committee is an excellent way to contribute to the organization and develop foundational leadership skills to inform continued involvement at higher levels of organizational leadership. If you are interested in learning more about a particular committee (including how you might join), you can start by contacting the committee

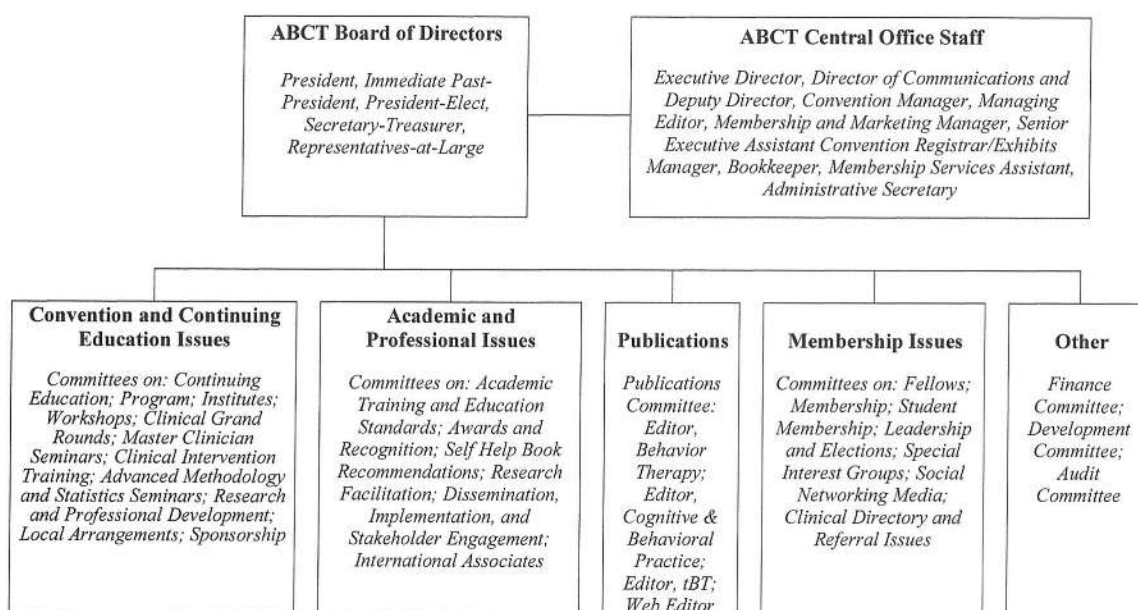


Figure 1. Relation of ABCT Committees to Current Governance Structure

chairs to see if they are accepting new members. As depicted in Table 1, the Membership Committee, Student Membership Committee, and Social Networking Media Committee regularly recruit and accept new members. Another pathway toward greater ABCT involvement is to become an ABCT Ambassador. The ABCT Ambassadors Program was created with the aim of having members “on the ground” who actively promote ABCT events, initiatives, and content. ABCT Student Ambassadors and Full Member Ambassadors receive monthly emails from the Ambassadors Program Chair with the latest information on upcoming events and deadlines within ABCT. Ambassadors then share this information to colleagues, students, friends, and social media platform followers. In addition to becoming an ABCT Ambassador or committee member, we recommend following the ABCT list serve and articles in *the Behavior Therapist*, as opportunities to become more involved in the organization are often advertised through these outlets.

We hope this article has shed light on how ABCT is organized and governed. ABCT is, at its heart, a membership organization, led by its members and acting for its members. As current ABCT Committee Chairs, we have found that being part of ABCT governance is a truly rewarding experience and privilege. We hope to work with more of you in the future! To learn more about and apply to join a committee, visit <https://www.abct.org/membership/get-involved/>.

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The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the United States Government or Department of Veterans Affairs (VA). Dr. Blakey was supported by a VA Office of Academic Affiliations Advanced Fellowship in Mental Illness Research and Treatment.

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Table 1. Descriptions of Select Membership Issues Committees

Membership Committee | *Current Chair:* Rebecca Skolnick, Ph.D.

