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ORIGINAL RESEARCH

Development, Implementation, and Clinical Utility of the Identities in Treatment Scale: A Self-Report Assessment of Patients' Demographic Characteristics and Sociocultural Identities

Melanie A. Hom, Felicia Jackson, Emily M. Bowers, Stephanie L. Pinder-Amaker, Lauren P. Wadsworth, Thröstur Björgvinsson, and Courtney Beard, *McLean Hospital/Harvard Medical School*

THOUGHTFUL CONSIDERATION of patients' demographic characteristics and sociocultural factors (e.g., age, race, ethnicity, gender identity, sexual orientation, and health status) in case conceptualization, treatment planning, and intervention delivery is critical to the provision of high-quality mental health services (Clauss-Ehlers et al., 2019). These factors often influence the onset and presentation of mental health symptoms (Alarcón, 2009), impact help-seeking behaviors and treatment engagement (Clauss-Ehlers et al.), and inform optimal treatment approaches (Benish et al., 2011; Hall et al., 2016). Efforts are needed, however, to improve mental health providers' ability to comprehensively and efficiently assess identity-related factors that may be salient to care (Hughes et al., 2016).

[continued on p. 83]

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DBT Skills for Pandemic Times and Beyond: Strategies for Clients and Therapists

— Shireen Rizvi, Ph.D.

MODERATOR: Laurie Zandberg, PsyD

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

The psychological impact of the COVID-19 pandemic is significant and mental health systems are strained by high demand. Numerous factors associated with the pandemic are risks for the development of mental health problems in the population at-large; infection (or fear of infection), extended periods of social isolation, economic stressors, and disruption to one's normal routine are all risk factors for subsequent problems. Dialectical Behavior Therapy is a comprehensive psychological treatment that was originally developed for borderline personality disorder but has been expanded to a variety of problems, many of which have been experienced by people during the pandemic. In this webinar, Dr. Rizvi will review the DBT skills modules, the proposed mechanisms of change within DBT, and will highlight specific skills that may be especially useful during this period. In addition, skills that therapists can use themselves to manage stress and burnout will be reviewed.

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.
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In clinical settings, demographic characteristics and other sociocultural factors are often assessed via fixed-response multiple-choice questions (e.g., using a self-report intake form). This assessment approach reduces time-burden on clinicians, minimizes the need to code and/or interpret responses for entry into electronic health records, and is useful in facilitating clinically oriented analyses comparing patients across categories (e.g., treatment outcomes by gender; Badgett, 2009; Broussard et al., 2018; Hughes et al., 2016). Yet, reliance on fixed-response options can be limiting, especially when assessing characteristics that may occur on a spectrum and/or be fluid (e.g., gender identity; Balarajan et al., 2011; Broussard et al.; Westbrook & Saperstein, 2015). Efforts to capture all possible responses can also be overwhelming given that dozens of fixed-response options may be needed to be considered comprehensive (Broussard et al.). Moreover, though the inclusion of an "other" response option that allows patients to write in their own response can help capture identity categories that are less commonly endorsed and not listed among fixed-response options (e.g., in the Boston Comprehensive Questionnaire, Revised [Suyemoto et al., 2016] or demographics questions developed by Hughes et al., 2016)—this approach can be problematic (Wadsworth & Hayes-Skelton, 2015). For example, it might lead some individuals to feel "othered" and excluded. Additionally, when assessing racial and ethnic identities, distinctions are better captured and accuracy is improved when patients use their own words to describe how they identify (Charmaraman et al., 2014).

Consequently, there have been efforts to encourage the use of open-ended response options when assessing patient demographic characteristics and sociocultural identities (Hughes et al., 2016). As one example, the 16-item Cultural Formulation Interview (CFI; Lewis-Fernández et al., 2014) was developed and introduced alongside the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5; American Psychiatric Association, 2013) to facilitate clinician assessments of identity-related factors critical to psychiatric care. This interview deliberately uses open-ended response questions to better capture the nuances and richness of patients' experiences. Rather than only asking patients how they identify, the interview also encourages patients to share how their background and identities impact their mental health. Field trials indicated that the CFI was considered by patients and clinicians to be generally acceptable, feasible, and useful (Lewis-Fernández et al., 2017); however, it has several limitations. Clinicians in field trials noted the time burden of CFI training and administration (Aggarwal et al., 2013; Lewis-Fernández et al.). It has also been recommended that identity-related information be collected using self-report surveys to enhance respondent comfort and accurate disclosure (Badgett, 2009; Balarajan et al., 2011); the CFI's interview format may thus adversely impact the quality of patients' responses. Taken together, it is clear that continued efforts are needed to improve the comprehensive assessment of demographic characteristics and sociocultural identities in a format that minimizes provider burden, enhances patient comfort, and meaningfully informs clinical care.

This article documents the development of the Identities in Treatment Scale (ITS), a web-based self-report survey designed to assess (a) patients' demographic characteristics and sociocultural identities and (b) patients' perceptions of how these factors might be contributing to their daily stress and/or how these factors might be relevant to treatment goals. We also detail the implementation of this measure within a partial hospital program (PHP) for adults with acute psychopathology and present data supporting the measure's acceptability, feasibility, and clinical utility. In so doing, we aim to offer a potential avenue by which clinicians might consider assessing relevant identity-related information.

Development of the ITS

For context, the ITS was designed for use in a PHP that offers intensive treatment to adults typically presenting to care with mood, anxiety, personality, and psychotic spectrum disorders. Patients attend up to five 50-minute group therapy sessions daily from Monday through Friday; group sessions are interspersed with individual meetings with a case manager, psychiatrist, therapist, and, if indicated, a vocational counselor. Interventions are evidence-based and draw from cognitive behavioral therapy (Beck, 2011), dialectical behavior therapy (Linehan, 2015), and acceptance and commitment therapy (Hayes et al., 2012). Length of stay is brief (i.e., approximately 10 treatment days), with primary goals being stabilization, diagnostic assessment and case conceptualization, and referral to appropriate aftercare. As a result, PHP providers strive to conduct rapid yet thorough clinical assessments to inform treatment planning and aftercare recommendations. The ITS was thus designed to prioritize and balance brevity and coverage, setting it apart from extant similar demographics measures that are either lengthier (e.g., the Boston Comprehensive Questionnaire, Revised; Suyemoto et al., 2016) or focus on a limited set of sociocultural factors (e.g., questions developed by Hughes et al. [2016]).

