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## PRESIDENT'S MESSAGE

## Updates to Strategic Goals and Initiatives for ABCT

David F. Tolin, *The Institute of Living*



AS I WRITE this column, we are gearing up for our virtual convention and I have high hopes. I would like to begin by gratefully acknowledging the efforts of our 2021 Program Chair, Greg Chasson;

our Associate Program Chair, Elizabeth Katz; and our Convention Manager, Stephen Crane. They, along with the Convention Committee, have worked hard not only to pivot us yet again to a virtual format, but also to present a stellar line-up of workshops, symposia, panel discussions, posters, and more. My hat is off to all of them.

This will be my last President's Message in *the Behavior Therapist*. By the time you're reading this article, Dr. Laura Seligman will have taken the reins as ABCT President, and I thank you for the opportunity to serve the organization. I look forward to continuing to work with Dr. Seligman and the Board of Directors over the coming year to help move ABCT in positive directions.

In previous columns in *the Behavior Therapist*, I have outlined highlights from the ABCT strategic planning meeting. These have included a discussion of relevant stakeholders, simplified guiding principles of action, and critical outcomes and shared learning priorities. In this column, I'll wrap up my discussion of our ambitious strategic plan with a discussion of strategic goals and initiatives for ABCT. Unlike previous strategic plan documents, the new

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## ERRATUM

In the article by Kryza-Lacombe (p. 361) in the October issue of *the Behavior Therapist* (Vol 44, issue 7), Elizabeth Richards’ affiliation appears as Stanford University School of Medicine. The correct affiliation is as follows:

Elizabeth Richards, *Private Practice*

## INSTRUCTIONS for AUTHORS

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

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

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

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

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

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

guidelines are meant to be a living document that can be modified as we obtain ongoing input from various stakeholders. Thus, I encourage you to think of these goals and initiatives as a work in progress, and I invite your input.

### **Goal 1: Build Relationships With Members and Diverse Stakeholders and Integrate Feedback Into ABCT Activities, Systemic Structures, and Governance**

The aim of this goal is to develop inclusive and mutually beneficial relationships with members and diverse stakeholders who are interested in building the future of behavioral health. Specific initiatives under this goal could include:

- Consulting with, and addressing the needs of, our diverse membership in a changing environment
- Developing and maintaining relationships and meaningful partnerships with stakeholders outside of ABCT whose expertise would be valued by ABCT members
- Developing and maintaining relationships with funding agencies such as the National Institutes of Health
- Developing and maintaining relationships with behavioral healthcare decision-makers (e.g., judicial system, opioid treatment programs, health care administrators) to better understand needs, barriers, and contingencies for adopting CBT practices and to advocate for the use of CBT for widespread use
- Developing and maintaining relationships with academic, social, and health care institutions that focus on serving primarily Hispanic, Black, Asian, Native American, and Pacific Islander populations (e.g., Historically Black colleges and universities, tribally controlled colleges and health care systems) and other institutions that serve diverse populations

How might we realize this goal? One planned tactic, in keeping with the recommendations of our Task Force on Diversity, Equity, and Inclusion (DEI), is to hire a full-time diversity and inclusion manager who would assist in training all staff and volunteers in DEI issues and help staff and volunteers overhaul, as needed, operating procedures on an ongoing basis. An interim step could be to hire a consultant

who is expert in DEI to help define the proposed full-time position, recruit applicants, and make sure the position is designed for success. We could also create a new fund managed by historically and currently underrepresented ABCT members that will allow them some autonomy in making ABCT more welcoming to students and professionals from those communities. I would welcome an increase in our workshop offerings, continuing education courses, and toolkits related to diverse stakeholder expertise. We should increase our joint activity with the American Psychological Association (APA), Canadian Psychological Association (CPA), and other stakeholders to advocate for increased funding for CBT practice and research, potentially including the establishment of official liaison position(s) within APA and CPA. We can also act to increase the presence of CBT-relevant material in NIH's Science of Behavior Change (SOBC) initiatives and Canadian agencies, as well as with relevant organizations in Mexico. Future ABCT leaders might develop meetings or workgroups, with special emphasis on high-need communities and partnering with groups that represent diverse communities in order to assess common interests. In collaboration with other organizations, we can initiate public health campaigns that include identification of opportunities for interacting with the press and members with content expertise for each opportunity, with a particular focus on education within high-need communities and promotion of minority members.

### **Goal 2: Disseminate Cognitive and Behavioral Research and Practice**

The idea here is to promote widespread awareness of, acceptance of, and access to behavioral and cognitive interventions to improve human well-being. Initiatives under this goal can include:

- Expanding access to CBT training, including for bachelor's- and master's-level clinicians as well as clinicians from, and those serving, diverse populations
- Reducing barriers that prevent implementation of cognitive and behavioral interventions and strengthen connections between scientific research and clinical practice in CBT

Outcomes for this goal might include disseminating best practices for telehealth

platforms, via webinars, workshops, podcasts, and town hall-style exchanges with the membership. We should create and disseminate CBT materials and tools (such as training videos and course syllabi) for use by undergraduate and graduate training programs. I recommend we conduct a needs assessment for master's-level clinicians, particularly those working in underserved areas, producing workshops on topics such as "CBT fundamentals," which those clinicians would likely find attractive. Other outcomes could include the development of a database of CBT supervisors or facilitating online supervision groups hosted by ABCT, developing a database of clinical service sites interested in participating in clinical research, and developing or disseminating tools to assess CBT training outcomes for graduate programs and internships, eventually culminating in a monograph of best practices.

### **Goal 3: Promote Innovation in the Science of Behavioral Health**

Here, we seek the sustained pursuit of innovation in CBT and related evidence-based approaches that improve human well-being. Specific initiatives under this goal include:

- Working with key behavioral health stakeholders to develop a shared understanding of the current state and future direction of innovation in the field
- Collaborating with stakeholders outside of behavioral health, including industry partners and technology companies, to expand innovation, dissemination, and implementation
- Using fundraising and grant-writing activities to expand innovation in CBT-related science and practice

Possible outcomes under this goal include increasing workshop offerings, continuing education courses, and tools related to technology and other innovation-related topics. We should further seek to integrate members and nonmembers with relevant expertise (such as technology or funding) into future think tanks and other initiatives, where relevant. I would advocate for increased collaboration with private industry, including digital mental health companies, which are a source of substantial innovation and dissemination.

#### Goal 4: Develop Coalition Partnerships to Enhance Public Education

We seek to increase understanding of the benefits of behavioral and cognitive therapies, and adoption of CBT principles and practices, among the public and public sector decision-makers. Specific initiatives under this goal include:

- Collaborating with partners on outreach to build the public's understanding of the benefits of CBT and related evidence-based behavioral health approaches
- Co-signing with partners on legislative efforts to increase awareness of, and coverage for, CBT and evidence-based mental health practices in the United States and Canada
- Continuing to expand our efforts to educate the public about CBT and related evidence-based mental health practices

In service of this goal, we should increase our production of public-facing materials related to CBT and evidence-based practice. Outreach initiatives should be aimed at early detection of and intervention for psychological problems. Those initiatives should be aimed not only at prac-

ticing clinicians but also at the graduate, undergraduate, and even high school levels of training. We would continue to develop partnerships to enhance public education offerings and to improve access to cognitive and behavioral interventions.

#### Goal 5: Promote Ethical Delivery of Science-Based Interventions

Finally, our aim is to protect the public and the reputation of the field through the ethical delivery of cognitive, behavioral, and related science-based interventions. Specific initiatives include:

- Outreach to the American Psychiatric Association, American Psychological Association, Canadian Psychological Association, and other allied organizations to participate in the development, review, and dissemination of educational and clinical practice guidelines
- Partnering with master's-level programs, doctoral programs, and the ABPP Behavioral and Cognitive Board to provide access to clinicians with verified expertise in CBT
- Promoting and organizing webinars/sessions that address issues of ethics, diversity, and cultural competency

To support this goal, we should support the Academic Training and Education

Standards Committee in the development and publication of education and training guidelines. We should strive to increase the number of members with ABPP certification and work with ABPP to verify that the ABPP exam verifies skills implicated in practice guidelines. We should work to better understand advanced training initiatives and opportunities for master's-level clinicians and clinicians from diverse disciplines. We will continue to support the ABCT Fellows Committee to attract more clinical applicants from different disciplines to apply for Fellow status.

The ABCT Board of Directors holds monthly teleconferences. As part of our goal of maintaining accountability, we will ask the Coordinators, Committee Chairs, and Editors to describe how their actions fit with these Strategic Goals and Initiatives. We will review the Strategic Intent Document annually to either reaffirm that it reflects our top priorities, or to amend it as needed.

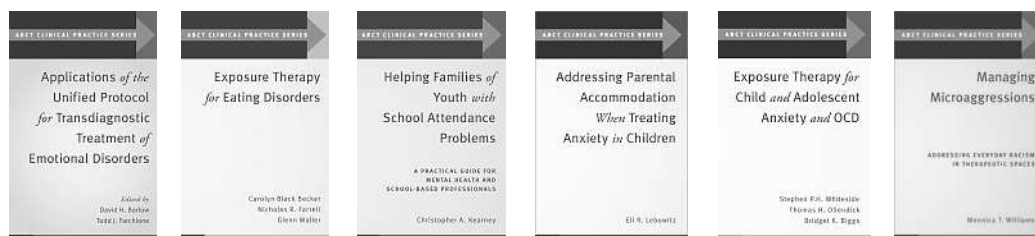
As always, I invite your comments and questions. Please feel free to email me at david.tolin@hhchealth.org.

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No conflicts of interest or funding to disclose.

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# Introduction to the Special Issue on Violence: Part II

Angela Moreland, *Medical University of South Carolina*

Richard LeBeau, *University of California, Los Angeles*

RaeAnn Anderson, *University of North Dakota*

IN JUNE 2021, *the Behavior Therapist* (tBT) published a special issue on violence. Our primary goal for the issue was to explore issues related to violence that extend beyond those typically discussed in our field (e.g., developing and disseminating evidence-based treatments for posttraumatic stress disorder [PTSD], understanding the sequelae of childhood abuse) to expand our field's discussions about the clinical implications of violence in new and important directions. We solicited broadly for this special issue, reaching out to numerous Special Interest Groups (SIGs), list serves, and colleagues. To our delight, we received 11 high-quality submissions that covered a variety of important topics related to violence. The first six articles were published in the June issue and covered interventions for domestic violence, sexual reoffending among adolescents, and maternal filicide.

The remaining five articles are included in this issue and cover a diverse array of topics including Mass Violence Incidents (MVI), sexual assault reporting, and moral injury. Below, we briefly summarize the articles included in the special issue.

## An Overview of the Second Special Issue

The second special issue on violence begins with two empirical articles examining interpersonal violence and sexual assault. In the first, Grace Packard and colleagues (2021) explore the effect of institutional racism on the development of PTSD and depression following interpersonal violence or rape among a large sample of Black women recruited from public hospital emergency room. Next, Katelyn Mills and colleagues (2021) delve into the barriers that prevent female victims of sexual assault from reporting to law enforcement. They extend the work that has been conducted in this area by exploring both quantitative and qualitative responses to a hypothetical scenario, providing a more nuanced picture of what prevents women

from reporting sexual assault and the potential steps that can be taken to address this. Combined, these articles significantly contribute to our understanding of the mental health and well-being of victims of interpersonal violence and sexual assault.

The special issue then presents three thought-provoking literature reviews on important topics that have been historically underresearched. Angela Moreland, Faraday Davies, and Dean Kilpatrick (2021) explore the topic of MVIs. Specifically, they review the state of the literature regarding interventions designed to prepare for and respond to MVIs. Next, Luci Dumas Espinoza, Sarah Steinmetz, and Matt Grey (2021) extend the work regarding moral injury, which has to date primarily focused on military personnel deployed in combat zones, to civilian offender populations. They explore the relevance of the construct to this population and provide a thought-provoking case example. Finally, Rufaro Chitiyo and Elisabeth Ramsey (2021) provide an in-depth literature review regarding household dysfunction, the negative impacts it has on the children who experience it, and the factors that contribute to growth and resilience among children despite these experiences. In addition to providing important overviews of the literature on poorly understood but essential topics, they also provide clear clinical implications.

We were pleased to see the discussions generated by the first special issue on violence and hope that these additional articles will stimulate further reflection and discussion with respect to our field's responsibility to working to reduce violence and the most effective and humane methods for doing so. We would like to express our deep gratitude to all of the individuals who contributed to this issue by authoring, reviewing, and editing these manuscripts and welcome your feedback.

## References

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# Intersections of Systemic Harm: The Relationship Between Interpersonal Violence and Institutional Racism on PTSD and Depression Symptoms Among Black Women

Grace Packard, Kelly Eason, Kimberly McKoy,  
*Georgia State University*

Yara Mekawi, Jessica Maples-Keller, Abigail Powers,  
*Emory School of Medicine*

Bekh Bradley, *Emory School of Medicine and Atlanta VA Medical Center*

Sierra Carter, *Georgia State University*

OVER A QUARTER of Black women experience intimate partner violence (IPV) at some point during their lifetime, and over 18% of Black women will be sexually assaulted (Abby et al., 2009; Tjaden & Thoennes, 2000; West & Johnson, 2013). Additionally, homicide is a leading cause of death for women under 44, and nearly half are connected to IPV (Petrosky et al., 2017). Black women experience stressors due to racism from the U.S. legal system and the police (Long, 2018a). Thus, it is particularly urgent to understand how racism from police and the U.S. court system is connected to PTSD and depression symptoms for Black women who may be experiencing these stressors in connection with sexual assault or IPV (Long, 2018b).

Police violence and racism from U.S. legal systems are examples of institutional racism, or “the policies and practices of institutions that operate to restrict the rights, mobility, access, or privileges of members in a given racial group” (Utsey, 1999, p.149). The U.S. carceral system exists and functions to enforce systems of White domination through the imprisonment, profit from, and terrorization of Black people (Davis, 2003). For example, “[the U.S. criminal justice system is] not just another institution infected by racial bias but another beast entirely... [it] has, in fact, emerged as a stunningly comprehensive and well disguised system of racialized social control that functions in a manner strikingly similar to Jim Crow” (Alexander, 2010, p. 4). This system operates by “legal-

izing” and justifying the denial of the ability to obtain employment, housing, and public benefits, the right to vote, and education (Alexander). This context of violence from the U.S. carceral system may be particularly salient to Black women who have experienced sexual assault or IPV over their lifetime. While experiences of sexual assault and IPV are rooted in multilevel issues of power and oppression for Black women, often the complexity of these experiences on health are not fully captured in research studies or acknowledged within oppressive systemic structures. For example, sexual violence is the second most common form of police misconduct reported after excessive force, and both are disproportionately used against Black people (Cato Institute, 2010). Sexual violence against Black women, particularly sexual violence perpetrated by police, is often ignored by U.S. courts (Duggan & Hunter, 1995; Jacobs, 2017). Black women who have delayed disclosure of sexual assault have identified racism in the criminal justice system and White domination of health and crisis intervention services as reasons for this delay (Neville & Pugh, 1997; Washington, 2001).

Measures of racism typically center on experiences of racism that occur within interpersonal contexts and often do not differentiate between how those experiences are situated within broader contexts of power and oppression. As a result, very little research has examined how experiences of racism that are embedded within oppressive and exploitative systems may

have unique relations to mental health outcomes. Given the role that institutions that enact racism play in responses to sexual assault and IPV, examining how these experiences of institutional racism may affect the mental health outcomes of Black women is necessary.

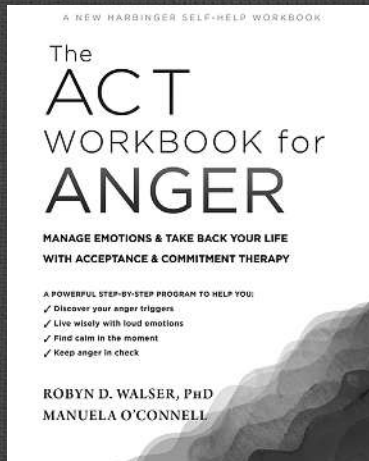
## *Racism, PTSD, and Depression*

Black Americans experience higher rates of trauma exposure and posttraumatic stress disorder (PTSD) than White Americans (Valentine et al., 2019). A growing body of literature has demonstrated that racism is a stressor that may exacerbate or directly lead to PTSD symptoms (Carter et al., 2019; Sibrava et al., 2019). Racism has been found to be related to intrusive symptoms, avoidance, hypervigilance, and depressive symptoms (Carter et al., 2020; Carter et al., 2019). While the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013) considers PTSD to include reactions resulting from “actual or threatened death, serious injury, or sexual violence” (p. 271), researchers have contended that experiences of racism can be conceptualized under a framework of race-based traumatic stress, where racism may lead to the development of trauma sequelae (Carter, 2007). The relationship between racism and depression symptoms has also been well demonstrated (Carter et al., 2020; Molina & James, 2016; Schulz et al., 2006; Watson-Singleton et al., 2021), including among Black women (West et al., 2010). This is often attributed to diminished self-worth, feelings of helplessness or hopelessness, ostracization, and dehumanization produced by racism (Walker et al., 2014), which may be buffered by culturally laden coping mechanisms, including racial identity attitudes (Carter & Reynolds, 2011). Carter and Reynolds found that racism is not only related to depressive symptoms among Black Americans, but that Black women are more likely to experience race-related stress from institutional racism. Despite this, there remains a dearth of literature examining how institutional racism may uniquely affect mental health symptomatology among Black women. Recent research has found that almost half of participants in a sample of Black women on probation or parole met criteria for clinical levels of depression, which has led researchers to call for future research examining how institutional racism and other stressors embedded within different axes of oppression are related to mental

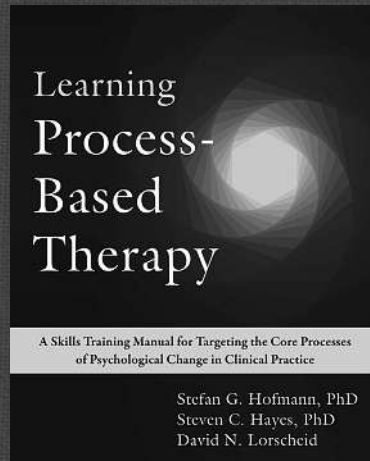


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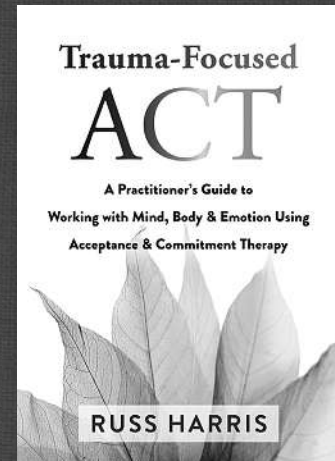
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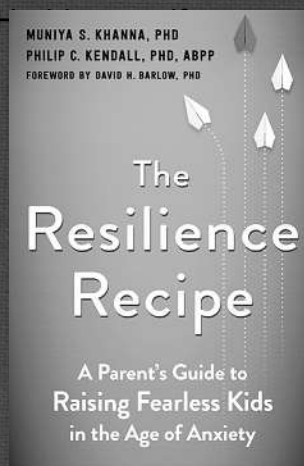
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health outcomes among this population (Malcome et al., 2019).

### ***Interpersonal Violence, PTSD, and Depression***

The experience of sexual assault or IPV is strongly associated with depression and PTSD symptoms. Interpersonal violence that includes sexual assault and IPV is more likely than other trauma types to be associated with more symptomatic presentations of PTSD (Smith et al., 2016). A study of gender discrimination and racism among HIV-positive Black women found that both gender discrimination and racism are related to depression symptoms (Logie et al., 2013). Rape, sexual assault, and/or IPV have also been demonstrated to be related to trauma and depression symptoms among Black women (Bryant-Davis et al., 2009; Bryant-Davis et al., 2010; Sabri et al., 2013). This intersection is particularly important because a unique confluence of trauma and oppression-related experiences affect Black women who experience sexual assault or IPV.

The issue of interpersonal violence against Black women has historically been marginalized, and its location at the intersection of race and gender calls for specific investigation into these experiences and how they are situated within institutions and power structures (Crenshaw, 1994). Black feminist scholars have highlighted how IPV and rape are connected to experiences of oppression across and between boundaries of social identities and status like race, class, gender, ability, ethnicity, age, and worker status, while highlighting the ways that the intersection of race and gender uniquely affect Black women (Collins, 2000; Davis, 1981). Black women who have been raped identify stereotypes that portray Black women as sexually deviant as a potential reason they had been raped (Neville et al., 2004) and that sexual violence against Black women is connected to the systemic and historic dehumanization of Black people (Zounlome et al., 2019). Therefore, it is especially important to understand how experiences of racism may be particularly relevant to PTSD and depression symptoms for Black women who have experienced sexual assault and IPV.

### ***Potential Moderating Factors***

Culturally grounded factors are also important to consider in order to further understand the complex relationship between racism and mental health among Black women. Racial identity, or the signif-

icance that Black individuals place on their race when defining themselves, has been implicated as a factor that is related to mental health outcomes (Willis & Neblett, 2020). Research has shown that racial identity may buffer or strengthen the association between racism and deleterious health outcomes (Banks & Kohn-Wood, 2007; Carter & Reynolds, 2011; Cross et al., 1998; Sellers et al., 2006). One aspect of racial identity includes public regard, or how one believes Black people are positively or negatively viewed by others (Sellers et al., 1997). A meta-analysis of 27 studies examining Black racial identity factors found that those who have higher public regard (i.e., believing that other view Black people more positively) report less experiences of racism and less psychological distress from these experiences (Lee & Ahn, 2013). Research also indicates that low public regard (i.e., believing that others view Black people more negatively) may be protective for the relation between racism and psychological distress (Sellers et al., 2003; Sellers et al., 2006; Sellers & Shelton, 2003). The link between cultural and individual racism and anticipatory racism-related stress responses is greater for Black individuals with low public regard (Hope et al., 2011), suggesting that lower public regard may also be a protective factor in the relation between experiencing institutional racism and mental health outcomes. However, no known research has examined how these relations may be unique for the relation between institutional racism-related stress and depression. Further, there is a paucity of research examining these relationships among Black women (Williams & Lewis, 2019), who may be more likely to experience stronger group identification attitudes with respect to racial identity (Martinez & Dukes, 1997). Black women report experiencing more race-related stress from institutional racism than Black men (Carter & Reynolds, 2011). Thus, public regard may be a particularly salient identity factor influencing the relationship between institutional racism-related stress and depression among Black women.

### ***Current Study***

Racism is systemic and embedded in institutions in the U.S., yet the bulk of research investigating the impact of racism on mental health focuses exclusively on individual-level experiences of racism. The current study aims to understand how experiencing racism from the police or the courts and interpersonal violence are

related to PTSD and depression symptomatology among Black women. Given that interpersonal violence and racism may have unique relations to mental health outcomes as stressors salient to experiences of oppression, we considered effects on conjoined and separate outcomes. Further, we aim to explore how racial identity, specifically public regard, may moderate the relationship between experiencing institutional race-related stress (i.e., a measure assessing stress related to experiences of institutional racism) and depression symptoms among Black women. We hypothesize that (a) when controlling for number of trauma types experienced, interpersonal violence (i.e., sexual assault or IPV) will be related to more severe combined and independent PTSD and depression symptoms even when other trauma types experienced are considered, (b) experiencing racism from police or courts will be related to higher combined and independent PTSD and depression symptoms as compared to those who do not experience racism from police or courts, (c) Black women who experience both racism from police or courts and interpersonal violence will report the highest levels of PTSD and depression symptoms, and (d) public regard will moderate the relation between institutional race-related stress and depression symptoms such that at low levels of public regard, experiencing institutional race-related stress will be related to lower depression symptoms.

## **Methods**

### ***Procedure***

Participants in Study 1 and Study 2 ( $n = 1,471$ ,  $n = 110$ ) were recruited from 2009–2017 and 2017–2019, respectively, and completed slightly different measures. Participants were approached in primary care, diabetes, and gynecology waiting rooms located in an urban, public hospital in Atlanta, GA. Trained research assistants assessed potential participants for eligibility criteria; all participants were between 18 and 65 years old, able to give informed consent, and were not demonstrating active psychosis. Each participant identified their sex as female and self-identified as Black or African American, or mixed-race with Black or African American as one of their identified races. While gender was not included in the demographic section of this study, we use the word “women” to describe this sample. After an eligibility assessment and participant completion of informed consent, research assistants ver-



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bally administered an interview that included demographic information, self-report measures, and trauma history. Participants were compensated \$15 for the full assessment. All procedures were approved by the Emory University Institutional Review Board and Grady Research Oversight Committee and were in accordance with the Declaration of Helsinki. For a full summary of procedures, see Gillespie et al. (2009).

### Study 1

#### PARTICIPANTS

The average age of participants ( $n = 1,471$ ) was approximately 40 ( $M = 39.54$ ,  $SD = 13.22$ ) and about half (48.8%) of participants had monthly incomes less than \$999 per month. About half (48.2%) had experienced sexual assault over the age of 14 or intimate partner violence. For a full summary of demographics for this sample, see Table 1.