Description: The ABCT Membership Committee is responsible for recruiting and retaining Full Members, Associate Members, and New Professional Members. The Membership Committee also oversees the ABCT Ambassadors Program (currently led by Dan Hoffman, PhD), which was created with the aim of having members “on the ground” who are active in promoting ABCT events, initiatives, and content. ABCT Ambassadors let colleagues, students, and friends know about upcoming events and deadlines within ABCT. The Membership Committee also sponsors a panel at the annual convention focused on a rotating professional topic. ***This committee regularly accepts volunteer members, as does the Ambassadors Program.***

Student Membership Committee | *Current Chair:* Shannon M. Blakey, Ph.D.

Description: The ABCT Student Membership Committee is responsible for recruiting and retaining Student Members and Postbaccalaureate Members. The Student Membership Committee oversees the Featured Labs Program, supports the annual “Getting into Graduate School” convention panel, and generates mixed media professional development application resources for prospective and current mental health students. The Student Membership committee also sponsors a panel at the annual convention on a rotating topic related to professional development and career paths. ***This committee regularly accepts volunteer members.***

Special Interest Groups (SIG) Committee | *Current SIG Leader:* Broderick Sawyer, Ph.D.

Description: The SIG Committee is responsible for coordinating the activities of the SIG program. The SIG Leader maintains regular communication with the 40+ SIG Chairs and serves as liaison between the individual SIGs/SIG Chairs and ABCT Central Office. To learn about and join a SIG, visit <https://www.abct.org/membership/special-interest-groups-sig/>

Leadership and Elections Committee | *Current Chair:* Patricia DiBartolo, Ph.D.

Description: The Leadership and Elections Committee is responsible for overseeing the nomination and selection of ABCT elected positions. This three-person committee includes the Chair and two ABCT members nominated by the Chair and approved by the ABCT Board of Directors. This committee places a Call for Nominations at least four months prior to the annual convention, from which a slate of final candidates is determined and subsequently distributed to the ABCT voting membership at least six weeks prior to the annual convention. This committee does not accept volunteer members.

Clinical Directory & Referral Issues Committee | *Current Chair:* Daniella Cavenagh, Ph.D.

Description: The Clinical Directory and Referral Issues Committee is responsible for maintaining the voluntary ABCT Clinical Directory, the ABCT Referral Service, and other associated activities. Through coordination with the ABCT Public Education and Media Dissemination Committee, this committee educates third-party payers, managed care organizations, and the general public on behavioral and cognitive therapies. This committee is not currently accepting volunteer members.

Social Networking Media Committee | *Current Chair:* Shari Steinman, Ph.D.

Description: The Social Networking Media Committee is responsible for managing and moderating open activity on ABCT-approved social media outlets (currently Facebook, Twitter, YouTube, and Instagram) as well as maintaining the ABCT members list serve. Through these platforms, the Social Networking Media Committee disseminates and promotes ABCT activities, products, and services; shares information relevant to behavioral and cognitive therapies; and communicates other information relevant to the organization and general public. ***This committee regularly accepts volunteer members.***

Note. Though the committees described above have distinct responsibilities and leadership, they regularly collaborate and certain committees may have standing monthly cross-committee conference calls with ABCT Central Office.



ABCT | Spotlight on a Mentor

The ABCT Academic Training and Education Standards committee annually solicits nominations for the “Spotlight on a Mentor” recognition to highlight the diversity of excellent mentors within the membership ranks of ABCT. Its goal is to spotlight promising early-career and well-established mentors across all levels of academic rank, areas of specialization, and types of institution. We asked the four 2020 winners to share some wisdom related to their own influential mentors and their mentorship philosophy. Learn more below, and you can find more information online: <https://www.abct.org/mentor-spotlights/>

Jonathan Abramowitz, Ph.D.



Jonathan Abramowitz, Ph.D., is Professor of Psychology and Psychiatry and Director of the Anxiety and Stress Disorders Clinic at the University of North Carolina. An internationally recog-

nized expert on OCD and anxiety, he has published over 300 research articles, books, and book chapters. Dr. Abramowitz is a Past President of the Association for Behavioral and Cognitive Therapies and the founding editor of the *Journal of Obsessive-Compulsive and Related Disorders*. He is a regular presenter at professional conferences and has received numerous awards for his contributions to the field.