The development of the ITS was prompted, in part, by our team's observations that patients' sociocultural identities often impacted their mental health and were relevant to treatment but were not being comprehensively and systematically assessed or documented across PHP providers. At admission, all PHP patients were completing a fixed-response self-report survey assessing demographic data (e.g., race, ethnicity, gender identity, sexual orientation). Yet, for the aforementioned reasons, it became clear that this survey format was only offering a limited window into relevant sociocultural factors. Although many PHP providers were assessing and considering these factors in their work with patients, these factors were not being attended to at a programmatic and organization level, as recommended by Sue (2001).

To address these gaps and build upon extant multicultural psychology practice recommendations (Broussard et al., 2018; Clauss-Ehlers et al., 2019; Hughes et al., 2016; Lewis-Fernández et al., 2014; Westbrook & Saperstein, 2015), we crafted the ITS as an assessment of patient demographic characteristics and sociocultural factors that uses (a) a self-report format to reduce clinician burden and increase patient comfort with disclosure and (b) open-ended response items to capture the diversity of patients' experiences (i.e., their sociocultural identities and how each of these identities might be relevant to care) in their own words.

Because it is important to explicitly state why individuals are being asked to share information regarding their identities (Balarajan et al., 2011), we designed the ITS to open with:

> For many people, aspects of identity are directly related to, or play a role in, the things they are coming to the PHP to work on. This questionnaire is intended to give us a better sense of aspects of your identity. These questions are all optional. We

understand that some may not feel safe to disclose, so please answer whatever and however you feel comfortable.

Patients are then given the option to respond to questions about 13 sociocultural identity factors. We used the adapted ADDRESSING framework (Hays, 2016) as a starting point for specific identities to include (i.e., Age and generational influences, Disability status, Diagnostic status, Religion and spirituality, Ethnicity and race, Sexual orientation, Socioeconomic status, Indigenous heritage, National origin and current national status, and Gender identity). After consultation with other PHP clinicians and topic experts (i.e., the hospital's Multicultural Psychology Consultation Team [https://multiculturalpsychology.com]), we elected to include several additional identity-related factors relevant to mental health (e.g., relationship roles, career interests/passions). See the Appendix for the full survey. Of note, for Item 1 (gender identity), we recommend removing the term "intersex" and changing "male" and "female" to "man" and "woman," respectively, so as not to conflate gender and sex.

For each sociocultural identity, patients are asked (1) how they would identify or describe themselves, with examples listed to reduce confusion (as recommended by Hughes et al., 2016); and (2) then the question, "Does this identity contribute to your daily stress or to problems you're hoping to address in this program?" We included this follow-up question based on recommendations that patients themselves be asked to share how salient their identities are to treatment, instead of clinicians potentially drawing their own assumptions about these identities' relevance (Owen et al., 2016). This question also allows patients to articulate how experiences of stigma, discrimination, and prejudice might be impacting their mental health—all of which can be critical in an acute psychiatric setting (Beard et al., 2017). It is emphasized that all questionnaire items were optional and that, for the purposes of patients' electronic health records and clinical research being conducted at the PHP, patients were still asked to complete a standard fixed-response demographics survey routinely administered to patients hospital-wide.

Implementation in a Partial Hospital Program

After finalizing an initial version of the ITS and orienting PHP clinicians to the measure, we began administering the questionnaire as part of an existing 30-minute self-report assessment battery completed at admission by PHP patients via a secure web-based survey platform. The battery assesses various clinically relevant constructs, including depression and anxiety symptoms, sleep patterns, suicidality and self-harm behaviors, substance use, functional impairment, and expectations for treatment. All patients are provided with verbal rationale for completing this survey battery, including the ITS, during an orientation on PHP procedures. Given that we were piloting the scale and aimed to minimize the impacts of its completion on responses to other clinical questionnaires, the scale was presented as the final assessment in the battery. Following completion of the battery, a report summarizing the patient's survey responses is generated by the survey platform and then uploaded to a secure, HIPAA-compliant shared folder that is readily accessible to PHP clinicians. These reports are also displayed and reviewed for each patient during team rounds meetings to support a data-driven approach to care.

Patient Responses

From July to December 2020, the ITS was administered to 197 patients at our PHP, with 60.9% (n = 120) responding to all 13 items, 24.4% (n = 48) to 10–12 items, 3.0% (n = 6) to 7–9 items, 2.5% (n = 5) to 4–6 items, 2.0% (n = 4) to 1–3 items, and 7.1% (n = 14) to 0 items. The PHP was operating entirely virtually during this time due to the COVID-19 pandemic. Sample patient responses to the ITS and response rates for each item are presented in Table 1; use of these deidentified data were deemed exempt by our hospital's Institutional Review Board.

On the hospital's standard fixed-response self-report demographics survey, among the 183 patients who responded to at least one ITS item, ages ranged from 18 to 75 years (M = 35.8, SD = 14.8). For gender identity, when given three response options, 62.9% (n = 117) selected "female," 32.3% (n = 59) selected "male," and 3.8% (n = 7) selected "other" and then wrote "nonbinary" and/or "transgender" in the corresponding open-text box. For sexual orientation, 0.5% (n = 1) identified as asexual, 16.4% (n = 30) bisexual, 6.0% (n = 11) gay/lesbian, 70.4% (n = 129) heterosexual/straight, 1.0% (n = 2) pansexual, and 4.9% (n = 9) queer; 0.5% (n = 1) reported not knowing their sexual orientation. Regarding race (categories not mutually exclusive), 1.1% (n = 2) identified as American Indian or Alaskan Native, 5.5% (n = 10) Asian, 2.2% (n = 4) Black, 1.6% (n = 3) Native Hawaiian or Pacific Islander, 0.5% (n = 1) something else, and 92.3% (n = 169) White; 0.5% (n = 1) reported not knowing their race. Six percent (n = 11) of the sample identified as Hispanic and/or Latino/a.

We examined how frequently patients' ITS responses differed from their responses to the hospital's fixed-response survey. For gender identity, 5 patients provided a disparate response on the ITS; 2 patients identified as "cis female," 1 as "cis male," and 1 as "female, although I thought I was bigender for a while." For race, 15 patients provided a disparate ITS response; 6 used language similar to but different from the racial categories provided on the fixed-response survey (e.g., 1 patient who selected "Asian" on the fixed-response survey wrote "Asian American" on the ITS), and 9 patients provided responses to the ITS that could not have been ascertained from their answers on the fixed-response survey (e.g., one patient selected "Do Not Know" on the fixed-response survey but wrote "possible Native American" on the ITS). Of the 11 patients who identified as Hispanic and/or Latino/a on the fixed-response survey, 5 described a more specific ethnic identity on the ITS (e.g., "Cuban," "Dominican American"), and 1 clarified that they identified both as "White American" and "Hispanic." For patients not identifying as Hispanic and/or Latino/a on the fixed-response survey, the ITS often captured more detailed information (e.g., 6 patients who selected "White" as their racial identity then described themselves as being "Jewish" or "Semitic" on the ITS, 7 patients who had selected "Asian" as their racial identity listed specific Asian countries on the ITS). For sexual orientation, responses to the ITS and hospital survey differed for 10 patients; 3 who identified as "bisexual" on the hospital survey wrote a different response on the ITS (i.e., "gay," "queer," and "pansexual"), 3 who identified as "heterosexual/straight" on the hospital survey offered a more nuanced description on the ITS (e.g., "mostly straight" or "hetero/asexual"), and 4 who identified as "queer" on the hospital survey provided a more detailed description on the ITS (e.g., "queer/pansexual," "bisexual/queer").