#### MEASURES

*Traumatic Events Inventory (TEI*; Schwartz et al., 2006). The TEI is a 14-item self-report screening measure that assesses lifetime occurrence and frequency of trauma exposure. This measure has been

used in previous studies with Black urban populations (Gillespie, 2009). For the purposes of this study, multiple items on this scale were used to recode whether or not women had experienced rape/sexual assault and/or intimate partner violence in their lifetime: (1) Between the ages of 14 and 17 did an adult or older teenager sexually abuse you or have any type of sexual contact with you? (2) After the age of 17 did someone rape you or sexually assault you? (3) Have you been attacked with a gun, knife, or other weapon by a spouse, romantic partner, or boyfriend/girlfriend? and (4) Have you been attacked without a gun, knife, or other weapon by a spouse, romantic partner, or boyfriend/girlfriend? If participants responded “yes” to any of these items, they were coded as having experienced interpersonal violence. Total trauma types experienced was calculated by summing the number of questions for which participants responded “yes.” Possible scores ranged from 0 to 12, with higher scores indicating higher incidences of a range of traumatic event exposure.

*Experiences of Discrimination Scale (EDS-Short*; Krieger et al., 2005). An 8-item modified version of the EDS-short was

used to measure experiences of racism. The full scale demonstrated high reliability among Black participants ( $\alpha = .81-.87$ ), and the shortened scale showed similar reliability ( $\alpha = .92$ ; Allen et al., 2019). Items query whether participants have experienced discrimination because of their race or ethnicity in accessing housing, medical care, the police or government, or interpersonally. For the purposes of our analyses, we used participants’ responses to one item: “Have you experienced discrimination from the police and/or courts?”

*Modified PTSD Symptom Scale (MPSS-SR*; Falsetti et al., 1993). The MPSS is an 18-item self-report measure that corresponds to the DSM-IV PTSD criteria. The scale assesses the frequency of PTSD symptoms over the past week, which are summed to calculate a score ranging from 0 to 54. The scale has been validated in community samples, and demonstrates high internal validity ( $\alpha = .86-.90$ ; Falsetti et al., 1993; Morgan-López et al., 2019). In our sample, the scale demonstrated excellent reliability ( $\alpha = .90$ ).

*Beck Depression Inventory (BDI*; Beck et al., 1996). The BDI is a 21-item, frequently used measure of depressive symptoms that has shown high reliability and internal consistency ( $\alpha = .90$ ) among low-income, Black, medical outpatients (Brantley et al., 2004; Grothe et al., 2005). The BDI assesses the severity of depressive symptoms over the past 2 weeks on a four-statement scale coded as 0 to 3. Ratings on each item are summed to calculate a total score ranging from 0 to 63. In our sample, the scale demonstrated excellent reliability ( $\alpha = .93$ ).

#### ANALYTICAL PLAN

A multivariate analysis of variance (MANOVA) was used to assess whether experiencing institutional racism (i.e., experiencing racism from police and the courts) and interpersonal violence (i.e., intimate partner violence or sexual assault over 14) would be related to higher PTSD and depression symptoms, considered simultaneously and separately. Number of trauma types experienced, age, education, and income were included as covariates. Age, education, and income were included as covariates as these factors may be associated with depression and PTSD symptoms, and we wanted to ensure that our predictors accounted for variability in outcome variables above and beyond the effects of age, education, and income. Number of trauma type experienced was included in order to examine the specific effects of

**Table 1.** Sample 1 Demographics

		Frequency	Percentage
<b>Education</b>	< 12th	284	19.3%
	12th or high school grad	467	31.7%
	GED	61	4.1%
	Some college or tech school	380	25.8%
	Tech school graduate	91	6.2%
	College graduate	148	10.1%
	Graduate school	40	2.7%
<b>Income</b>	\$0-249	219	14.9%
	\$250-499	121	8.2%
	\$500-999	378	25.7%
	\$1000-1999	461	31.3%
	\$2000 or more	292	19.9%
<b>Employment</b>	No	968	65.8%
	Yes	502	34.1%
<b>Disability Support</b>	No	1187	80.7%
	Yes	208	19%
<b>Relationship Status</b>	Single or never married	860	58.5%
	Married	167	11.4%
	Divorced	255	17.3%
	Separated	87	5.9%
	Widowed	38	2.6%
	Domestic partner	64	4.4%

experiencing interpersonal violence on depression and PTSD. Univariate tests were used to examine simple main effects.

## Study 2

### PARTICIPANTS

The average age of participants ( $n = 110$ ) was approximately 40 ( $M = 39.54$ ,  $SD = 13.22$ ) and about half (48.8%) of participants had monthly incomes less than \$999 per month. About half (48.2%) had experienced sexual assault over the age of 14 or IPV. For a full summary of demographics for this sample, see Table 2.

### MEASURES

*Index of Race-Related Stress-Brief (IRRS-Brief; Utsey, 1999).* Based on the original, 46-item Index of Race-Related Stress developed by Utsey and Ponterotto (1996), the short IRRS-B is a validated 22-item self-report measure that assesses the frequency and degree of race-related stressors on a five-point Likert scale from 0 (*this never happened to me*) to 4 (*this event happened and I was extremely upset*). For the present study, only the Institutional Racism subscale was used, which demonstrated good reliability in other sample

groups ( $\alpha = .85$ ). Example items include: “you were refused an apartment or other housing,” “you suspect it was because you are Black,” and “you have heard racist remarks or comments about Black people spoken with impunity by White public officials or other influential White people.” In our study, the full scale demonstrated excellent reliability ( $\alpha = .93$ ). The Institutional Racism subscale also demonstrated acceptable reliability ( $\alpha = .75$ ).

*Multidimensional Inventory of Black Identity–Short Form (MIBI; Sellers et al., 1997).* Racial identity was measured using the short form of the MIBI, which has been used in similar samples (Mekawi et al., 2020). The MIBI consists of 27 items and consists of seven subscales across three dimensions of racial identity: (1) Ideology, (2) Centrality, and (3) Regard, which consists of two subscales: Private and Public Regard. For this study, the Public Regard subscale was used, which is a 4-item measure of how an individual believes Black people are positively or negatively viewed by others (e.g., “In general, others respect Black people”). Higher scores indicate that

one believes others view Black people more positively, and lower scores indicate that one believes others view Black people more negatively. Participants rate each item on 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Internal consistency for the Public Regard subscale is moderately high ( $\alpha = .73$ ; Simmons et al., 2008;  $\alpha = .77$ ; Vandiver et al., 2009). In our sample, the MIBI demonstrated acceptable reliability ( $\alpha = .76$ ).

*BDI (Beck et al., 1996).* See Study 1 for a full summary of this scale. Among this sample, the Beck Depression Inventory demonstrated similar, excellent reliability ( $\alpha = .94$ ).

### DATA ANALYTICAL PLAN

We conducted a hierarchical regression ( $n = 110$ ) analysis using the moderation model from PROCESS macro for SPSS Version 3.4 (Hayes, 2013) in order to examine whether public regard moderated the relationship between institutional race-related stress and depression symptoms. There was inadequate power to assess whether public regard moderated the rela-



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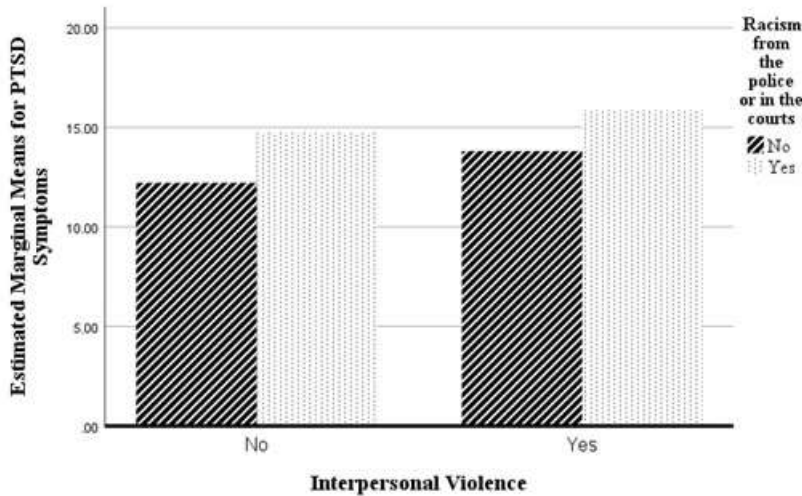
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Covariates appearing in the model are evaluated at the following values:

TEI\_TOTAL\_TYPES\_ Experienced = 3.0967, How old are you? = 39.54, What was the highest grade you completed in school? = 2.09, What is your approximate household monthly income? = 2.33

\* = significant difference

**Figure 1.** Graph of PTSD Scores by Experiencing Interpersonal Violence and Racism from Police or the Courts

**Table 2.** Sample 2 Demographics

		Frequency	Percentage
Education	< 12th	14	12.7%
	12th or high school grad	31	28.2%
	GED	4	3.6%
	Some college or tech school	33	30.0%
	Tech school graduate	4	3.6%
	College graduate	18	16.4%
	Graduate school	6	5.5%
Income	\$0-249	10	9.1%
	\$250-499	11	10.0%
	\$500-999	20	18.2%
	\$1000-1999	30	27.3%
	\$2000 or more	39	35.5%
Employment	No	67	60.9%
	Yes	43	39.1%
Disability Support	No	80	72.7%
	Yes	30	27.3%
Relationship Status	Single or never married	55	50.0%
	Married	11	10.0%
	Divorced	21	19.1%
	Separated	5	4.5%
	Widowed	9	8.2%
	Domestic partner	9	8.2%

tionship between institutional race-related stress and PTSD symptoms due to low sample size. Age, education, and income were included as covariates as these factors may be associated with depression, and we wanted to ensure that our predictors accounted for variability in depression symptoms above and beyond the effects of age, education, and income. Significant interactions were probed using the PROCESS macro. To interpret these interactions, simple slopes were calculated at low ( $-1$  SD), moderate (mean), and high ( $+1$  SD) values of the moderator variable (public regard).

## Results

### Study 1

Means, standard deviations, and inter-correlations for all measured variables for the first sample (Study 1,  $n = 1471$ ) are presented in Table 3. The results of our MANOVA indicated that there was no significant interaction effect between experiencing interpersonal violence and racism from police or the courts on the combined dependent variables of PTSD and depression symptoms,  $F(2, 1462) = .119$ ,  $p = .888$ , Wilks'  $\Lambda = 1.00$ , partial  $\eta^2 = .000$ . There were significant main effects for both experiencing interpersonal violence,  $F(2, 1462) = 3.685$ ,  $p = .025$ , Wilks'  $\Lambda = .995$ , partial  $\eta^2 = .005$ , and experiencing racism from police or the courts,  $F(2, 1462) = 5.598$ ,  $p = .004$ , Wilks'  $\Lambda = .992$ , partial  $\eta^2 = .008$ , for simultaneous PTSD and depression symptoms.

Follow up univariate two-way ANOVAs were conducted to consider main effects of racism from police and the courts and interpersonal violence for PTSD (See Figure 1) and depression (See Figure 2) symptoms separately. There was a significant main effect of experiencing interpersonal violence for depression,  $F(1, 1,463) = 7.372$ ,  $p = .007$ , partial  $\eta^2 = .005$ , but not PTSD,  $F(1, 1,463) = 2.721$ ,  $p = .099$ , partial  $\eta^2 = .002$ . Thus, Black women who experienced IPV or rape reported significantly higher depression symptoms ( $EMM = 16.70$ ,  $SE = .519$ ), than those who had not ( $EMM = 14.42$ ,  $SE = .582$ ). The difference in estimated marginal means for PTSD between Black women who experienced IPV or sexual assault ( $EMM = 14.851$ ,  $SE = .508$ ) and those who had not ( $EMM = 13.496$ ,  $SE = .569$ ) was not significant. The effect of experiencing racism from police or the courts was significant for both PTSD,  $F(1, 1,463) = 10.187$ ,  $p = .001$ , partial  $\eta^2 = .007$ , and depression symptoms,  $F(1, 1,463)$

= 7.716,  $p = .006$ , partial  $\eta^2 = .005$ . Thus, Black women who experienced racism from police or the courts reported significantly higher depression symptoms ( $EMM = 16.567$ ,  $SE = .645$ ) than those who had not ( $EMM = 14.550$ ,  $SE = .320$ ). Black women who experienced racism from police or the courts reported significantly higher PTSD symptoms ( $EMM = 15.307$ ,  $SE = .631$ ) than those who had not ( $EMM = 13.040$ ,  $SE = .313$ ).

### Study 2

Means, standard deviations, and intercorrelations for all measured variables in the second sample (Study 2,  $n = 110$ ) are presented in Table 4. Public regard was related to depression scores ( $r = -.201$ ,  $p < .05$ ) and institutional race-related stress ( $r = -.202$ ,  $p < .05$ ).

Regression analysis revealed that institutional race-related stress and public regard accounted for a significant amount of variance in depression symptoms,  $R^2 = .1507$ ,  $F(6, 103) = 23.05$ ,  $p < .01$ . The interaction between public regard and institutional race-related stress was significantly related to depression symptoms,  $\beta = .0836$ ,  $SE = .0399$ ,  $p < .05$ ; 95% CI [.0044, .1628]. See Table 5 for a summary of analysis. When examining the simple slopes for these analyses, the effect of institutional race-related stress predicting depression symptoms was significant at one SD above the mean for public regard,  $\beta = .7761$ ,  $SE = .3647$ ,  $p < .05$ ; 95% CI [.0528, 1.4994]. At the mean ( $\beta = .2742$ ,  $SE = .2315$ ,  $p = .24$ ; 95% CI [-.1850, .7334]) and one SD below the mean ( $\beta = -.2276$ ,  $SE = .2984$ ,  $p = .45$ ; 95% CI [-.8194, .3642]) for public regard, the relation between institutional race-related stress and depression was not significant. Thus, the relation between experiencing institutional race-related stress and depression symptoms was only significant at high levels of public regard (see Figure 3).

### Discussion

This study examined intersecting associations between experiencing interpersonal violence (i.e., sexual assault or IPV) and racism from police/courts and depression and PTSD symptoms among Black women. In a second sample, we also examined how public regard, or how one views others as seeing Black people more positively or negatively, moderates the relation between experiencing institutional race-related stress and depression symptoms. No research to date has examined how

**Table 3.** Summary of Intercorrelations, Means, and SDs for All Measured Variables for Study 1

Measures	1	2	3	4	5	6	7	8
1. Discrimination from police or courts	-							
2. IPV or sexual assault	.182**	-						
3. Depression symptoms	.176**	.306**	-					
4. PTSD symptoms	.210**	.338**	.701**	-				
5. # of trauma types experiences	.292**	.606**	.389**	.491**	-			
6. Age	.060*	.131**	.000	.001	.142**	-		
7. Income	-.053*	-.035	.137**	.100**	-.028	-.003	-	
8. Education	.081**	.022	-.064*	-.038	.113**	.084*	.217**	-
Means	.22	.48	14.92	13.49	3.10	39.54	2.33	2.09
SD	.41	.50	11.87	12.21	2.27	13.22	1.30	1.71

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

**Table 4.** Summary of Intercorrelations, Means, and SDs for All Measured Variables for Study 2

Measures	1	2	3	4	5	6
1. Institutional race-related stress	-					
2. Public regard	-.202*	-				
3. Depression symptoms	.137	-.201*	-			
4. Age	.161	-.003	.093	-		
5. Income	-.213*	-.078	-.108	-.189*	-	
6. Education	.034	-.222*	-.186	.044	.249**	-
Means	11.51	17.56	21.22	42.18	2.70	2.55
SD	5.86	5.41	13.83	12.97	1.30	1.82

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

**Table 5.** Summary of Moderation Analyses among Black Women Reporting Racism and Sexual Assault

Variable	$\beta$	SE	$t$	$p$
Covariates				
Age	.087	.100	.872	.385
Income	-.193	1.050	-.184	.854
Education	-1.813	.732	-2.476	.015
Predictors				
Institutional Race-Related Stress	-1.234	.710	-1.734	.086
Public Regard	-1.570	.516	-3.040	.003
Interaction term				
Institutional racism $\times$ public regard	.084	.040	2.094	.039

$F(1, 103) = 4.386$ ,  $p < .05$ ;  $R^2 \Delta = .036$

racism specifically experienced from the police or courts relates to PTSD and depressive symptoms among Black women who have experienced interpersonal violence.

Black women who reported experiencing racism from police or the courts reported significantly higher PTSD and depression symptoms than those who did not. These findings have especially significant relevance for Black women who have experienced sexual assault or IPV. As police and the court system are often involved in responses to sexual assault and IPV (Washington, 2001; Weist et al. 2014), racism from these sources may act as a second stressor that may exacerbate depression and PTSD symptoms. In addition to these novel implications, these findings add to literature that has demonstrated relations between racism to depression (Carter et al. 2020; West et al., 2010) and PTSD symptoms (Carter et al. 2019), as our findings demonstrate that experiences of racism from the police or courts are related to mental health outcomes among Black women.

When the simultaneous outcome of PTSD and depression symptoms was considered, experiencing interpersonal violence was related to significantly higher scores on these outcomes even when controlling for total trauma types experienced.

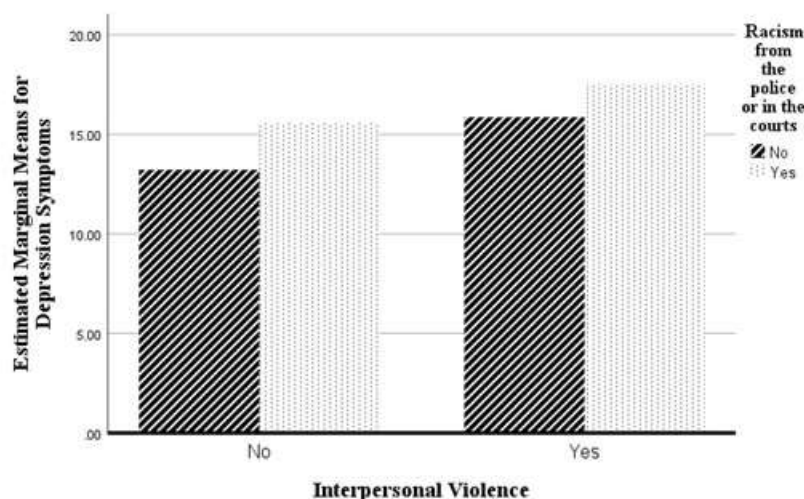
When PTSD and depression symptoms were considered independently, experiencing interpersonal violence was not uniquely related to PTSD symptoms above and beyond the effect of total traumas experienced. However, experiencing interpersonal violence was related to higher depression symptoms, even when controlling for total trauma type exposure. Thus, interpersonal violence has a stronger relation to depression symptoms for Black women compared to other trauma types. One explanation of these findings is that violence connected to contexts of oppression may be particularly related to feelings of helplessness or loss of control, which have been implicated as playing a crucial etiological role in the development of depressive symptoms (Abramson et al., 1978). If violence connected to oppression is particularly related to feelings of helplessness or hopelessness, this association could be compounded by additional oppression related to being a Black woman. Further, as both this effect of interpersonal violence and racism were significant when combined, but not independent, outcomes of PTSD and depression were considered, it may be that more holistic models of mental health outcomes to these stressors are necessary.

Recent research has found that feelings of helplessness mediates the relation

between racism and depression among Black young adults (Madubata et al., 2018). Future research could consider if feelings of hopelessness and powerlessness are a mechanism through which oppression-related stressors are linked to depression symptoms in Black women. Some research has found that problem-focused coping, or active engagement to change a stressor, buffers the relation between racism and depression symptoms among Black women, such that experiences of racism were related to lower symptoms of depression for Black women who reported higher levels of problem-focus coping (West et al., 2010). If interventions that promote problem-focused coping styles or increasing feelings of agency and control are effective at reducing this relation, this approach may have important clinical utility for Black women who have experienced interpersonal violence.

We also examined if public regard moderated the association between institutional race-related stress and depression symptoms. No research to date has examined how components of racial identity could influence the relations between institutional race-related stress and depression symptoms among Black women with high levels of trauma exposure. We found that the relation between institutional race-related stress and depression was only significant at relatively higher levels of public regard, suggesting that experiencing institutional race-related stress is only related to higher depression symptoms for Black women who report feeling that Black people are viewed positively by others. This is consistent with previous research demonstrating that lower public regard serves as a protective factor in the relation between racism and psychological distress (Sellers et al. 2006; Sellers & Shelton, 2003). One potential reason for this relationship is that when individuals believe others think more negatively of Black people (i.e., low public regard), experiences of racism are consistent with their expectations, which may lead to lower rates of endorsed stress (Sellers et al., 2001). On the other hand, individuals who endorse high positive regard may experience more dissonance in the context of experiencing institutional racism, and consequently may experience higher depressive symptoms.

In addition to providing support to existing literature, our findings lend themselves to future studies that contextualize experiences of interpersonal violence for Black women and how systems of care could further perpetuate inequity. One



Covariates appearing in the model are evaluated at the following values:

TEI\_TOTAL\_TYPES\_ Experienced = 3.0967, How old are you? = 39.54, What was the highest grade you completed in school? = 2.09, What is your approximate household monthly income? = 2.33

\* = significant difference

**Figure 2.** Graph of Depression Scores by Experiencing Interpersonal Violence and Racism from Police or the Courts



potential area for further investigation would be post-assault interventions divested from carceral systems that may subject Black women to racist stressors. Black women have and continue to form post-assault responses to meet these needs, which have been incorporated and called for in research (Bryant-Davis et al., 2015; Nicolaidis et al., 2010). Researchers should consider how to address potential effects of institutional racism in post-assault care settings, in addition to ways that institutions responding to sexual assault and intimate partner violence may subject Black women to additional stressors that exacerbate symptoms of PTSD and depression and inhibit use of post-assault resources (Weist et al., 2014).

Future research should also consider how racial identity and other culturally relevant factors like religiosity impact Black women's physical health. Interpersonal violence and racism are both related to deleterious health outcomes such as cardiovascular disease, accelerated aging, and chronic pain (Bonomi et al., 2007; Burgess et al., 2009; Carter et al., 2019), and there is some evidence that racial identity factors and religious involvement may buffer these associations (Cooper et al., 2014; Volpe et al., 2018). Understanding these culturally relevant buffering factors would provide more holistic models of how interpersonal violence and racism impact Black women's health.

### Limitations

While this study makes important contributions to our literature, several limitations should be noted. First, our samples consist of Black women living in urban contexts that may have unique relations to stressors like institutional racism. Thus, our findings may not be generalizable to Black women living in rural or exurban contexts. Second, our measure of racism from police or the courts is a single item measure that does not capture the severity or degree of how stress these events caused. Third, this study is cross-sectional in nature. We cannot be certain about the directionality or make temporal conclusions about the relation between experiencing racism from the police or the courts to PTSD and depression symptoms. Thus, longitudinal research is important to fully understand these relations. Future research could investigate the current study's research questions in recent assault survivors to determine how these factors prospectively impact subsequent mental health symptoms and could investigate

specific institutional experiences when interacting with these systems. Current longitudinal research indicates that early experiences of racism may be particularly related to physical health and depression symptoms in later life (Carter et al., 2019; Sellers & Shelton, 2003). Further, research has found that individuals with low public regard demonstrate different longitudinal responses in depression symptoms after racist stressors (Hoggard et al., 2015). Thus, examining these longitudinal relations for institutional racism and potential moderating factors may be particularly important to fully understand the effects of these stressors on mental and physical health outcomes.

Finally, we did not consider gender or gendered racism in our assessment of racism-related stressors. Black women experience oppression unique to their identity as *Black women*, which was not encapsulated in our measures for racism. Experiencing gendered racism is related to PTSD and depression symptoms for Black women (Moody & Lewis, 2019; Williams & Lewis, 2019). Future research should consider the ways that experiencing gender and gendered racism interpersonal violence as an act of gendered racism might affect PTSD and depression outcomes. Further, additional contexts of oppression

that are also related to both experiences of racism from the police and interpersonal violence (e.g., gendered racism, disability, sexual orientation, immigration status, and sex worker status) are particularly important to consider with respect to the relation between experiences of racism from the police, interpersonal violence, and mental health outcomes.