I take mentoring students very seriously and see it as “job one” of faculty members in clinical psychology training programs. It is definitely the most rewarding part of my job! I aspire to be a mentor who provides my students with tools, support, guidance, and constructive feedback they can use to thrive in their career as a psychologist. Having navigated the same path they are currently on, I’m in a position to help guide them.

My mentoring philosophy is to treat my graduate students as junior colleagues, as most scientific learning and development occurs through collegial discussion and activity. It is also my role to challenge and support my students with constructive feedback and advice. This includes observing and identifying their strengths, as well as areas that they can build on, and encouraging and pushing them to better and better define and describe their ideas, perspectives, and results. Graduate school is a training period, and students are individuals developing toward independence. Given this, I want my students to get involved in ongoing lab projects and collaborate with each other, as well as take full control over their own research projects under my supervision. I find this helps them become more receptive to frank discussions, advice, and critical feedback. It is also my philosophy to be generative. As such, I give my students

no shortage of opportunities to collaborate with me on books, journal articles, invited book chapters, conference workshops, and editorial work. I also encourage them to take the lead (and assume the lead author role) on most papers and presentations from our lab (as I am fortunate to now be at a stage where I do not need first-authored articles for myself). Nothing makes me happier to see them succeed and add entries to their CV!

As for my strengths, I believe I am good at respecting students’ privacy and boundaries, and allowing them to have a work-life balance. I try never to intrude on their time away from work/school and believe it’s important for them to have a fulfilling life outside of their school work (as I certainly do!). I would also say that my generativity is a strength. I’m extremely proud when my graduate students publish a first-authored paper, receive a grant, and present papers at conferences (unfortunately, I have had mentors who did not feel this way). Finally, I think students would say that I excel at teaching them how to write for scientific/academic audiences. Indeed, some of my favorite (and most valuable) experiences as a graduate student and postdoc involved sitting down and writing together with some of my mentors. We would discuss our thoughts and ideas, work through how to voice them in a succinct and thoughtful way, revise over and over until we were happy with how it read, and all the while have fun doing it! I learned to love writing this way, and I believe I’m pretty good at passing this love for writing on to my own mentees.

Norman Cotterell, Ph.D.



Norman Cotterell, Ph.D., earned his AB in Psychology from Princeton University and his Ph.D. from the University of Delaware. He completed his postdoctoral fellowship at

the Center for Cognitive Therapy at the University of Pennsylvania in 1990, under the direction of Dr. Aaron T. Beck. Dr.

Cotterell is a Founding Fellow of the Academy of Cognitive Therapy and has served as a protocol therapist on a variety of large-scale psychotherapy outcome studies, including drug abuse, panic disorder, and the prevention of depression. He has lectured extensively for hospitals, churches, and support groups, and has conducted workshops across the United States and in Brazil. He has supervised residents and fellows in cognitive therapy and is a past recipient of the O. Spurgeon English Faculty Award for teaching psychiatry residents at Temple University. He is a faculty member and therapist at Beck Institute who treats older adolescents, adults, older adults, and couples with a variety of difficulties.

I strive to provide a mix of meaningful activity in mentoring students: I’m sometimes a coach, a counselor, a sounding board, an advisor, a resource, a student, a seeker, and even a role play partner providing practice in skills they have or may hope to apply. My philosophy is to discover what they want and need and do my best to fulfill it. My primary strengths may be my passion and curiosity for the field. And it’s large field! I love to learn about mentees’ culture, experiences, academic interests and how these intersect. I love to immerse myself in all they introduce to me and how that dovetails with my training in cognitive behavioral therapy. My mentees have enabled me to step outside my own frame of reference to understand a bit more of the world: from the Nigerian Igbo experience in America, to the challenges of being Telugu Dalit (former Untouchables) in India, to the entrepreneurial experience in North Carolina. I’ve learned how such experiences can enable people to be more empathic clinicians, more able researchers, and more powerful agents of change. In sum, I have one word of advice to professionals starting out as mentors: Listen.

Anna Lau, Ph.D.