During a discharge assessment, patients had the option to respond to the open-ended question, "Do you have any addi-

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tional comments on how we addressed aspects of your identities during your treatment?" Sixteen patients responded to this prompt. The first author reviewed all responses to generate a start list of codes. The third author then reviewed all responses to identify additional codes. Next, both authors independently coded all responses using the finalized coding scheme, and coding discrepancies were resolved via open discussion. Positive comments included themes of feeling that (1) the PHP had provided an accepting, inclusive, and comfortable environment in which to discuss identity-related factors (n = 3); (2) they had been appropriately challenged to engage with salient aspects of their identities in treatment (n = 3); (3) their pronouns were respected (n = 2); and (4) it was helpful to attend a group on identity and mental health (n = 1). Suggestions for improvement were (1) that identity-related factors could have been incorporated even further into care (n = 3) and (2) to find another approach to sharing pronouns (e.g., not at the start of every group; n = 3). One patient also expressed feeling alienated from other patients due to having a less common psychiatric diagnosis, and another patient reported not feeling comfortable sharing in the group on identity and mental health.

Clinician Feedback

In May 2021, approximately 10 months after incorporating the ITS into our admission survey battery, we surveyed PHP clinicians regarding their experiences with the measure thus far. Of the 20 clinicians working with patients individually and who would have utilized the questionnaire (e.g., case managers, psychiatrists, therapists), 14 responded to this anonymous self-report survey. To probe the clinical utility of the ITS, we adapted five items from the Debriefing Instrument for Clinicians (DIC), which was designed and has been used to assess the clinical utility of the aforementioned CFI (Lewis-Fernández et al., 2017). PHP clinicians rated their agreement with various statements about the ITS on a 4-point Likert-type scale (-2 = *Strongly Disagree*, -1 = *Disagree*, +1 = *Agree*, +2 = *Strongly Agree*). On average, PHP clinicians expressed agreement that the ITS (1) helped them understand their patients' identities (M = 1.43, SD = 0.85, range = -1 to 2, mode = 2); (2) facilitated a good assessment of identity factors relevant to clinical care (M = 1.29, SD = 0.83, range = -1 to 2, mode = 1); (3) facilitated treatment planning (M = 0.93, SD = 1.14, range = -1 to 2, mode = 1); (4) would be recommended by them for use by other mental health providers (M = 1.14, SD = 1.23, range = -1 to 2, mode = 2); and (5) was useful overall (M = 1.15, SD = 1.28, range = -1 to 2, mode = 2).

Clinicians also had the opportunity to provide written responses to open-ended questions asking (1) what was most and least helpful about the ITS and (2) for additional comments or feedback about the questionnaire. Ten clinicians provided written responses. The same coding approach was used for evaluating these responses as was used for patient feedback. Clinicians appreciated that the questionnaire (1) provided comprehensive and nuanced identity-related information (n = 4), (2) assessed information not captured elsewhere and/or that they had not had time to probe in detail during their intake sessions (n = 4), and (3) improved their understanding of patients (n = 3). Suggestions for improvement focused on administrative aspects of the ITS—for instance, whether it could be made available to clinicians even earlier (n = 1) and the format of the clinical reports themselves (n = 1). One clinician also reported wishing that patients would elaborate further on their responses, and another noted that certain items were particularly helpful (i.e., gender identity, sexual orientation, race, ethnicity, and religion/spirituality items).

Implications for Clinical Practice

Our experiences to date using the ITS have been both informative and encouraging. Overall, the ITS appeared acceptable to patients in our PHP setting. As noted, the literature has documented concerns regarding the practicality of using open-ended response questions when assessing patient demographic characteristics and sociocultural identities (Badgett, 2009; Broussard et al., 2018; Hughes et al., 2016). Because open-ended questions can be time-consuming, we considered that a nontrivial portion of patients might decline to complete the ITS, especially given that all items were optional. It is promising, then, that three-fourths of patients responded to 10 or more of the 13 ITS items. Items that received the lowest response rates (e.g., relationship roles, additional identity aspects) perhaps were most likely to be skipped due to some patients not finding them to be applicable. Moreover, as seen in Table 1, patient responses were not uncommonly quite detailed and clinically relevant. We caution against interpreting this response rate to mean that patients were necessarily comfortable with or appreciated being able to provide responses to this survey. However, it is noteworthy that we did not receive any specific negative patient feedback regarding the ITS after nearly 6 months of its administration.

The ITS also appeared feasible to implement in a short-term transdiagnostic treatment setting among adult patients with a range of presenting problems. The self-report format lent itself well to inclusion in an existing clinical survey battery routinely completed by patients. Although we do not have data regarding how long it took patients to complete the ITS itself, as noted, the vast majority of patients responded to it despite all items being clearly optional and it being the last survey of the battery. It seems, then, that the addition of this brief questionnaire may not have markedly burdened patients.

Based on PHP clinician feedback, it also appeared feasible to include responses from the ITS in clinical reports, team rounds meetings, and clinical care delivery. These findings are heartening, especially given concerns that assessing sociocultural factors in a structured interview may place an undue burden on clinicians (Aggarwal et al., 2013). Further research is needed to formally evaluate the acceptability and feasibility of administering the ITS across treatment settings and with other patient populations. Yet, data from both patients and providers at our PHP offer initial support for incorporating the ITS into mental health care settings.