### Conclusions

This study has important implications for the health and care of Black women, particularly Black women who have experienced interpersonal violence. Clinicians, researchers, and policymakers should consider the effects of racism-related stressors on mental health outcomes for Black women, particularly those who have experienced interpersonal violence. As public regard moderated the relation between institutional race-related stress and depression symptoms among Black women, our findings also inform how culturally relevant factors like racial identity or attitudes relating to one's identity as a Black woman may be important risk and resiliency factors in these relations. Finally, this research emphasizes the importance of considering how experiences of oppression are related to mental health outcomes for Black women. Racism and interpersonal violence

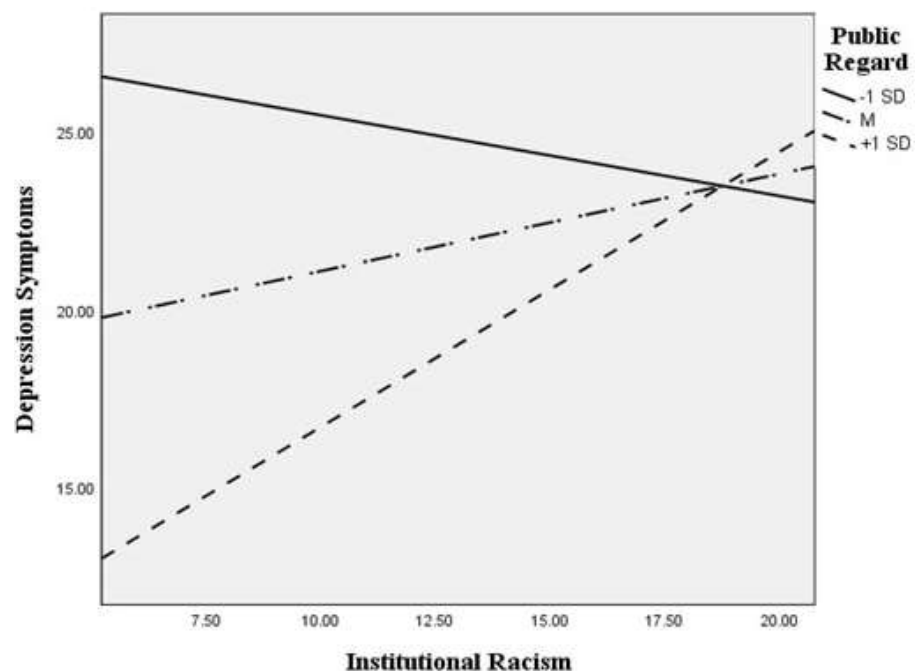


Figure 3. Graph of Public Regard as a Moderator Between Institutional Race-Related Stress and Depression Symptoms Among Black Women

may have unique relations to mental health outcomes as stressors intimately connected to contexts of oppression. These considerations may inform potential mechanisms, and therefore clinical approaches, to address connections between these stressors and mental health outcomes among Black women.

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## ABCT Researcher Spotlights

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# Victims of Sexual Assault Report Different Barriers Preventing Them From Reporting Than Nonvictims

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SEXUAL ASSAULT is one of the least reported crimes in the United States (Langton, 2012). In 2018, only an estimated 25% of sexual victimizations were reported to police (Morgan & Oudekerk, 2019). This was nearly a 15% decline in reports from the year prior. Furthermore, the majority of cases reported to the police were not prosecuted, which may discourage individuals from making a formal report (Campbell et al., 2014; Lonsway & Archambault, 2012). There are many other reasons, or barriers, that may prevent an individual from reporting sexual victimization, ranging from structural to personal. Women in particular have reported shame, a fear of retaliation, confidentiality concerns, and a fear of not being believed as the most serious barriers preventing them from reporting (Sable et al., 2006). Another barrier identified among women who were sexually assaulted included the feeling that the incident was “handled by the survivor,” indicating that they did not feel it was serious enough to report, did not view the assault as a crime, or did not want to pursue legal or criminal ramifications for the perpetrator (Zinzow & Thompson, 2011). Further, many women have indicated that they are unsure about what constitutes sexual assault (Schwarz et al., 2017), so they may not report a potential instance of sexual assault to authorities. This uncertainty about what constitutes sexual assault is a key barrier for reporting. Certain resources might also be necessary for reporting sexual assault. It can take considerable time, social support, and knowledge about the reporting process to come forward about a sexual assault, and individuals who do not have these resources may face greater difficulties if they do try to report (Spencer et al., 2017).

For many women who report being a victim of sexual assault, potential consequences of coming forward are considered greater than any potential benefits (Schwarz et al., 2017). This can be especially true for racial or ethnic minority victims. African Americans, in particular, identified a distrust or dislike of the police as a major barrier to reporting sexual violence (Thompson et al., 2007) and specifically believed that the police would blame them for the assault. While many women identified fear of being blamed as a barrier, perceptions of and experiences with discrimination by the criminal justice system may be of particular concern for African-American women. Racial disparities in sexual assault victimization indicate that minority women may be at higher risk of victimization than White women. National surveys have found that African American/Black women, Native American/Indigenous women, and women of mixed racial or ethnic identity report experiencing higher rates of sexual assault victimization, with the largest discrepancies between White women and Native American/Indigenous women or women of mixed racial or ethnic identity (Planty et al., 2013; Rosay, 2016; Tjaden & Thoennes, 2006). It is important to understand what barriers, such as a distrust of police, might impact minority victims because they disproportionately suffer from sexual violence and may face additional barriers that prevent them from reporting.

Other consequences of coming forward may involve the disclosure of illegal behaviors or behaviors that others might view as negative, such as substance use, underage alcohol use, sex work, or other activities one might feel uncomfortable disclosing to the police or to the legal system. In qualitative responses to the presence of alcohol,

survivors have reported statements such as: “I was drunk and felt like it was my fault and no one would believe me” and “The guy probably didn't know how drunk I was. I don't want to ruin his entire life” (Schwarz et al., 2017). These responses suggest that victims worry that the involvement of substances may lead others to blame them for the assault, rather than place the blame on the perpetrator. Further, the researchers identified many survivors who viewed the risk of coming forward about being assaulted while using controlled substances as a deterrent to reporting sexual assault to authorities, including drinking alcohol while underage (Schwarz et al.). Often, multiple barriers are present in a sexual victimization case, which can make it even more difficult to report.

## Literature Review

### Rape Culture

Rape culture is defined by Phipps and colleagues (2018) as encompassing general cultural beliefs, attitudes, and expectations that support sexual violence against women. Rape culture includes an acceptance of objectifying women, using sexist and homophobic language, and normalizing or minimizing sexual assault and harassment (Phipps et al.). Rape culture may also contribute to the difficulty that many women have in coming forward about sexual assault, the negative experiences associated with reporting, and the low conviction rate of alleged perpetrators of sexual assault. It is difficult to quantitatively measure or define rape culture; however, multiple studies have attempted to qualitatively describe it.

Boswell and Spade (1996) identified specific places that women viewed as more threatening or dangerous for women, including local bars and fraternities. The researchers sought to identify factors that made those places more dangerous than other bars or party settings that were not considered as dangerous. Additionally, they collected qualitative responses from men and women who engaged with fraternity parties and the local bar scene. The authors described several factors that were present at high-risk fraternity house parties and not often at low-risk ones—namely, an uneven ratio of men and women at these parties, a poor quality of social interactions, and a greater level of hostility toward women. This study described situational factors that increased the likelihood of sexual assault, and, similarly, decreased the likelihood of reporting sexual assault.

These factors included alcohol consumption, hostile behavior, and sexist behavior.

Research by Burnett and colleagues (2009) also focused on rape culture but specified their research to focus on communication about consent, sex, sexual assault, and responses to sexual assault. They also discussed barriers to reporting sexual assault in focus groups. One topic the participants discussed was the difficulty of knowing when an instance of unwanted sex, specifically date-rape, was considered sexual assault. The participants felt that consent could be ambiguous and therefore did not understand where to draw the line between sexual assault and consensual sex. Burnett and colleagues went on to conclude that rape culture muted victims and perpetuated the stigma surrounding sexual assault before, during, and after it occurred.

### Experiences With Legal Systems

When women report being victims of sexual assault to law enforcement, many indicate having negative experiences. In a qualitative study with victims of sexual assault, the majority (63%) of participants who reported to formal service providers received negative reactions such as blame, unsympathetic responses, and cold or detached responses (Ahrens et al., 2007). One survivor described how they felt after having a negative reaction from the police as: "It was painful. It felt like being raped again" (Ahrens et al.). These negative experiences involved in formal sexual assault reporting can deter victims from reporting and cause further trauma.

Perceptions of the police and perceived likelihood of experiencing institutional bias have been shown to play a role in victims' decisions to report sexual assault (Lorenz et al., 2019). It is not uncommon for victims to experience secondary victim-

ization, in which they feel assigned responsibility for the incident by law enforcement or feel additional trauma due to interactions with law enforcement (Patterson, 2011). Police may believe and invoke "rape myths" during their interactions with survivors, contributing to secondary victimization. Research has suggested that a large proportion of police officers ascribe to rape myths, though not necessarily a larger proportion than the general public (Edwards et al., 2011; Smith et al., 2016), and that these beliefs may impact up to half of official police reports (Shaw et al., 2017). Further, how police interact with victims may impact whether or not their case is prosecuted; Patterson found that victims of sexual assault who experienced secondary victimization by law enforcement were less likely to have their cases prosecuted than those who were treated compassionately.

While many sexual assault victims (and victims of other crimes) have negative experiences with police and legal systems, positive experiences with the justice system have been shown to improve some of the negative consequences of victimization, including providing a feeling of closure, empowering victims, and helping them feel safer (Elliott et al., 2014). Although many victims who indicated that they went to the police had negative experiences, one notable exception was in the case of a former sex worker who was initially reluctant to report, but whose report was responded to in a positive manner by law enforcement, resulting in prosecution (Lorenz et al., 2019). Positive experiences with law enforcement seem to mitigate some of the trauma that sexual assault inflicts; at the very least, they avoid adding additional trauma or victimization to the victim.

### Significance, Purpose, and Hypotheses

Women who have been sexually assaulted may have a different perspective when responding to vignette research that describes a sexually aggressive scenario than women who have not been assaulted. Sexual assault victims do not need to imagine what barriers may prevent someone from reporting when they have experienced a similar situation. In the current study, we explored if women who identified as victims of sexual assault differed in their perception of barriers that would prevent them from reporting than women who do not identify as having been previously assaulted. Additionally, we sought to obtain qualitative responses about this topic to further explore how women feel about reporting sexual victimization and examine themes regarding formal and informal reporting.

Due to the negative experiences many women describe when reporting sexual assault to law enforcement (Ahrens et al., 2007; Patterson, 2011) and the feeling of being muted and shamed after sexual assault, as described by Burnett and colleagues (2009), we hypothesized that women who identified as victims of sexual assault would perceive distrust of the criminal justice system, disbelief in successful prosecution, and shame as larger barriers to reporting sexual assault than women who did not identify as being victims of sexual assault. We did not hypothesize that there would be differences between the groups for the other barriers we were investigating, including a fear of not being believed, stigma, confidentiality concerns, fear of retaliation, lack of knowledge about reporting, unawareness of the importance of treatment, lack of resources to report, and cultural or language barriers. Additionally, we hypothesized that women who reported being victims of assault would select more barriers overall than women who did not report being victims of sexual assault.

### Method

#### Participants

Three hundred twenty-five female students and members of the surrounding community were recruited to participate in the study. Student participants were recruited from a large Midwestern university using an online psychology subject pool in exchange for .5 course credits. Participants from the community were

**Table 1.** Frequencies and Chi-Square Results for Barriers Reported by Women Who Do and Do Not Identify as Victims of Sexual Assault

Barriers	Identify		Do Not Identify		$\chi^2$
	<i>n</i>	%	<i>N</i>	%	
Stigma	47	59%	129	56%	1.279
Shame	58	73%	161	70%	.181
Fear of retaliation	38	48%	95	41%	3.018
Fear of not being believed	62	78%	151	66%	3.886
Confidentiality concerns	29	36%	44	19%	10.955*
Disbelief in prosecution	40	50%	88	38%	4.754
Unawareness of treatment	14	18%	25	11%	2.455
Lack of knowledge	20	25%	43	19%	1.458
Lack of resources	16	20%	28	12%	4.711
Distrust of the police/legal system	28	35%	46	20%	13.867*
Cultural/Language Barriers	3	4%	13	6%	.995



recruited by word-of-mouth and with physical flyers posted in community locations. Community participants were compensated with \$10 Amazon gift cards. The majority (61.5%) of participants were students, while the remainder (38.5%) were members of the community. Most participants (70.5%) selected that their age was between 18 and 22 years old. White women made up the majority of the sample (67.6%), followed by African American/Black women (11.5%), Asian American women (8.7%), Middle Eastern/Arabic women (4.7%), Hispanic/Latina women (4.7% each), women of mixed racial or ethnic identities (1.6%), and women who identified as Native Hawaiian/Pacific Islander (.3%). The remaining respondents preferred not to disclose their race/ethnicity.

### Procedure

Women who wished to participate signed the informed consent form before moving on to the study measures. Participants completed a demographic questionnaire, then read a sexual assault vignette that was adapted for this study based on a vignette used in previous research (Parkhill et al., 2016). The participants were asked to imagine that they were the woman in the vignette. In the scenario, a woman is brought to a dinner party and introduced to the man who is throwing the party, Robert, by a mutual friend, Lisa. Robert and the woman flirt and she starts to become interested in him. She sticks around after the dinner party while everyone else leaves so that she and Robert can talk more. Robert starts to become physical with the woman, but she says that she does not want to move that fast. Robert ignores her and uses physical force to hold her down and assault her as the woman continues to protest and cry. The vignette ends with the woman leaving Robert's apartment. After reading the vignette, participants were asked to write what they would do next. Next, the participants completed measures about their likelihood of reporting, the barriers that would prevent them from reporting, and the victimization scale. Participants were thanked for their time and were provided with a list of various local and national resources for victims of sexual assault.

### Measures

#### QUALITATIVE RESPONSES

Qualitative responses were obtained with an open-answer response option to the question, "After leaving Robert's (the

perpetrator's) apartment, what would you do?"

#### LIKELIHOOD OF REPORTING

Likelihood of reporting was assessed with two questions, one indicating how likely the participant would be to tell someone about the assault, and the other indicating how likely the participant would be to tell police or law enforcement about the assault. Likelihood of reporting was indicated using a 5-point Likert-type scale ranging from 1 (*extremely likely*) to 5 (*extremely unlikely*).

#### BARRIERS

To assess which barriers might prevent a woman from reporting sexual assault, a checklist of potential barriers was created. Barriers used in the checklist consisted of the most commonly listed barriers identified in previous research conducted by Sable and colleagues (2006). Additionally, participants could write in barriers that were not listed.

#### VICTIMIZATION

Prior sexual assault victimization was assessed with one question: "Have you ever been a victim of sexual assault?" Participants were given the opportunity to give the response, "prefer not to answer."

## Results

A one-way ANOVA was conducted to examine differences in the overall number of barriers those who identified as victims and those who identified as nonvictims reported. Women who identified as victims of sexual assault selected more barriers on average ( $M = 4.44$ ,  $SD = 2.16$ ) than women who did not identify as victims ( $M = 3.58$ ,  $SD = 1.95$ ),  $F(1, 308) = 10.90$ ,  $p = .001$ .

There were no significant differences in the barriers reported by community and student participants. Therefore, the participants were combined and analyzed together. Participants who chose not to disclose their victimization status ( $N = 47$ ) were not included in the data analysis. A chi square analysis was conducted to examine the differences in reported barriers between women who did ( $N = 80$ ) and did not ( $N = 230$ ) identify as victims of sexual assault (see Table 1). Relative to nonvictims, women who identified as victims of sexual assault were more likely to report a dislike or distrust of the police/justice system as a barrier of reporting,  $\chi^2(2, N = 310) = 13.867$ ,  $p = .001$ . Additionally, women who reported being victims of sexual assault were more likely to report

confidentiality concerns as a barrier to reporting,  $\chi^2(2, N = 310) = 10.955$ ,  $p = .004$ .

There were no significant differences between those who identified as victims and those who identified as nonvictims on the other potential barriers, including shame, fear of retaliation, cultural or language barriers, fear of not being believed, stigma, disbelief in successful prosecution, lack of knowledge about reporting, unawareness of the importance of treatment, or lack of resources to report (see Table 1). The factors that were most often selected as potential barriers to reporting were shame, a fear of not being believed, and stigma, with the majority of women in both groups indicating that these would be barriers for them.

### Qualitative Responses

Participants responded qualitatively to one question: "After leaving Robert's (the perpetrator's) apartment, what would you do?" Researchers independently sorted through the responses based on if participants mentioned reporting, and if yes, if they sought out formal reporting (police, doctor, hospital), informal reporting (tell a friend, tell a family member), or both. The responses were observed for similar themes. Informal reporting alone was the most common response ( $n = 114$ , 35%), followed by formal reporting alone ( $n = 81$ , 25%), both formal and informal reporting ( $n = 79$ , 24.3%), and, last, no type of reporting ( $n = 51$ , 15.7%).

A minority of women ( $n = 142$ ; 38%) specifically mentioned that they would go to the police/authorities/cops or consider calling the police (e.g., "Rape kit. Go to a police station and get a rape kit. Call my friend and cry on the way."). Four others mentioned going to the hospital and having a sexual assault forensic examination done, but did not mention the police so they were not included in the percentage of participants who would report to police first (e.g., "Immediately call my Mom [or close friend] to escort me to the nearest hospital to obtain a rape kit"). Several participants mentioned having an experience similar to what happened to the woman in the vignette, and this impacted what they would do if they were assaulted again (e.g., "I personally would immediately call Lisa, who set me up with him. I am not one to stay silent anymore as I have been a victim myself," "I would call the police and report it. Being in a situation similar to this I now know to call the police.").

The majority of respondents ( $n = 193$ , 59.3%) indicated that either their first

action or one of their first actions after being in a similar situation would be to talk to friends or family about what happened (e.g., “I would call my friend Lisa since she would know exactly where I’m at and know the circumstances. I’d tell her what happened and have her come get me.”). However, some discussed why they would not report to police, what hardships they would expect to face if they came forward, or why they would not tell anyone. “I might tell one person that I really trust. I would not probably call the cops. If it were a complete stranger it would be different,” described one participant, implying that they might be less comfortable reporting an assault perpetrated by an acquaintance than an assault perpetrated by a stranger. Another participant, after indicating that they would not tell anyone about the assault, explained that she felt she would be deemed a liar if she came forward (e.g., “I wouldn’t tell anyone. Being a woman is hard enough in society. The world will tell you that you lied and that’s what you’re made for.”). One participant was similarly worried about being perceived as a liar, but thought that she would come forward anyway (e.g., “I would call for help even if I was told I was lying”).

Most participants selected barriers that had been identified by previous research. Five participants chose to write in responses about other barriers that might prevent them from formal reporting. These responses included “confusion,” “fear and anger,” “fear of change, fear of losing that person in your life, doubt in your own judge of character, fear of ruining someone’s life for one mistake, and the weirdest of all not wanting to push my own issues onto others,” “trust issues,” and “therapists are too expensive, so I wouldn’t know where to go for help.”

## Discussion

We found that women who identified as victims of sexual assault were more likely to perceive confidentiality concerns and a distrust of the police/legal system as barriers that would prevent them from reporting sexual assault to the police than women who did not identify as victims of sexual assault. These results support our hypothesis that those who identified as victims would view a distrust of the police/legal system as a larger barrier than women who did not identify as victims. Another hypothesis that was supported by our results was that women who identified as sexual assault victims would report more

barriers, on average, than women who did not identify as victims. Our other hypotheses, that disbelief in successful prosecution and shame would be larger barriers to those who identified as victims than those who did not identify as victims, were not supported. Additionally, we found that confidentiality concerns were a larger barrier to those who identified as victims than those who did not identify as victims. It is possible that confidentiality and mistrust are more immediate concerns for victims than future successful prosecution and shame.

We suspect there are several factors involved that may explain these differences and similarities between groups, though further research on the topic is recommended. Many victims of sexual assault have reported negative experiences with the police and justice system when they attempted to report (Greeson et al., 2014; Patterson, 2011), which may partially explain why women who identified as victims reported distrust of the police and justice system as a larger barrier than women who did not identify as victims of sexual assault.

Additionally, there may be some similarities between women who are disproportionately sexually victimized and women who have negative perceptions of or experiences with police based on demographic characteristics. From 1999 to 2010, African American/Black and Native American/Indigenous women were sexually assaulted more often than White women (Planty et al., 2013), and it was previously found that African American/Black women considered a distrust of the police to be a barrier preventing them from reporting sexual violence (Thompson et al., 2007). Additionally, those with a household income of \$25,000 per year or less were sexually victimized nearly twice as often as women in the next lowest income bracket between the years of 1994 and 2010 (Planty et al.). Women who indicated belonging to a lower socioeconomic status who were previously abused by an intimate partner were less likely to call police than women who indicated belonging to a higher socioeconomic status (Cattaneo & DeLoveh, 2010). Studies have shown that one consideration survivors have when deciding to report sexual assault is their perceived likelihood of experiencing blame from police and legal systems (Lorenz et al., 2019), so it is possible that these factors intersect to form a barrier that prevents formal reporting.

There were fewer differences in barriers between women who did and did not identify as victims of sexual assault than initially expected. This indicates that women who do not identify as victims may have similar perceptions of the hardships involved in reporting as women who do identify as victims. Rape culture, which minimizes and normalizes sexual assault and harassment toward women (Phipps et al., 2018), may explain the similarities between these groups because it is embedded in a shared culture. Furthermore, though the majority of women in the current study did not identify as victims of sexual assault, roughly 20% of women in college and 18% of women in the United States do identify as such (Black et al., 2011; Muehlenhard et al., 2017). Given that roughly half of women who are assaulted disclose it to someone, usually informally (Jacques-Tiura et al., 2010), nonvictims may learn based on secondhand experience about the barriers involved in reporting.

Our qualitative findings align with previous research suggesting that informal disclosure of sexual assault is more common than formal reporting of sexual assault (Ahrens et al., 2007). The majority of qualitative responses that we received indicated that our participants would engage in some type of disclosure (either informal, formal, or both). Out of those who considered formal reporting, the police/law enforcement were mentioned by participants more often than other authorities, such as hospital staff or sexual assault centers. These findings highlight the perceived importance of reporting sexual assault to those who do and do not identify as victims of sexual assault.

There are some notable limitations involved with our vignette and self-report methodology. One limitation was in our use of a vignette that depicted a sexual assault; sexual assault occurs in many different ways, and women may differ in which barriers they perceive depending on the assault. As one of our qualitative responses alluded to, women may feel more comfortable reporting a sexual assault perpetrated by a stranger than a sexual assault perpetrated by an acquaintance, friend, partner, or family member. Our method of disclosing sexual victimization involved a one-item self-report. This was a limitation to our study because we distinguished participants who identified as victims of sexual assault, whereas for many women, what does and does not constitute sexual assault is difficult to pinpoint (Burnett et al., 2009). Therefore, for future

research on this topic, a scale that assesses a variety of unwanted sexual experiences may be beneficial.

Another limitation to this study was our unrepresentative sample. The majority of our participants were White, and our findings may have been different if we had assessed more racially/ethnically representative sample. Minority women may be at greater risk for sexual assault victimization (Planty et al., 2013; Rosay, 2016) and may experience different barriers to reporting than White women. Other groups, such as members of the LGBT+ community and men, may also experience different barriers. Future research could extend our results to investigate these topics with non-White victims, LGBT+ victims, and male victims of sexual assault. Further, future research may investigate the degree to which these barriers are impactful.

Our findings suggest that women who identify as victims of sexual assault consider confidentiality and a distrust of the police to be larger barriers, and perceive more barriers to reporting, than women who do not identify as victims. This suggests that some improvements to the criminal justice system may be necessary to increase the number of sexual assaults reported to police.

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ABCT is delighted to announce a partnership with **PsyberGuide**, a nonprofit website reviewing smartphone applications and other digital mental health tools. This partnership was established with the aim of disseminating reviews of digital mental health tools to a broad audience of researchers, psychologists, psychiatrists, and other mental-health practitioners. App reviews from both PsyberGuide and *Cognitive and Behavioral Practice* are integrated on both sites.

PsyberGuide.org's goal is to help people make responsible and informed decisions about the technologies they use for management of mental health. PsyberGuide is committed to ensuring that this information is available to all, and that it is free of preference, bias, or endorsement.

PsyberGuide is funded by One Mind (Dr. Stephen Schueller, Executive Director), a leading nonprofit organization supporting collaborative brain research to provide patients who suffer from brain disease and injury better diagnostics and treatment. With over 325,000 emerging digital health technologies, and an estimated 15,000 of those designed for mental health, One Mind recognized the lack of advice or guidelines to help people navigate the expanding marketplace of mental health apps. Thus in 2013, One Mind established PsyberGuide to address this growing problem.

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## LITERATURE REVIEW

# A Review of Preparation for and Responses to Mass Violence Incidents

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THE UNITED STATES has experienced over 100 mass violence and domestic terrorism incidents over the past decade (Gun Violence Archive, 2019; Mother Jones, 2019). These incidents have killed and injured thousands, adversely affected the health of countless others, and taken away the freedom of Americans to live life without fear (Jose, 2018; Lowe & Galea, 2017; Richman et al., 2008; Shultz et al., 2014). While several definitions of mass violence incidents (MVIs) exist, the most common definition includes a criminal act that is investigated, caused some type of injury to a large number of people, and significantly challenges the responding systems to meet the great needs of survivors (Office for Victims of Crime, 2016). Some examples of MVIs include the Boston Marathon bombing in Boston, MA, in 2013; the school shooting in Parkland, FL, in 2018; the bar shooting in Dayton, OH, in 2019; and the shooting

and attempted bombing in San Bernardino, CA, in 2015. The goal of this article is to review the literature available on preparation for and responses to MVIs, including a review of common activities and practices in the field.