Dr. Anna Lau is a Clinical Psychologist and Professor of Psychology and Asian American Studies at UCLA. Dr. Lau's translational research on risk and protective factors for youth in immigrant families and her identification of racial disparities in youth mental health services have informed her efforts to study the implementation of evidence-based practices in community settings. Her research has been supported by NIMH. Dr. Lau trains doctoral students in delivery of evidence-based psychotherapy for youth and teaches courses related to Asian American Mental Health and the Psychology of Diversity. Dr. Lau is dedicated to inclusive excellence in higher education and is the Vice Chair for Graduate Studies in Psychology, has chaired the Academic Senate Committee on Undergraduate Admissions and Relations with Schools, and is a member of the Asian American Studies Center Faculty Advisory Committee and Co-Chairs the Life Sciences Diversity Advisory Committee.

I've been blessed to have many wonderful mentors at every stage of my career. I had not one but two great advisors on my undergrad thesis, developmentalists Phil Zelazo and Charles Helwig. I learned that hatching an idea that integrated two areas of inquiry was a fun way to stimulate collaboration. In grad school, I had the fortune of being mentored first by Stan Sue and then John Weisz. Both are visionaries who built supportive environments where I was mentored by them as well as brilliant grad student peers, postdocs, and affiliated investigators. So, I learned it takes a village and you can find specific types of mentoring—scientific knowledge, skill coaching, and professional development—from different folks. Don't expect to rely on one mentor for all your needs. As a postdoc, I worked with John Landsverk, who immersed me in services research and was an incredible sponsor—always thinking about how to give his mentees access to opportunities that would get them to their next right step. As an early-career researcher, Jeanne Miranda gave me confidence to run my own community-based RCTs with underserved families. I've never stopped needing mentorship. After tenure, I was lucky to be accepted as a fellow of the Implementation Research Institute led by Enola Proctor, which introduced me to a

network of implementation scientist collaborators from whom I still receive mentorship. There's always more to learn! I'm indebted to many others, including David Takeuchi, Ann Garland, Bahr Weiss, and Jill Waterman, to name a few, who were always generous with their mentorship. These folks are not only clinical psychologists, but also developmental psychologists, social workers, and sociologists/epidemiologists. I recommend crossing those disciplinary training boundaries whenever possible. Finally, nowadays, it is a fact that I learn as much from my students and postdocs as they learn from me.

Sue Orsillo, Ph.D.



At the time of the award conferral, Dr. Orsillo was Professor of Psychology and Associate Director of Clinical Training at the Suffolk University, where she had been a member of the faculty since 2004. Dr. Orsillo maintains an active research lab and has served as primary mentor to 16 students who have completed Suffolk's APA accredited Ph.D. program in clinical psychology. Dr. Orsillo received her Ph.D. from University at Albany, State University of New York, in 1993 under the mentorship of Dr. Rick Heimberg and she completed an internship and postdoctoral fellowship at the National Center for PTSD—Behavioral Sciences Division at the Boston VA. She is a currently an ABCT Fellow.

Dr. Orsillo has published over 100 journal articles and book chapters, and co-edited two books broadly focused on the nature, causes, prevention and treatment of anxiety and related clinical problems. In collaboration with Dr. Lizabeth Roemer, she developed an acceptance-based behavioral therapy for generalized anxiety and comorbid disorders, examined its efficacy, and identified mediators of change in a series of studies funded by the National Institute of Mental Health. Drs. Orsillo and Roemer are co-authors of *The Mindful Way Through Anxiety, Worry Less, Live More: The Mindful Way Through Anxiety Workbook*, and the newly released *Acceptance-Based Behavioral Therapy Treating Anxiety and Related Challenges*. In collaboration with her doctoral students, Dr. Orsillo's current work explores how the cultivation of acceptance and self-compassion, along with encouragement to clarify

and affirm personally meaningful values, may help to buffer people from contextual stressors, build resilience, improve psychosocial functioning, and enhance quality of life.

I have been engaged in direct mentorship of clinical doctoral students for 25 years (most recently as a mentor in the Suffolk University clinical psychology program for 17 years). As I prepare to transition into a very different type of role as the Senior Director of Education and Training at APA, I have definitely spent time deeply reflecting on the impact of mentors on my career path, as well as the ways in which serving as a mentor has brought meaning and purpose to my work.