Indeed, our data underscore the potential clinical utility of using this type of open-ended response questionnaire to assess patients' demographic characteristics and sociocultural identities, as well as their salience to patients' daily stress and mental health treatment. In a number of cases, patients' responses to the hospital's fixed-response demographics survey differed from those provided on the ITS (e.g., 2.8% of the sample for the gender identity item, 8.4% of the sample for the racial identity item, 45.5% of those identifying as Hispanic/Latino on the fixed-response survey, and 5.6% of the sample for the sexual orientation item), with ITS responses providing greater specificity, clarification, and nuance. Even if patients' responses to both surveys were similar, we assert that there were other advantages to the open-ended format of the ITS. Importantly, the open-ended questions allowed providers to learn

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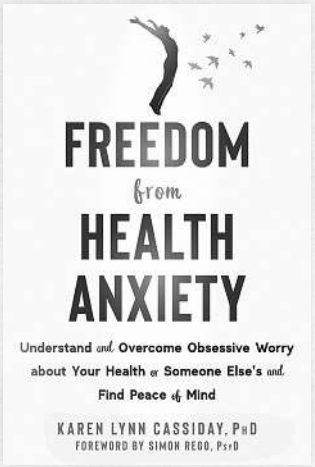

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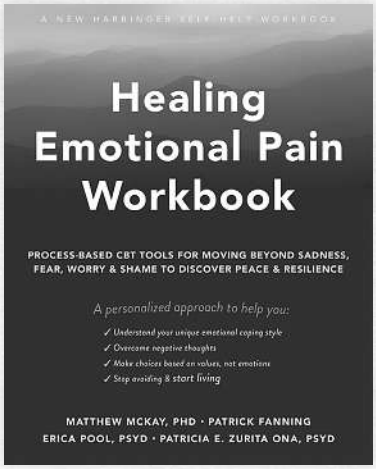

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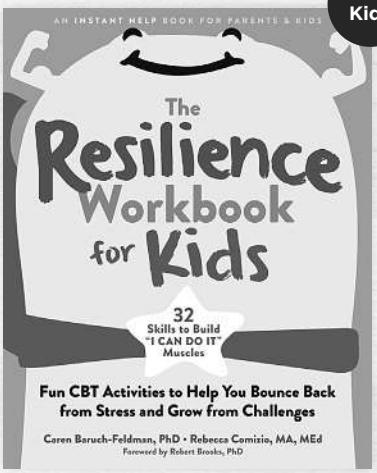

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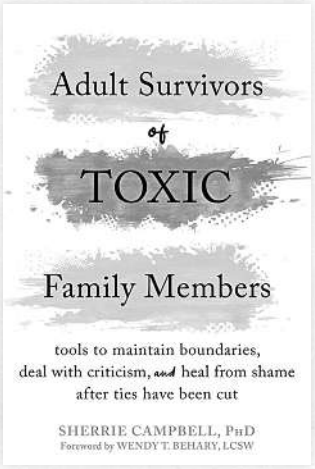

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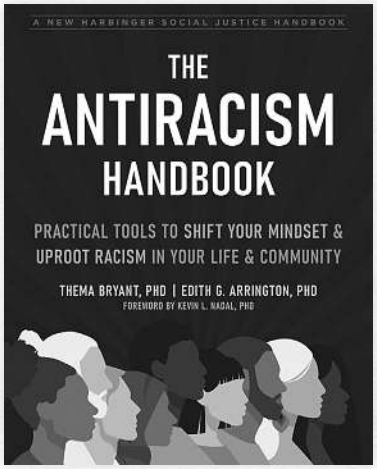

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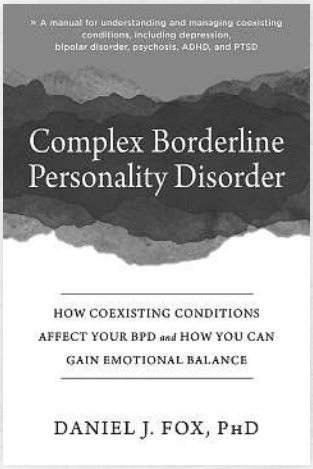

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the words a patient uses to describe themselves (Charmaraman et al., 2014). As an example, one of our patients selected their race as "Black" on the fixed-response survey but described their race as "African American" on the ITS; though this patient might find "Black" to be an accurate descriptor of their race, they may prefer the term "African American." Further, as discussed earlier, an "other" fixed-response option that allows patients to write in their own response might contribute to some patients feeling "othered" and excluded. Thus, while the responses captured might have ultimately been similar, a patient's experience providing this information might have differed based on survey format. We acknowledge, however, that for most of our patients, the standard self-report demographics survey appears to have accurately captured certain facets of their identity. In these instances, the utility of the ITS may instead lie in its follow-up probes.

On this point, as displayed in Table 1, responses to the follow-up questions about the impacts of each identity-related factor yielded unique, detailed, and potentially clinically relevant insights. These questions allowed patients to clarify whether they considered certain aspects of their identity to be salient to their PHP care. Research suggests that clinicians often only probe further regarding certain aspects of their patient's identity if the patient belongs to a minority group, with the assumption that those belonging to majority groups do not experience stress associated with their identities (Owen et al., 2016). As was evident from our patients' responses, identity-related factors are important to consider in treatment regardless of whether a patient belongs to a majority or minority group, or a group with historically more or less power or privilege (Alarcón, 2009; Hays, 2016; Winer et al., 2018). For instance, a patient identifying as "male" detailed how their gender identity contributed to daily stress, and another patient identifying as a "U.S.-Born American" noted that this nationality contributes to guilt about their anxiety because of how fortunate they have been. Patients belonging to minority groups may also not necessarily experience this identity as being relevant to care; for example, a patient identifying as "African American" responded "No" to the follow-up question regarding whether this identity contributed to their daily stress or to problems they were hoping to address in the program.

To this point, the follow-up probes often revealed germane information about patients that might not emerge through typical intake interviews or standardized symptom measures—for example, identity-related barriers to treatment engagement, experiences of stigma and discrimination, and a sense of isolation from one's peer group. Patients might disclose this information organically over time, but there remain advantages to providing a formal space for patients to share these experiences when care is initiated, perhaps especially in short-term settings such as PHPs. As discussed, consideration of identity-related factors is key to case conceptualization and treatment planning (Alarcón, 2009; Clauss-Ehlers et al., 2019). Asking about patients' identities early on also sends a meta-message to patients that such factors are considered important by their treatment team, creating further opportunities for dialogue around these factors throughout the course of treatment.

PHP clinicians' quantitative and qualitative feedback regarding the ITS dovetails with these points and supports the measure's clinical utility. Clinicians, on the whole, rated the measure as providing a good assessment of clinically relevant identity factors, enhancing their understanding of patients, and facilitating treatment planning. Several clinicians noted, in particular, that the questionnaire captured critical information that would not normally have been elicited by standard PHP assessment procedures. PHP clinicians also rated the measure as being useful overall, with no clinicians suggesting that the measure be removed or significantly modified, demonstrating its potential utility in its current form.

Implications for Research

Though not developed or piloted as a research tool, specifically, we wish to briefly acknowledge that the ITS and other open-ended demographics questionnaires may be useful in the context of research. By allowing participants to use their own language to describe their identities, researchers may be able to more meaningfully group individuals for analyses. The use of open-ended questions may also be generative with regard to novel research questions (e.g., categories or identities might emerge that would not have otherwise been captured). Finally, as noted by Hughes et al. (2016), open-ended options allow for a more accurate description of one's research sample, which is critical when generating scientific knowledge.

