

the Behavior Therapist

Contents

Original Research

*Caitlin Rancher, Grace S. Hubel, Caroline E. Shanholtz,
Angela D. Moreland*

Parenting Stress and Low-Income Preschool Family Well-Being
During COVID-19 • 49

Clinical Practice Forum

Kathariya Mokru

Limited English Proficiency Population: A Call to Action • 58

Academic Forum

*Amanda K. Gilmore, Angela D. Moreland, Ruschelle M. Leone,
Nada M. Goodrum, Isha W. Metzger, Funlola Are, Cristina López*

Women-Led Research Support Groups to Bolster Success
in Academia During Social and Historic Change • 63

At ABCT

Fellows

Call for Nominations, Fellows Committee • 67

Call for Applications, Fellows • 68

Annual Convention

Call for Papers/General Sessions • 69

Preparing to Submit an Abstract • 70

ABCT & Continuing Education • 71

Understanding the ABCT Annual Convention • 72

Awards & Recognition

Call for Award Nominations • 76

Call for Nominations: Champions • 79

ORIGINAL RESEARCH

Parenting Stress and Low-Income Preschool Family Well-Being During COVID-19

*Caitlin Rancher, National Crime
Victims Research and Treatment
Center, Medical University of South
Carolina, and The College of
Charleston*

*Grace S. Hubel, The College of
Charleston*

*Caroline E. Shanholtz and Angela D.
Moreland, National Crime Victims
Research and Treatment Center,
Medical University of South Car-
olina, and The College of Charleston*

THE COVID-19 PANDEMIC has disrupted the well-being of millions of preschool children and their families (National Association for the Education of Young Children, 2020). Between March and June 2020, as part of national efforts to control the spread of the COVID-19 virus, most schools and childcare programs were physically closed, nationally affecting over 55 million children and their families (Education Weekly, 2020). Given that 80% of children under age 5 are enrolled in center-based care or in-home childcare programs (Cui & Natzke, 2020), this drastically increased the number of children at home during the day. As workplaces closed, millions of parents lost their employment and primary sources of income (Long & Van Dam, 2020). Concurrently, many parents were faced with competing demands of essen-

pp. 67
& 68

*Call for Nominations
& Call for Applications*

**Fellows Committee
& Fellows Status**

[continued on p. 51]

the Behavior Therapist

Published by the Association for
Behavioral and Cognitive Therapies

305 Seventh Avenue - 16th Floor
New York, NY 10001 | www.abct.org
(212) 647-1890 | Fax: (212) 647-1865

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Subscription information: *tBT* is published in 8 issues per year. It is provided free to ABCT members. Nonmember subscriptions are available at \$40.00 per year (+\$32.00 airmail postage outside North America). **Change of address:** 6 to 8 weeks are required for address changes. Send both old and new addresses to the ABCT office.

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Best Practices for CBT With LGBTQA+ Adults

— Debra Hope, Ph.D.

MODERATOR: Lily Brown, Ph.D.

11 am – 12:30 pm Eastern | 10 am – 11:30 pm Central

9 am – 10:30 am Mountain | 8 am – 9:30 am Pacific

Clients who identify as sexual and gender minorities seek therapy for many of the same reasons as heterosexual and/or cisgender clients including anxiety, depression, substance abuse, and relationship problems. Typical evidence-based interventions are likely to be effective, but best practice demands clinicians consider the cultural context when implementing a treatment plan. Despite progress in recent years, sexual and gender minorities continue to face structural inequities and marginalization in their daily lives that are exacerbated if they also hold other minoritized identities. Even with the best intentions, bias can intrude into the therapy room. This clinically focused webinar will emphasize incorporating sexual and gender identities into the case conceptualization and adapting common CBT interventions such as cognitive restructuring, exposure, and behavioral activation to meet the needs of clients. Considerations for practice such as creating an affirming environment and engagement with LGBTQA+ communities will also be discussed.

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.
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tial employment outside the home without access to childcare programs (Petts et al., 2020). As of February 2021, the United States reported more than 27 million COVID-19 related infections and over 500,000 COVID-19 related deaths (Adeline et al., 2021). These changes in social isolation, education and childcare, economic hardship, illness, and loss of life are sources of extreme stress for families with unknown effects on parenting behaviors and child well-being. As policymakers are weighing decisions about financial relief packages, school openings, and vaccine administration, there is an urgent need to understand the associations between COVID-19-related stressors and family functioning, including parenting behaviors and preschool family well-being.

Theory suggests that the cumulative impact of daily stressors, such as those related to parenting, are more strongly associated with parent and child well-being than single major stressful events (Almeida, 2005). Faced with single major stressful events, parents often remain able to provide positive and nurturing care to children, helping children build the emotion regulation skills necessary for independent stress-coping (Britto et al., 2017; Shonkoff, 2017). On the other hand, when minor daily stressors are chronic, parental resources and internal capacities for coping with these stressors can be exhausted, in turn reducing their caregiving capacities (Fava et al., 2019). This has been well-established in the literature, with higher levels of chronic parenting stress associated with more problematic child behavior, including aggression, disruptive behavior, anxiety, and depression (Crum & Moreland, 2017). Chronic parenting stress is also related to higher levels of parent psychological distress, including depression and aggressive behavior (Vreeland et al., 2019). Given the importance of parenting stress on parent and child well-being, it is crucial to understand how the unique stressors of the COVID-19 pandemic are affecting preschool aged children and their families.

Research on the associations between COVID-19-related stress and family well-being are scarce; however, literature examining the effects of other large-scale stressors can provide some insight. Past research on community-wide disasters suggests there can be extensive consequences for children and their families (see North, 2016, for review). This research indicates greater proximity to the disaster, or the more personal the impact, is positively associated with psychological distress

(North). It seems likely that the more personal the impact families are experiencing as a result of the COVID-19 pandemic, such as family illness, employment loss, or difficulty accessing daily resources, would similarly disrupt preschool family well-being.

Consistent with previous research on community-wide disasters, a handful of studies from the first few months of the COVID-19 pandemic have documented substantial increases in psychological distress among adults (Rajkumar, 2020). Additionally, one study found that 84% of households reported that they have been affected by school closures (Elizabeth Dole Foundation, 2020), which has been associated with increased parent and child psychological distress (Patrick et al., 2020). Furthermore, this study found that more than half of women report reductions in caregiver effectiveness as a result of the COVID-19 pandemic, which is reportedly due to increased stress and time demands (Elizabeth Dole Foundation, 2020). While studies have alluded to the significant impact that the COVID-19 pandemic has had on parents, the longitudinal impact, past the first few months of the COVID-19 pandemic on parent and early childhood well-being, remains unknown.

It seems probable that the effects of the COVID-19 pandemic are disproportionately affecting marginalized groups of preschool children and their families. Early childhood is a critical developmental period where children learn behaviors and form attachment relationships that determine their physical and mental health across their lifespan (McCartney & Phillips, 2011). Promoting mental health in preschool children can help offset long-term psychological impairment; however, few children, particularly those from low-income families, have access to mental health services or prevention programs. Low-income preschool children and their families are confronted with higher levels of financial, social, and psychological stressors compared to higher-income families (Evans & English, 2002). As a result, there is a well-documented longitudinal link between stress exposure among low-income preschool children and mental and physical health problems (Noroña-Zhou & Tung, 2021). The effects of the COVID-19 pandemic are likely magnified for low-income families of color due to longstanding systemic inequity; yet, to date, research on the well-being of these families with preschool-aged children in response to

COVID-19-related stressors has not been examined.

Present Study

The present study examines the associations between COVID-19-related stressors and family functioning 6 months into the COVID-19 pandemic among a sample of low-income caregivers and their preschool-aged children. We hypothesize that COVID-19-related stressors, family illness, job loss, and difficulties accessing resources will be positively correlated with parenting stress, parent psychological distress, and child behavior problems. In line with theory suggesting that parenting stress is a critical predictor of well-being, we hypothesize that parenting stress and caregiver psychological distress will be positively associated with child behavior problems, even after accounting for other COVID-19-related stressors.

Method

Participants

Participants were 42 caregivers recruited from a Head Start preschool program in the southeastern United States. Caregivers ranged in age from 16 to 70 years ($M = 30.24$, $SD = 9.42$) and reported the youngest child in their home was nearly 3 years old ($M = 2.72$, $SD = 1.21$). Most caregivers in the present study were mothers 86%, while 7% were fathers, 5% were aunts or uncles, and 3% were grandparents. Most caregivers in the sample were Black (93%) and 7% were Hispanic. The population in the current study is representative of families who are typically enrolled in Head Start centers in the region. Roughly a third (31%) of caregivers reported their annual household income was less than \$5,000. Approximately 45% of caregivers reported they were living in a single-parent household with 25% reporting living with one child, 50% with two children, and 21% living with three or more children.