## Impact of MVIs

Most MVIs occur suddenly and in typically peaceful settings, and result in death and/or physical injury to many direct victims. Beyond direct impact, the effect of MVIs extends to family members, friends, and loved ones of victims; members of the affected community; first-responders; and recovery service providers. The immediate and long-term effects can be physical (e.g., injury, disability), instrumental (e.g., housing, financial), psychological/behavioral (e.g., shock, anxiety, depression, grief, problematic substance use), and social (e.g., loss of relationships, work; Bardeen et

al., 2013; Benedek et al., 2007; Lowe & Galea, 2017; Smith et al., 2015). Well-established literature has identified significant short- and long-term mental health impact of MVIs, including posttraumatic stress disorder, depression, anxiety, substance use, and persistent grief (Boin et al., 2016; Galea et al., 2005; Lowe & Galea, 2017; Smith et al., 2015; Sullivan et al., 2018; Wusik et al., 2015). Key findings from large research studies examining the impact of MVIs have found that: (a) direct exposure, proximity to the MVI, and close relationships to victims increased risk for mental health concerns following the MVI; (b) many individuals who were not direct victims of the MVI also developed mental health problems; (c) many individuals affected had mental health problems for months or years following the MVI; and (d) MVI exposure increased fear of crime and impacted lifestyles and behavior among community members (Galea et al.; Hanson et al., 2000; Lowe & Galea; Natale et al., 2017; Wilson, 2014; Wusik et al., 2015).

## Response to MVIs

Following MVIs, the community response and ability to restore social and behavioral functioning of the impacted victims and community is a key element that has been examined (Hobfoll et al., 2007; Nucifora et al., 2007; Turunen et al., 2014).

Some communities have accessible and effective resources to respond to MVIs, while others have inadequate resources to meet the needs of the direct victims and impacted community. Many factors influence a community's ability to adequately respond to a MVI, including preparedness, resources and training available, prior experience, collaborative attitudes among providers, uncertainty and fear felt by individuals in the community, and quality of community leadership (Beinecke et al., 2017; Norris & Stevens, 2007). To date, a standardized, evidence-based framework or protocol for response to MVIs has yet to be developed, although some minimal research on specific interventions and practices has been conducted.

Although not comprehensive, a body of literature exists on common activities and practices employed by a community and professionals related to MVI response. These activities are implemented either in preparation for, or following an MVI, and are each reported as critical to the overall response and community impact following the MVI. However, the evidence supporting these multiple activities is varied. It is imperative that we explore the common practices so that evidence can be gathered to support their effectiveness.

### *The Current Paper*

The goal of this project was to conduct a review of preparation for and responses to MVIs, with particular emphasis on activities that improve mental health outcomes following MVI response. The review paper also includes a brief overview of specific interventions that have evidence for improving mental health following an MVI. This review was not intended to be a systematic review, but rather to gather an overview of information obtained through compilation of after-action reviews and literature searches on common activities conducted by communities in preparation for and in response to MVIs. Following an MVI, after-action reports are produced that include information about pre-event preparations, acute response, and post-event support services that can help community leaders prepare for and respond to future MVIs. However, there are not many guidelines for generating after-action reports, or what is included within the reports, and most reports do not contain any information about mental-health-related activities or outcomes related to response. Findings from these studies are extremely important to clinical psychologists and other mental health professionals,

as they can uniquely contribute to components of MVI response both as clinicians and researchers.

## **Method**

### *Search Strategy and Selection Criteria*

The electronic databases PsycInfo, PubMed, and Google Scholar were used to identify relevant studies published between 2010 and 2020. Searches were based on keyword terms "mass violence incidents," "mass violence," "mental health," "active shooter," "response," "recover," "preparedness," and "after action report," "after action," and "resilience." Articles included qualitative and quantitative studies, as well as theoretical articles. Following the identification of relevant studies, we checked the reference sections of identified articles for additional studies that met inclusion criteria. We then searched Google for any after-action reports that could provide information for the review. A total of 221 articles were identified in the search, of which 62 were used in the final literature review based on relevance to the topic.

### *Common Forms of Response to MVIs*

Examination of the literature on response to MVIs found seven key elements of response, which are helpful in improving resilience among individuals and the community: (1) training and collaboration; (2) planning, policies, and protocols; (3) leadership and on-scene management; (4) communication, public information, and the media; (5) survivor and family support services; (6) mental health for personnel and volunteers; and (7) community impact and involvement. These seven key elements were selected given that they had the highest level of content included within the reviewed literature. The following review outlines the common components, activities, and recommendations related to each of these categories, which were compiled from peer-reviewed empirical manuscripts as well as published after-action reports following MVIs.

#### *• Training and Collaboration*

Several articles focused on response to MVIs specifically outlined procedures related to training and collaboration in the community, which primarily takes place prior to MVI occurrence and assists in preparing the community for the impact of an MVI (Jacobs et al., 2019; Te Brake & Schaap, 2017). First, it was recommended that communities regularly practice MVI drills at all levels of response, with multiple

agencies/departments and with different scenarios, with the goal of ensuring that leaders of different response teams are in communication and effectively exchanging information (Center for Mental Health in Schools at UCLA, 2016; Kaplowitz et al., 2007; National Institute of Mental Health, 2002). For example, prior to the MVI that occurred at a country music concert in Las Vegas, NV, on October 1, 2017, the Las Vegas Municipal Police Department had been conducting MVI drills for 10 years, to review scenarios and potential dangers, gauge response times and readiness to respond, and reinforce training (Federal Emergency Management Agency, 2018). Scenarios included practice of multiple elements such as critical infrastructure and key resources, hotels, utilities, schools, and other entities. According to the after-action report following this MVI incident, the police department and other coordinating agencies found these drills to be helpful in preparation for the MVI that occurred on October 1, 2017. However, effectiveness and consequences of these drills were not specifically evaluated. Overall, qualitative feedback from providers and departments has suggested that regularly practicing MVI drills at all levels of response, with multiple agencies/departments, and with regular scenarios, is critical to effective response to MVIs, although limited research has focused on evaluation of these types of activities. Future work should focus on understanding the feasibility and effectiveness of universal implementation and sustainability of these drills.

Second, articles outlined the importance of developing strong relationships with other agencies and close jurisdictions and the need for collaboration in preparedness, protocol development, and training (Albert & Bullard, 2016; Center for Mental Health in Schools at UCLA, 2016; Hu et al., 2014; Jacobs et al., 2019; Kaplowitz et al., 2007; National Institute of Mental Health, 2002). Examples of interagency and multi-jurisdictional activities to promote relationships and collaborations included working together to develop and implement trainings, cross-training on skills when appropriate, tabletop walk-throughs where key agency personnel share available details about the MVI incident, sharing information and clarifying roles across agencies, interagency communication and knowledge of agency language, discussion of response plans with media to clarify roles and rules, and developing a strategy to deal with confidentiality around family notifications (Albert & Bullard, 2016; Fed-

eral Emergency Management Agency, 2018; Hu et al.; Massachusetts Emergency Management Agency et al., 2014; Straub et al., 2016).

Recommendations from the Las Vegas after-action report include improving cross-agency collaboration with statewide operations and agencies, based upon noted barriers in communication that negatively impacted effective response coordination (Federal Emergency Management Agency, 2018). In addition, partnering with nontraditional agencies, such as schools, religious institutions, and local businesses, was mentioned as key a component for preparedness and response to MVIs, as these organizations may be able to assist and provide essential activities and resources that would be helpful before or following an MVI (Del Vecchio-Scully & Glaser, 2018; Gil-Rivas & Kilmer, 2016; M. A. Hoffman & Kruczek, 2011; Straub et al., 2016). Specifically, following the Boston Marathon bombing on April 15, 2013, it was noted in the after-action report that partnerships with nonprofit organizations (e.g., American Red Cross, Salvation Army) and private sector partners (e.g., Target, Home Depot) were critical to the MVI response mission. For example, partnerships allowed for seamless donation and delivery of resources (e.g., water, food, blankets) and for communication regarding what resources were actually needed at different time points. In addition, a key lesson learned following the Pulse Nightclub shooting on June 12, 2016, included the critical importance of partnering with private and public businesses, associations, and stakeholders (e.g., airlines, LGBTQ and Hispanic community groups; Straub et al.). Feedback and findings regarding developing strong relationships with other agencies and close jurisdictions and the need for collaboration in preparedness, protocol development, and training prior to MVIs demonstrate positive outcomes at the individual and organizational level. The field would benefit from a systematic examination of these collaboration practices to determine which practices are the most effective and produce the most sustainable outcomes.

#### • *Planning, Policies, and Protocols*

Literature strongly suggests the importance of communities in being prepared to mobilize assets, resources, and social support networks following MVIs (Boin & Bynander, 2015; Center for Mental Health in Schools at UCLA, 2016; Jacobs et al., 2019). Many sources recommend develop-

ing formal documents and procedures outlining peri- and postresponse actions and activities, including having mutual aid agreements in place, strategies and security for mass gatherings, and checklists and forms that are readily available and easy to use during and after an MVI. These should be reviewed annually to update plans and policies as needed (Jeeninga et al., 2010; Metropolitan Police Department, 2014; Oklahoma City National Memorial Institute for the Prevention of Terrorism, 2002). However, while this recommendation is made in the literature, there are not any standard, evidence-based procedures or plans in the literature to use as a guide for development of these resources. Future work should aim to develop evidence-based procedures and plans that can then be tested for feasibility, effectiveness, and successful implementation.

Another key component to MVI response involves planning ahead for incorporation of mental health impact. Specifically, incorporating and integrating mental health interventions into the emergency response plan is essential (Naturale et al., 2017; Nucifora et al., 2007; Ritchie, 2003; Young, 2006). For example, in a document outlining lessons learned from the Oklahoma City bombing on April 19, 1995, a key recommendation includes developing and implementing a long-term approach to mental health and its detrimental consequences prior to the MVI. This includes the need for developing terrorism-specific mental health plans, creating networks among mental health professionals, identifying funding sources to support mental health, and incorporating research and evaluation into the mental health plan (Oklahoma City National Memorial Institute for the Prevention of Terrorism, 2002). In addition, it is recommended that mental health psychoeducation about the importance of evidence-based trauma-focused interventions, and what those interventions entail, is provided to community personnel and members prior to the event and again following the MVI (Center for Mental Health in Schools at UCLA, 2016; Hobfoll et al., 2007; National Institute of Mental Health, 2002; Young).

#### • *Leadership and On-Scene Management*

Leadership and on-scene management has been identified as an important component of response to MVIs. Specifically, literature has found that clear on-scene leadership and management are critical both during and immediately after the

MVI to best manage victims, witnesses, and the community in general (Metropolitan Police Department, 2014; Straub et al., 2016). First, swift development of a unified command center and roles was identified as important to positive response to MVIs (Metropolitan Police Department). Specifically, following the Navy Yard shooting, the after-action report indicated that a unified command center was established quickly, but roles were not identified or established, which negatively impacted the MVI response efforts (Massachusetts Emergency Management Agency, 2014; Metropolitan Police Department). Second, effective management of witnesses and personnel, and level of on-scene communication with personnel, were found to impact the perception of effective response to MVIs (City of Aurora, 2015; Metropolitan Police Department, 2014; Straub et al., 2016). Overall, after-action reports following several MVIs recommend establishment of a multi-agency coordination center to support leadership and on-scene management during MVI response (Federal Emergency Management Agency, 2018; Massachusetts Emergency Management Agency et al., 2014). While it is known that clear on-scene leadership and management are helpful, evaluation of various implementation methods is necessary to determine the best way to establish and maintain helpful leadership and management in response to MVI incidents.

#### • *Communication, Public Information, and the Media*

Literature on response to MVIs frequently indicates the important role of communication, public information, and the media in the MVI response activities. These include having a plan for the most effective way to communicate relevant and essential information accurately (Armstrong & Frykberg, 2007; Del Vecchio-Scully & Glaser, 2018; Hobfoll et al., 2007; Norris & Alegria, 2005) and the critical need to control or be aware of media content and its effect on the community (Haravuori et al., 2011; Hobfoll et al.; Naturale et al., 2017).

First, literature outlines the critical need to have clear and concise communication from key leaders to media and the public, with a plan of action from Press Information Officers and Joint Information Centers (Kapucu, 2008; Massachusetts Emergency Management Agency, 2014; Oloruntoba et al., 2018). Specifically, it is extremely important that local media provide priority access to leadership when pos-



sible and requested, as local leadership should be the first to address the media and the public in response to a MVI. This point has been noted in multiple after-action reports following MVIs, including the MVIs that occurred in Aurora, IL (City of Aurora, 2015); Boston, MA (Massachusetts Emergency Management Agency); Las Vegas, NV (Federal Emergency Management Agency, 2018); Navy Yard, Washington, DC (Metropolitan Police Department, 2014); Orlando, FL (Straub et al., 2016). For example, a significant problem following the Boston Marathon bombing included that, although coordination was made with media who arrived immediately on the scene, the updates and unfolding footage was not well-coordinated or controlled and, in turn, messages relayed through different media channels and across social media were inconsistent and often contradicted one another (Massachusetts Emergency Management Agency). This is detrimental to recovery from MVIs, as research shows that victims viewing media reports display significantly more distress and anger than victims who were exposed to accurate reports (Del Vecchio-Scully & Glaser, 2018; Maercker & Mehr, 2006). In addition, it is equally important that the leadership continue to update the media and the public with accurate information as updates are made available. For example, research on social media coverage following MVIs has shown that when information is lacking or not updated to the public, individuals are at higher risk for exposure to rumors, which have been linked to detrimental mental health consequences (Jones et al., 2017).

In addition, it is critical that all involved individuals (e.g., public service workers, victims, family members, agency leaders) are aware of the effect that media content can have on the mental health of victims, family members, and the community (Ahern et al., 2002; Ahern et al., 2004; Haravuori et al., 2011; Hobfoll et al., 2007; Maercker & Mehr, 2006; Naturale et al., 2017; Norris & Alegria, 2005; Pfefferbaum et al., 2014; Slone & Shoshani, 2010). Research has repeatedly shown the link between quality of media coverage and mental health impact, as lower-quality media coverage (e.g., inaccurate, inconsistent) was associated with more significant mental health outcomes (Ahern et al., 2002; Ahern et al., 2004; Jones et al., 2017; Maercker & Mehr).

Finally, prolonged coverage of the MVI is extremely discouraged, as prolonged exposure has been linked to more adverse

mental health reactions following MVIs (Haravuori et al., 2011; Hopwood & Schutte, 2017; Houston, 2009; Lachlan et al., 2010; Pfefferbaum et al., 2014). For example, findings from a meta-analysis conducted by Hopwood and Schutte (2017) indicated that more prolonged exposure to MVIs was associated with higher negative mental health outcomes.

On a positive note, media can be strategically used to communicate critical information about family assistance centers, safety measures, impact on the local community (e.g., road closures, places to avoid), and assistance with establishing help lines and an emergency alert system for the community (Massachusetts Emergency Management Agency, 2014; Straub et al., 2016). Specifically, in the Pulse Nightclub shooting in Orlando, the media informed all victims that they came into contact with of the family reunification center and instructions for seeking help, as well as broadcasted this information through local media channels and across all social media sites. This was beneficial in light of the number of individuals that the media come into contact with both directly and indirectly (Straub et al.).

#### • *Survivor and Family Support Services*

Literature on response to MVIs includes a range of recommendations for addressing consequences experienced by survivors and family members following MVIs, as well as increasing access to services among this population. Overall, it is recommended that large-scale psychoeducation and mental health resources be provided to victims and family members in the immediate aftermath of the MVI, as well as on a long-term basis (Beinecke et al., 2017; Bisson et al., 2010; Del Vecchio-Scully & Glaser, 2018; Pfefferbaum & North, 2016; Pietrzak et al., 2012; Reifels et al., 2013; Suzuki et al., 2012). Regarding the long term, it is critical that preliminary plans be discussed regarding the length of time for mental health services and how/when they will end if continuation is not feasible.

First, recommendations include the importance of providing quality, evidence-based mental health services to survivors and family members (Benedek et al., 2007; Hobfoll et al., 2007; Landau et al., 2008; National Institute of Mental Health, 2002; Young, 2006). To ensure quality services, it is critical that volunteers and service providers be vetted to ensure that evidence-based PTSD services are being delivered. It has also been recommended that a centralized source be developed to identify

specialists and resources specific to mental health services following trauma exposure, or MVI specifically if available (City of Aurora, 2015). For example, the after-action report following the Las Vegas shooting highlights the importance of providing a list of vetted mental health professionals to first responders for use in referring victims and family members to treatment (Chandra et al., 2011; Federal Emergency Management Agency, 2018). Overall, while vetting for evidence-based PTSD services is recommended, no structured assessment methods have been developed to determine what constitutes these services or how the vetting would occur. It is highly recommended that practitioners and researchers collaborate to determine what should be involved in the vetting system and how to implement this system.

Second, response to MVIs in multiple impacted cities has included the development of a well-planned, off-site family assistance center. A family assistance center is a place that victims and families can go to receive information about the well-being of loved ones, as well as receive services such as social assistance, food, grief counseling, clergy, access to communication, and child care to the families (Metropolitan Police Department, 2014; Oklahoma City National Memorial Institute for the Prevention of Terrorism, 2002; Straub et al., 2016). Multiple after-action reports suggest that the location and logistics of the family assistance center be planned prior to the MVI, to ensure quick implementation and avoid confusion by victims and family members. For example, there was significant confusion by victims following the Oklahoma City bombing, as more than one family assistance center was established and family members were often unsure of which location they were supposed to attend (Oklahoma City National Memorial Institute for the Prevention of Terrorism). Relatedly, literature discusses the critical need for developing and ensuring successful implementation of a plan for informing victims and families of mental health services available during the MVI response period. Specifically, literature mentions providing immediate and longer-term needs (e.g., assistance with claims processing, counseling, financial assistance, disability, spiritual care, and security and privacy from the media).

Finally, the literature outlines a range of recommendations surrounding victim service providers and ways to ensure that services are the most effective during the MVI

response period. First, it is recommended that victims are assigned a specific victim advocate in the aftermath of the MVI, and that this victim advocate remain consistent once assigned. Next, collaboration of mental health professionals with community agencies, first responders, and religious leaders increases the potential for referrals and access to services among victims and families. Finally, setting up walk-in disaster mental health clinics has been beneficial to providing needed services to victims in response to MVIs (Massachusetts Emergency Management Agency, 2014). For example, due to the surge in mental health counseling needs following the Boston Marathon bombing, a walk-in disaster mental health clinic was established, where 20 providers with specific disaster mental health expertise were available to provide crisis stabilization services to victims and their families for 2 weeks following the MVI (Massachusetts Emergency Management Agency, 2014). In addition to crisis stabilization and Psychological First Aid (PFA) services, an evidence-informed approach to reduce distress and foster short- and long-term adaptive functioning following a traumatic event (Brymer et al., 2006), the mental health providers assessed the need for ongoing services and provided referrals as necessary. The majority of evidence regarding whether services are effective is based upon individual feedback and access, although standardized evaluation of the effectiveness of services is often not conducted. Evaluating effectiveness factors and ways to implement these services throughout communities is needed. For example, MVI response effectiveness could be measured as number of people receiving knowledge of services, number of people who accessed and engaged in services, referrals to outside agencies, follow-up calls and assessments, improvement in acute stress symptoms, and satisfaction in services reviewed.

#### • *Mental Health Services for Personnel and Volunteers*

The literature indicates the importance of incorporating mental health services for personnel and volunteers into the protocol for response to MVIs, due to the significant documented need for mental health services among this population (Benedek et al., 2007; National Institute of Mental Health, 2002; Pietrzak et al., 2012). Specifically, studies on police officers involved on the scene following the 9/11 World Trade Center bombing demonstrated heightened

mental health symptoms directly following the MVI and the need for targeted mental health services (Maia et al., 2007; Pietrzak et al.). Literature on response to MVIs suggests that prior training and psychoeducation on mental health needs associated with MVIs should occur prior to the MVI, and should specifically describe the mental health consequences of trauma over time (Del Vecchio-Scully & Glaser, 2018; Straub et al., 2016). For example, prior training in PFA may assist in preparing personnel for the likely mental health impact following a potential MVI. PFA has been recently adapted for disaster responders (Shultz & Forbes, 2014), and has been used in departments across the United States following traumatic events. While PFA is ideally implemented prior to the MVI, it can also be utilized as an effective targeted intervention in the immediate aftermath of the MVI (Rudow, 2012).

Several additional recommendations in the literature outline common response practices to address mental health of personnel and volunteers during and following a MVI. First, it is recommended that accessible, anonymous, on-site mental health services be provided both during and following the MVI. Specifically, an improvement area highlighted in the after-action report following the Boston Marathon bombings included the need for targeted mental health services for personnel that supported victims and their families during and following the MVI (Massachusetts Emergency Management Agency, 2014). In addition, personnel are strongly encouraged to utilize their Employee Assistance Programs (EAPs) for additional support following MVIs, as well as identifying additional support services in the effected area (Federal Emergency Management Agency, 2018; Straub et al., 2016). For example, per the after-action report, the EAP programs were extremely beneficial to personnel following the Pulse nightclub shooting in Orlando, FL, as the EAP programs were supported by sworn and civilian personnel and mental health service professionals (Straub et al.). Finally, literature has noted that it is imperative that mental health services be extended to personnel and volunteers on a long-term basis, as mental health needs of this population continue into months and years following the MVI (Federal Emergency Management Agency, 2018; Massachusetts Emergency Management Agency; Pietrzak et al., 2012).

#### • *Community Impact and Involvement*

Literature indicates that it is critical for response to MVIs to include activities and plans to address the needs of the broader community impacted by the MVI. The definition of the “community” can greatly vary based upon the particular details of the MVI, so it is important to view the community in a flexible and broad manner (Del Vecchio-Scully & Glaser, 2014). First, community members and leaders receive psychoeducation and information about the emotional, physiological, and mental health consequences of MVIs in the immediate aftermath and over time (Del Vecchio-Scully & Glaser, 2018), which can be most effectively provided via community-wide trainings (Del Vecchio-Scully, 2014).

Identifying key individuals in the community to lead the community effort is essential, as these individuals can promote ongoing community support via rallies, meetings, vigils, and other community events that foster connectedness and social support (Del Vecchio-Scully & Glaser, 2018; Hobfoll et al., 2007; Norris & Stevens, 2007; Nucifora et al., 2007). The literature has supported that these types of activities help individuals feel that they can make a difference by offering outreach and interventions to support victims of MVIs and their family members. Existing community support systems can be utilized to lead these efforts, although individuals must be aware of preexisting relationships and dynamics, and the impact that they will have on the community (Del Vecchio-Scully & Glaser; M. M. Hoffman, 2018; Landau et al., 2008; Wilson, 2014).

To provide support for community efforts, stakeholders can research the available state and government resources that can be utilized to assist with financial or other support, such as federal funding organizations, post-disaster grant opportunities, and public assistance programs offered through public and private organizations (Del Vecchio-Scully & Glaser, 2018; DiLeo et al., 2018; Naturale et al., 2017). It is also critical that providers and advocates plan a way to manage donations that come into the community, as this can often be overwhelming and cause unforeseen stress (Del Vecchio-Scully & Glaser, 2018; Kapucu, 2008; Katz, 2003; Liebelson, 2013). For example, following the Sandy Hook school shooting on December 4, 2012, the community received donations totaling over \$28 million, which was managed by immediately creating bank accounts and procedures to manage these funds (Del Vecchio-Scully & Glaser).

## Conclusion

Given the significant and growing prevalence of MVIs over the past decade, and the detrimental short- and long-term mental health outcomes of these events to direct victims, family members, and community members, it is essential to examine activities and recommendations for response to the MVIs in the United States. Literature on response to MVIs outlines several elements involved in response to MVIs, including common practices and activities, lessons learned and recommendations, and perceived effectiveness by some involved individuals. Specifically, the key components outlined and repeatedly referenced in response to MVIs include activities related to training and collaboration; planning, policies, and protocols; leadership and on-scene management; communication, public information, and the media; survivor and family support services; mental health for personnel and volunteers; and community impact and involvement.

While practices, activities, and recommendations are outlined both in peer-reviewed empirical articles, and examples provided in after-action reports following MVIs, little effort has focused on comprehensively evaluating the feasibility or effectiveness of these practices. Of the small amount of evaluation effort that has been made, the majority has focused on satisfaction and subjective opinion of these activities and practices, often evaluated by city personnel or first responders. Thus, it is extremely critical to evaluate these practices in a more comprehensive and systematic way. In addition, although research has shown that individuals closer in proximity to the MVI experience more significant mental health symptoms, research has not examined differences in response to MVIs that may vary as a function of the type of MVI (e.g., bombing versus shooting) or contextual aspects of the MVI (e.g., number of people injured or killed, whether the MVI targeted minoritized communities). Understanding these differences would assist in clarifying differences in response and needed resources to assist with response. Additionally, feedback from victims and families has rarely examined the perceived effectiveness of the activities involved in response to MVIs. Given the critical importance of examining practices among consumers of those services, as well as the significant mental health impact of MVIs on victims and family members, it is imperative to examine the feasibility and

effectiveness among these individuals. Relatedly, it is extremely critical that after-action reports include more information related to mental health outcomes and recommendations regarding improved response to MVI activities, so that we can learn from past MVI incidents. Individuals and agencies can collaborate with groups with expertise on evaluation of mental health outcomes, or encourage funding agencies to provide templates for after-action reports that indicate sections to include and mental health outcomes that should be measured.