One possible barrier to implementing the ITS in research settings is the coding necessitated by its open-ended response format. Depending on the research question at hand, it may be that researchers elect to administer only a subset of the most salient ITS items as open-ended questions, with other demographic variables assessed using fixed-response items; the aforementioned measures developed by Suyemoto et al. (2016) and Hughes et al. (2016) might be useful in this context. Extant fixed-response measures can also be used to generate a "start list" of codes for what might be the most common survey responses. During coding, responses can be more rapidly categorized using this start list. We recognize, though, that the ITS may not be optimal for all research contexts, and we echo Hughes et al.'s (2016) points that a researcher's unique goals and limitations (e.g., lack of coding resources) are important to consider.

Limitations and Future Directions

Given that the ITS was recently developed, it is important to note its limitations and outline future directions for research and clinical practice. For one, though we sought to construct a broad assessment of demographic characteristics and sociocultural identities, the final items included by no means provide comprehensive coverage of all identity factors relevant to mental health treatment. Other factors often central to identity (e.g., personality traits, regional identities, language, neighborhood, and relationship status) or physical traits with which a person may identify (e.g., physical appearance, skin tone and complexion, body size; for instance, "black woman with natural hair") would be useful to include in future iterations of the ITS. For some identities, it might be worth explicitly acknowledging their multifaceted nature. For instance, sexual orientation has been conceptualized as including multiple dimensions (i.e., self-identification, sexual behavior, and sexual attraction; Badgett, 2009). Likewise, it may be useful to assess various dimensions of racial identity, including self-reported identification and third-party perceptions of one's racial-ethnic identity (Charmaraman et al., 2014). Patient identity may differ from the identity they are ascribed by strangers, and, as a result, may impact the degree to which they experience bias or discrimination. For example, a person of color with light skin

who is often ascribed the racial identity of "white" may experience less bias than a person of color with darker skin. This experience might lead to a sense of rejection or not belonging to one's community, which could negatively impact mental health. Some factors (e.g., socioeconomic status) may also change over time (e.g., from childhood to the present); direct acknowledgment and assessment of these shifts may be informative.

Another limitation of the ITS is its focus on negative aspects of patients' identities (e.g., their contribution to stress). Research suggests that it may be helpful to consider patients' strengths and resources when exploring the relationship between identity and mental health (Alarcón, 2009; Winer et al., 2018). Future studies thus might consider directly probing more positive components of patients' identities, such as ways their identity serves as a source of support, strength, and/or pride. It will also be critical to capture whether patients' identities intersect with one another and to explore the interplay between these intersecting identities and mental health. Studies have demonstrated the importance of attending to patients' multiple cultural identities, especially when they view multiple identities as highly salient (Anders et al., 2020). Further, it might be useful to consider modifying the timing of questionnaire administration. As articulated, there are clear benefits to having patients provide identity-related information early on in treatment. However, at this juncture in care, patients might not be comfortable disclosing identity-related information and/or might not yet have insight into the relationship between identity factors and their mental health. It might be helpful, then, to revisit patient responses to this questionnaire throughout treatment.

Overall, research is needed to directly solicit patient feedback regarding their experiences with the ITS. Data collected at our PHP only spoke indirectly to patients' experiences by probing their general impressions of how their identities were addressed in treatment. It would be informative to ask about patients' comfort with responding to the questionnaire, if there were critical aspects of their identities not captured by the measure, and how well they felt that providers incorporated their questionnaire responses into their care. We additionally encourage implementation and evaluation of the ITS in other treatment settings and levels of care, among diverse samples (e.g., with respect to presenting problems, age groups, racial and ethnic identities) and across institutions and geographic regions. As noted, this measure has only been administered in a virtual PHP context due to the COVID-19 pandemic; it would be useful to explore administration of this measure when patients are receiving in-person care. We also strongly recommend that cognitive interviewing be conducted when developing and piloting future versions of the ITS, as it is unclear whether patients were interpreting questions in the way they were intended to be interpreted and whether the phrasing of questions could be improved.

Finally, though we examined PHP clinicians' perceptions regarding the clinical

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Table 1. Examples of Patient Responses to the Identities in Treatment Scale (ITS)

Written Response	Does this identity contribute to your daily stress or to problems you're hoping to address in this program?
1. How do you describe your gender? *(e.g., male, female, trans, gender queer, non-binary, intersex, etc.)*; RR: 98.9% (n = 181)	
Female	"I get sexually harassed multiple times in a typical day when I am out and about. This causes me immense stress."
Male	"…I feel societal pressures to present a certain way that is rather counter to how I want to carry on."
Non-Binary	"…[I] often feel very disconnected from my body."
2. What pronouns do you use? What would you like us to use in the program? *(e.g., she/her/hers, he/him/his, they/them/theirs, ze/zir/zirs, etc.)*; RR: 97.3% (n = 178)	
they/them and he/him	"[M]y family isn't perfect about using the correct ones."
he/they	"I do feel a fair amount of stress around my pronouns and I wasn't planning on addressing it in this program but now that you mention it I'm starting to think it would be a good idea. The stress is about if people will genuinely recognize me with my pronouns, if I look like my pronouns, if people understand using two sets of pronouns."
3. What racial group(s) do you belong to? *Racial categories are based on visible traits (often skin or eye color, facial and physical features, etc.) and self-identification (e.g., American Indian/Alaska Native, Asian, Black, Pacific Islander, White, etc.)*; RR: 97.8% (n = 179)	
Asian	"Fighting discrimination at work."
White, Native American, Mexican	"I feel alone in my identity. I am unsure of how my racially [sic] identity has impacted the way people have treated me in the past and if I disclose this information how it will make people treat me in the future…"
African American	"No."
White	"…some guilt that I should be able to handle things better since I have so much privilege."
4. With which ethnic group(s) do you identify? *Ethnicity emphasizes the common culture, history, nationality, language, cuisine or dress of groups of people (e.g., Cuban, Haitian, African American, White American, Italian, Hispanic, Latino, Ukrainian, etc.)*; RR: 95.1% (n = 174)	
Ashkenazi Jewish	"When looking for transmasculine role models online, I sometimes get frustrated that I don't see any with my features."
Dominican American	"I think it affects how I feel others view me as being inferior to them because I believe they may think I am not good enough."
5. How would you describe your age? *(e.g., adult, older adult, elder, young adult, adolescent, etc.) Age is the amount of time a person has lived, which may affect a person's life experiences and identity (e.g., Vietnam era, Civil Rights era, etc.)*; RR: 97.3% (n = 178)	
Young adult (25)	"…I have not been able to enjoy the things that a typical person in their mid-20s would (socializing, working, etc.) and I worry about the long-term consequences of my ability to achieve basic life events (dating, starting a family, etc.)."
Adult	"Sometimes I feel like I should be 'further along' at this stage in my life than I currently am, especially with regards to financial status."
Old	"It affects my health which is one of the main problems I wish to address."
6. How would you describe your sexual orientation? *(e.g., heterosexual, gay/lesbian, bisexual, pansexual, queer, asexual, etc.)*; RR: 96.7% (n = 177)	
Bisexual	"… I feel that people do not take my orientation seriously"
Lesbian	"Coming out contributed to alot [sic] of my depression and anxiety."
Queer	"I think I'm homophobic towards myself, and this causes me stress."