As a first-generation college student, I understand the incredible life-changing opportunities that committed mentorship can provide. The transformational connections I have forged with mentors enabled me to achieve personal career goals I thought were beyond reach and to contribute to the development of a cadre of scientist-practitioners who are making the world a better place. I am deeply grateful to the mentors who encouraged me to stretch beyond my comfort zone. From my doctoral mentor, Rick Heimberg, who invested considerable time and effort into developing my critical thinking and writing skills, I learned that mentorship requires deep engagement with your mentees' work and a sustained commitment to their development. My internship and postdoctoral mentor, Brett Litz, taught me the importance of conducting research that is conceptually rich, scientifically rigorous, and clinically meaningful. My friend, collaborator, and peer mentor, Liz Roemer, continuously demonstrates to me the countless benefits of forging deeply authentic, caring, and supportive relationships with mentees. And my students have challenged me to remain humble about all that I don't know, to embrace the process of lifelong learning, and to think broadly and creatively about the potential career paths available to them as future clinical psychologists.

Over the last 25 years, I have tried to apply all that I have learned from my mentors to my own mentorship philosophy and style. I have strived to encourage my students to engage in high-quality, rigorous, and meaningful work while providing them with a safe space in which they can explore, take risks, make mistakes, learn, and grow. It's been an incredible privilege to have contributed to the professional development of so many wonderful psychologists. ■

Get to Know the Education Directorate at APA

Sue Orsillo, *American Psychological Association*



I AM WRITING this column approximately 1 month into my new position as Senior Director of Education and Training at the American Psychological Association (APA). Up to this point

in my professional trajectory, I have been on a more traditional academic path. Starting as an Assistant Professor at Oklahoma State University, I did a brief stint as a Research Psychologist at the National Center for PTSD: Women's Health Sciences Division, and then went on to spend 17 years on faculty at Suffolk University. Why such a major career transition after 24 years of teaching, supervising, and mentoring undergraduates, clinical doctoral students, interns, and postdoctoral fellows? What motivated me to join the "giant game of musical chairs" workers across industries participated in during the pandemic as we reassessed our career values and aspirations (Pressman & Gardizy, 2021). And why am I reaching out to you, members of ABCT, to share the news of the most recent stop in my professional journey?

As members of ABCT, bonded by our common desire to alleviate human suffering through the application of scientific principles, we are all deeply concerned by the heavy psychological toll the pandemic has taken, particularly on parents, essential workers, and communities of color (APA, 2021). Those of us who are educators are bearing witness to the many ways that the pandemic is disproportionately impacting members of historically marginalized and underserved students, deepening historical divides in educational opportunities (Department of Education [DoE], 2021). The pandemic heightened the barriers that students of colors, students with disabilities, and those in caregiver roles face entering, continuing, and completing their academic studies (DoE, 2021). Increases in identity-based harassment and violence toward Black, Asian American and Pacific Islander communities, women, and students who are transgender, non-binary, or gender non-conforming threaten well-being and may limit academic capacity

(DoE). As educators, we have scrambled to adapt to our new environment, assembling supports and resources for students, reinventing the methods used to select and admit candidates into doctoral programs, relaxing and revising academic policies and procedures to best meet the shifting needs of our students. Amid this period of intense change and reflection, I saw my transition to APA as an opportunity to make a larger, more long-lasting impact. To join with others in the shared mission of the Education Directorate, which is to advance the science and practice of psychology for the benefit of the public through educational institutions, programs, and initiatives.

Most of you are probably already familiar with certain aspects of the Education Directorate at APA. Those training doctoral students, interns, and postdoctoral residents are well acquainted with the work of the Office of Program Consultation and Accreditation. Most readers likely also know about the Office of Continuing Education in Psychology, as it provides a wide range of CE opportunities for psychologists to expand their skills through workshops, webinars, and independent study, offered within and outside of ABCT. But I would like to highlight a few additional resources you may be less familiar with and invite you to learn more about the ways in which the Education Directorate can serve and support members of ABCT.

Educators are increasingly recognizing the importance of advising graduate and undergraduate students early and often about their career options. The Center for Workforce Studies (CWS) is the definitive source for high-quality, employment data most relevant to psychologists. I highly recommend that all educators read, discuss, and share the CWS report on psychologist workforce projections from 2015-2033. Moreover, I suggest you follow the monthly "data points" shared by this group that highlight everything from the top 20 skills undergraduates build majoring in psychology to psychologists' practice settings and salaries across career stages.