Procedures

Participants were recruited via an email message that was sent out to all caregivers who were enrolled in the Head Start preschool program district. The email explained the purpose of the study and invited caregivers to click on a link to provide consent and complete the survey. The Head Start preschool program regularly communicates program updates or parent reminders via email communication. Furthermore, recent reviews indicate that in the United States, more than 94% of the

Table 1. Specific Types of Resource Loss Reported by Caregivers

Variable	Not at all	A little	Somewhat	Very much	Extremely	Mean (SD)
Financial Loss (e.g., lost wages, job loss)	18.9%	10.8%	13.5%	21.6%	35.1%	3.43 (1.54)
Difficulty paying rent or bills	16.2%	18.9%	13.5%	18.9%	32.4%	3.32 (1.51)
Difficulty getting supplies (e.g., food, water)	21.6%	18.9%	37.8%	5.4%	16.2%	2.76 (1.32)
Difficulty getting medical services or medication	51.4%	21.6%	18.9%	2.7%	5.4%	1.89 (1.15)
Loss of childcare or difficulty obtaining childcare	27.0%	18.9%	8.1%	13.5%	32.4%	3.05 (1.67)

Note. Possible range for each specific type of resource loss was 1 to 5.

population has access to a computer or a smart device and over 82% have a broadband internet subscription (see, Singh et al., 2020, for review). Surveys were completed between September 8, 2020 and October 3, 2020. At the time of this data collection, participant families were all receiving in-person services at the Head Start program and all teachers and staff were required to wear face masks or coverings. This Head Start program had decreased enrollment slots to 50% capacity, which limited each classroom to 5 to 10 children to allow for 6 feet of social distance. The survey took approximately 10 minutes to complete and participants were compensated \$10 for their time. A total of 280 caregivers received the link to the survey, with a response rate of 15%, resulting in the final sample of 42 caregivers. This response rate is consistent with other online surveys conducted in the last 5 years that involve a single email contact (Burgard et al., 2020). Participants were informed that no information about involvement or responses would be disclosed to Head Start staff and participation in the research study would not impact any services they or their child received at the Head Start program. The study was approved as quality improvement by the University IRB.

Measures

• COVID-19 Illness

Caregivers completed 3 items related to personal or family COVID-19 illness. Specifically, caregivers reported whether they or their family had “experienced COVID-19 symptoms,” “received a COVID-19 diagnoses,” and “a family member was diagnosed with COVID-19.” Responses to each item were dichotomously coded, 0 = No, 1 = Yes.

• Job Loss

Caregivers completed 1 item assessing changes to their employment as a result of

COVID-19. Responses to this item were dichotomously coded such that 0 = *Lost their job or were furloughed due to the COVID-19 pandemic*, 1 = *Did not lose their job*.

• Resources Loss

Caregivers completed 5 items related to resources they lost or material difficulties they experienced during the COVID-19 pandemic. Items included “financial loss (e.g., lost wages, job loss),” “difficulty paying your rent or bills,” “difficulty getting supplies (e.g., food, water),” “difficulty getting medical services or medication,” and “loss of childcare or difficulty obtaining childcare.” Responses were made on a 5-point scale (1 = *not at all*, 2 = *a little*, 3 = *somewhat*, 4 = *very much*, 5 = *extremely*). Responses were summed to create an aggregate assessment of resource loss. Coefficient alpha for the present sample was .89.

• Caregiver Psychological Distress

Caregivers completed 4 items assessing their psychological distress (e.g., “Increased mental health concerns [e.g., anxiety, depression]”) during the COVID-19 pandemic. Responses were made on a 5-point scale (1 = *not at all*, 2 = *a little*, 3 = *somewhat*, 4 = *very much*, 5 = *extremely*) and summed to create a total score. Coefficient alpha for the present sample was .84.

• Child Behavior Problems

Caregivers completed 6 items assessing their child’s behavior problems (e.g., “Increased disruptive behavior [e.g., tantrums, arguing, not minding directions]”) during the COVID-19 pandemic. Responses were made on a 5-point scale (1 = *not at all*, 2 = *a little*, 3 = *somewhat*, 4 = *very much*, 5 = *extremely*) and summed to create a total score. Coefficient alpha for the present sample was .85.

• Parenting Stress

Caregivers completed 3 items assessing their parenting stress (e.g., “I have been less patient with my child”) during the COVID-19 pandemic. Responses were made on a 5-point scale (1 = *not at all*, 2 = *a little*, 3 = *somewhat*, 4 = *very much*, 5 = *extremely*) and summed to create a total score. Coefficient alpha for the present sample was .71.

Results

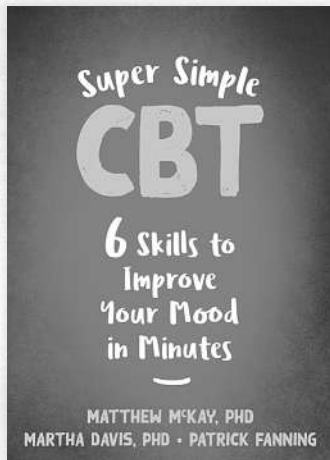
Descriptive Statistics

Only 14% of caregivers in the present study reported experiencing COVID-19 symptoms and 5% reported they had received a COVID-19 diagnosis at the time of study completion. The majority of caregivers, 60%, indicated they had a family member diagnosed with COVID-19. Most caregivers reported they had consistent employment during the COVID-19 pandemic (69%), while 31% reported losing their job. On average, caregivers reported moderate levels of resource losses ($M = 14.46$, $SD = 5.99$, possible range 5 to 25). The specific types of resource loss are summarized in Table 1. Over a third of caregivers reported “extremely” to difficulties in financial loss, paying rent or bills, and accessing childcare. Difficulty getting medical services or medication was the least frequently reported resource loss with approximately 51% of caregivers reporting “not at all.”

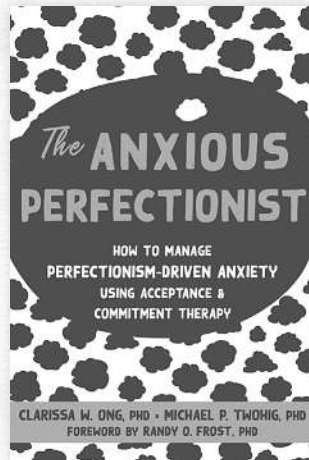
Correlations Between COVID-19-Related Stressors and Family Functioning

Means, standard deviations, and correlations for the study variables are summarized in Table 2. Caregiver diagnosis of COVID-19 was correlated with higher levels of child behavior problems, $r(35) = .37$, $p = .022$, and parenting stress, $r(34) =$

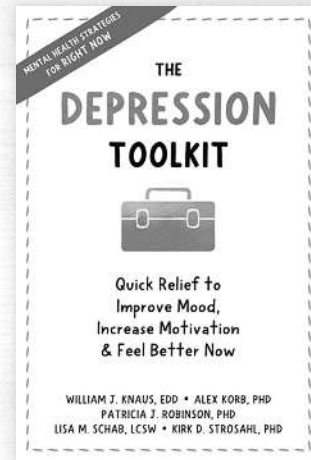
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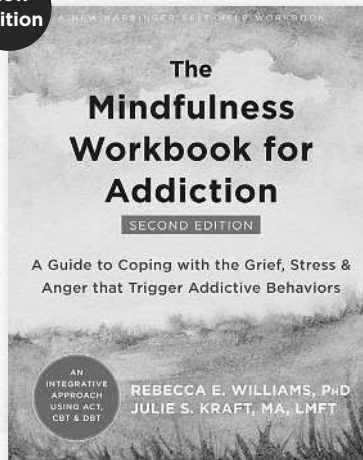
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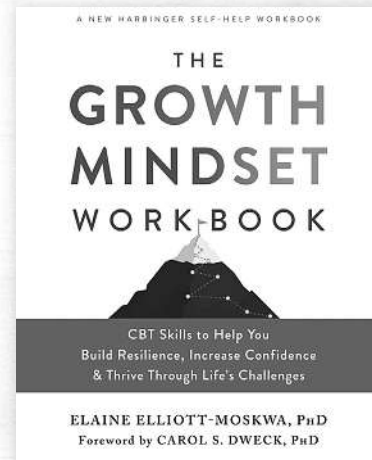
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.420, $p = .011$. Higher levels of resource loss was correlated with higher levels of caregiver psychological distress, $r(35) = .69$, $p < .001$, child behavior problems, $r(35) = .71$, $p < .001$, and parenting stress, $r(34) = .60$, $p < .001$. Higher levels of caregiver psychological distress was correlated with higher levels of parenting stress, $r(34) = .70$, $p < .001$, and child behavior problems, $r(35) = .78$, $p < .001$.