Overall, various forms of literature on response to MVIs have established a foundation for practices, activities, and recommendations related to MVIs. Critical next steps in this area revolve around development of a systematic and standardized plan for response to MVIs, which can be implemented in areas impacted by MVIs, as well as a solid plan for evaluating victim, family member, and community member perceived feasibility and effectiveness of these components.

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# Moral Injury: Relevance and Applicability to Offender Populations

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ALTHOUGH MENTAL HEALTH researchers and clinicians have long recognized the lasting psychological and emotional impacts that can ensue following a traumatic event, attention has been disproportionately paid to victims and to those who are the recipients of harms perpetuated by others, as opposed to those who have perpetrated the traumatic acts. Distress emanating from traumatic event exposure in the form of posttraumatic stress disorder (PTSD; American Psychiatric Association, 2013), for instance, has garnered significant scholarly attention as research and treatment development efforts have proliferated over the past 4 decades since its inception in the DSM (as evidenced by over 40,000 scholarly articles indexed by PsycINFO as of this writing). Only quite recently has the psychological research community substantively considered significant and functionally debilitating impacts of harming others and the emotional implications (i.e., pronounced guilt and shame) that can result from transgressing against others. In this article, we provide a brief overview of the moral injury (MI) construct—including its origins in military psychology, how it is meaningfully distinct from victimization-based event adversity, its relevance for civilian contexts, and—notably—how it may be fruitfully applied to offender populations in order to reduce distress and potentially recidivism.

## Overview of Moral Injury

Litz and colleagues (2009) define MI as “perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations that may be deleterious in the long term, emotionally, psychologically, behaviorally, spiritually, and socially” (p. 695). In their seminal paper, these authors noted that conventional conceptualizations of combat stress injuries focused nearly exclusively on fear and anxiety-based responses to life threat, injury, and harm and, in so doing, neglected moral and ethical conflict expe-

rienced by many combatants that result from killing or harming others. As such, conventional approaches to treatment rely on exposure-based habituation and extinction principles (which work well for anxiety stimulated by objectively safe trauma-reminiscent cues, contexts, and stimuli) and cognitive restructuring techniques (which work well for erroneous, exaggerated, or misplaced appraisals). These treatment techniques are much less suitable for well-placed and rational self-blame, guilt, and shame, which can ensue following intentional violation of personal ethics and moral standards that are common in warfare.

Importantly, although a transgression against another or a violation of one’s ethical code is necessary for MI to occur, scholars and clinicians generally agree that the event itself does not define or necessarily culminate in MI (Litz & Kerig, 2019). As with PTSD, it is the downstream emotional and psychological impacts of the stressor (i.e., transgression) that determine whether a potentially morally injurious event (PMIE) leads to MI. The same transgression may be mildly troubling to one individual but may result in incapacitating guilt and shame to another individual (Griffin et al., 2019). Certainly, transgressive acts causing significant harm to others—such as participation in atrocities in a warzone context or causing a fatality by drinking and driving—are often associated with intense moral emotions, but this is not invariably so. Clearly, intense emotional distress must accompany the transgressive act in order for MI to occur.

Experientially, MI is thought to share some similarities with PTSD—notably, reexperiencing or preoccupation with the event and concomitant efforts to avoid or distract oneself from thinking about it, as well as depressive symptoms and associated functional impacts such as problematic substance use and deficits in self-care (Litz & Kerig, 2019). What most differentiates MI from other event-related stress

disorders is the pervasive experience of pronounced moral emotions of guilt and shame (Steinmetz et al., 2019), changes in self-schema or identity (e.g., perception of oneself as bad, defective, or evil), and social withdrawal resulting from self-condemnation (Purcell et al., 2016). Although empirical delineation of MI from other event-related stress disorders is in its infancy, it does seem clear that dominant fear- and anxiety-based reactions characteristic of victimization experiences or accident-related traumas do not fully capture the phenomenology of distress owing to commission of morally injurious acts. As with other variants of distress warranting clinical attention, a true MI would entail chronic, not transient, distress and would likely be associated with functional impacts.

In addition to being defined by conceptually distinct symptoms and experiences, researchers have found that MI predicts functional deficits above and beyond the contribution of PTSD and depression (Maguen et al., 2020), thereby bolstering the case for MI being more than a mere variant or subtype of established stressor-related conditions. Arguably, for the construct of MI to be clinically useful, there must be evidence that the distress is persistent and impactful such that we do not run the risk of pathologizing situationally appropriate but transient emotional upset or normative and well-placed guilt and shame for transgressive acts. People should experience guilt and/or shame when they betray their values and transgress against others. The degree and duration of distress and the threshold for functional impairments necessary to demarcate MI is a matter of significant interest and extensive, recent research activity and debate by scholars (Litz & Kerig, 2019). As Litz and Kerig point out, there must be meaningful separation between moral challenges that are ubiquitous but modestly upsetting, and substantive deviations from one’s moral code, which are typically rare and inordinately distressing.

## Treatment Approaches for MI

With respect to treatment implications, varied approaches have been developed and have demonstrated success in treating MI. Though they diverge slightly, they tend to share common elements of self-forgiveness, real or symbolic amends making, disclosure to supportive others to combat shame and self-condemnation, and reappraisal attempts designed to clarify that a



single act does not wholly define a person (for an excellent compendium of current approaches see Currier et al., 2021). Although treatment approaches share some similarities with PTSD treatments to target similar symptom domains (e.g., exposure techniques to counter maladaptive avoidant tendencies), there are unique intervention implications for aspects of MI that diverge from other stressor-related maladies. For instance, MI differs from most variants of psychopathology in that distressing appraisals may be appropriate and well-placed as opposed to “irrational” or erroneous (Gray et al., 2017). Deeming participation in atrocity, for instance, to be evil, horrific, and irreversible is arguably true. As such, conventional cognitive restructuring techniques such as Socratic questioning—designed to challenge the veracity of erroneous appraisals—could be a target-treatment mismatch. Instead, providers may more fruitfully attempt to “facilitate perspective taking and to shift beliefs from blameworthiness (which may be objectively true) to forgiveness and compassion (which are nonetheless possible) and in doing so, to facilitate the potential for living a moral and virtuous life going forward” (Gray et al., 2017, p. 386). Although the transgression cannot be undone, it need not be destiny and need not forever define the transgressor. Treatment can facilitate a recommitment to pre-transgression values without negating or disputing the legitimacy of the wrongdoing.

Considering the effectiveness of treatments for MI, it should be noted that, to date, although promising data have emerged for a number of MI-focused treatments, there does not yet seem to be a superior approach (Litz et al., in press). Cognitive Processing Therapy (CPT; Resick & Schnicke, 1992) is considered a gold standard for treatment of PTSD and may be particularly effective for types of MI wherein the patient did not volitionally transgress against others (e.g., taking unreasonable responsibility for unforeseeable outcomes). However, some have expressed concern about CPT’s primary emphasis on Socratic questioning being ill-suited to address some types of MI (Gray et al., 2017). Although much of the early conceptualization and treatment literatures have focused on military populations and contexts, as described below, MI can certainly be relevant to civilian contexts and is particularly germane to forensic populations and correctional settings.

## Moral Injury in Civilian Contexts

The concept of MI has not been studied within the general population until recent years. Yet, a glance at the literature throughout history reveals a paradoxical trend marked by the absence of studying the psychological impact of committing perpetration, given the longstanding evidence that emotional distress associated with acts of transgressions can lead to the development of additional mental health problems (Griffin et al., 2019). The lack of research on distress emanating from perpetration may stem in part from a fundamental human tendency to categorize individuals who have transgressed as a distinct and separate group of people from the general population of individuals who act by a standardized set of morals.

The historical consideration of these issues can be traced back to nearly a century ago in the clinical literature (Freud, 1930). Individuals who perpetrate serious moral transgressions have historically been studied under labels such as incarcerated offenders, criminals, prison inmates, psychopaths, psychopathic deviates, or labeled with the diagnosis antisocial personality disorder (Tangney et al., 2011). Yet, even our most classically cited research studies in psychology demonstrate that social situational factors can lead average individuals to act immorally and feel severe emotional distress afterward (Milgram, 1963; Zimbardo, 2007). For example, in the abstract for Milgram’s 1963 obedience study, Milgram himself noted his participants’ distress associated with the task of delivering an electrical shock to a confederate research participant by observing that, “the procedure created extreme levels of nervous tension in some Ss [ . . . ]” (Milgram, 1963). Not surprisingly, MI research has been less voluminous in civilian settings as compared to military contexts and VA settings due to funding disparities and relative exposure to violence and transgressive acts.

Still, even before the conceptualization of MI and subsequent research on the topic began, decades of research conducted on disparate circumstances of perpetration (e.g., police shootings, reckless driving) suggests that MI can arise under a variety of occupational demands and social and psychological circumstances within the general population. For example, early research conducted with police officers demonstrates that killing or severely injuring another person on the job is associated with high rates of PTSD, preoccupation and rumination about the event, anger,

sleep disturbances, flashbacks, guilt, and depression (Gersons, 1989; Loo, 1986). Research conducted with healthcare providers shows that death or serious injury of patients due to medical error can cause intense emotional distress, depression, functional impairments, job burnout, increased risk for future medical errors, leaving the profession, and increased risk for suicide (Schwappach & Bouluarteb, 2008; Wu & Steckelberg, 2012). Similar distress responses have been demonstrated with slaughterhouse workers (Dillard, 2009) and prison executioners (MacNair, 2015).

Distress stemming from transgressive acts can arise from a number of social and psychological conditions beyond occupational demands. Individuals who have unintentionally killed or severely injured another person due to accidental or reckless behavior (e.g., reckless driving) are at increased risk for PTSD, depression, anxiety, alcohol and drug abuse problems (Connorton et al., 2011; Lowinger & Solomon, 2004). Further, although most women who have an abortion do not suffer psychological harm because of the procedure, a small percentage of women who believe that the procedure is morally unacceptable appear to demonstrate distress in the form of flashbacks, guilt, denial, and emotional repression (Hess, 2004). Last, research conducted on guilt and shame associated with addictive behaviors such as substance abuse, gambling, and hypersexual behaviors shows that acts of transgressions predict increased risk for psychological symptoms, proneness to anger, aggression towards others, and risk for future transgressions (Gilliland et al., 2011; Weichelt, 2007; Yi & Kanetkar, 2011).

More recently, the development of several psychometric scales to measure MI beyond military populations has aided research efforts to detect and quantify pathological levels of distress associated with perpetrating harm against others (Chaplo et al., 2019; Steinmetz et al., 2019; Williamson et al., 2020). More specifically, validation studies on perpetration-induced distress measures support the presence of MI in civilian adults across a number of PMIEs, including but not limited to physical and sexual assault, reckless driving accidents, intimate partner violence, and severe harm caused to others while being intoxicated (Steinmetz et al.; Williamson et al.). Further, a validation study conducted on an MI scale for young adults, adolescents, and children supports the presence of a positive relationship between interpersonal

transgressions and MI in emerging adults (Chaplo et al.). Indeed, there appears to be increasing interest in studies examining MI in a civilian context. For example, recent studies suggest the presence of MI among journalists covering refugee or migration crisis territories (Feinstein et al., 2018) and social workers (Haight et al., 2017). Further, some evidence appears to suggest that stressful circumstances surrounding limited resources in the fight against the COVID-19 pandemic may be causing increased risk for MI in healthcare workers and family and friends of individuals who have contracted the virus (Williams et al., 2020).

Findings from civilian studies seem to converge on the hypothesis that the sequelae of symptoms emanating from MI stem from shame and guilt caused by traumatic dissonance or appraisal that one cannot atone for violating a belief system that is important to one's identity (Steinmetz et al., 2019; Williamson et al., 2020). This theory may help explain findings from research that suggest variable outcomes between unintentional and intentional perpetration (Nickerson et al., 2011), and the presence of cyclical risk for future moral violations due to characterological self-blame appraisals that may cause one to attempt to escape their shame through emotional numbing or use of substances (Dearing et al., 2005).

### **Applicability of Moral Injury With Offenders**

While studies that directly examine the construct of MI in criminal offenders are generally lacking, the literature reviewed to this point has highlighted substantive distress among individuals who have killed another person in combat, perpetrators of sexual assault, perpetrators of intimate partner violence, and those who have killed another person while driving under the influence. Many such cases exist in correctional or forensic populations. While there is a relative dearth of literature in these populations, components of the MI construct, such as guilt and shame, have been found to mediate the relationship between criminal transgressions and distress, indicating these components as integral parts of the model. There are likely several explanations as to why this deficiency in the literature exists. Most notably, research within correctional facilities is notoriously difficult due to limited access to the population, which has limited the amount of research on many different concepts inte-

gral to criminal offending including MI. Additionally, it is possible that many do not view individuals with MI as worthy of rehabilitation. General societal assumptions about criminality and one's potential for positive behavioral change likely play a role in that the general population may consider criminals as a perceived "other" and unlike themselves. Criminal behavior is often thought of by laypersons as a product of their personality alone, as opposed to influence by one's environment and experiences, including a history of trauma.

With respect to studies that have been conducted among forensic populations and have implications for the applicability of MI, researchers have examined how guilt and shame influence criminal behavior. While there is some evidence to suggest guilt protects against further criminal behavior (Stewig & McCloskey, 2005; Tangney & Dearing, 2002; Tibbets, 2003), heightened shame was predictive of recidivism at a 6-year follow-up (Hosser et al., 2008) and psychological symptoms or problematic substance use (Tangney et al., 2011). These findings are consistent with the broader MI literature which suggests that shame can result in social withdrawal and negative personal identity (i.e., self as evil—which may contribute to recurrent transgressive behaviors).

Shame remains surprisingly understudied in forensic populations. Though some conceptualizations have focused on the degree to which it might initially precipitate violent behavior (Velotti et al., 2014), little empirical work has been devoted to examining shame as an emotional response to criminal behavior. This is unfortunate because shame may well hold the key to understanding and addressing recidivism and continued transgressive behaviors. Specifically, it has been postulated that behaving in a way that represents a stark violation of one's ethical code can result in cognitive dissonance (Litz et al., 2009). Believing oneself to be generally good and virtuous but subsequently acting in an egregious and perhaps violent manner is a contradiction that may cause considerable discord. To resolve this state of dissonance, one may attempt to minimize the significance or importance of the act (thereby making such an action more likely to occur in the future), or one may redefine the self as "bad," "evil," or "criminal," which also may contribute to recidivism. This psychological maneuvering coupled with very real practical barriers to successful reentry may well help to explain historical failures in rehabilitation and reintegration among

those who are not antisocial and experience painful moral anguish and distress.

MI could present when working with offenders in a clinical context and, therefore, requires effective identification and treatment to reduce distress and the potential for future acts of perpetration. Laypersons may understandably focus largely on the "deservingness" of incarceration and any emotional distress that a perpetrator may experience. Importantly, however, exclusive focus on such consequences does little to reduce recidivism and promote reintegration. Though criminal sanctions and attending emotional stress may indeed be warranted and unavoidable following a criminal transgression, they need not preclude, nor are they incompatible with, interventions designed to more successfully promote meaningful rehabilitation and reintegration. Quite the opposite, those who do experience genuine shame and guilt following a crime may be especially good candidates for MI-focused therapeutic interventions. Though empirical research evaluating such a possibility is desperately needed, it may well be the case that attending to these oft-neglected issues in forensic populations may well pay individual and societal dividends.

### **Treatment Implications for Offenders and Case Example**

As previously mentioned, specific interventions for MI have been developed, drawing from CBT treatments while also integrating strategies relevant for an individual who has perpetrated a traumatic act. One such treatment is Adaptive Disclosure (AD; Litz et al., 2016). AD consists of three main foci: imaginal exposure, addressing loss/traumatic grief (if applicable), and addressing MI guilt and shame. In the imaginal exposure component, the client is encouraged to disclose the most distressing event in some detail and to describe impacts and surrounding appraisals. Accordingly, it serves less of a habituation or extinction function than exposure typically serves and is instead designed to activate particularly pernicious and damaging appraisals. This allows for subsequent cognitive processing that, as noted, is not necessarily designed to challenge appraisals that may be accurate but to promote possibilities of forgiveness or amends making. AD includes exercises designed to facilitate perspective-taking, prosocial behavioral activation to challenge appraisals of self as evil, and to consider a recommitment to pre-event values and ethos. Accordingly, it

is not chiefly focused on reappraising or reconstructing past events but is more future-oriented in promoting a consideration of a reparative path forward rather than disputing interpretations of past actions that may well be accurate and valid. Extreme and rigid thinking is addressed so that the clients are able to move beyond defining themselves solely by the transgressive act and instead commit to a virtuous or moral life moving forward.

While this treatment approach was developed with and used primarily with military service members, it can easily be adapted for use in offender populations. By way of example, a 30-year-old incarcerated male was being seen for distress and guilt emanating from his crime. The client was convicted approximately 10 years prior for murder of a man in front of his family that occurred while he was acting as an “enforcer” for a prolific street gang. Since beginning to serve his life sentence and leaving the gang, the client experienced significant feelings of guilt, shame, and worthlessness that he had not experienced prior to leaving the gang. In working with this individual, the following MI-focused treatment techniques were used: detailed exposure and recounting of the murder, consideration of ways that he could express genuine contrition and remorse, and ways that he could use his story to reach others who may be at risk for similar transgressions. Notably, such actions would not undo or mitigate harm caused but could represent a form of symbolic amends making. Further, the intervention focused on a commitment to future actions and choices that honor the best and most virtuous aspects of himself going forward. Here again, the focus on future orientation does not deny the reality of past transgressions, but shifts focus to that which is controllable—daily decisions and actions that allow for a positive influence on others and a recommitment to pre-gang affiliation positive self. The client was able to partially resolve debilitating guilt and shame related to the murder, commit himself to continued change, and redefine himself moving forward. These changes in turn relaxed extreme rigidity he held regarding his self-concept, with improvements in institutional behavior (e.g., decrease in rule infractions and increase in meaningful religious group membership) also noted.

MI-focused treatments such as AD may be helpful in reducing recidivism by challenging conceptualizations of self as evil or criminal, promoting a return to pre-transgression values and ethics, and suggesting

mechanisms for actual or symbolic amends making that can help to counter shame-based withdrawal and dysfunction. Similarly, Acceptance and Commitment Therapy (Hayes et al., 2009) could also allow individuals to work towards self-forgiveness and recommit to their values. Both treatments are accessible and seek to resolve, to some degree, the distress associated with MI and allow clients to identify their values and recommit themselves to moving towards those values in a meaningful way.

MI in offender populations is a relatively new area of consideration and the authors encourage individuals working with justice-involved clients to begin assessing for and considering the presence of MI in their clients. Recent research strives to clarify the construct of MI and how MI relates to outcomes (e.g., Nieuwsma et al., 2021), but continues to focus on military populations exclusively. Thus, it remains important for individuals with access to, or interest in, offender populations to consider research of MI and related concepts in order to grow our understanding of how MI may manifest similarly, or distinct from, our understanding of the manifestation in military populations.

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# Resilience and Growth in the Face of Household Dysfunction

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“MORE THAN TWO THIRDS of children (in the U.S.) reported at least 1 traumatic event by age 16” (National Child Traumatic Stress Initiative [NCSTI], 2015, para. 1). Adverse Childhood Experiences (ACEs) are one such category of trauma that children encounter as they develop, and those ACEs are considered major sources of trauma in childhood (Houry, 2019). The Centers for Disease Control and Prevention (CDC) has broken down ACEs into three major categories: abuse, neglect, and household dysfunction. In this article we are focusing on household dysfunction defined by the original ACE study as a type of trauma encompassing the following: (a) the presence of mental illness; (b) having an incarcerated relative; (c) witnessing a mother being treated violently; (d) the presence of substance abuse in the home; and (e) experiencing parental divorce (Tennessee Department of Education, 2018). In order to further understand household dysfunction, the CDC (2013) published the following prevalence statistics for each of the components under household dysfunction: (a) the presence of mental illness = 19.4%; (b) having an incarcerated relative = 4.7%; (c) witnessing a mother being treated violently = 12.7%; (d) the presence of substance abuse in the home = 26.9%; and (e) experiencing parental divorce = 23.3%. In the literature, witnessing a mother being treated violently is often referred to as either domestic violence (DV) or intimate partner violence (IPV). In this article, we are using DV and IPV interchangeably. When families experience problems such as these that interrupt their parenting or put them into a category where they are considered high risk or vulnerable, they are considered fragile families (Bigner & Gerhardt, 2019). Often, professionals intervene on behalf of fragile families and work to offset the negative factors and help build resiliency, especially for the children. Having experienced trauma does not imply being doomed for life. Therefore, in this article we will explore factors proven to build resilience and mitigate the negative outcomes for children,

ages birth to 17 years, and their families who are experiencing or have experienced household dysfunction as defined in the original ACE study. Why household dysfunction? Because sometimes families are not aware that the five categories making up household dysfunction are ACEs. In addition, in our work with children and their families we are often faced with the challenge of explaining to parents and/or caregivers how family struggles such as divorces, having an incarcerated parent, mental illness, violence within the home, and substance abuse negatively affect children.

As a disclaimer, we must mention that even healthy families are not always perfect or functioning optimally. Once in a while (i.e., not all the time) they exhibit characteristics evident in dysfunctional families. Al Ubaidi (2017) characterized healthy families as outlined below:

1. Allow and accept emotional expressions of an individual's character and interests.
2. Obvious and consistent rules in the family and boundaries between individuals are honored.
3. Consistently treating members with respect and building a level of flexibility to meet the individual's needs.
4. All family members feel safe and secure (no fear from emotional, verbal, physical, or sexual abuse).
5. Parents provide care for their children (not expecting their children to take their parental responsibilities).
6. Responsibilities given are appropriate to their age, flexible and forgiving to a child's mistakes.
7. Perfection is unattainable, unrealistic, besides potentially dull and sterile. (p. 1)

Dysfunctional families, on the other hand, are marked by instability and conflict. According to King University (2017) and ZwavelStream Clinic (n.d.), below is a

list of some of the traits that are often used to define the dynamics of dysfunctional families:

- Excessive criticism (of children)
- Violence
- Lack of empathy (parents not showing unconditional love)
- Fear
- Control (especially of children)
- Denial
- Drug and/or alcohol abuse (by parents)
- Lack of consistency
- Perfectionism (in one or more adults)
- Neglect
- Poor communication (often not direct, but disjointed)
- Sexuality intolerance
- Abandonment
- Disrespect for boundaries
- Shame

This paper is organized into five subheadings aligning with the five original ACEs falling under household dysfunction. These five subheadings are as follows: mental illness in the family, having an incarcerated relative, witnessing a mother being violently treated, substance abuse in the home, and parental divorce.

## Mental Illness in the Family

Mental challenges in families are believed to be a result of genetics as well as social and economic constraints (Al Ubaidi, 2017; Behere et al. 2017). Social and economic challenges have evolved over time, resulting in additional stressors on both parents (particularly single parents) and children. The long-term effects associated with being raised in a single-parent home in which a parent has a mental illness include, but are not limited to: strained parent-child relations, emotional and behavioral problems, academic difficulties, challenges in the future (such as relationship struggles during emerging adulthood, parenting problems, separation and/or divorce and depression in adulthood), substance abuse, and suicide (Al Ubaidi; Behere et al.). A history of parental mental illness is associated with higher chances of children experiencing psychopathology in the future (Jackson, 2016; Patrick et al., 2019).

Campbell's (n.d.) research showed that “80% of patients agreed that their mental health conditions had had a detrimental effect on their family” (para. 1). Sadly, children's behavioral and emotional outcomes

arising from mental issues in adults in their lives are often ignored (Campbell, n.d.) and that further increases the odds of a plethora of struggles later in life. During the times of living through an adult's mental challenges, children are often forced to grow up quickly by taking on parental roles, albeit not fully comprehending mental illness and its consequences. Campbell's (n.d.) work highlighted that the stressors linked to caring for a family member with mental struggles often results in "somatic problems (migraines, loss of appetite, fatigue, insomnia), cognitive and emotional problems (anxiety, depression, guilt, fear, anger, confusion) and behavioural troubles (changes in attitude, and social withdrawal)" (para. 3).

As mentioned earlier, suffering adversity doesn't mean a bleak future. As such, when it comes to building resilience, the American Academy of Child and Adolescent Psychiatry (2015) proposed protective factors that can mitigate negative outcomes in children when they have a parent (or two) with mental illness. These factors are as follows:

Knowledge that their parent(s) is ill and that they are not to blame; Help and support from family members; A stable home environment; Psychotherapy for the child and the parent(s); A sense of being loved by the ill parent; A naturally stable personality in the child; Positive self-esteem; Inner strength and good coping skills in the child; A strong relationship with a healthy adult; Friendships, positive peer relationships; Interest in and success at school; Healthy interests outside the home for the child; Help from outside the family to improve the family environment (for example, marital psychotherapy or parenting classes). (para. 4)

### Having an Incarcerated Relative

Nearly 6 million children have lost a parent due to incarceration in America at some time during their life (Annie E. Casey Foundation, 2017). According to Bockneck et al. (2009), this type of loss can be considered an ambiguous loss—a loss where there is uncertainty that the incarcerated family member will return, and if they do, whether they will be the same. Parental incarceration can have devastating effects on a family, including the children's well-being. Typically, children with a parent who is incarcerated live in low socioeconomic households and neighborhoods that are less likely to be supportive (Annie E.