ABCT members currently mentoring doctoral students, interns, and post-doctoral fellows may want to refer their

mentees to the web resources the Education Directorate provides for early career psychologists. Information on salary negotiation skills, loan forgiveness programs, parenting challenges, and new models of practice are all readily available.

A deeper dive into the broad-reaching work of the Education Directorate reveals even more subtle ways in which this group can support ABCT members. For example, ABCT's mission is to advance the scientific understanding, assessment, prevention, and treatment of human problems through behavioral, cognitive, and biological evidence-based principles. Yet public understanding of the scientific basis of psychology is limited (Lilienfeld, 2012). One highly underutilized method of educating citizens about the empirical foundation of psychological science is the Introductory Psychology course. Between 1.2 and 1.6 million undergraduates take a course in introductory psychology each year (Gurung et al., 2016), the majority of whom will not major in psychology. Thus, this course introduces students who will become educators, business leaders, health care providers, and policy makers to the broad applications of psychological science to their organizations, communities, and personal lives. Unfortunately, introductory psychology is a challenging course to teach given its large enrollments, heterogeneous population of students with diverse academic interests and varying motivation, and breadth of content.

In response to this challenge, APA's Board of Educational Affairs appointed two working groups who produced a set of key recommendations for how to strengthen the impact of a course in introductory psychology. I encourage ABCT educators to check out the APA Introductory Psychology Initiative website to learn about how they can transform the way in which introductory psychology is taught in their departments by using course design and models informed by recommended student learning outcomes the emphasize developing an understanding of the overarching themes in psychology over rote memorization of content.

Even before college, an increasing number of high school students are introduced to psychology through some form of survey course. Over 300,000 students take the AP Psychology exam each year and that number represents only a subset of students taking a high school psychology course. Introducing high school students to psychology as a discipline grounded in science, that appreciates and is informed by

cultural differences, and that has broad reaching applications is essential for improving public perception of psychology and diversifying the field. Yet, only about half of the states in the U.S. require, or even offer, any credentialing of high school psychology teachers. The Education Directorate of APA offers an Advocacy Toolkit for those committed to enhancing teacher preparation nationally, as well as providing an array of resources to current teachers including, but not limited to, National Standards for High School Psychology Curricula, freely accessible lesson plans, classroom activities, a course template, and a self-reflection tool aimed to help teachers enhance their cultural sensitivity.

As a broader guide to curriculum development for the undergraduate major APA also provides both Principles and Guidelines for the Undergraduate Psychology Major. These policy documents can help departments align their curriculum with nationally recognized indicators of high-quality undergraduate education in psychology. To support the implementation of these guidelines, APA offers Project Assessment, a collaboratively developed repository of assignments and evaluations that can be used to assess students' achievement of the learning goals outlined in the Guidelines document. Instructors access to this repository is free, although it currently requires registration. Educators may also be interested in using APAs Online Psychology Laboratory (OPL) of experiments to enhance their teaching (or sharing them with their departmental colleagues). Edu-

cators can login with an APA or Google account to access online experiments on cognition, individual differences, learning, sensation and perception, and social psychology that can be assigned as a class activity. The OPL site also provides instructors and students access to data sets for analysis.

Although I have only scratched the surface, I hope this article inspires ABCT members to explore the ways in which APA's Educational Directorate might support your work. I also hope you will consider actively contributing to our mission. Currently, the Board of Educational Affairs is seeking nominees for the Committee on Associate and Baccalaureate Education (CABE) and early career psychologists and members of underrepresented groups are particularly welcome to self-nominate. More information can be found here. I also invite ABCT members to spread the word that APA is seeking a Chair-elect and member-at-large for our Teachers of Psychology in Secondary Schools. Nominations for this committee as well as for CABE are due in August.

Finally, I welcome any thoughts, questions, or suggestions you may have for me in my new role at APA. Please feel free to contact me at sorsillo@apa.org. I am deeply grateful to ABCT for inviting me to share information about my new role with my ABCT colleagues. I hope you all find moments of rest, self-care, and inspiration as we emerge from the pandemic.

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