Relations Between COVID-19-Related Stressors, Parenting, and Child Distress

We conducted a linear regression analysis to examine our hypothesis that parenting stress and caregiver psychological distress will be positively associated with child behavior problems, even after accounting for other COVID-19 related stressors. This model included parenting stress and caregiver psychological distress as our independent variables. Based on examination of the pairwise correlations, we included caregiver COVID-19 diagnosis and resource loss as covariates. Child behavior problems was our dependent variable. The results of the regression analyses indicated that higher levels of parenting stress were associated with higher levels of child behavior problems, $b = 0.53$, $t(35) = 2.07$, $p = .047$, $sr^2 = .12$, even after accounting for resource loss, $b = 0.37$, $t(35) = 2.78$, $p = .009$, $sr^2 = .20$, and caregiver COVID-19 diagnosis, $b = 4.79$, $t(35) = 1.86$, $p = .072$, $sr^2 = .10$. Caregiver psychological distress was not associated with child behavior problems, $b = 0.36$, $t(35) = 1.97$, $p = .057$, $sr^2 = .11$. The full model accounted for 77% of the variance in child behavior problems, $F(4, 35) = 26.51$, $p < .001$, $R^2 = .77$.

Discussion

The current study examined the associations between COVID-19-related stressors and family functioning among a sample of low-income preschool families. Our findings suggest that COVID-19 diagnoses and higher levels of family resource loss are correlated with parenting stress, caregiver psychological distress, and child behavior problems. Our hypothesis that parenting stress and caregiver psychological distress would be associated with child behavior problems, even after accounting for other COVID-19-related stressors, was partially supported. Only parenting stress was associated with child behavior problems after controlling for COVID-19 diagnoses and resource loss. While promising, the present findings should be interpreted with some caution. Given the timing of our assessment in Fall 2020, the impact of the COVID-19 pandemic cannot be fully disentangled from our measurement of parenting stress and caregiver psychological distress. Also, the sample included a small number of caregivers drawn from a single Head Start preschool program. Nevertheless, the present findings extend the limited literature examining the effects of the COVID-19 pandemic on low-income preschool families.

The results of our regression analyses suggest that parenting stress may be an important correlate of child behavior problems, even after accounting for major stressful events related to the COVID-19 pandemic. Throughout early childhood, preschool children rely on their caregivers to answer questions, comfort them, and meet their basic needs for food and safety (McCartney & Phillips, 2011). Even for families not experiencing illness, job loss,

or resource loss, the COVID-19 pandemic is a consistent source of daily stress. It may be the case that for families in our study, minor daily stressors related to the pandemic or preexisting contributors to parenting stress had a greater impact on their ability to support their children emotionally and behaviorally. This finding is especially concerning given the duration of the pandemic, as over time, increased parenting stress and child behavior problems can lead to negativity and weakened parent-child relationships (Prime et al., 2020). As noted above, it is difficult to disentangle daily parenting stressors from the larger effects of the COVID-19 pandemic; however, parenting stress will likely be an important target for policy and intervention aimed at the unique impacts that the COVID-19 pandemic has had on families with young children.

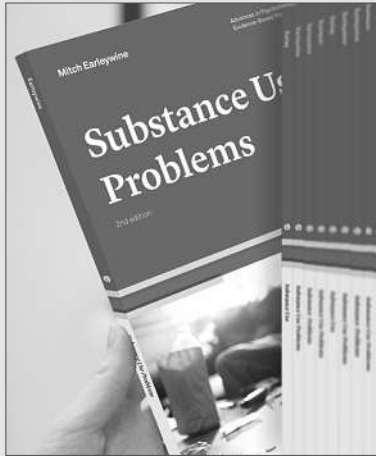
The present findings also suggest that resource loss may be important to consider in policies designed to aid families with young children. We observed that resource loss was highly correlated with child behavior problems ($r = .71$) and it had a moderate-sized effect in the regression analyses ($sr^2 = .20$). Studies on the early impact of COVID-19 have shown that the financial impacts on families are paramount, with up to 70% of people in one study reporting that their family has been financially impacted by the pandemic (Elizabeth Dole Foundation, 2020). Our findings suggest these effects may be magnified for low-income preschool families, with over a third reporting extreme difficulty in terms of financial loss, ability to pay rent and bills, and access to childcare. Prior to the COVID-19 pandemic, long-standing systemic issues, such as disparities in inherited wealth, made marginalized low-income

Table 2. Means, Standard Deviations, and Correlations Among Study Variables ($n = 42$)

Variable	1	2	3	4	5	6	7	Mean (SD)
1. Experienced COVID-19 symptoms	—							—
2. Caregiver COVID-19 diagnosis	.08	—						—
3. Family COVID-19 diagnosis	-.34*	-.04	—					—
4. Job loss	.04	-.09	-.34*	—				—
5. Resource loss	-.04	.02	-.02	-.32	—			14.46 (5.99)
6. Parenting stress	-.03	.42*	.10	-.18	.60**	—		7.67 (3.13)
7. Caregiver psychological distress	.10	.24	-.12	-.13	.69**	.70**	—	9.51 (4.49)
8. Child behavior problems	-.03	.37*	.11	-.31	.71**	.77**	.78**	11.92 (5.88)

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

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families more vulnerable to being in situations where acute stressors associated with COVID-19 could lead to long-term problems. Although these long-term effects are beyond the scope of the present study, findings do indicate that increased financial and childcare resources may need to be directed to those who experienced preexisting vulnerabilities.

Finally, the present findings may offer some suggestions for mental health professionals working with families with preschool-age children during the COVID-19 pandemic. First, the results of this study highlight the need for mental health professionals to consider parenting stress. Previous research has long highlighted parenting stress as a predictor of child behavior problems (Neece et al., 2012); however, with the increase of stressors from the pandemic, it becomes more important for clinicians to assess for parenting stress when working with families. Furthermore, given the correlation between resource loss and caregiver psychological distress, collaborating with case managers to connect families to resources, especially those in low-income communities, may help reduce the psychological distress associated with resource loss. Finally, given that it is unclear the length of time that families will continue to be exposed to pandemic-related stressors, it is essential for clinicians to continue to assess family needs and parenting stress over the course of treatment as new needs may arise.

This study provides novel information on an understudied population of low-income preschool families during an unprecedented global event. Still, there are several important limitations to consider. Foremost, this research included cross-sectional, correlational data, precluding conclusions regarding temporal precedence or causality. Some have suggested that child behavior problems can also contribute to parenting stress (Stone et al., 2016) and additional longitudinal research is needed to fully understand the direction of the documented associations. Second, many of the measures were created for the quality assessment survey and their psychometric properties have not been rigorously evaluated. The authors of the items attended to the readability of the measures and although we found evidence of adequate internal consistency (coefficient alpha) across the aggregated measures, interpretation of these results should be done with caution. Additionally, our assessment of COVID-19 illness was limited to a dichotomous report of whether or not the care-

givers or their family had received a COVID-19 diagnosis. It seems plausible that differences in the severity or course of the illness, including whether a family member died from COVID-19 complications, may differentially impact parenting stress and psychological distress. Future research separating out these stressors is warranted. Further, all measures were completed by caregivers. The inclusion of multiple reporters (e.g., teachers or child self-report) would mitigate concerns that a caregiver's experience of distress influenced their perception of their child's behavior and family functioning. Finally, the study included a small sample of 42 caregivers from a single Head Start preschool program whose children were receiving in-person services in Fall 2020 and responded to an emailed survey request. This limited the statistical power to detect small effect sizes and may have limited the generalizability of the observed effects. Specifically, there may be important differences in the present sample and their experience of COVID-19-related stressors, as opposed to families who did not have access to in-person childcare. Future research including larger samples from multiple Head Start programs would strengthen confidence in the observed associations.

In conclusion, the present findings contribute to our understanding of how the COVID-19 pandemic is affecting parenting stress and well-being among low-income preschool families. Results suggest that low-income families are experiencing a range of COVID-19-related stressors, and these stressors, in turn, are related to parenting stress, caregiver psychological distress, and child behavior problems. The study suggests that addressing parenting stress alongside resource loss may help manage children's behavior problems, even in the context of a major community-wide stressful event. While promising, these findings should be interpreted with some caution and warrant further, longitudinal replication.

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This work was supported by the Head Start Mental Health Consultation Program. The authors report no conflict of interest.

Correspondence to Caitlin Rancher, 67 President Street, 2nd Fl. IOP S., MSC861 Charleston, SC 29425-8610; rancher@muscedu



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Limited English Proficiency Population: A Call to Action

Kathariya Mokrue, *York College, The City University of New York*

THE PRIMARY PURPOSE of this article is to call attention to an issue that is both understudied and poorly understood: the unmet needs of individuals with Limited English Proficiency (LEP), which is defined as “limited ability to read, write, speak, or understand English” (Department of Health and Human Services, 2013). This article additionally seeks to offer suggestions to improve access to quality care for this population.