Casey Foundation, 2016). Children whose parents are incarcerated can face food insecurity, loss of residence, and ridicule from society (Annie E. Casey Foundation, 2016). Because these families have lost a family member who has oftentimes been the breadwinner, the family is left on the edge of surviving (Annie E. Casey Foundation, 2016). While there is no confirmed cause-and-effect relationship between having an incarcerated parent and children's problems, scholars today know that the majority of children of incarcerated parents face a multitude of risk factors. Among other things, the frequently cited risk factors are family instability, academic and behavioral problems, dropping out of school, poverty, exposure to violence, poor psychological development/mental health issues, high levels of stress, anger, anxiety, and becoming homeless (Annie E. Casey Foundation, 2016; Ashmitha & Annalakshmi, 2020). According to Martoma (2020), in some instances, having an incarcerated parent results in a unique type of stress linked to witnessing the arrest of a parent. Another consequence of having an incarcerated parent during childhood is poor health and well-being in adulthood (Martoma).

Even with such a dreary outlook, research has proven that intervention can help allay some of these outcomes in children (Poehlmann, 2013). In order to build resilience in children of incarcerated parents, family members and the community at large can help build resilience in the following ways:

1. Providing consistent social support (both material and emotional),
2. Building cohesion within the family,
3. Building a positive environment,
4. Ensuring at least one positive interpersonal relationship with an adult, and
5. Seeking out support from child's teachers (Ashmitha & Annalakshmi, 2020).

Martoma (2020) proposed that whoever is left responsible for children who have incarcerated parents (parent or other caregivers/family members) should prioritize helping the child connect with the incarcerated parent. In addition, Martoma also pointed out the importance of contacting programs/organizations whose missions are specifically to work with and advocate for children of incarcerated parents.

Parents face difficulties regaining employment and housing after incarceration;

therefore, community-based programs can aid families with regaining employment and housing and help promote child development (Annie E. Casey Foundation, 2016). While parents are incarcerated, children need access to counseling services and also quality caregiving in the absence of a parent (Annie E. Casey Foundation). If the parent-child relationship is considered a healthy relationship for the child, then it is best for the child to maintain a connection to the parent. This can help a child offset the loss that the child may feel. Writing letters, emails, and making phone calls are important in maintaining the connection (Martoma, 2020). Programs that offer mentorship and support for children and adolescents while their parents are incarcerated are also beneficial (Annie E. Casey Foundation). A few professional organizations have proven methods/strategies for building resilience in children of incarcerated parents. One such organization is KidsMates, which published the C.A.R.E.S. Approach to empower adults to help children build resilience by (a) creating environments that are safe for children to freely speak, (b) acknowledging and validating any concerns the child may have, (c) reassuring the child so they know that they are not alone, (d) encouraging skill building and active play in the child and, (e) sharing age-appropriate information honestly with the child (KidsMates, n.d.).

### Witnessing a Mother Being Treated Violently

According to the World Health Organization (2017), "1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime" (para. 1). In the United States, an estimated 1 in 4 women have suffered some form of DV/IPV in their lifetime (CDC, 2020). As such, DV/IPV is clearly a global crisis affecting millions of women and can contribute to illness, injury, and sometimes death (McFarlane et al., 2014; Roberts et al., 2010).

Witnessing domestic violence during childhood is linked to a multitude of negative mental, behavioral, and physical outcomes for the child. Among other things, these children "have heightened risk for poor school performance, cognitive delay, emotional and behavioral issues, trauma symptoms and mental health diagnoses in childhood" (Forke et al., 2019, p. 1). When abused mothers have depression and anxiety,



ety, their children also tend to have the same problems and when they have aggression and hostility, their children also exhibit the same external behaviors (McFarlane et al., 2014). In addition, there is evidence in the literature that exposure to domestic violence as a child is correlated with below-average health and well-being during adulthood (Bair-Merritt et al., 2006; Ehrensaft et al., 2017; Ireland & Smith, 2009). Sadly, research has also proven that sometimes witnessing a parent being abused during childhood contributes to perpetration of the same abuses during adulthood. This is particularly true in men (Roberts et al., 2010).

In their 7-year prospective study, Binder et al. (2013) were presumably the first to assess child functioning by gender and age as a means to develop preventative interventions for children who witnessed their mother being violently treated. Results of their study indicated that younger boys whose mothers were abused exhibited challenging behaviors that increased their risk for aggression, hostility and delinquency. Sadly, these behavior outcomes resulting from chronically witnessing domestic violence also increased the likelihood for child abuse. Peled (2011) also examined existing literature and found that sometimes women who experience IPV become abusive towards their children. Consequently, in order to minimize child abuse, Binder et al. proposed the following:

1. Assessing child behaviors that place child at risk when the mother is seeking help for domestic violence;
2. Raising awareness about this correlation by educating professionals working with children;
3. Raising awareness about this link by educating mothers seeking help for experiencing domestic violence;
4. Creating educational programs with emphasis on children's behavioral outcomes after witnessing their mother being abused.

Human beings are resilient and while some children never recover, some can thrive after witnessing violence in the home. The Atlanta Legal Aid Society (2020) created an outline of steps to take in order to alleviate negative outcomes in children who have witnessed a parent being abused: assuring and reminding the child that this issue is not unique to them, that they are not alone, assuring the child

that there is help somewhere, unconditionally loving the child, seeking intervention services for both the child and the domestic violence victim, and seeking legal services. Tyson (2021) proposed that caregivers can support resilience in children through the following:

- Sharing vulnerabilities with children,
- Allowing children to witness the struggles as they occur,
- Allowing children to figure out problems without prematurely intervening (including during games/play activities),
- Giving children personal time and space as needed, and
- Allowing children to age appropriately make decisions.

The authors understand that the original ACEs study focused on mother being treated violently as a variable without specifying the relationship to the male perpetrating the abuse. Consequently, future researchers could explore DV/IPV in different relationship types such as child's father, child's stepfather, or mother's boyfriend. In addition, researchers could also investigate different types of intimate partner violence within the home in relation to child outcomes.

### Substance Abuse in the Home

When children are exposed to parental substance abuse in the home, whether it is alcohol, drugs, or prescription medication, they sometimes reap the negative consequences of their parent's addiction. Some of these consequences include, but are not limited to: challenges adjusting behaviorally, emotionally, and socially, anxiety, struggling academically, and poor cognitive development (Solis et al., 2012). Children who live in a home with a parent with substance use disorders are three times more likely to be abused than their counterparts (American SPCC, n.d.). Additionally, in the United States, an estimated one-third to two-thirds of child maltreatment cases that were filed involved substance abuse (American SPCC, n.d.). Likewise, children are more likely to enter the foster care system when they have a parent with substance use disorders (Becci et al., 2015). Alcohol and drug abuse are also related to higher incidents of sexual and physical abuse of children (Bigner & Gerhardt, 2019).

Often, children are not aware that one or both of their parents have a substance

abuse problem because parents pretend that their substance abuse problem does not exist (Bigner & Gerhardt, 2019). In fact, children frequently do not realize that parental destructive patterns are not part of a healthy family life, and they themselves become vulnerable to unhealthy adult relationships (Bigner & Gerhardt). According to Bigner and Gerhardt and Santiago (2019), children who live with parents who are addicts need to break the silence. Children are often taught the following:

- Keep the family secret—do not talk about it.
- No one outside of the family can be trusted with the problem—do not trust anyone.
- Do not feel things because it might destroy the integrity of the family unit—do not feel anything about this.

With these three unstated rules that seem to govern families struggling with a drug or alcohol problem, professionals can help break the silence through early intervention by being a safe place for children to share their experiences and emotions while validating their feelings (Santiago, 2019).

Therefore, the question remains: What can we do as professionals? First and foremost, as professionals, if you suspect abuse or neglect, you must report it. Second, recognize factors within the family unit that contribute to healthy developmental outcomes. This is called a strength-based approach (Fiore, 2012). Look for things that the family is doing well, and build on those strengths. Third, because children of addicts are often abandoned emotionally, it is important to promote emotional resilience. Counseling can be a helpful tool for children of addicts. Additionally, parents need services too. Parents who are addicts not only need services to help them with their recovery, but they also need parenting resources to help them rebuild the parent/child bond with their child. Programs such as Family Checkup (Arizona State University Research Institute, 2021) can help provide parent training to help parents rebuild their relationship with their children (The Center for Parents & Children, 2021). Last, it is important to recognize that parents who are addicts have oftentimes experienced trauma themselves (TN Department of Education, 2018). Offering services to the parent regarding past traumas and addiction can bring healing and restoration to the family and children.

## Parental Divorce

About 40–50% of marriages end in divorce (APA, 2021), and it is estimated that one in every two children will see their parents divorce. The aftermath of divorce changes the family structure, requiring adaptations and adjustments on behalf of both the parents and children. One of the most challenging aspects of divorce is that parents must come to the realization that they share parenting responsibilities, which leaves previously married individuals in each other's lives—regardless of a dissolved marriage. Ex-spouses still have contact through visitation exchanges, shared information by the child/ren, and shared major decisions (Tennessee State Courts, 2021).

Divorce has short-term and long-term effects on children. Children who experience divorce are more likely to have lower academic achievement, experiment with drugs and alcohol, have difficulties with authority figures, drop out of school, and experience emotional or psychological problems (Seccombe, 2012). With that said, it is important to determine how parents and key stakeholders can offset the negative outcomes of divorce and build resiliency for the child.

Havermans et al. (2017) found that the parent-child relationship, both mother-child and father-child, was significantly related to school engagement and higher test scores. Additionally, when children were in shared residence situations, the children had a better relationship with their fathers, regardless of stepparents. Considering that higher school engagement is associated with shared living time with each parent, it is important that professionals working with families advocate for shared residence whenever possible.

Mahoney et al. (2015) also found that teachers suggested that their top priority had to be emotional support for young children who were experiencing divorce because their students needed to “feel emotionally secure before they could learn” (p. 2849). Additionally, teachers found it beneficial to promote caring and supportive relationships with both parents and students. Experts suggest that students need predictable yet flexible environments, routines, and expectations, and less emphasis on academic achievement because students may not show academic gains when first faced with a divorce. As far as behavior was concerned, teachers in Mahoney et al.'s study suggested that their students needed opportunities to regulate their behavior, but also needed guidance to help regulate

inappropriate behavior. The guidance strategies that teachers used in Mahoney et al.'s study included consistency, counseling, encouraging, collaborating with parents, being lenient when needed, and supporting self-regulation. Teachers also expressed the importance of understanding each individual circumstance and to tailor strategies and approaches to each individual child and family.

Bearing in mind that children of divorce can exhibit behavior problems for up to 2 years after divorce, and sometimes longer (Weaver & Schofield, 2014), what can be done to help curb these negative behaviors? Weaver and Schofield found that behavior issues were largely connected to the post-divorce environment; that is, when the environment is less supportive, has a lower income, or the mother is depressed, children were more likely to exhibit behavior challenges. Likewise, when children have a supportive environment post-divorce, including quality parenting, there can be positive effects—again, suggesting that the quality of the parental relationship and home environment can serve as a protective factor in mitigating the negative effects of divorce. Therefore, parent education and services mentioned throughout this section that support parents are pivotal in helping families through divorce.

## Conclusion

In this article we explored household dysfunction defined in the original ACE study as a type of trauma in which children experience the following: the presence of mental illness, having an incarcerated relative, witnessing a mother being treated violently, the presence of substance abuse in the home, and parental divorce (Tennessee Department of Education, 2018). Sometimes, professionals and families alike must grapple with intervening in the event that children experienced ACEs. While it is a reality that some children will never bounce back from adversity, building resilience for children and families who are experiencing or who have experienced household dysfunction can lead to not only healthy individuals and families, but also healthy societies (TN State Government, 2017). Providing support that builds resiliency works to offset the negative outcomes for children, and eventually leads to prevention of ACEs for future generations. We have examined each of the components of household dysfunction, how experiencing them affects children, and what can be done to alleviate negative effects in children

who would have experienced such afflictions. It is imperative that professionals continue to act on behalf of children and families not only to bring restoration, but also prevention. Serving fragile families in the suggested ways can make lasting differences in the outcomes of children, families, and communities, impacting each generation, and, in turn, stop the generational cycle of household dysfunction.

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## ► ABCT Election Results

- **Sandra Pimentel**, PRESIDENT ELECT (2022-23)
- **Daniella Cavenagh**, REPRESENTATIVE-at-LARGE (2022-25)
- **Bylaws**: the membership voted to approve adding a sixth purpose: "Collaborate with global partners in the development, evaluation and dissemination of CBT and related evidence-based treatment."



## The Evidence Base for Treating Adolescents With a History of Sexual Offenses: Comment on Mii et al. (2021)

Kaitlin M. Sheerin, *Alpert Medical School of Brown University*

Cynthia E. Brown, *Stony Brook University and Pacific University*

Alex R. Dopp, *RAND Corporation*

THE ARTICLE by Mii and colleagues (2021) that appeared in Volume 44(5) of *the Behavior Therapist* provided a review of the literature on an important and timely topic: the assessment and treatment of intrafamilial adolescent sexual reoffending. The authors addressed several key issues in this area, including risk assessment, family reunification, and community-based treatment; their focus on these important issues deserves commendation. However, the authors' review of treatment and prevention strategies for adolescent sexual reoffending focused primarily on individual-level cognitive-behavioral therapy (CBT) for relapse prevention with general recommendations about family incorporation in treatment. As such, the only intervention model with strong empirical support for treating problematic sexual behavior, as well as one promising early-intervention model, was omitted. Therefore, we seek to supplement Mii and colleague's article with more information about these evidence-based approaches.

It is important to recognize that systemic interventions have the greatest empirical support for adolescent sexual offending and should be the first line of interventions for youths who have engaged in illegal sexual behaviors—including intrafamilial offending. Mii and colleagues (2021) primarily present the results of two meta-analyses. The first meta-analysis (Walker et al., 2004) drew conclusions from 10 treatment studies published between 1986 and 1997. Most studies did not include recidivism rates or a control/comparison group, which the authors note "made it impossible to document the treatment efficacy of the treatments" (p. 290). The second meta-analysis (Schmucker & Lösel, 2015) incorporated only 5 studies with adolescent samples—the remaining 24 studies included adult, mixed, or "unclear" samples—and recom-

mended both CBT and multisystemic treatment approaches. In fact, some of Mii and colleagues' recommendations, such as deviant sexual arousal reduction being effective for youths, were actually derived from adult treatment studies. Notably, there were also only two randomized clinical trials for adolescents reviewed by Schmucker and Lösel, both of multisystemic therapy for problem sexual behaviors (MST-PSB; Borduin et al., 2016), a family- and community-based treatment model adapted from MST for justice-involved youths (Henggeler et al., 2009).

Systematic reviews of treatment studies for problems such as juvenile sexual offending offer a complement to meta-analyses when identifying evidence-based practices. Using a structured approach to synthesize findings from treatment outcome studies, Dopp and colleagues (2017) conducted a systemic review of treatment studies for adolescents with a history of illegal sexual behaviors. Of note, only 10 treatment studies from three modalities (i.e., MST-PSB, CBT for relapse prevention, behavior management through adventure) met the inclusion criteria (i.e., the inclusion of a comparison condition and a posttreatment measure of sexual offending) for this review. Ultimately, the authors concluded that MST-PSB, with three randomized clinical trials (i.e., Borduin et al., 1990; Borduin et al., 2009; Letourneau et al., 2009), had the most research support for any existing treatment model for adolescent sexual offending. Further, MST-PSB was the only treatment model evaluated in randomized clinical trials. Unlike relapse-focused CBT approaches, MST-PSB treatment model uses Bronfenbrenner's (1994) ecological systems theory to conceptualize and target youths' sexual and nonsexual problem behaviors within their interconnected social systems (e.g., family, peers, school, and community). Despite the

strengths of the evidence for MST-PSB, Dopp et al. concluded that replication of these randomized trials without involvement of the treatment developer would be necessary to fully establish its effectiveness. Conversely, CBT that focuses on relapse prevention and behavior management through adventure were rated as "experimental" due to a combination of weak research designs and limited evidence of effects on illegal sexual behavior.

Unfortunately, as noted by Mii and colleagues (2021), research on the prevention and early intervention to address illegal sexual behaviors in youths has been limited. However, Problematic Sexual Behavior CBT (PSB-CBT; Carpentier et al., 2006) holds promise. PSB-CBT is intended to treat problem sexual behaviors in school-age youth and prevent the continuation of sexual offending into adolescence. This model is distinct from the CBT for relapse prevention model, as PSB-CBT incorporates groups for both caregivers and youths, providing structured evidence-based methods for peers and caregivers to support youths' development of prosocial behaviors. In addition, PSB-CBT is also guided by input from a multidisciplinary team (e.g., juvenile justice, child welfare, law enforcement, behavioral health). Results from the sole randomized clinical trial of this model indicated that, as compared to individual play therapy, youths in the PSB-CBT condition were less likely to be involved in juvenile and adult sexual offenses 10 years after treatment. Notably, this model is also in the process of being adapted upwards for 10- to 14-year-olds, with a study utilizing a pre-post design yielding promising results (Silovsky et al., 2019).

Viewed together, the current literature indicates that multilevel systemic interventions are the most well-supported for treating adolescent sexual offending, whether delivered in an intensive home- and community-based format (MST-PSB) or a family- and systems-inclusive group format (PSB-CBT). It remains concerning that, to date, so few randomized clinical trials have been conducted regarding adolescent sexual offending, even for the most promising treatment and early intervention models. As such, even though we have highlighted two evidence-based practices for this population, we look forward to future rigorous examinations of treatment and prevention efforts of adolescent sexual offending, including those targeting intrafamilial offending.

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## STUDENT FORUM

# Interview Series: Clinical Psychology Careers “Off the Beaten Path”: Part 3

Samantha Moshier, *Emmanuel College*

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. This is the third of three sets of interviews conducted with 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, tech start-up, and public sectors, illustrating 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 Dr. Cassidy Gutner and Dr. Ellen Healy appear below. Drs. Sarah Kleiman and Michelle Davis were featured in the September issue, and Drs. Lisa Benson and Andrea Niles were featured in the October issue.

### ■ Ellen Healy, Ph.D.

*U.S. Department of Veterans Affairs*

**What type of degree do you have and where did you receive it from?**

I have a Ph.D. in Clinical Psychology from The Catholic University of America in Washington D.C.

### What is your current position?

I am currently the Training and Education Coordinator for the Cognitive Processing Therapy (CPT) Training Program in the Veterans Health Administration within the U.S. Department of Veterans Affairs (VA). The CPT Training Program is a VA nationwide initiative to train mental health clinicians to provide CPT to veterans. CPT is an evidence-based psychotherapy for the treatment of posttraumatic stress disorder. The training program is funded by Office of Mental Health and Suicide Prevention at VA Central Office, and I am located at VA Boston Healthcare. In this role, I coordinate the CPT regional training efforts VA-wide. As a program we have developed a curriculum and standard training process for CPT and now have over 70 VA regional CPT trainers who offer these trainings locally within their region. I have been in this position for over 10 years.

**Describe your job. What does a typical day or week look like for you?**

My job is to manage and coordinate all aspects of the CPT Training Program and

to provide consultation and training to VA clinicians. I maintain a small caseload of therapy patients and provide clinical supervision. In my role as coordinator of the CPT training program, in a given week, I collaborate with our CPT team to update training materials, connect clinicians to CPT training opportunities, answer CPT-related questions from the field, and provide specific guidance to regional trainers including consulting about their training plans and consultee progress as well as troubleshooting any unique issues they may have. I lead twice-monthly calls with regional trainers to disseminate information and guidance, facilitate journal article discussions, and provide opportunities for trainers to learn from each other. In my role as a CPT consultant, I lead 3–5 hours of group consultation per week by phone or video. During consultation meetings, I check in with each clinician about their CPT cases, and we discuss the case progress, discuss case conceptualization, and answer questions. I also collaboratively plan and co-lead CPT training workshops and CPT train-the-trainer workshops annually. Finally, I have worked with our team to create educational products including a CPT promotional video, an online web-course, and a recurring webinar tutorial series.

***What attracted you to your current position?***

This job offered me with a unique opportunity to integrate my clinical skills with teaching and leadership responsibilities. The unique and diverse nature of this challenge was really appealing to me. Also, I embraced CPT in my clinical practice and found it to be a treatment that could truly be life changing. Seeing veterans challenge their thinking and come to a new understanding of their trauma and of themselves inspired me to work to ensure CPT was available to the many who would benefit from it. This position provided me the opportunity to teach and train others in a therapy I believe in, and to facilitate training on a large scale to VA clinicians.

***What prior experiences or positions made this career path possible for you?***

Certainly, my training in CPT was foundational for this position. In addition to training in CPT, I had a number of clinical and research experiences that introduced me to the value of evidence-based psychotherapy. These experiences included a practicum focused on the treatment of anxiety and obsessive-compulsive disorders and a posi-

tion as a research study therapist providing group social skills training and individual cognitive behavior therapy for serious mental illness. Beyond my evidence-based psychotherapy training, the demands of graduate school and learning to balance many commitments and responsibilities prepared me for the many moving parts of this job. Frankly, I felt somewhat junior to be taking on this role when I started in this position over 10 years ago. I was lucky to have mentors like Dr. Kathleen Chard and Dr. Patricia Resick, who really pushed me to take ownership over my role even though I was younger than many of the clinicians to whom I was providing consultation.

***What skills from your graduate training do you use most often?***

I certainly use the clinical skills I learned in graduate school all the time, not only as a therapist and consultant, but also having to navigate my role as a program coordinator and administrator. I learned how to bring up difficult conversations and provide feedback in a way that it can be heard. This is an important skill for providing feedback in consultation, but also when working with consultants or training participants to troubleshoot when something is getting in the way of a participant's training engagement. My experience doing research in graduate school allows me to be able to understand and integrate research evidence to inform our training and consultation and informs my approach to program evaluation now. Also, my experience teaching Introduction to Psychology as a graduate student certainly helped refine my public speaking skills and was important practice for synthesizing and conveying concepts in a digestible way.

***What do you enjoy about your work?***

I love helping clinicians discover a new therapy that can really make a difference in their patients' lives. For clinicians new to trauma-focused treatment, there can be a lot of anxiety that trauma treatment could be making things worse for the patient. By helping clinicians understand the therapy and learn how to deliver it effectively, I then get to witness their increased confidence and trust in the therapy. I love when a new therapist in CPT sees dramatic change in PTSD symptoms for the first time—it often comes as a surprise and solidifies the clinician's belief that CPT is an effective therapy. As a consultant and therapist, I get to be witness to the incredible cognitive shifts that CPT clients make

as they think about their trauma and themselves differently. In my role overseeing large-scale training efforts of CPT in VA, the work of getting effective treatment to veterans feels very meaningful.

***What do you find most challenging about your work?***

My job involves juggling many tasks and responsibilities. When programmatic or logistical changes need to be made, given the size of our program, any changes have ripple effects in many areas (e.g., training materials revised, guidance drafted, stakeholders notified). For example, this past year, with COVID-19, we could no longer host in-person trainings safely and had to very quickly pivot to designing and implementing virtual CPT training workshops. We needed to quickly develop the infrastructure to host virtual trainings and I worked with our team to design and execute a process and then trained our trainers on how to lead a training on the online platform. I was suddenly in the position of providing tech support and troubleshooting for online training workshops (certainly not something I learned about in graduate school!). I often find myself needing to quickly engage in problem-solving and address various distinct issues as they arise on a daily basis—it's exciting, but also can be challenging.

***As a graduate student, what was your intended career path?***

I knew I wanted to be a clinician, but I was interested in many things (and frankly, I was a bit indecisive!). My dissertation was focused on understanding chronic versus acute suicidality. I also had a love for neuropsychology, so I was debating a career in neuropsychology versus clinical psychology. In order to keep the neuropsychology path open, on internship, I spent 50% of my training in neuropsychology. I then completed the PTSD rotation and got my first exposure to CPT by attending an intensive training workshop. Here was my first experience learning how to effectively treat trauma, and I was so moved by the changes that patients could make. These experiences helped me hone my interests in my search for a postdoctoral position. I then went to VA Boston for a clinical postdoctoral fellowship in PTSD, where I attended my second CPT training with Dr. Patricia Resick and had the opportunity to participate in group consultation with her. I didn't have a clear vision of what my career path would look like when I was in graduate school. It was the opportunities



along the way that helped me sharpen my focus.

***What advice would you give to a graduate student who is interested in pursuing a similar line of work?***

For me, I appreciated the opportunity in graduate school to have exposure to so many different areas of clinical psychology through practicum, jobs, and training experiences. I think it is important to take advantage of the exposure to many areas to find what resonates best along the way (even if you think you already know). There are many graduate students that have their path planned out, with specialized interests and very specific goals from the start. I was not one of those students. Having room to explore in graduate school helped me find my path. I so appreciated my mentors who helped me think through where my interests lie and what steps to take to get there. So, my advice is to soak up training opportunities as they present themselves. Take the chance to try working with a new population, or learning a new therapy, or joining a new research collaboration. To pursue a career in training specifically, building the competence and expertise is the first step. When you know it well yourself, then you can teach others.