[Table 1 continued on next page]

[Table 1 continued]

7. Do you identify as someone with a disability? If so, please describe. *(e.g., non-disabled, chronic pain, cognitive, sensory, physical, psychiatric, and/or learning disabilities, etc.)*; RR: 93.4% (n = 171)	
ADD	"Impacts my ability to stay on task, I'd like to explore ways to help with this."
Chronic Pain	"…chronic pain is persistent throughout the day and limits my ability to do the things I enjoy and care for myself, or be independent."
Hearing Loss	"…I have bad social anxiety from my hearing loss."
8. Do you identify with a religion or spiritual tradition? If so, please describe. *(e.g., Buddhist, Catholic, Christian, Jewish, Muslim, non-religious, atheist, agnostic, etc.)*; RR: 91.3% (n = 167)	
Catholic	"I am not practicing which may be contributing to lack of connection."
Unsure	"…unsure if I believe in God anymore after everything that's gone on in my life in the past months."
Spiritual	"Past childhood related to trauma and experience being raised in a Christian setting."
9. How would you describe your socioeconomic status (SES)? *SES is a measure of social standing that may include a combination of education, income and occupation (e.g., wealthy/upper class, middle class, lower income, inner city, rural habitat, etc.)*; RR: 93.4% (n = 171)	
Lower income urban	"…there are constant worries about money and paying bills."
Middle Class	"…my parents are working class and I feel a bit disconnected from my family and upbringing."
10. How would you describe your nationality? *(e.g., U.S.-born American, immigrant, refugee, international student, etc.)*; RR: 94.5% (n = 173)	
French	"In depression I have a very hard time talking, even more in English."
International Student	"...I have to get a job to stay here and don't want to go back."
U.S.-Born American	"I feel I should not have anxiety/etc. since I've been so fortunate."
11. Are there any relationship roles in your life that are a significant part of your identity? *(e.g., parent, grandparent, spouse, child, mentor, caregiver, etc.)*; RR: 88.5% (n = 162)	
Parent/Caregiver	"I'm often unable to properly take care of my child when in depression."
No	"I think the lack of relationship roles contributes to feeling worthless/useless and lonely."
Son	"I am worried about how my state affects my parents."
12. Do you have a job, career, passion, interest that you consider to be a significant part of your identity? *(e.g., first responder, nurse, teacher, veteran, student, athlete, artist, etc.)*; RR: 89.1% (n = 163)	
Artist	"I can't make anything creative because of my depression."
Computer Science	"When I decided on a major it became part of my identity and now I don't enjoy it and feel lost."
No	"I do not feel that I have a passion in life. I have been a stay-at-home-mom for 20 years, and I feel lost, now that my children are young-adults and don't need me very much."
13. Are there any additional aspects of your identity that may help us better understand you and your experiences? RR: 74.9% (n = 137)	
Abuse Survivor	"My father was emotionally abusive for my entire life, including now. It has affected me in many ways."
Polyamory, Kink	"I struggle with deciding who/what to pursue, and who/what to accept when I am pursued. Sometimes I find myself in relationships or dynamics I'm not sure I really want."

Note. RR = response rate among the 183 patients who completed at least one item on the ITS

utility of the ITS, we did not investigate how and the degree to which responses to this questionnaire were incorporated into mental health service delivery. It is unclear whether PHP clinicians were able to effectively integrate information from the questionnaire into treatment delivery or whether this questionnaire improved the quality of services provided. Efforts to provide formal guidance and training for clinicians on how to use this questionnaire are likely needed to optimize its utility. As a starting point, it would be useful to examine themes among patient responses regarding the role of their identities in their presenting concerns. It is also essential that clinicians interpret and utilize these data with cultural humility and a recognition of how their own identities and backgrounds impact their work (Mosher et al., 2017). Here, too, further research is needed.

Conclusions

In sum, this paper details the development, implementation, and utility of the ITS, an open-ended self-report questionnaire designed to succinctly yet comprehensively assess patient demographic characteristics and sociocultural factors relevant to care. Our experiences administering the ITS in a partial hospital program suggest that such a survey is acceptable to both patients and providers, can be feasibly implemented in a short-term acute psychiatric treatment setting with adults with a range of presenting problems, and is considered clinically useful by providers. Notably, our experiences underscore the advantages of assessing identity-related factors using open-ended rather than fixed-response questions. We look forward to additional work that aims to improve mental health providers' ability to assess and consider various aspects of patients' identities and backgrounds in case conceptualization, treatment planning, and intervention delivery. It is our hope that such efforts will improve our field's ability to provide high-quality, equitable treatment to the diversity of patients that present to care.

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Appendix

Identities in Treatment Scale (ITS)

For many people, aspects of identity are directly related to, or play a role in, the things they are coming to the BHP to work on. This questionnaire is intended to give us a better sense of aspects of your identity. These questions are all optional. We understand that some may not feel safe to disclose, so please answer whatever and however you feel comfortable.