First, it may help to learn a bit about my background and how I became interested in elevating the discussion on the needs of LEP, particularly those who speak less-common languages. I am a first-generation immigrant from Thailand and am fluent in Thai. I am a clinical psychologist and work in a teaching college, in addition to seeing private patients from time to time. As a budding clinical psychologist, inquiries for a Thai-speaking psychologist were few and far between, a fact that quickly changed as inquiries began flowing in more frequently, for example, from families, social agencies, clinics. Notably, very few came from the identified patient. Issues presented were often acute, moderately severe, and requiring more than outpatient psychotherapy—consistent with the literature on help-seeking among Asian populations (Hwang et al., 2015; Kim & Zane, 2016). Inquiries came from all over the country, an indication that there was great difficulty in locating language-congruent care.

This led me to the conclusion that if this was happening in the Thai community, it must be happening in other communities with few to no bilingual providers to serve them. Several questions came to mind. How are individuals with LEP in these communities accessing mental health care? Where are they looking for help? Are there providers who can speak their language? Is this a supply-demand problem? How often do providers come across clients with LEP? When they do, how do they navigate the language barrier? As I explored the literature on this topic, I realized that there is limited systematic research on the mental health needs of individuals with LEP who

speak less-common languages and experiences of providers that work with them. Most notable is that this is an out-of-sight, out-of-mind problem—had I not indicated on my profile that I speak Thai, I doubt that I would be privy to the insight of the demand and need in the Thai community. Although there is no systematic data available on the mental health needs of individuals with LEP, I speculate that providers in outpatient or traditional care settings (vs. those in primary care) are generally unaware of the disparity in language access in many communities with LEP and how language access serves as a significant logistic barrier to mental health care. Issues of inadequate resources may be more apparent and less avoidable in primary care and hospital settings, where many individuals with LEP first seek care.

If we are to be more inclusive, equitable, and accessible, it is crucial that we reorient our attention toward this marginalized sector and seek to understand the unmet needs of individuals with LEP; we need to make a decision, as a field, to better serve these underserved communities.

What Is the Problem?

According to the U.S. Census, over 28 million people rate their ability to speak English as “less than very well” (Gambino et al., 2014). Although a significant proportion of individuals with LEP in America speak Spanish, the most recently available census report documented over 350 languages spoken in the United States, including native North American languages (U.S. Census Bureau, 2015). The number of individuals with LEP is estimated to reach 67 million or 19% of the population by 2050 (Gambino et al.).

Language barriers create obstacles in accessing and receiving mental health care, in addition to creating a “cultural distance” (Berry, 1997; Snowden et al., 2007), which makes it challenging for individuals with LEP to develop social networks outside their shared language community, as well as access English-language resources. Individuals with LEP tend to be recent immi-

grants and of low socioeconomic status (Snowden et al.). Although the relationship among LEP status and physical health, health service access and utilization, and health outcomes is increasingly recognized (cf. Diamond et al., 2019; Zhang et al., 2012), less is known about the intersection of LEP status, ethnicity, stigma, cultural beliefs, mental health needs, and help seeking. However, the few available studies indicate that populations with LEP endorse more psychological distress (Zhang et al.), report more discrimination (Gee & Ponce, 2010), and experience greater social isolation than those with English proficiency (Kim et al., 2011); yet, they are less likely to seek out or receive quality care (Le Meyer et al., 2009; Matsuoka et al., 1997; Ohtani et al., 2015; Snowden et al.).

It is important to note that LEP status may impact cultural groups in different ways. For example, Zhang and colleagues (2012) investigated the potential effects of LEP on the mental health of Latino and Asian samples. They found that LEP asserts independent impacts on the mental health of Asian Americans above demographic, socioeconomic status, immigration related stressors, and discrimination. In contrast, LEP was found to be less of a factor when compared to socioeconomic status and discrimination on psychological distress among Latinos. The authors attributed the finding to different language experiences, immigration background, and education. They suggested that the confluence of language and the stereotype of the “perpetual foreigner” may be more psychologically distressing to Asian Americans. Further, it may be easier for Latinos with LEP to navigate their daily lives due to the increased use of the Spanish language in the United States.

Research on the mental health needs of individuals with LEP, how they access help, and the experiences of both individuals with LEP and mental health providers is scarce. However, evidence from studies based on Spanish-speaking samples with LEP suggest that when clients with LEP seek help, they prefer providers who speak their language (Villalobos et al., 2016). The use of common language between patient and provider is associated with greater rapport, satisfaction, compliance with physician-recommended behavioral changes, and well-being among patients with chronic health issues (Hsueh et al., 2021; Masland et al., 2010). When common language is used, clients process emotional content better and experience more positive outcomes in therapy (Soto et al., 2018).

It is important to note, however, that there are simply not enough mental health providers to reflect the diverse language needs represented in the United States. The disparity between language need and availability of bilingual mental health services is likely to persist. There are over 60 million people of Hispanic descent in the United States, but only 5.5% of psychologists indicated that they were able to provide services in Spanish, as indicated in a recent American Psychological Association survey (APA, 2016; Smith, 2018). Although the relationship between ethnicity and language skills is imprecise, the available data is sobering. For less common languages, including indigenous languages, this disparity is undoubtedly even more dismal.

Recently, the U.S. Census Bureau released the most comprehensive data on languages spoken in the U.S. In the New York City metro area, according to the data, 192 languages are spoken at home (U.S. Census Bureau, 2015) with Bengali highlighted as spoken by 104,765 people, yet there are no Bengali-speaking providers listed on commercial mental health professional directories such as abct.org, adaa.org, or psychologytoday.com. In fact, directories including state databases either do not offer an option to select language spoken by providers or offer commonly used languages (e.g., *Psychology Today*). The data also indicated that in Houston, TX, there are 145 identified languages, with Chinese (Mandarin and Cantonese) spoken by nearly 40,000 people. *Psychology Today* lists 7 mental health professionals offering services in Cantonese.

Why Does This Disparity Persist?

The problem of diverse representation in the psychology workforce has been the topic of much discussion and is not new (Hall, 2006; Santiago & Miranda, 2014; Turpin & Coleman, 2010). Systemic barriers to becoming a psychologist, lack of cultural diversity among faculty, and lack of support or inadequate mentorship for underrepresented students are some of the factors that contribute to the impediment to diversifying the field (Stewart et al., 2017). Although there has been increased attention to the lack of racial and ethnic diversity in graduate programs (in both faculty and student body), bilingual ability has been discussed less frequently. Representation of both is needed since increasing racial and ethnic representation may not yield greater linguistic representation.

At present, the clinical psychology field trains very few bilingual providers, leading to massive shortages of bilingual providers to serve communities with LEP. Bilingual ability is simply not a factor for admissions to many programs. More often than not, GRE scores and research skills are valued above other criteria, including language ability. This is particularly true in Ph.D.-level programs. There have been calls to use more holistic approaches to identify students who could succeed in graduate programs (Williams et al., 2021). The general lack of diverse representation in clinical psychology, including bilingual ability, informs research priorities in the field and the types of grants that are funded, perpetuating the status quo in the current system. Hence, it is not surprising that research on communities with LEP remains understudied.

Role of Interpreters

One way to address language barriers is to utilize interpretation services. Title VI of the 1964 Civil Rights Act requires that all recipients of federal funds, such as Medicaid agencies, managed care plans, and hospitals provide language assistance free of charge to those who request it. There are now more options to utilize interpreter services in-person or remotely via video or telephone (Carter-Pokras et al., 2004). Hospitals and community centers are using more of the available technology, offsetting costs and improving access to healthcare. However, a similar uptake has not been seen in medical private practice settings (Center for Medicare and Medicaid Services, 2017) where staff and physicians rely more on bilingual staff and family members. Of relevance to the present paper, there is no systematic data on how language needs are met or not met across mental health settings.

Despite these laws, there are many obstacles that discourage mental health clinicians from using these services, not the least of which is that bilingual interpreters with specialized mental health training are relatively scarce, even for common languages. Miller and colleagues (2005) noted that among interpreters who work in long-term therapy, only 20% have had formal mental health training. Currently, there are differing certification bodies and varying requirements (Jacobs et al., 2018). New laws can and should compel insurance companies to improve reimbursements for using interpreters and encourage use of

interpreters in mental health service settings.

Currently, although costs for bilingual interpreters can be prohibitive, insurance companies do not always allow for reimbursements (Masland et al., 2010). Other barriers involve significant time commitment to locating, scheduling, and meeting with the interpreters, particularly if using in-person services or video services, before and after each session. Once services are secured, there is also a possibility that there may be different interpreters at different sessions, given challenges in scheduling and availability of three parties versus two. Additionally, an interpreter's time needs to be compensated even if the client fails to show up to an appointment.