**■ Cassidy Gutner, Ph.D.**

*ViiV Healthcare*

***What type of degree do you have and where did you receive it from?***

I received my Ph.D. in Clinical Psychology from Boston University.

***What is your current position?***

I am the Director of Global Implementation Research at ViiV Healthcare, a small pharmaceutical company focused solely on HIV. I also have a part-time position at Boston University School of Medicine, Department of Psychiatry.

***Describe your job. What does a typical day or week look like for you?***

My job is focused on leaving no person with HIV left behind. In my role, that means I help support and design efforts to utilize implementation science to ensure we find real-world solutions to end the HIV epidemic through research and training. I currently serve as the implementation science lead on two large studies that span six countries and lead implementation science capacity building effort both inter-

nally and externally. My day-to-day activities span from developing and designing new studies, overseeing the implementation science components of studies, and creating and running implementation science trainings. My work allows me to collaborate with external investigators to capitalize on implementation research to close the research-to-practice gap in HIV across the care continuum.

***What attracted you to your current position?***

I had spent the past several years building expertise in implementation science, but the pace of academia did not seem to match the ideal pace for translation of research into public health impact. Additionally, implementation science is inherently multidisciplinary, but I had primarily used my skill within mental health. The idea of taking my research skills and applying them to a new area that would allow for more rapid real-world impact while developing new skills attracted me to the position. The position has taken my research knowledge and general thinking beyond my previous training and has allowed me to work on impactful work focused on identifying solutions for real-world barriers to both individuals and systems working to end the HIV epidemic. The mission of the company being truly committed to leaving no person with HIV behind and their appreciation that implementation science would play a key role in this mission was another big draw.

***What prior experiences or positions made this career path possible for you?***

My research methodology training coupled with my specialization in implementation science made this career path possible. I was lucky enough to have strong training in research methodology and randomized control trials in graduate school, which is a transferable skill across content areas. After completing my degree, I re-specialized in implementation science, which is a multidisciplinary field that can be utilized across all disease areas. Some of the contexts I currently work in also involve mental health, or quality of life more broadly, which allows my training as a psychologist to come into play as well.

***What skills from your graduate training do you use most often?***

Making the switch from a job that is primarily focused on mental health to HIV resulted in a large learning curve in many

respects, but many of the skills are transferable.

In my current role I most obviously use my research training on a daily basis. However, the way that we are taught to approach patients as clinicians (e.g., going in with an open mind, asking questions, examining situations from multiple vantage points, acknowledging there may be multiple solutions rather than one right answer) is a skill that helps in nonclinical settings as well.

***What do you enjoy about your work?***

There are many things I enjoy about the work I do, including the challenges that come with making this type of a career change. However, the first one that comes to mind is the ability to work on a multidisciplinary team and be challenged to think outside of the box. Our teams span the spectrum from early development scientists, virologist, statisticians, and operational trial experts. This allows for friendly challenging of ideas and generation of creative solutions that may not be identified in teams of people with similar training backgrounds. It also means I am frequently learning new information that expands my way of thinking about solutions to get information and treatment most efficiently to people in need.

Second, compared to my experience in academia, I get to see the rapid impact of the work we do. Although there are still strict review processes and regulations that have to be followed, the timeline from idea generation to data collect is more rapid than I have experienced before. It is nice to be able to see the direct impact of work on a faster timeline.

***What do you find most challenging about your work?***

Learning a new system and communicating with others about my expertise and its value in this setting have been the most challenging. In my training, we never discussed alternative career paths and I never asked about them because I had a different idea of where I would be with respect to my career trajectory. I have had to learn the infrastructure of a new system and a new approach to doing research in a larger team than I have previously worked on, which is very different than academia. Additionally, the way we tend to speak in academia is not always the most accessible. Translating the information into a new context has helped me to think about the best way to communicate information about research to maximize accessibility to people outside of

mental health and implementation science in a way that I had previously not needed to do.

***As a graduate student, what was your intended career path?***

As a graduate student I wanted to work in research, which was solidified for me during my clinical internship year. I worked towards becoming a full-time academic researcher on soft money and was lucky to spend the first part of my career doing that. I really enjoyed the opportunity to have my clinical work and research inform and strengthen one another and enjoyed the grant-writing process in this position.

***What advice would you give to a graduate student who is interested in pursuing a similar line of work?***

My advice is to learn as much as you can in graduate school about how to become a strong clinician and researcher. Although those skills may seem very specific to a certain career path within behavioral and cognitive therapy, the foundation that you will have coming out of graduate school will provide you with an invaluable skill set that can be used to support you in multiple career paths moving forward. The job you may have 5 or 10 years from now may not be on your radar or even exist yet, but your strong training will serve you well regardless of the path you end up going down. I would also encourage them to keep an open mind about alternative career paths. For many people, there can be stigma about talking about going outside of academia and working in industry. In hindsight, I was resistant to thinking there were other paths outside of academia that I would find challenging and meaningful in the way that academia was for me. However, finding a position in industry in a patient-focused company has made me realize the options are wide open and there are many meaningful ways to apply your skills as a psychologist, even when they do not fit into a traditional job description.

...

No conflicts of interest or funding to disclose.

**Correspondence to** Samantha Moshier, 400 The Fenway, Emmanuel College, Boston MA 02115; moshiers@emmanuel.edu



OBITUARY

## Steven Fishman

Barry Lubetkin, *Institute for Behavior Therapy, New York City*

ON NOVEMBER 4, 2021, I lost my best friend and my practice partner of 50 years. Steven Fishman, Ph.D., ABPP, died after struggling with cancer for many months. He had just passed his 80th birthday.

Steve was married to Cheryl, who passed 5 years ago, father to Stephanie, and grandfather to two great children, Charley and Jack.

I had first met Steve when we both were postdoctoral fellows in behavior modification at SUNY Stony Brook. We became fast friends and the year after that program ended we opened the Institute for Behavior Therapy in New York City in 1971.

Steve grew up in St. Louis, Missouri, where he spent his youth being an active athlete, brilliant student, and helping out his father service the vending machines they owned at Busch Stadium. He had originally planned on a career in sports broadcasting but ultimately changed course and received his degree in Clinical Psychology from Washington University in St. Louis.

Steve was a scholar. His early work was pioneering in the field of systematic desensitization in groups. Numerous important papers and book chapters followed, particularly in the field of anxiety management.

Steve was a great friend of the ABCT (formally the AABT) and served as an early Board of Directors member. He was also an early president of the New York City Behavior Therapy Society. Steve was given the ABCT Outstanding Service Award in 2002 and was a fellow of the association. In addition Dr. Fishman served as Secretary of the American Board of Behavioral Psychology for 12 years.

But of course more important than any of the above is that I lost the man who was closest to me. For 50 years we had the longest partnership in professional psychology. Steve was honest, caring, and kind to every person who was lucky enough to become his patient. He was a skilled, masterful clinician and an equally skilled trainer of other clinicians who now number in the hundreds and are bringing Steve's wisdom to centers around the world.

A patient of Steve's recently wrote to me that "he was the most influential human being that I have ever met."

Rest well, my dear friend. ■



## Explore & Remember Featured Therapists

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**Steve Fishman**  
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<https://www.abct.org/featured-therapists/>



OBITUARY

## Aaron Temkin Beck: In Memoriam

Steven D. Hollon, *Vanderbilt University*

Robert J. DeRubeis, *University of Pennsylvania*

AARON TEMKIN BECK (Tim to his many friends and colleagues) passed away on November 1, 2021, at the age of 100. Tim was the progenitor of cognitive therapy, one of the best-established and most widely practiced of the cognitive behavioral interventions, and arguably the major theorist of psychopathology and psychotherapy in the second half of the 20th century.

The essence of cognitive therapy is the assumption that the way that a person interprets a situation determines the ensuing emotions and behaviors. What Dr. Beck did, exquisitely, was to discover from the perspective of, and along with, the patient, the beliefs that allowed them to connect the dots. He found that this was so whether a patient was anxious, depressed, or in the throes of delusional beliefs and the passions they fueled. With this crucial information, he found he could guide the patient to examine the accuracy of their beliefs, using the patient's logic and his or her own observations in the world or in memory. His approach was simple, direct, and highly pragmatic, which led to its being widely emulated and disseminated across the professions and around the world.

Tim graduated summa cum laude in 1942 from Brown University before pursuing his medical degree at Yale University. He completed his residency in psychiatry at the Cushing Veterans Administration Hospital in Framingham, Massachusetts, after first specializing in pathology and then neurology. A shortage of psychiatry residents led the VA to conscript residents in other specialties for 6-month stints in psychiatry. Tim wrote to a friend that he found psychiatry "soft," but eventually the phenomena lured him to the field. He completed a 2-year fellowship at Austin Riggs Center in Stockbridge Massachusetts (where he was supervised by Erik Erickson) before volunteering to serve at the Valley Forge Army hospital outside of Philadelphia. He was board certified in psychiatry in 1953 and became an instructor in psychiatry at the University of Pennsylvania, where he remained for the rest of his career. He graduated from the Philadelphia

Psychoanalytic Institute in 1958 (a key step for a young psychiatrist in those days) and was appointed as an Assistant Professor at Penn that same year.

Tim's early empirical investigations tested the Freudian claim that depression was a consequence of "anger turned inward" (inward because it was too risky to express the anger directly at its true target, typically one's parent). He did this by examining the dream content and free associations of his depressed patients (Beck, 2006). He was surprised to find little evidence for Freud's thesis. Reflections of the "unconscious" content of his depressed patients contained no more evidence of retroflected anger than did that of his patients who were not depressed. What he found instead were themes of personal unlovability and incompetence, which paralleled the content of their waking discourse. Spurred by this observation, he "crossed the street" to the Penn's Department of Psychology and made common cause with its experimentalists to test another Freudian tenet, that depressed patients had a "masochistic" need to suffer. He and his colleagues devised a task that virtually guaranteed success in the initial stages. Depressed patients, rather than sabotaging the task or reacting negatively to it, engaged with it in such a way that their mood improved and their motivation to succeed on subsequent trials increased.

These dual disconfirmations led him to what he later called "a simple-minded hypothesis"—that the negative way in which patients see themselves is the core of the problem. The problem lay not in the unconscious, but rather in the waking thoughts and beliefs that patients had that served them poorly. He began to have his patients sit upright in their sessions (to maintain eye contact and monitor their facial expressions) and to talk about their thoughts and beliefs about troublesome life situations. He engaged them in Socratic dialogue and encouraged them to gather evidence between sessions, often in the context of bespoke experiments, to test the accuracy of their beliefs. His papers in the

*Archives of General Psychiatry* in the early 1960s laid out his theory of the disorder (Beck, 1963) and his theory of change (Beck, 1964), thus marking his conversion to a new way of thinking about maladaptive behaviors and emotions, and at the same time laying down a gauntlet to psychoanalytic theory and psychodynamic therapy.

The immediate consequence of this "nailing of principles" to the proverbial door of the established church was his loss of membership in the Philadelphia Psychoanalytic Society. (One colleague suggested that he was "not well analyzed.") This led to his being shunned by most of his departmental colleagues, and he became unpopular with psychiatry residents. This was a tenuous situation for an untenured professor in what was then a traditional, psychoanalytic-theory-friendly Department of Psychiatry.

Dr. Beck's funded research at the time focused on the nature and classification of suicide. When his grant was not renewed, he faced a personal and professional crisis. As he did numerous times throughout his life, he turned "adversity to advantage" (Weishaar, 1993) and used his unexpected free time to write a major treatise on the nature of depression that moved him to the forefront of the field (Beck, 1967). The breadth of his scholarship was evident and the quality of his ideas captivating. No one in the field had a better handle on depression.

Tim had a special affection for ABCT and described his presentation at its Annual Convention in Denver in 1969 as a major turning point in the acceptance of his ideas. He had been invited to present a paper in a symposium based on his clinical observations and his nascent version of "cognitive therapy." Armed with 20 mimeographed copies of his presentation, he was amazed to find that not only was the room filled, but that all 20 copies of his paper were taken by those present, and several dozen other members of the audience added their names and addresses to a list to ask for copies. He would later say that this was the first time that he sensed that he might be more than just a "voice in the wilderness." His approach, an integration of cognitive theory and behavioral procedures, was laid out in the inaugural issue of *Behavior Therapy*, and cognitive therapy was born (Beck, 1970).

Tim went "transdiagnostic" decades ahead of the rest of the field in his remarkable *Cognitive Therapy and the Emotional Disorders* (Beck, 1976). In that monograph,



he showed how his cognitive model applies to a variety of disorders, noting the primacy of beliefs in the etiology and maintenance of excessive or unpleasant emotional reactions and the behaviors that followed. He posited that an empirical approach to examining the accuracy of the beliefs would be an effective and efficient way to help patients who suffered from manifestations of anxiety or depression. The breadth of his approach inspired a generation of research on the cognitive model and treatment of depression and a vast array of other problems and disorders, both in the United States and abroad.

Although in his early years at Penn it was rare for psychiatry residents to seek him out, a few did, most notably Augustus John Rush. John, the great grandson many generations removed from Benjamin Rush, the father of American psychiatry, was intrigued with Tim's new and bold ideas. He proposed a trial like those that were used to test new pharmaceuticals for depression, in which cognitive therapy would be pitted against antidepressant medications. Tim, always the empiricist, was up to the challenge, and the two were joined by Marika Kovacs, who would go on to become a major figure in childhood depression. The finding from the acute phase of the trial, published in the inaugural issue of *Cognitive Therapy and Research*, represented a first: a psychosocial intervention had held its own relative to antidepressant medications (Rush et al., 1977). This finding has been replicated many times since (notably first by Ivy Blackburn in Edinburgh), as has the finding from the follow-up (Kovacs et al., 1981) indicating that a brief course of cognitive therapy, unlike an equally brief medication treatment, provides protection against relapse (Cuijpers et al., 2013).

The treatment manual followed in the Rush et al. trial, published as *Cognitive Therapy of Depression* (Beck et al., 1979), is considered by many the prototype of a specific strategy for ensuring therapist fidelity and competence (Luborsky & DeRubeis, 1984). It did not prescribe specific procedures to be followed in a rote fashion. Rather, it laid out principles that inform the course of treatment, leaving room for the clinician to decide when and whether to implement the specific techniques and strategies described in the manual.

During the 1980s cognitive therapy was becoming widely accepted in the field. Tim spent considerable time in the United Kingdom, largely at the invitation of Michael Gelder, Chair of Psychiatry at

Oxford (himself a distinguished friend of ABCT), where he came into contact with numerous leaders and future leaders, including John Teasdale and Mark Williams, who along with Zindel Segal from Toronto, were the progenitors of mindfulness-based cognitive therapy (MBCT); David Clark and Paul Salkovskis (anxiety disorders and OCD) and later Anke Ehlers (PTSD); Jan Scott (bipolar disorder), and Daniel Freeman (schizophrenia). Chris Fairburn developed his cognitive behavioral intervention for eating disorders largely independently, but Kelly Bemis Vitousek, another leader in eating disorders research, was heavily influenced by Beck.

As practitioners implemented cognitive therapy for depression during the 1980s, they discovered that the brief version was sometimes insufficient to address the problems of patients whose clinical picture included comorbid personality disorders (Beck et al., 1990). Additional therapeutic strategies would be needed, some of which drew upon Tim's psychoanalytic training (sans any allusion to the dynamic unconscious) to introduce what he referred to as the "three-legged stool." Whereas "standard" cognitive therapy, highly effective for patients without comorbid personality disorders, focused on beliefs and behaviors relevant to current life situations, it became clear that it was important to connect these beliefs and behavioral patterns to their genesis, which could be discovered by reviewing patterns or traumas the patient could recall from their childhood. Moreover, with these patients Tim recognized the importance of utilizing the themes and experiences within the therapeutic relationship for therapeutic purposes, whereas in earlier versions of cognitive therapy tensions observed by the therapist were addressed only insofar as they might be resolved quickly, to allow the work of therapy to continue. Tim noticed that patients with personality disorders often enacted compensatory strategies, intending to "cut their losses," much as patients with anxiety disorders engage in safety behaviors. Just as safety behaviors maintain the problems with anxiety, the compensatory strategies serve to maintain the maladaptive beliefs and patterns, often leading to problematic relationships with family and coworkers. This was the major revision in 1970s cognitive therapy that extended the approach.

In recent years, Tim had returned to his early work on the treatment of schizophrenia. Along with colleague Paul Grant, he developed a recovery-oriented approach

that emphasizes building up a sense of meaning and purpose. The intervention aims to cut through the sense of demoralization that can afflict people suffering from a major psychiatric illness, thereby helping them reconnect with a world that seemingly had passed them by.

One of the authors (RJD) and Tim's daughter Judy Beck (a major theorist in her own right) organized a virtual 100th birthday party for Tim in July 2021. What was remarkable was the consistency of the stories shared by the 16 participants, each of whom were leaders in their field. The theme was Tim's kindness toward, support of, and interest in these psychologists and psychiatrists when they were in training or just starting out in their profession. Each one described how Tim would inquire about their interests and ideas, and how he would then introduce them to others who could serve as colleagues or mentors. Stories told by the women who participated emphasized how supportive Tim was to them when they were just beginning their careers. They noted how unusual it was, at a time when the field was dominated by men, to be noticed for their ideas and encouraged to pursue them. The question of how Tim has had a monumental impact on the field is answered in part by the clarity of his theories, which allowed for rigorous tests of the propositions and of the effectiveness of the treatments. But that is only a partial explanation, much of the rest having to do with his interest in promoting the careers of junior colleagues on the cusp of important breakthroughs.

Tim Beck was clearly a giant in the field. We will not recount his many awards and accolades. (Ben Carey, the science writer for the *New York Times* and himself a Friend of ABCT, wrote an excellent obituary.) Suffice it to say that he has won every major award in the field and inspired multiple generations of clinical researchers who have followed his lead. Tim was first and foremost an empiricist; he did not care what the truth turned out to be, but he wanted to know the truth whatever it was. He did not do studies to show that his theories were correct or that his therapies worked, he did studies to find out whether his theories were correct and if his treatments worked. If they did not, he revised his theories or modified his therapies. In his approach to treatment, he was a phenomenologist above all else. He was simply, in our view, unparalleled in his ability to occupy the perspective of his patients and to help them discover whether their beliefs provide an accurate represen-

tation of reality that has served them well. In other words, he was an exceptional therapist. But more than that, he was a courageous trailblazer, an exceptional judge and supporter of talent as evidenced in its early stages, and a persistent seeker of the truth. This will be his legacy.

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## OBITUARY



## S. Jack Rachman

January 19, 1934–September 2, 2021

Maureen L. Whittal, *University of British Columbia/Vancouver CBT Centre*

Roz Shafran, *University College London/ Great Ormond Street Center for Child Health*

Adam S. Radomsky, *Concordia University*

STANLEY (JACK) RACHMAN was born in Johannesburg, South Africa, and completed his undergraduate degree at the University of Witwatersrand where he took his first lectureship. At 22 years of age, Jack was the youngest lecturer in the university. It was the time of apartheid in South Africa. The university was encircled by wealthy white neighborhoods. Jack was deeply affected by the difficulties that the black students endured walking through these neighborhoods to reach the university. He did say that once the black students crossed the gates of the university, there was a measure of freedom that did not exist elsewhere in Johannesburg. It was a place where black and white students mixed and academic ideas carried the day and not race.

Jack completed his Ph.D. at the Institute of Psychiatry at London University under the supervision of Professor Hans J.

Eysenck in 1961. Eysenck's reputation preceded him. Jack recounted the story of meeting Hans for the first time. He was anticipating a difficult interview and travelled to London with some trepidation. They reportedly had a lovely wide-ranging conversation, none of which included psychology. At the end of the meeting Eysenck pointed at an empty desk and told the young Jack it was where he was to sit when he came to the Institute. In recounting the story decades later, Jack remained amazed at his good fortune.

Jack continued at the Institute and was involved in the pioneering studies of exposure and response prevention for obsessive-compulsive disorder. During his time at the Institute he began teaching in the clinical psychology training course, the first in England. Students were eager to learn about the work on systematic desensitiza-

tion Jack had done with Joe Wolpe at Witwatersrand. Jack moved to the University of British Columbia in 1982 where he was tasked with building the clinical program. Jack remained the Director of the Clinical program until 1987 and retired from the UBC Psychology Department in 1999 where he maintained Emeritus status. He was also Emeritus Professor at the Institute of Psychiatry, London University.

Jack was a prolific researcher. His areas of focus over the years were in the anxiety disorders, fear and courage, and, broadly, cognitive behavior therapy. Jack was most well-known for his work in obsessive-compulsive disorder, approaching it from a behavioral perspective early in his career, but transitioning to more of a cognitive focus in his later work on obsessions and contamination concerns. According to Google Scholar, Jack received 46,636 citations on 577 articles for a H-index of 107. Jack was a firm believer of the scientist-practitioner model and the importance of having clinical work inform research and vice versa. It was in his clinical work that Jack identified and honed his more recent ideas on mental contamination in OCD. As was the case for many ideas he initiated, it stimulated research worldwide.

*Behaviour Research and Therapy* (BRAT) was formed by Professors Eysenck and Rachman and was one of the first behavioral journals in psychology. Hans and Jack had many rejections for their idea of a journal dedicated to behavioral psychology. Psychodynamic theories were predominant at the time. It was finally

Robert Maxwell (Pergamon Press) at the end of a long wine-filled dinner who sealed the deal with a handshake. Jack was Associate Editor of BRAT from 1963–1978 and Editor-in-Chief from 1978–2002. Under Jack's watchful eye, BRAT became the pre-eminent journal to publish work in behavior therapy and later cognitive behavior therapy. Jack had a keen eye for the next great thing and encouraged many of our current-day stars to write up their work for the journal. Jack did much of his own reviewing. He was not a stickler for detail but more focused on ideas and innovation.

In addition to his many contributions in the science and practice of cognitive-behavior therapy, Jack worked with and trained many of the world's leading CBT researchers and practitioners, many of whom became close and lifelong friends. He was a Fellow of the Royal Society of Canada and received a lifetime achieve-

ment award from the British Psychological Society.

Jack was a consummate academic with a broad range of interests including music, politics, and world history. He was a voracious reader, a connoisseur of the finer things in life and a well-known oenophile. He combined his love of the fermented grape with the use of psychological methods and rating scales for a book he maintained gave him the highest royalty cheques—*Wine: A Matter of Taste*, penned by Jack Durac, his pseudonym. Jack continued to use this pseudonym over the years to poke fun at various things, including himself.

Jack was a father to 4 amazing children and 7 grandchildren of whom he was extremely proud. He was sadly predeceased by his daughter Emily. Jack was married to his best friend, Clare Philips, for 50+ years. His wit was legendary and he was quite

fond of a good practical joke. To say that he will be missed is an understatement. We all feel extremely fortunate to have crossed paths with Jack Rachman. To say that he profoundly changed our lives is another understatement.

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*If you would like to add your own personal memory of Jack to an online book of remembrance, you can do so at <https://www.kudoboard.com/boards/ZqRMx4Vg>. Additionally, a recent video conversation where Jack discusses his professional life can be found at <https://www.youtube.com/watch?v=s-Vo3XJYY8o&t=190s>.*

## Call for Nominations

## FELLOWS Committee

The ABCT Fellows Committee is soliciting nominations for two new members. The committee is comprised of a chair, who is nominated by the Membership Issues Coordinator and serves a three-year term. Committee members are recruited by the chair or solicited from the membership at large and usually include six additional ABCT members who represent diversity with regard to type of professional activities (e.g., academic researchers as well as clinicians). All committee members must be Fellows at the time of appointment by the chair. Committee members are on a staggered term to insure continuity of the review process. ABCT is committed to supporting diversity, equity, and inclusiveness when evaluating members for Fellow status. We encourage applications from all eligible members, and particularly members of underrepresented groups.

A complete list of current ABCT Fellows can be found at [https://www.abct.org/wp-content/uploads/2021/05/Fellow\\_PDF.pdf](https://www.abct.org/wp-content/uploads/2021/05/Fellow_PDF.pdf)

Duties of the Fellows Committee include the review and discussion of Fellows' applications, leading to a vote for each applicant. The Committee meets at least 2 times per year to review applications.

*To nominate yourself or a colleague, please send the individual's vitae and a brief biosketch via:*

<https://services.abct.org/i4a/forms/index.cfm?id=29>

► NOMINATION DEADLINE: May 1, 2022



## Call for Applications

# FELLOWS

ABCT Fellow Status for 2022



The ABCT Fellows committee is pleased to announce that 11 new members were recognized at the virtual awards ceremony at the annual ABCT convention in November 2021. For a complete list of all Fellows, please see <https://www.abct.org/membership/fellow-members/>. This past year the Fellows Committee used the revised Fellows guidelines in selecting new Fellows. In brief, ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role. Because members' career paths come with unique opportunities, the committee was sensitive to the environment in which the potential applicant was functioning, and we weighed the contributions against the scope of the applicant's current or primary career.

### Multiple Routes to ABCT Fellow Status

The 2021 revision of the Fellows application materials now offers 6 areas of consideration for fellowship: (a) clinical practice; (b) education and training; (c) advocacy/policy/public education; (d) dissemination/implementation; (e) research; and (f) diversity, equity, and inclusion. Applicants for fellowship will be asked to endorse the area(s) in which they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow; demonstrating outstanding, sustained effort in one area is all that is required. What guides the committee's decision making is determining if an applicant has made an exceptional, sustained contribution that goes beyond their work role expectations.