	Does this identity contribute to your daily stress or to problems you're hoping to address in this program?
1. **How do you describe your gender?** *(e.g., male, female, trans, gender queer, non-binary, intersex, etc.)*[1]	
2. **What pronouns do you use? What would you like us to use in the program?** *(e.g., she/her/hers, he/him/his, they/them/theirs, ze/zir/zirs, etc.)*	
3. **What racial group(s) do you belong to?** *Racial categories are based on visible traits (often skin or eye color, facial and physical features, etc.) and self-identification (e.g., American Indian/Alaska Native, Asian, Black, Pacific Islander, White, etc.)*	
4. **With which ethnic group(s) do you identify?** *Ethnicity emphasizes the common culture, history, nationality, language, cuisine or dress of groups of people (e.g., Cuban, Haitian, African American, White American, Italian, Hispanic, Latino, Ukrainian, etc.)*	
5. **How would you describe your age?** *(e.g., adult, older adult, elder, young adult, adolescent, etc.) Age is the amount of time a person has lived, which may affect a person's life experiences and identity (e.g., Vietnam era, Civil Rights era, etc.)*	
6. **How would you describe your sexual orientation?** *(e.g., heterosexual, gay/lesbian, bisexual, pansexual, queer, asexual, etc.)*	

[Appendix continued on p. 94]

[Appendix, continued]

	Does this identity contribute to your daily stress or to problems you're hoping to address in this program?
7. **Do you identify as someone with a disability? If so, please describe.** *(e.g., non-disabled, chronic pain, cognitive, sensory, physical, psychiatric, and/or learning disabilities, etc.)*	
8. **Do you identify with a religion or spiritual tradition? If so, please describe.** *(e.g., Buddhist, Catholic, Christian, Jewish, Muslim, non-religious, atheist, agnostic, etc.)*	
9. **How would you describe your socioeconomic status (SES)?** *SES is a measure of social standing that may include a combination of education, income and occupation (e.g., wealthy/upper class, middle class, lower income, inner city, rural habitat, etc.)*	
10. **How would you describe your nationality?** *(e.g., U.S.-born American, immigrant, refugee, international student, etc.)*	
11. **Are there any relationship roles in your life that are a significant part of your identity?** *(e.g., parent, grandparent, spouse, child, mentor, caregiver, etc.)*	
12. **Do you have a job, career, passion, interest that you consider to be a significant part of your identity?** *(e.g., first responder, nurse, teacher, veteran, student, athlete, artist, etc.)*	
13. **Are there any additional aspects of your identity that may help us better understand you and your experiences?**	

[1]We recommend removing "intersex" and changing "male" and "female" to "man" and "woman," respectively, so as not to conflate gender and sex.

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Qualifications: Ph.D. degree in clinical psychology from an American Psychological Association or Association for Psychological Science accredited program and completion of an internship accredited by the American Psychological Association. The candidate must have a current license to practice by the GA State Board of Examiners of Psychologists or be license-eligible in GA. The candidate must have the ability to work successfully in a complex environment and to communicate effectively. The candidate must have academic qualifications commensurate with an appointment at or above the level of Assistant Professor.

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ORIGINAL RESEARCH

Episodic Future Thinking and COVID-19 Vaccination Intent in Trauma-Exposed Military Veterans: A Pilot Study

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AS NEW VARIANTS of COVID-19 continue to emerge with associated surges of high population prevalence, vaccine hesitancy represents a current public health focus, with decision making around vaccination behavior poorly understood and likely varying across individuals. Such factors such as disadvantaged socioeconomic status, self-identified racial/ethnic minority status, and beliefs about both limited vaccination safety and invulnerability to serious health consequences of the virus have been identified as contributory to vaccination hesitancy (see Aw et al., 2021, for a review). In this study, we examine associations of a potentially modifiable cognitive process (i.e., episodic future thinking) with vaccination intent.

Episodic future thinking is the ability to imagine a detailed future and is thought to depend on cognitive processes supported by the medial temporal lobes (Schacter & Addis, 2007). The degree to which an individual can imagine a detailed future can bear on decision-making and has been associated with health behavior decision making (e.g., Rösch et al., 2021) and balancing trade-offs between short-term gains and long-term benefits when the two are not fully aligned (e.g., Palombo et al., 2015). In a recent study of adults across the lifespan, participants were asked to make risk predictions of contracting COVID-19 in the context of different social scenarios (e.g., large gatherings) and were then given numerical feedback on actual risk. The study additionally randomized participants to COVID-related or COVID-unrelated future imagining conditions in which they engaged in future imagining prior to making risk estimations. As compared with participants who were asked to imagine an event unrelated to COVID, those participants who were asked to imagine a COVID-19-related scenario with social consequences showed a larger effect in response to being given numerical risk feedback on learning (i.e., "prediction error learning"), leading to greater beneficial change in COVID-19 risk beliefs and behaviors (Sinclair, Hakimi, et al., 2021). A follow-up report examining age effects on prediction error learning and future imagining indicated that although the effect of numerical feedback on risk prediction accuracy was not sustained in older adults, imagining a personalized experience exerted an enduring beneficial impact on perceived risk of COVID-19 (Sinclair, Stanley, et al., 2021). Qualitative features such as the ability to produce concrete, specific details about future events may further influence the relative effectiveness of such future imagining interventions on vaccination behavior, but such individual differences in future thinking have not yet been examined in relation to vaccination behavior or intent.

Emotional factors may also influence vaccination decisions. COVID-19 vaccine hesitancy has been understudied in psychiatric populations, although one recent study found that trauma-exposed mothers with a history of posttraumatic stress disorder (PTSD) had less confidence in COVID-19 vaccines and less intent to seek vaccination for both themselves and their children (Milan & Dáu, 2021). Similarly, Palgi et al. (2021) found that more severe PTSD symptoms among older trauma-exposed Israeli citizens were associated with COVID vaccination hesitancy. Of relevance to future imagining and vaccination intent, PTSD has been associated with attenuated ability to imagine a detailed future (e.g., Brown et al., 2014; Kleim et al., 2014).

The primary aim of this study was to explore the prospective association between the quality of episodic future imagining and subsequent COVID-19 vaccination intent in a sample of trauma-exposed military veterans who had previously undergone assessment of PTSD and participated in a larger study of episodic future imagining. We hypothesized that the number of event-specific (i.e., internal) details generated while imaging a future event would be positively associated with greater intention of getting vaccinated whereas the lifetime severity of PTSD symptoms would be inversely associated with vaccination intention. We additionally explored associations of PTSD symptom severity, future imagining, and COVID-19 vaccination intent with pandemic risk-taking behaviors and pandemic-related beliefs.

Method

Participants

Participants were 19 trauma-exposed U.S. military veterans (1 female; 18 male) between the ages of 34 and 62 years (M = 41.2; SD = 7.9) who were recruited from a larger study examining episodic future thinking and PTSD that was conducted at the Veterans Affairs Boston Healthcare System (VABHS) and recruited regionally. We attempted to contact all 28 individuals who had participated in the larger study prior to February 2021, when we began the vaccination survey. Of the 28 veterans that we attempted to contact, 7 were not reachable; the remaining 21 all agreed to participate, but 2 did not follow through with their scheduled appointment, yielding a sample of n = 19. Most participants identified as White (n = 14); 1 identified as Black, 3 identified as Hispanic/Latino, and 1 endorsed mixed ethnicity. As part of the larger study, participants had previously undergone (M = 40.2 months prior; SD = 14.4 months) assessment of PTSD and completed an episodic future thinking paradigm (described below). Inclusion criteria for both studies required trauma exposure. Participants were excluded if they expressed lifetime history of psychotic disorder, bipolar I disorder, or obsessive-compulsive disorder, current (past 3 months)

substance use disorder, suicidal ideation, moderate to severe traumatic brain injury (TBI), or other major neurological disorders.