Beyond the structural barriers to interpreting services, there is evidence to suggest that there are perceptual barriers as well. Even in graduate programs where there is a focus on multicultural training, there appears to be very little attention paid to this work (Frandsen et al., 2019). Hence, it is not surprising that there are perceptual and attitudinal barriers to working with interpreters. Studies found that providers with limited bilingual ability believe that their language skills are satisfactory, that they do not need interpreters' help, and that interpreters may interfere with building rapport (cf. Masland et al., 2010; Tutani et al., 2018). Unfortunately, there is insufficient evidence to support or refute this concern as this remains an understudied area in mental health services fields.

Despite numerous challenges in locating and engaging interpreter services, research supports its use over ad hoc interpretation such as the use of family members or bilingual office staff (Bauer & Alegria, 2010). The use of family and friends or office staff has been associated with poor translation quality, privacy issues, and ethical concerns (Frandsen et al., 2019), even though many studies indicate this form of interpreting assistance is the most common (Frandsen et al.; Gadon et al., 2007).

Solutions: A Call to Action

Individual providers and mental health systems must commit to making changes in order to improve mental health services to those with LEP.

Individual Providers

- Make Language Representation More Visible

First, consider your organization or practice's mission, values, and goals and how they are related to the needs of individuals with LEP. One positive change we have seen over the past year is many statements of solidarity and commitment to improving access and providing care to those traditionally underserved. These well-intentioned and welcome statements may be bolstered further if they include individuals with LEP and are accompanied by concrete and measurable changes, securing contracts with interpretation services and making this information visible on their website.

Providers can also make simple changes such as translating literature and website content to languages that are reflective of the community or the use of more multifaceted approaches such as hiring bilingual providers. Providers can visit www.lep.gov/maps to get specific information about LEP in the area that they serve. Translation of literature or website content is a cost-effective option and is often a one-time investment. Providers can reach out to communities by distributing translated literature at health fairs or community events.

Community-based organizations, which may already have contacts with interpreters or language agencies, already serve a variety of needs. They provide services, including legal services, home care, case management, and are better equipped to handle language needs. Mental health providers can develop partnerships with community-based organizations and offer to add mental health information workshops to the community.

Resource-sharing models can be helpful in small practice settings (Gadon et al., 2007). There are a few examples where organizations have pooled resources to provide more access to most commonly used languages. Co-op models or pooled video interpretations, such as the Healthline Interpreter Network, where video and telephone interpreting services are shared by nine hospitals and associated clinics, offers 15 languages provided by 35 full-time trained interpreters, can improve access while keeping costs manageable.

• Seek Out Training

Fortunately, there are a number of options for clinicians who want to learn more and do more for individuals with LEP. Clinicians can seek out training on how to work with interpreters. Workshops are offered by community-based centers and in some hospitals, like the Children's

Hospital of Philadelphia, on the role of interpreters in mental health services. If trainings or workshops are difficult to find, helpful guidelines do exist. Searight and Searight (2009) developed recommendations for how psychologists can work with interpreters, with suggestions for presession, the interview process, and postsession interactions. Frandsen and colleagues (2019) described nine "areas of competence" for working with language interpreters as part of graduate training in psychology. Both recommended taking care to select interpreters to suit the language needs of the client, ensuring that they have mental health experience, proper certification, and availability for continued therapy. Presession principles include discussing confidentiality and boundaries, clarifying expectations of roles for the session, discussing therapy process, and review of therapeutic techniques that may be employed in the session. Discussion of potential privacy issues, particularly if the language interpreter is from the same ethnic community as the client, is recommended. Both Searight and Searight (2009) and Frandsen (2019) recommend conducting a postsession debriefing session with the interpreter to elicit their general impressions and gather information on cultural and historical content that might be relevant to the session.

Systemic Changes

• Training Programs

One way to improve bilingual representation in the field and thus better serve individuals with LEP is for training programs to prioritize bilingualism as a skill. Heavily relying on GRE scores, despite its questionable validity (Miller & Stassun, 2014; Williams et al., 2021), may contribute to the "leaks" in the graduate program admission pipeline of underrepresented groups. Efforts should be made to recruit and support bilingual students as well as students traditionally underrepresented in the field. The intention of this paper is not to argue to eliminate the use GRE scores, but to encourage open discussions on how to promote diversity (including language ability) as well as to improve the integrity of graduate school admissions.

Language competency needs to be professionalized and rigorous standards set to ensure standards in delivering care in non-English language are met. If language competency is elevated to a professional standard, then training programs should invest in language training and assessment. Of course, language training is limited by the

available pool of bilingual providers who are fluent and competent in delivering services in languages other than English. Hence, we have a chicken-egg problem. Programs may need to explore resources and seek guidance and collaboration with other fields in the meantime.

Other worthwhile changes in the academic/research setting can include improving representation in graduate school, in the availability of mentors of color and bilingual mentors, encouraging discussion of the needs of individuals with LEP and working with interpreters in multicultural training modules, and offering training in a variety of languages. Offering tracks or certifications with specialized training on the use of interpreters would likely strengthen these skills in new providers.

Specialized scholarships and training support for bilingual speakers may encourage more native speakers to consider careers as mental health providers and English speakers to devote undergraduate training to fluency in non-English languages. While there are programs that offer clinical training in languages other than English, those programs focus exclusively on Spanish (e.g., University of Miami, William James). Although Asians constitute the second largest population with LEP in the United States, the same opportunities are not available for providers who speak Asian languages.

• Research Priorities

Research on the mental health needs of individuals with LEP, clinician-interpreter collaboration, and best practices when working with individuals with LEP is needed. There is a dearth of research on the efficacy of interpreter use. Studies are needed to understand the contexts in which they improve or worsen or have minimal effect on therapy processes and outcome. These should include studies that systematically examine the mode of interpretation (i.e., telephone, video, in person), working alliance and rapport, cultural and clinical issues, theoretical model, and training. Studies examining barriers and obstacles to interpreter use are also needed.

Studies on the experiences of stakeholders (i.e., clinician, interpreter, patient) in interpreter-mediated therapy services are needed. Although existing evidence suggests collaboration between clinician and interpreter is possible (Chang et al., 2021; Tutani et al., 2018), challenges regarding role ambiguity, imbalance of power, and navigating three-way interactions have

been noted as well (Tutani et al.). Preferences of individuals with LEP and experiences working with interpreters are also not fully understood. Some groups with LEP may have a preference for working with interpreters outside their immediate community due to concerns about privacy and confidentiality (Tutani et al.).

Finally, also lacking are studies that explore alternative models to improving access to mental health care among populations with LEP. While there has been notable progress in culturally informed evidence-based treatments for Spanish-speaking populations (Interian et al., 2008; Paris et al., 2018), Chinese-speaking populations, and some refugee populations (Hinton et al., 2012; Hwang et al., 2015), studies that examine individuals with LEP who speak other languages with a bilingual clinician or interpreter-mediated therapy are lagging behind.

There are some promising models in low- and middle-income countries with a shortage of professional mental health providers that leverage lay workers in communities with LEP to deliver evidence-based treatments (Barnett et al., 2018). Collaborative care approach where care coordination, proactive symptom monitoring, and regular case reviews occur in primary care settings has also shown promise among Spanish-speaking patients with LEP being treated for depression (Garcia et al., 2018). The primary care setting is often where patients with LEP first seek and receive mental health care (Sentell et al., 2007).

• Payment and Reimbursement Systems

The current payment and reimbursement system disincentivizes the use of interpreters outside of large healthcare settings. Most states are not required to reimburse providers for the cost of language services. Only 14 states allow for the reimbursement of interpreter services through patients' federally funded medical insurance. However, most states do not have such requirements, and if they are in place, there are limitations in the mode of interpretation services or in expenses covered. Advocacy by stakeholders, including families, providers, and lawmakers, is needed to ensure equitable access to quality mental healthcare through sufficient coverage of interpreter services. Some states (e.g., Arizona) are trying to keep the cost of interpretation services from falling on individual providers by requiring managed care organizations to provide free telephonic interpretation services. More states need to

follow suit and expand the mode of coverage to video or in-person services and simplify the process of billing and claim submissions to fairly compensate qualified interpreters for their services.

• Provider Databases

Currently therapist directories including national professional databases and professional organizations such as abct.org or adaa.org do not include language skills or offer a language filter for therapist searches. Thus, even if a client with LEP or their family is able to recognize their issue as having a mental health component, is willing to seek help despite potential costs, and begins the search for help, they may encounter another barrier: the inability to find a language concordant provider. Professional organizations, national provider databases, and commercial databases should include language ability in their searches. This can help facilitate those who are seeking providers with specific language abilities. It is important to include information about the languages that are spoken in the United States that do not have a provider with language ability. If we commit to being honest as a field about our limitations, we might increase our commitment to finding solutions.