**Who is Eligible to Apply for Fellow Status?** (a) Full membership in ABCT for > 10 years (not continuous); (b) Terminal graduate degree in behavioral and cognitive therapies or related area(s); and (c) > 15 years of professional experience following graduation. Two letters of reference are required; one should be from an existing ABCT Fellow. If the latter requirement is a barrier to applying, please contact the Chair of the Fellows committee at [fellows@abct.org](mailto:fellows@abct.org) who will then assist in determining how to best handle this request. The Committee encourages qualified and diverse applicants to apply.

The Fellows Committee strongly recommends that potential Fellow applicants as well as their letter writers describe the applicant's specific contributions that are outstanding and sustained. To aid in writing these letters the Fellows committee prepared Guidelines for Applicants and Letter Writers for how to write fellow status contributions <http://www.abct.org/Members/?m=mMembers&fa=Fellow>. While these guidelines provide examples of what the Fellows committee considers outstanding, sustained contributions, they are far from exhaustive.

**Deadline for Fellow Status Applications:** July 1, 2022, is the deadline for both applicants and letter writers to submit their references. Applicants will be notified of the decision on their application by mid-October 2022. For more information, please visit the Fellowship application page <https://www.abct.org/Members/?m=mMembers&fa=Fellow>

### ABCT Fellows Committee

*Linda C. Sobell, Ph.D., Chair*

*J. Gayle Beck, Ph.D.*

*Brian Chu, Ph.D.*

*Debra Hope, Ph.D.*

*Christopher Martell, Ph.D.*

*Simon Rego, Ph.D.*

*Maureen Whittal, Ph.D.*

*Antonette Zeiss, Ph.D., Vice Chair*

APPLICATION  
DEADLINE:  
July 1, 2022



# Call for Award Nominations

*to be presented at the 56th Annual Convention in New York City*

*The ABCT Awards and Recognition Committee, chaired by Sara R. Elkins, Ph.D., University of Houston Clear Lake, is pleased to announce the 2022 awards program. Nominations are requested in all categories listed below. Applicants from traditionally underrepresented backgrounds are particularly encouraged to apply. Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.*

## Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, Marsha Linehan, Dianne L. Chambless, Linda Carter Sobell and Mark B. Sobell, Philip C. Kendall, Richard G. Heimberg, and Patricia Resick. Applications should include a nomination form (available at [www.abct.org/awards](http://www.abct.org/awards)), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "Career/Lifetime Achievement" in the subject line. **Nomination deadline:** March 1, 2022.

## Outstanding Educator/Trainer

This award is given to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Past recipients of this award include Gerald Davison, Leo Reyna, Harold Leitenberg, Marvin Goldfried, Philip Kendall, Patricia Resick, and Christine Maguth Nezu. Applications should include a nomination form (available at [www.abct.org/awards](http://www.abct.org/awards)), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one PDF document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "Outstanding Educator/Trainer" in the subject line.

**Nomination deadline:** March 1, 2022

## Outstanding Mentor

Eligible candidates for this award are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Previous recipients of this award are Richard Heimberg, G. Terence Wilson, Richard J. McNally, Mitchell J. Prinstein, Bethany Teachman, Evan Forman, Ricardo Munoz, and David A. F. Haaga. Please complete the nomination form at [www.abct.org/awards](http://www.abct.org/awards). Email the completed form and associated materials as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org), and include "Outstanding Mentor" in the subject line. **Nomination deadline:** March 1, 2022

## Sobell Innovative Addictions Research Award

The award is given to an individual who, through the performance of one or more research studies, has developed a novel and very innovative (1) program of research or (2) assessment or analytic tool or method that advances the understanding and/or treatment of addictions. The emphasis is on behavioral and/or cognitive research or research methods that have yielded exceptional breakthroughs in knowledge. The recipient receives \$1500 and a plaque. The 2020 recipient of this award was Christopher Correia, Ph.D. Candidates must be current members of ABCT and are eligible for the award regardless of career stage. Candidates may self-nominate or be nominated by others who need not be members of ABCT. Submissions should include the nomination form (available at [www.abct.org/awards](http://www.abct.org/awards)), nominee's curriculum vitae, a statement describing the addictions research contribution and why it is novel and advances the field (maximum 3 pages), two letters of support, and copies of publications, web materials, or other documents supporting the innovation and impact described in the nomination. Please e-mail the nomination materials as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "Sobell Research Award" in the subject line. **Nomination deadline:** March 1, 2022

## David H. Barlow and Beverly A. Barlow Research Innovation Award

The David H. Barlow and Beverly A. Barlow Research Innovation Prize is an endowed named award that will be presented annually at the ABCT convention. A past president of the organization, Dr. Barlow has been actively involved in ABCT for over 50 years. Members of ABCT whose published work has contributed innovations that have significantly advanced cognitive behavioral theory, methodology, assessment, and intervention and/or related areas are eligible. These innovations will have made significant contributions to clinical practice or research on cognitive and/or behavioral modalities including their implementation and dissemination. Such contributions will be evident in one or more publications in high impact journals, citations of the candidate's work, evidence

that the work has advanced the field in important ways and letters by peers supporting these contributions and highlighting the innovations. The first award of \$2,500 plus a personalized plaque will be given in November 2022 to a recipient chosen by the ABCT Awards and Recognition Committee. Candidate must be a current ABCT member and can be at any stage of their career. Applicants may be self-nominated or nominated by a colleague. Please complete the nomination form at [www.abct.org/awards](http://www.abct.org/awards), and include CV, statement of clinical research contributions, list of relevant publications and citations, and two letters of support for the nomination based on the criteria in the nomination form. Email the nomination materials as one PDF document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "The Barlow Prize" in the subject line. **Nomination deadline:** March 1, 2022

### **The Francis C. Sumner Excellence Award**

The Francis Cecil Sumner Excellence Award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the "Father of Black Psychology," he is recognized as an American leader in education reform. This award can be given on an annual basis, awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree. Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and professional members of ABCT at the time of the nomination. The award is intended to acknowledge and promote the excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional within 10 years of award of the PhD/PsyD/EdD/ScD/MD who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. The Francis C. Sumner Excellence Award is meant to reflect the overarching goal of ABCT supporting its members of color. The 2021 recipient of this award was Isha Metzger, Ph.D. The recipient will receive \$1,000 and a certificate. Please complete the online nomination materials at [www.abct.org/awards](http://www.abct.org/awards). Email the nomination materials as one PDF document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org), and include "Francis C. Sumner Award" in the subject line.

**Nomination deadline:** March 1, 2022

### **Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice**

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. The 2021 recipient of this award was Christian Webb, Ph.D. This award includes a cash prize of \$1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 10 years of receiving his/her the doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Applicants should submit: nominating cover letter, CV, personal statement up to three pages, and two supporting letters. Application materials should be emailed as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include candidate's last name and "Albano Award" in the subject line.

**Nomination deadline:** March 1, 2022

### **Distinguished Friend to Behavior Therapy**

This award is given annually to an individual or organization that supports the aims of ABCT in providing awareness, advocacy, or evidence-based behavioral health services in the field of cognitive and behavioral therapies. Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Candidates are nominated by an ABCT member and applications should include a letter of nomination/support and a curriculum vitae of the nominee. Recent recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, Vikram Patel, Benedict Carey, and Bivian "Sonny" Lee III. Please e-mail the nomination materials as one PDF document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "Distinguished Friend to BT" in the subject line. **Nomination deadline:** March 1, 2022

### **President's New Researcher Award**

ABCT's 2021-22 President, Laura Seligman, Ph.D., invites submissions for the 44th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent, innovative work published in high-impact journals; and promise of contributing to cognitive and behavioral theory to advance the field. Scholars who trained in smaller labs or who work in less research-intensive environments are encouraged to apply, as the quality and potential impact of one's work, not the number of publications, will be the focus. Requirements: must have had terminal degree (Ph.D., M.D., etc.) for at least 1 year but no longer than 5 years (i.e., completed during or after 2015); must submit an article for which they are the first author (in press, or published during or after 2018); 2 letters of recommendation must be included; self-nominations are accepted; the author's CV, letters of support, and paper must be submitted in electronic form. Applicants from traditionally underrepresented backgrounds, or whose work advances our understanding of behavioral health disparities, are particularly encouraged to apply. E-mail the nomination materials (including letter of recommendation) as one pdf document to [PNRAward@abct.org](mailto:PNRAward@abct.org). Include candidate's last name and "President's New Researcher" in the subject line. **Nomination deadline:** March 1, 2022.



### Student Dissertation Awards

- Virginia A. Roswell Student Dissertation Award (\$1,000)
- Leonard Krasner Student Dissertation Award (\$1,000)
- John R. Z. Abela Student Dissertation Award (\$500)

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2022. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted, or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at [www.abct.org/awards](http://www.abct.org/awards). Email the nomination materials (including letter of recommendation) as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org), and include candidate's last name and "Student Dissertation Award" in the subject line. **Nomination deadline:** March 1, 2022

### Graduate Student Research Grant

The ABCT Research Facilitation Committee is sponsoring a grant of up to \$1000 to support graduate student research. The grant will be awarded based on a combination of merit and need. Eligible candidates are graduate student members of ABCT seeking funding for an unfunded (including internal sources of funding) thesis or dissertation project that has been approved by either the faculty advisor or the student's full committee. Applications should include all of the materials listed in GSRG Application Guidelines (<https://www.abct.org/membership/abct-awards/>) and one letter of support from a faculty advisor. Please email the application, excluding the advisor letter, in a single pdf to the chair of the Research Facilitation Committee, Ryan Jacoby, Ph.D. Include "Graduate Student Research Grant" in your subject heading. Please ask your faculty advisor to e-mail a letter of support separately.

**Application deadline:** March 1, 2022

### Student Travel Award

This award recognizes excellence among our student presenters and is intended to defray some of the travel costs associated with presenting at the convention with a cash prize of \$500. This award money is to be used to facilitate travel to the ABCT convention. To be eligible, students must 1) have their symposium or panel submission for the 2022 ABCT convention accepted for presentation; 2) be a symposium presenter (i.e., first author on a symposium talk) at the ABCT annual convention; 3) be a student member of ABCT in good standing; and 3) be enrolled as a student at the time of the convention, including individuals on predoctoral internships, but excluding post-baccalaureates. Awards are highly competitive and preference is given to projects demonstrating student initiation and independence, and innovation for the field. Two awards are given annually, with one granted to an underrepresented student member, defined broadly as race, ethnic background, sexual orientation, or discipline. Additional requirements and submission instructions are available on the Student Travel Award Application found online at [www.abct.org/awards](http://www.abct.org/awards). Award winners will be announced in mid-September 2022. **Application deadline:** July 22, 2022

### Elsie Ramos Memorial Student Poster Awards

This award is given to student first authors whose posters have been accepted for presentation at ABCT's Annual Convention. The winners each receive an ABCT Student Membership and a complimentary general registration at the next year's ABCT's Annual Convention. To be eligible, students must 1) have their poster submission for this year's ABCT convention accepted for presentation; 2) be student members of ABCT in good standing; and 3) be enrolled as a student at the time of the convention. Awards are highly competitive and preference is given to projects demonstrating student initiation and independence and innovation for the field. Three awards are granted annually. Additional requirements and submission instructions are available on the Elsie Ramos Memorial Student Poster Award Application found online at [www.abct.org/awards](http://www.abct.org/awards). Award winners will be announced in mid-September 2022.

**Application deadline:** July 22, 2022

### Outstanding Service to ABCT

This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form found online at [www.abct.org/awards/](http://www.abct.org/awards/). Email the completed form and associated materials as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "Outstanding Service" in the subject line. **Nomination deadline:** March 1, 2022

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

Mary Jane Eimer, *Executive Director*



WE HAVE JUST FINISHED our 2nd virtual convention and took a brief respite celebrating Thanksgiving. As we gear up for the end-of-year holiday festivities and prepare for the New

Year, I want to say thank you. Thank you for your support and active participation in ABCT. Considering the number of benefits and activities your professional home offers, it does take a very large number of volunteers to partner with your staff. A very big thank you to your Board of Directors; your 4 Coordinators; your 26 committee chairs and their members; and your four editors. Thank you to our 42 Special Interest Groups (and growing) helping you to find like-minded professionals who share your clinical interests and research. They have all worked diligently and creatively throughout the pandemic.

I also want to thank my Central Office colleagues publicly: Amanda, Dakota, David, Kelli, Stephanie, Stephen, and Tonya. Our office has been open since July 2020 and we continue to come in on a staggered schedule. We have been learning a new database program, fine-tuning the switch to forums, continually updating our new website, installing more cyber security measures, and learning more nuances of Zoom. The biggest learning curve has been mastering all the modules of Cadmium, our system for convention submissions and the foundation of our virtual conventions. All hands were involved in the November convention and the feedback we have received has been positive for content, with thanks to Greg Chasson, Liz Katz, Katharina Kircanski, the convention committee chairs, and all the members who served on the Program Committee. Central Office staff monitored all the sessions, with additional backup to troubleshoot as needed. We are definitely sending positive energy into the universe that our 56th Annual Convention in NYC will be in person. But just in case, we are contingency-planning too.

Our focus now is on 2022. If you haven't renewed, please do so. The January issue of *tBT* will be your last, if you don't. We've held membership rates at the same level for the past 3 years. We are working to get the November convention presentations edited and loaded into the system. We expect to have it posted in early January. Those who participated in November can use the same code for access in 2022. Those who didn't register in 2021 can do so in 2022 and earn CE credit. The 2021 convention will be available on line until the end of September 2022.

Speaking of continuing education credit, we are seeing a trend that some states are no longer recognizing nationally based professional organization as CE sponsors (APA, NASW) and instead creating their own criteria that is unique to them. This makes for a difficult, fractured state of CE. Staff is working in partnership with the appropriate members of our governance to address the changes we need to make to ensure continuing education credits for our membership.

President Tolin, in his final Presidential Message, has laid out our strategic intent for the next 2 years. You voted to accept a 6th purpose, "Collaborate with global partners in the development, evaluation and dissemination of CBT and related evidence-based treatments" which has been added to our bylaws. We are thinking big with a long reach and working to have a greater impact in science-backed research and treatment. The Board also added "innovation" to ABCT's core values of accountability, diversity, mentorship, quality and science.

We just transitioned to our 2021-2022 Board of Directors: Laura Seligman, President; David F. Tolin, Immediate Past President; Jill Ehrenreich-May, President Elect; Sandra Pimentel, Secretary Treasurer; Amie Grills, Representative-at-Large and liaison to Academic and Professional Issues; Carolyn Black Becker, Representative-at-Large and liaison to Membership Issues; and Katherine Baucom, Representative-at-Large and Liaison to Convention

and Education Issues. Our coordinators include Nathaniel Herr, Academic and Professional Issues; Katharina Kircanski, Convention and Education Issues; Shari Steinman, Membership Issues; and Susan White, Publications Committee. It is important you know your leadership and the decision-makers. They welcome your input. Expect to see a few more surveys and town hall style meetings via Zoom over the coming year. I know you join me in wishing them clarity of vision and determination to make ABCT the premier organization you expect us to be.

Next November at the Annual Meeting of Members we will be welcoming Sandra Pimentel as President-Elect; Barbara Kamholz as Secretary Treasurer; and Daniella Cavenagh as Representative-at-Large and liaison to Academic and Professional Issues. We begin the orientation and transition to their responsibilities early in the new year. Again, I know you join me in hearty congratulations and appreciation for their willingness to serve in our governance.

Diversity, inclusion, access and equity continues to be a high priority in ABCT's outlook and operations. We currently have requests for proposals out to hire a consultant to help us. Leadership and staff understand the importance that our organization reflects the membership's values and needs. Much headway has been made this past year by special series in *the Behavior Therapist*, content and presenters in our webinars and Annual Convention, the addition of two new awards, and very conscious efforts to ensure our awards program and committee chair appointments be reflective of our membership.

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 your new website and give us feedback. It isn't just numbers of membership 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 submissions, submit an article, join a SIG, run for office, .

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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



# ABCT 2022

November 17–20 | New York City

Emergency & Disaster Preparedness and Response: Using Cognitive and Behavioral Science to Make an Impact

## Call for Ticketed Sessions

*Emergency & Disaster Preparedness and Response:  
Using Cognitive and Behavioral Science to Make an Impact*

PROGRAM CHAIR: Rosaura Orenco-Aguayo, Ph.D.

ASSOCIATE PROGRAM CHAIR: Emily Thomas, Ph.D.

### Workshops & Mini Workshops

Workshops cover concerns of the practitioner/ educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than 4 presenters. Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than 4 presenters. When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

→ **For more information** or to answer any questions before you submit your abstract, email Christina Boisseau, Workshop Committee Chair, [workshops@abct.org](mailto:workshops@abct.org)

### Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than 4 presenters.

→ **For more information** or to answer any questions before you submit your abstract, email Samantha G. Farris, Institutes Committee Chair, [institutes@abct.org](mailto:institutes@abct.org)

### Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday. Please limit to no more than 2 presenters.

→ **For more information** or to answer any questions before you submit your abstract, email Tejal Jakatdar, Master Clinician Seminars Committee Chair, [masterclinicianseminars@abct.org](mailto:masterclinicianseminars@abct.org)

### Research and Professional Development

Presentations focus on "how to" develop one's own career and/or conduct research, rather than on broad-based research issues (e.g., a methodological or design issue, grantsmanship, manuscript review) and/or professional development topics (e.g., evidence-based supervision approaches, establishing a private practice, academic productivity, publishing for the general public). Submissions will be of specific preferred length (60, 90, or 120 minutes) and format (panel discussion or more hands-on participation by the audience). Please limit to no more than 4 presenters, and be sure to indicate preferred presentation length and format.

→ **For more information** or to answer any questions before you submit your abstract, email Amanda Raines, Research and Professional Development Committee Chair, [researchanddevelopmentseminars@abct.org](mailto:researchanddevelopmentseminars@abct.org)

### AMASS (Advanced Methodology and Statistics Seminars)

Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday or during the course of the Convention. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

→ **For more information** or to answer any questions before you submit your abstract, email Miryam Yusuf, AMASS Committee Chair, [amass@abct.org](mailto:amass@abct.org)

- Ticketed submission opens: January 3, 2022
- Ticketed submission closes: February 7, 2022

*Information about the convention and how to submit abstracts will be on ABCT's website [www.abct.org](http://www.abct.org), after January 1, 2022.*





## Call for General Sessions

The COVID-19 pandemic revealed incredible strengths and formidable weaknesses in our preparedness and response to a global health emergency. While many questioned how vaccines were brought to market seemingly quickly, it was years of basic science and theory development that provided the foundation for effective translation to practice. ABCT's 56th Annual Convention will spotlight research that helps us answer the question of where we are in developing the robust theory and sound science to be able to respond to health emergencies and syndemics that we face. Public discussions around changing behavior to end the COVID-19 pandemic were often not led by scientists with expertise in behavior change and consequently many efforts were not empirically based. Concurrently, additional emergencies were revealed, some of which were caused or exacerbated by COVID, others were longstanding but became more noticeable (e.g., police brutality, mass shootings, hate-based crimes, opiate addiction, youth suicide, rise in disasters due to climate change).

Do we have the basic science to respond to these emergencies? Do we know enough about the mechanisms of action and essential ingredients of our interventions so that we can quickly develop, adapt, and deploy cognitive and behavioral interventions to prepare and respond to emergencies (e.g., epidemics, pandemics, syndemics, disasters)? Do we have the public health systems and evidence-based policies in place to recognize mental/public health emergencies and respond to them effectively? Do we have evidence-based ways to communicate the evidence for cognitive behavioral interventions to the public and policymakers to effect change? Are we equipping current and future professionals with the necessary tools to respond to disasters? Finally, do we have the contingencies in our field to encourage this kind of science?

We encourage submissions across the spectrum of science (i.e., basic, translational, clinical, and public policy) to effectively meet the behavioral health needs of our communities during and after emergencies/disasters. We are particularly interested in highlighting research from multidisciplinary teams that address these issues in novel ways. Example topics include:

- Basic science or clinical/translational studies examining evidence-based approaches to addressing health emergencies
- Panel discussions of evidence-based approaches to changing public policy in the way that behavioral health emergencies are addressed or prevented (e.g., substance use, trauma, mental health disparities)
- Empirical studies/theoretical papers on effective methods of graduate/professional training on how to develop/implement the science of emergency/crises preparedness and response, particularly those that address evidence-based approaches to the development of cultural competence needed to address these issues
- Studies examining a theory-based mechanism of change in cognitive-behavioral interventions and statistical and methodological advances to better test mechanistic hypotheses
- Examinations of evidence-based CBT approaches within different cultural contexts and developmental levels to address mental health emergencies and behavioral change that impacts health and well-being across the US and its territories, as well as globally
- Basic science or clinical/translational studies on effective public information campaigns, particularly those aimed at promoting scientific literacy and promoting evidence-based health behaviors during emergencies
- Validation of measures of target mechanisms, particularly those implicated by behavioral theory, which are largely missing from current repositories, or reports on development of repositories for such measures
- Empirical studies/discussions of methods to modify professional contingencies or develop resources to facilitate a greater focus on theory development and high-quality basic science and translational research in behavioral health. Examples include open-science efforts and resources, efforts to affect reimbursement, and evidence-based approaches to peer review
- Examination of ways to facilitate and support novel methods of treatment delivery (telehealth, apps), particularly in underserved communities or communities in which mental health treatment is particularly stigmatized, which can be leveraged during emergencies

Submissions may be in the form of symposia, clinical round tables, panel discussions, and posters. Information about the convention and how to submit abstracts will be on ABCT's website, [www.abct.org](http://www.abct.org), after January 1, 2022.

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- The online submission portal for general submission opens February 7, 2022
  - The online submission portal for general submission closes March 7, 2022
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The ABCT Forums have replaced the list serve. The Forums are a place to communicate and network with other ABCT members. Users of the ABCT Forums will receive email notifications whenever a new thread is created, and have the ability to subscribe to threads and receive email notifications whenever a new post is made on that thread. Users of the ABCT Forums will also have the ability to create new topics of discussion and message other ABCT members privately.

You can access the ABCT Forums by visiting [abct.org](http://abct.org) and clicking on ABCT Forums link, or by logging in to your ABCT account. If you have not already set up your ABCT Forums profile, you will be prompted to do so. Once that has been set up you will have complete access to the Forums!

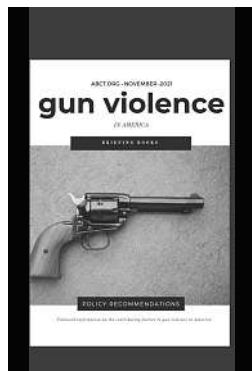
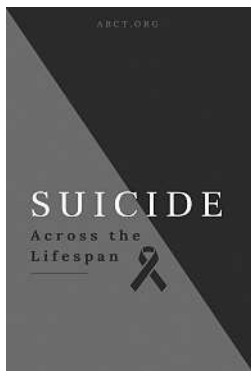
We hope to expand the scope of our Forum topics over the coming months. For now, we encourage you to share any job/internship opportunities, clinical referrals, or general discussion topics to the Forums! If you have any questions, please reach out to [membership@abct.org](mailto:membership@abct.org).

*A new-online platform  
that provides connection  
to fellow professionals*



# ABCT's Briefing Books Initiative

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## ABCT's Briefing Books:

Brainchild of Emily L. Bilek, Ph.D., ABPP, of the Public Education and Media Dissemination (PEMD) Committee, and David Teisler, CAE, Director of Communications/Deputy Director. PEMD coordinates projects with the Publications Committee and handles press relations for ABCT.

*The driving force behind the Briefing Books was the desire to provide resources for media and the public who want quick access to materials that explain evidence-based treatments for mental health.*

► *Suicide Across the Lifespan* covers the prevalence of death by suicide in youth (5 to 24 years), adulthood and midlife, and seniors. In addition, death by suicide within sexual and gender minorities and veterans is included, as well as the contributing role of nonsuicidal self-injury, trauma, and disease.

[https://www.abct.org/wp-content/uploads/2021/05/0\\_Complete\\_Briefing\\_Book.pdf](https://www.abct.org/wp-content/uploads/2021/05/0_Complete_Briefing_Book.pdf)

► *Gun Violence* discusses the powerful influence that imitation has and its ramifications, community violence, the disproportionate effects on LGBTQ+ community, suicide and the correlation between successful attempts and easy access to a loaded weapon, racial issues, and mass shootings. This book also contains additional readings and references for journalists looking for all the facts as well as many resources for those looking for help.

[https://www.abct.org/wp-content/uploads/2021/12/Gun\\_Violence\\_BB\\_2021\\_Complete.pdf](https://www.abct.org/wp-content/uploads/2021/12/Gun_Violence_BB_2021_Complete.pdf)



Visit ABCT's YouTube and discover valuable, enlightening, and educational videos—including interviews, past presidential addresses, demonstrations, and presentations spanning a variety of topics.



*the Behavior Therapist*

Association for Behavioral  
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**ABCT 2021 •**

Annual Convention Virtual

**On Demand**

<https://www.abct.org/2021-convention/>