Conclusion

For broader impact in reducing disparities and addressing the needs of those with LEP, changes are needed across systems, including clinical settings, graduate programs, community spaces and research priorities. Clinicians/community leaders as well as stakeholders in academic/research arenas need to be involved in elevating the discourse around mental health to include individuals with LEP and taking action to address this growing need. Policymakers can consider a number of options to reduce barriers to better serve individuals with LEP. Policies are needed to standardize interpretation certification requirements and provide guidelines for mental health specialization. Laws can compel insurance companies to improve reimbursements for using interpreters and encourage use of interpreters in mental health service settings.

Understanding the hurdles to addressing language barriers is only the first step in working towards creating fair and equal access to mental health services. Other factors include considering motivation for treatment; ideas, perception, and expectations for therapy; stigma (self and social);

roles of family and loved ones; and the role of therapist as a cultural broker, advocate, and educator. Attention to all of these essential issues starts with a commitment to ensuring access to effective communication with a qualified clinician for every person who needs our services.

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No conflicts of interest or funding to disclose.

Correspondence to Kathariya Mokrue, Ph.D., York College of The City University of New York, 94 20 Guy R. Brewer Boulevard, AC-4D06, Jamaica, NY 11451; kmokrue@york.cuny.edu

ACADEMIC FORUM

Women-Led Research Support Groups to Bolster Success in Academia During Social and Historic Change

Amanda K. Gilmore, *School of Public Health, Georgia State University*

Angela D. Moreland, *National Crime Victims Research and Treatment Center, Medical University of South Carolina*

Ruschelle M. Leone, *School of Public Health, Georgia State University*

Nada M. Goodrum, *University of South Carolina*

Isha W. Metzger, *Georgia State University*

Funlola Are, *University of Texas Health Science Center at Houston*

Cristina López, *College of Nursing, Medical University of South Carolina*

THE BARRIERS FACED by women in academia are a well-documented phenomenon that have led to disadvantageous consequences for women, as well as the potentially decreased quality of science (Ceci et al., 2014; Gruber et al., 2020). These barriers are especially present for women who identify as Black, Indigenous, and People of Color (BIPOC). Barriers exist pre-college, during college, and throughout academia, and have resulted in the underrepresentation of women in academic institutions, especially among women who identify as BIPOC and at higher faculty ranks. Despite programs and equality policies implemented to help overcome this problem (e.g., National Science Foundation's ADVANCE IT and PAID programs aimed at increasing number and success of female scientists), women are still underrepresented in higher faculty ranks (Danell & Hjerm, 2013), editorial boards (Cho et al., 2014), and number of journal submissions (Amano-Patiño et al., 2020). Women in academic positions are paid less and are given more service assignments than men (Gruber et al.). Additionally, less research funding at the National Institutes of Health is awarded to women who identify as BIPOC, potentially due to topic choice given that BIPOC individuals tend to propose research focused on community and population levels (Hoppe et al., 2019). BIPOC investigators are more likely than their White counterparts to submit research proposals focusing on social

determinants of health, perhaps in part due to lived experiences in communities that have been historically marginalized and as a result encounter health disparities (Clark & Hurd, 2020). In contrast, predominantly White and/or male review panels may develop cultural norms that de-prioritize research topics proposed by BIPOC women scholars, given evidence that fields with a lower proportion of majority culture individuals become devalued (Levanon et al., 2009). To combat the systemic bias of funding, the National Institutes of Health (NIH) have recently updated their strategic plan for 2021–2026, which includes a new NIH-wide priority of improving minority health and reducing health disparities as a cross-cutting theme (NIH, 2021). Given that minority health and health disparities are not an individual-level problem, but a systemic one that requires community- and population-level research and intervention, this may shift the funding gaps that currently exist. However, reviewers may still hold bias and additional work is likely needed to combat bias on NIH review panels. Similarly, publication trends suggest that women BIPOC authors are underrepresented in peer-reviewed manuscripts, again potentially due to the topic choice and because BIPOC individuals are underrepresented on editorial boards (Roberts et al., 2020). Thus, efforts are needed in general to increase representation of women in academia and research careers, especially among women who

identify as BIPOC. The purpose of this article is to present an opportunity to implement women-led research support groups within academia. While we argue that the burden of discrimination should not be placed on women and women who identify as BIPOC, given that inequities still exist, we propose that women-led research support groups within academia may help mitigate the impact of bias on women.

The COVID-19 pandemic and protests related to racial injustices are skewing an already uneven playing field in academia. Prior to March 2020 (i.e., start of the coronavirus lockdowns), women only made up 29% of the tenure-track investigators funded by NIH, which is surprising given that women constituted approximately 45% of postdoctoral fellows in U.S. universities and research institutions (Martinez et al., 2007). Likewise, BIPOC students enrolled in U.S. colleges and universities climbed from 25% to 30% from 1997 to 2007 (Ryu, 2010), while full-time faculty positions held by BIPOC individuals only increased from 13% to 17% and women of color held only 17% of full-time faculty positions in 2017. Not surprisingly, this percentage declined steadily with rising academic rank, with women of color holding only 10.8% of faculty positions as full professors (U.S. Department of Education, 2018). In another study, women of color comprised 10.4% of instructors and lecturers, 9.9% of assistant professors, 6.6% of associate professors, and only 3.4% of full professors (Ryu). Several mechanisms may be responsible for these marked gender and racial disparities. Some examples include “leaky pipelines” where underrepresented groups are hired but are not promoted or who leave academia due to discrimination, bias in promotion and tenure committees, and gender harassment/racial discrimination. Additionally, service contributions/the minority tax (i.e., additional responsibilities placed on minoritized faculty including, leading diversity committees and initiatives, and mentoring minoritized students and faculty due to lack of other available minoritized mentors) may likely play a role. Finally, (more recently highlighted and heightened) family/caregiving obligations may exacerbate existing gender and racial disparities.

Impact of Social Isolation and Protests to End Racial Discrimination on Women in Science/Academia

Social isolation due to the COVID-19 pandemic, compounded by antiracist

protests, has led to a disproportionate impact on women and BIPOC individuals in science/academia. Journal submissions during the pandemic have been significantly higher for men compared to women (Amano-Patiño et al., 2020), with solo-authored submissions showing the most impact with only 17% by women since the pandemic compared to 22% prior to March 2020. Further, with increased teaching responsibilities and time associated with transitioning to online courses, as well as the heightened mentoring needs of students during the pandemic, even less time remains for research activities. A large quantitative survey of scientists revealed that although time devoted to research declined overall during the initial months of the pandemic, the impacts have disproportionately fallen on women and parents of young children (Myers et al., 2020).

Several factors contribute to this disproportion in scientific output and time for research activity for women during the pandemic, including heightened childcare and homeschooling responsibilities, increased household burden (e.g., cooking, cleaning), and the need to take care of additional family members, which tend to fall primarily on women, regardless of career path or role in the workplace compared to the man of the household (Amano-Patiño et al., 2020). This disparity is even more pronounced for women underrepresented in terms of ethnicity, race, and economic class, and for single women and those caring for sick/elderly family members.

In addition to the pandemic, antiracist protests have materialized into disproportionate burden on women and BIPOC individuals in academia, given the emotional and time burden on women to lead movements of change at their universities for themselves and their students consistent with women traditionally bearing more service-oriented tasks at their universities (Gruber et al., 2020). With faculty women of color expected to take on additional service and mentorship duties related to university diversity and inclusion goals (Malisch et al., 2020), as well as being approached by students more frequently for mental health support than male faculty, increases in activities to end racial discrimination further limit women’s research time. In addition to the short-term impact of this disproportion, institutions often value research and teaching activity more than service, which can impact long-term advancement in terms of tenure and promotion, external funding, and salary increases, which already suffer due to the

preexisting gender gap of salaries in academia. Given the far-reaching impact of the COVID-19 pandemic and antiracist protests on scientists who are women, caregivers, and/or BIPOC, creative solutions are needed to support productivity and reduce long-term disparities in professional advancement.

The Role of Women-Led Research Support Groups

Collaborative writing groups are a strategy to encourage research productivity within academic settings (e.g., Salas-Lopez et al., 2012). Women-led research support groups have the potential to mitigate some of the gender-specific bias of academia. The bias is mitigated both through an empowerment theoretical lens and behavior theoretical lens. Within the empowerment theory, women-led research support groups can bolster individual strengths, provide support within the natural helping system of the group and external to the group, and promote a proactive approach to social change (Rappaport, 1981, 1984). Within the behavioral theoretical lens, such support groups can provide modeling as well as reinforcement for engaging in behaviors that support research productivity. There are other models for writing accountability groups, including GeoLatinas and Paper-in-a-day (International Society for Traumatic Stress Studies); however, we present one focused on building faculty support for women and women who identify as BIPOC in academia to bolster success in academia.

An example is Women Who Write (WWW), an interdisciplinary research support group that consisted of six women (33.3% White/Non-Latinx, $n = 2$; 16.7% Black/African American, $n = 1$; 16.7% American Indian/Alaska Native, $n = 1$; 16.7% Latinx, $n = 1$; and 16.7% Middle Eastern/Arab, $n = 1$) aged 29–40 with academic ranks ranging from postdoctoral fellows to associate professors. WWW included several disciplines, including psychology, public health, and nursing. A total of 66.7% ($n = 4$) of WWW members had young or school-aged children, ranging from 1 to 2 children ages 1 to 10. The purpose of WWW was to create a supportive community of women to encourage research productivity. WWW provided support protecting time to dedicate to work that counted towards tenure or professional advancement and discussing research-related accomplishments to

increase empowerment in more biased, traditional academic circles.

The initial structure of WWW included both in-person and virtual protected time (approximately 5–10 hours per week) to dedicate to research tasks that count towards tenure, including grant writing, manuscript preparation, and tenure preparation. This excluded tasks that are not counted towards tenure that are disproportionately assigned to women and BIPOC individuals in academic institutions, including administrative assignments and service roles. During the first few meetings, it was clear that there was a pattern of our weeks being filled with service-related tasks that did not count for tenure rather than research tasks that did count towards tenure. Therefore, the first meetings focused primarily on encouragement and empowerment to carve out specific time for research tasks to progress towards tenure. WWW used an empowerment theoretical framework that encouraged members to draw on their strengths to help both themselves but also other group members complete their goals. Within a behavioral framework, WWW provided modeling for each other for each of the empowerment-related goals in addition to providing reinforcement for protecting writing time and accomplishing grant and paper submissions. WWW bolstered self-efficacy, skills, and coping behaviors to combat the common issues that arose in the group, including demands related to administrative tasks and service taking up all or most of the time allotted for research productivity.

Throughout WWW, it was inevitable that something would come up each week that made the protected time seem unattainable. Therefore, some of our efforts were spent helping each other protect time with flexibility due to demands that occur at work or at home. One key example was that a group member had administrative tasks that made it seem impossible to resubmit an NIH grant. The group helped that member carve out time and work towards that goal each week, which allowed that grant to be submitted and subsequently funded. The protected time included check-ins to ensure that the time was being spent on quantifiable research tasks and to help problem-solve any issues that arose. The group also provided a venue for informal consultation for questions or challenges related to research productivity and professional development. The WWW structured time and meeting has been ongoing for 2.5 years and typically

included 1–2 entire days or half-days, when the members would meet together and work on research tasks. The members would check in every 2 hours to report research productivity and problem-solve barriers. WWW was also used to practice job talks, provide feedback on important job-related meetings, and brainstorm ways to increase the likelihood of promotion and tenure.

The structure of WWW changed after the COVID-19 pandemic and antiracism protests. Specifically, due to increased childcare demands, new workload demands, and social distancing requirements, WWW moved to a daily 15-minute check-in to support the group in dedicating one research task per day or to allow space for encouragement if research was simply not possible that day. On average, WWW members dedicated 50.8 hours per week towards work pre-pandemic, which decreased to 41.7 hours per week during the pandemic. This average decrease of 9 hours per week of available time to dedicate towards work was compounded by the average increase of 4.2 hours per week dedicated to university-led initiatives focused on the COVID-19 pandemic and 17 hours per week on initiatives toward ending racial discrimination. Therefore, these changes resulted in an average decrease of 30.2 hours per week on typical academic tasks. This decrease in work hours was compounded by increases in childcare responsibilities. On average before the pandemic, WWW members dedicated 30% of their week to childcare responsibilities (including both work and nonwork hours). During the pandemic, this increased to 70%. Pre-pandemic childcare responsibilities were shared more equally with spouse and other childcare (e.g., childcare professional, family, school). In addition, 33.3% of the members reported additional household duties of taking care of children in their extended family and/or family members at high risk for COVID-19. Despite the increased demands, WWW encouraged grant and manuscript submissions to ensure the tenure path and continued professional advancement. Between March and July 2020, WWW members submitted an average of 1 PI and 1 Co-I extramural grant submission as well 1.8 manuscripts as first author and 2.5 as co-author, despite the unique challenges faced among women and BIPOC individuals in academia that is likely to further the gender and racial/ethnic inequities of tenure within academia. WWW is just one example of a women-led research group that could be

used to create a supportive community to encourage research productivity.

Conclusion

Ultimately, it is the responsibility of the university and the larger scientific field to dismantle the inequities that exist for women, especially for women who identify as BIPOC. At the systemic level, it may be worthwhile for the National Institutes of Health (NIH) to intervene when inequities are identified. NIH recently took an anti-sexual harassment stance and allowed reports to be sent directly to NIH instead of only through individual universities. This policy could be implemented for women where discriminatory behaviors occurring within the context of science projects could be reported directly to NIH. Universities could take several approaches to furthering the progress of women scientists including implementing free childcare on site, expanding tenure benchmarks to include service tasks that are often led by women, and/or randomly assigning service tasks to faculty stratified by gender, race/ethnicity, and faculty rank.

If women are interested in starting their own women-led research support groups, they could reach out to colleagues at their universities via professional listservs and on social media to find others interested in joining. Based on our experience, smaller groups (e.g., 4–10) are needed to ensure that each member has time to receive support within the group. Group members should discuss expectations for the group and develop an understanding of what each group member needs for the group to be successful. For instance, some group members may need support around managing competing expectations while another group member may be relying on members of the group for accountability. Regardless of each member's particular needs, clarifying these at the outset allows the group members to best support one another. In addition, specifying the specific date and time, setting (online or in-person), and other characteristics is critical to ensure sustainability and accountability. We have found that an initial meeting to outline goals of the day, followed by routine check-ins (via video or text), has increased productivity of the group. Although this article focuses on tenure-track productivity, productivity in other positions—for example, therapists, non-tenure-track faculty—could be prioritized within a women-led support group with goals specific to that position.

It is important to note that some women in academia, including those who are single parents, taking care of elderly or sick family members, or who are experiencing significant financial burdens, may simply not be able to engage in the same level of tasks that advance research careers as those who do not face such burdens. Therefore, for those individuals, a systemic change at the university level might be needed to ensure success. However, for those with the ability to do so, women-led research support groups may be a helpful tool to encourage women and BIPOC individuals in academia to work towards research tasks that count towards tenure with the goal of reducing inequities in academia. We note that other underrepresented populations (e.g., sexual and/or gender minority scientists) may similarly benefit from research support groups that are tailored to their unique barriers faced in academia. Notably, creating an interdisciplinary support group with diversity across personal and organizational dimensions lends itself to unique perspectives that can provide support and encouragement in the face of documented gender and racial disparities, especially during times of uncertainty or social instability.

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No conflicts of interest or funding to disclose.

Correspondence to Amanda Gilmore, Ph.D., PO Box 3995, Atlanta, GA 30302 Agilmore12@gsu.edu

ABCT Researcher Spotlights

<https://www.abct.org/researcher-spotlights/>

Sharing the perspectives of researchers across varied backgrounds, settings, paradigms, and populations



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 here:
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**

See next page for instructions on how to apply for ABCT Fellow status.

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 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 Whittall, Ph.D.

Antonette Zeiss, Ph.D., Vice Chair

APPLICATION
DEADLINE:
July 1, 2022



ABCT 2022

November 17–20 | New York City

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

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, after January 1, 2022.

- The online submission portal for general submission opens February 7, 2022
- The online submission portal for general submission closes March 7, 2022

56th Annual Convention

November 17–20, 2022 | New York City

✓ PREPARING to SUBMIT an ABSTRACT

The ABCT Convention is designed for scientists, practitioners, students, and scholars who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions, Targeted and Special Programming, and Ticketed Events.

ABCT uses the Cadmium Scorecard system for the submission of general session events. The step-by-step instructions are easily accessed from the Abstract Submission Portal, and the ABCT home page. Attendees are limited to speaking (e.g., presenter, panelist, discussant) during no more than FOUR events. As you prepare your submission, please keep in mind:

- **Presentation type:** For descriptions of the various presentation types, please visit http://www.abct.org/Conventions/?fa=Understanding_The_ABCT_Convention
- **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The total number of speakers may not exceed 6. Symposia are either 60 or 90 minutes in length. The chair may present a paper, but the discussant may not. Symposia are presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.
- **Title:** Be succinct.
- **Authors/Presenters:** Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their degree, ABCT category (if they are ABCT members), and their email address. (Possibilities for “ABCT category” are current member; lapsed member or nonmember; postbaccalaureate; student member; student nonmember; new professional; emeritus.)
- **Institutions:** The system requires that you enter institutions before entering authors. This allows you to enter an affiliation one time for multiple authors. **DO NOT LIST DEPARTMENTS.** In the following step you will be asked to attach affiliations with appropriate authors.
- **Key Words:** Please read carefully through the pull-down menu of defined keywords and use one of the keywords on the list. Keywords help ABCT have adequate programming representation across all topic areas.
- **Objectives:** For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the objectives of the event. Sample statements are: “Described a variety of dissemination strategies pertaining to the treatment of insomnia”; “Explained data on novel direction in the dissemination of mindfulness-based clinical interventions.”
- **Overall:** Ask a colleague to proof your abstract for inconsistencies or typos.

For an in-depth explanation of ABCT’s convention program, including the differences among ticketed, general, and special programming, visit us at:

www.abct.org > Conventions & CE > Understanding the ABCT Convention

The submission portal will be opened from February 8–March 8. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 56th Annual Convention.

➔ **Questions?** FAQs: <http://www.abct.org/Conventions/> > Abstract Submission FAQs

ABCT & Continuing Education

At the ABCT Annual Convention, there are Ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and General sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. See the end of this document for a list of organizations that have approved ABCT as a CE sponsor. Note that we do not offer CMEs. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit. General session attendees must check in and out and answer evaluation questions regarding each session attended. For those who have met all requirements according to the organizations which have approved ABCT as a CE sponsor, certificates will be available electronically.

TICKETED EVENTS Eligible for CE

All Ticketed events offer CE in addition to educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee. For ticketed events, attendees must complete an individual evaluation form. It remains the responsibility of the attendee to check in at the beginning of the session and out at the end of the session. CE will not be awarded unless the attendees check in and out.

Clinical Intervention Training One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction. Participants attending a full-day session can earn 7 continuing education credits, and 14 continuing education credits for the two-day session.

Institutes Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday and are generally limited to 40 attendees. Participants in the full-day Institute can earn 7 continuing education credits, and in the half-day Institutes can earn 5 continuing education credits.

Workshops Covering concerns of the practitioner/ educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees. Participants in these workshops can earn 3 continuing education credits per workshop.

Master Clinician Seminars (MCS) The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees. Participants in these seminars can earn 2 continuing education credits per seminar.

Advanced Methodology and Statistics Seminars (AMASS) Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

GENERAL SESSIONS Eligible for CE

There are more than 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. Most of the sessions are eligible for CE, with the exception of the poster sessions, some Membership Panel Discussions, the Special Interest Group Meetings (SIG), and a few special sessions. You are eligible to earn 1 CE credit per hour of attendance. General session attendees must check in and out and answer evaluation questions regarding each session attended. General session types that are eligible for CE include the following:

continued on p. 73

Understanding the ABCT Annual Convention

GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. An individual must limit to 6 the number of general session submissions in which he or she is a **SPEAKER** (including symposia, panel discussions, clinical round tables, and research spotlights). The term **SPEAKER** includes roles of chair, moderator, presenter, panelist, and discussant. Acceptances for any given speaker will be limited to 4. All general sessions are included with the registration fee. These events are all submitted through the ABCT submission system. The deadline for these submissions is 3:00 a.m. ET, Monday, March 8, 2021. General session types include:

Symposia. In responding to convention feedback requesting that senior researchers/faculty present papers at symposia, while also recognizing the importance of opportunities for early career, student, and postdoctoral fellows to present their work, we strongly encourage symposia submissions that include a mix of senior and early career presenters. Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. The total number of speakers may not exceed 6.

Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Panel Discussions. Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Spotlight Research Presentations. This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Poster Sessions. One-on-one discussions between researchers, who display graphic representations of the results of their studies and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,500 posters are presented each year.

continued on p. 74

Clinical Grand Rounds Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Invited Panels and Addresses Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.

Mini-Workshops Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long. Mini-workshops are offered on Friday and Saturday and are generally limited to 80 attendees. Participants can earn 1.5 continuing education credits.

Panel Discussion Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Clinical Round Tables Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Spotlight Research Presentations This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Symposia Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. The total number of speakers may not exceed 6.

GENERAL SESSIONS NOT Eligible for CE

Membership Panel Discussion Organized by representatives of the Membership Committee and Student Membership Committees, these events generally emphasize training or career development.

Poster Sessions One-on-one discussions between researchers, who display graphic representations of the results of their studies and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,100 and 1,500 posters are presented each year.

Special Interest Group (SIG) Meetings More than 40 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

Special Sessions These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training. These sessions are not eligible for continuing education credit.

Other Sessions Other sessions not eligible for CE are noted as such on the itinerary planner, in the PDF program book and on the convention app.

TARGETED and SPECIAL PROGRAMMING

Targeted and special programming events are also included with the registration fee. These events are designed to address a range of scientific, clinical, and professional development topics. They also provide unique opportunities for networking.

Invited Addresses/Panels. Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge.

Mini Workshops. Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long.

Clinical Grand Rounds. Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Membership Panel Discussion. Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

Special Sessions. These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years, the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings. More than 40 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

Research and Professional Development. Provides opportunities for attendees to learn from experts about the development of a range of research and professional skills, such as grant writing, reviewing manuscripts, and professional practice.

TICKETED EVENTS

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment. The deadline for these submissions is 3:00 AM ET, Tuesday, February 8, 2022.

Clinical Intervention Training. One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

Institutes. Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday and are generally limited to 40 attendees.

Workshops. Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

Master Clinician Seminars. The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

Advanced Methodology and Statistics Seminars. Designed to enhance researchers' abilities, they are 4 hours long and limited to 40 attendees.

How Do I Get CE at the ABCT Convention?

The continuing education fee must be paid (see registration form) for a personalized continuing education credit letter/certificate to be distributed. The current fee is \$99.00.

Which Organizations Have Approved ABCT as a CE Sponsor?

• Psychology

ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

For ticketed events attendees must scan in and scan out and complete and return an individual evaluation form. For general sessions attendees must scan in and scan out and answer particular questions in the CE booklet regarding each session attended. It remains the responsibility of the attendee to scan in at the beginning of the session and out at the end of the session.

• Counseling

ABCT is approved by the National Board of Certified Counselors (NBCC) Approved Continuing Education Provider, ACEP No. 5797 and may offer NBCC-approved clock hours for events that meet NBCC requirements. Programs that do not qualify for NBCC credit are clearly identified. ABCT is solely responsible for all aspects of the program.

• Licensed Professionals

ABCT is approved by the California Association of Marriage and Family Therapists (CAMFT) to sponsor continuing education for counselors and MFT's, Continuing Education Provider (#133136). The ABCT Annual Convention meets the qualifications for 28 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences. ABCT maintains responsibility for this program/course and its contents.

Continuing Education (CE) Grievance Procedure

ABCT is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. ABCT will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Coordinator of Convention and Education Issues in conjunction with the Convention Manager.

Although ABCT goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the convention staff which require intervention and/or action on the part of the convention staff or an officer of ABCT. This procedural description serves as a guideline for handling such grievances.

All grievances must be filed in writing to ensure a clear explanation of the problem.

If the grievance concerns satisfaction with a CE session the Convention Manager shall determine whether a full or partial refund (either in money or credit for a future CE event) is warranted. If the complainant is not satisfied, their materials will be forwarded to the Coordinator of Convention and Continuing Education Issues for a final decision.

If the grievance concerns a speaker and particular materials presented, the Convention Manager shall bring the issue to the Coordinator of Convention and Education Issues who may consult with the members of the continuing education issues committees. The Coordinator will formulate a response to the complaint and recommend action if necessary, which will be conveyed directly to the complainant. For example, a grievance concerning a speaker may be conveyed to that speaker and also to those planning future educational programs.

Records of all grievances, the process of resolving the grievance and the outcome will be kept in the files of the Convention Manager.

A copy of this Grievance Procedure will be available upon request.

If you have a complaint, please contact Stephen R. Crane, Convention Manager, at scrane@abct.org or (212) 646-1890 for assistance.



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), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 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), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one PDF document to 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. Email the completed form and associated materials as one pdf document to 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), 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. 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, 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. 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. Email the nomination materials as one PDF document to 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. 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. 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. 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. Email the nomination materials (including letter of recommendation) as one pdf document to 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. 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. 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/. Email the completed form and associated materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Service" in the subject line. **Nomination deadline:** March 1, 2022

ABCT's **Champions of Evidence-Based Interventions**

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

► **Potential Candidates**

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

► **Recognition**

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

► **How to Nominate**

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

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

www.abct.org/membership/abct-awards/abct-champions/

the Behavior Therapist

Association for Behavioral
and Cognitive Therapies

305 Seventh Avenue, 16th floor

New York, NY 10001-6008

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