All participants had provided informed consent to participate both in the larger study and the current study. The study was approved by VABHS research oversight committees.

Instruments

Current and lifetime PTSD was assessed by a doctoral-level clinical psychologist using the Clinician Administered PTSD Scale for DSM-5 (Weathers et al., 2013), a structured clinical interview that generates summary scores indicative of symptom severity in addition to diagnoses. For participants not meeting PTSD criteria, we used the symptom severity scores pertinent to their most symptomatic period. Exclusion criteria were assessed with the Structured Clinical Interview for DSM-5, research version (First et al., 2015; psychopathology), the Boston Assessment of Traumatic Brain Injury-Lifetime (Fortier et al., 2014; TBI), and a health questionnaire confirmed by chart review, as necessary.

The episodic future thinking paradigm (Addis et al., 2008) required participants to describe in as much detail as possible 12 future events in response to emotionally positive (e.g., success, joy) and negative (e.g., pain, defeat) cue words. Narratives were scored using an adapted autobiographical interview scoring procedure (Levine et al., 2002). Of greatest interest was the number of internal details, defined as episodic details pertaining to the main future event described (e.g., what will happen, where it might take place), produced.

Procedures

The current study involved telephone administration of a survey (February 2021 – May 2021). The survey queried the frequency in the past month (0 = *never*, 1 = *once or twice*, 2 = *three to four times*, 3 = *more than four times)* of behaviors considered at the time to be higher risk (e.g., eating indoors at a restaurant), extent of agreement/disagreement (1 = *strongly agree*; 5 = *strongly disagree*) with pandemic-related beliefs (e.g., "the risks of COVID are overstated"; "masks are effective"; "vaccines are dangerous"), and intent to be vaccinated (0 = *definitely will not get vaccinated*, 1 = *undecided*, 2 = *already vaccinated or certain to get vaccinated*). Because VABHS Veteran vaccination clinics opened in February 2021 and not all participants would have had appointment availability at the time of the survey, being vaccinated was combined with intent to be vaccinated.

Analyses

Continuous associations were analyzed with Pearson product-moment correlations. Associations involving ordinal variables were analyzed with Spearman's rho.

Results

At the time of their initial future thinking procedures (an average of 40.2 months prior to the COVID-19 survey), most (n = 13) participants reached diagnostic threshold for current PTSD, whereas 16 met criteria for lifetime PTSD. CAPS lifetime summary scores, however, indicated a broad range of symptom severity (range: 1–60; M = 31.2; SD = 16.2). On average, participants generated 23.1 internal details on the episodic future thinking task (SD = 12.0). Interrater reliability of scoring for internal details, based on the narratives of 12 participants in the larger study from which participants were recruited, was excellent (Cronbach's a =.92). Over half (52.6%) of participants reported engaging in high-risk behavior three to four times/month, and 31.2% engaged in high-risk behavior over four times/month; 42.1% somewhat or strongly endorsed the belief that COVID-19 risks are overstated; 73.7% somewhat or strongly endorsed the belief that masks are effective; 15.8% somewhat or strongly endorsed the belief that vaccines are dangerous; 47.4% reported that they had either received the vaccination or intended to receive it, whereas 42.1% reported vaccine hesitancy, and 10.5% reported outright refusal.

Table 1. Correlations Among Prepandemic Lifetime PTSD Symptom Severity and Future Thinking Internal Details, Pandemic Precautions and Risk Behaviors, Pandemic Beliefs, and COVID-19 Vaccination Intent (n = 19)

Measure	*1*	*2*	*3*	*4*	*5*	*6*	*7*
1. Internal details, no.[a]	-						
2. CAPS, summary score[b]	-.51*	-					
3. Risk behaviors[c]	-.06	.35	-				
4. Belief: vaccines dangerous[d]	-.26	.40	.33	-			
5. Belief: mask effectiveness[e]	.33	-.12	-.21	-.05	-		
6. Belief: COVID19 risk overstated[f]	.10	-.07	.39	.32	-.45*	-	
7. Vaccination intent[g]	.45*	-.44	-.49*	-.73**	.33	-.51*	-

Note. PTSD = posttraumatic stress disorder. CAPS = Clinician Administered Scale for PTSD.
[a]Higher scores indicate more internal details in future thinking narratives. [b]Higher scores indicate more severe symptoms. [c]Higher scores indicate more participation in higher-risk behaviors. [d]Higher scores indicate stronger beliefs that vaccinations are dangerous. eHigher scores indicate stronger beliefs that masks are effective in reducing COVID-19 transmission. [f]Higher scores indicate stronger beliefs that the risks of COVID-19 are overstated. gHigher scores indicate stronger intent to be vaccinated/already vaccinated.
*p < .05 (2-tailed)
**p <.001 (2-tailed)

Results of correlational analyses (Table 1) indicated that more internal details generated on the future thinking task and greater restraint from engagement in higher-risk pandemic behaviors were associated with stronger vaccination intent, whereas stronger beliefs that COVID-19 risks are overstated and beliefs that vaccines are dangerous were inversely associated with vaccination intent. The association of pre-pandemic PTSD lifetime symptom severity with vaccination intent approached but did not reach statistical significance (r = -.44; p = .06). Pre-pandemic PTSD symptom severity, however, was inversely associated with generation of internal details on the future thinking task, which in turn was associated with vaccination intent.

Discussion

In this study of future thinking and vaccination intent in a small sample of trauma-exposed war-zone veterans, as predicted, generation of more internal details on an episodic future thinking task was prospectively associated with greater vaccination intent, as measured by intention to seek COVID-19 vaccination or being vaccinated. These results suggest that better ability to imagine a detailed and specific future may influence vaccination behavior and is consistent with prior literature indicating that the quality of future imagining can dictate a variety of health behaviors (Rösch et al., 2021). Also consistent with previous literature, more severe lifetime PTSD symptoms were associated with less detailed future imagining. Finally, although not central to our hypotheses, but consistent with previous literature (Aw et al., 2021), greater restraint from higher risk behaviors, beliefs that minimized health risks of COVID-19, and beliefs that vaccinations were dangerous were also associated with vaccination hesitancy.

Associations between future thinking and vaccination intent are not surprising in the context of prior research indicating that individuals who have difficulty imagining a detailed and specific future tend to make decisions that favor short-term gains at the expense of long-term benefits (Palombo et al., 2015). In our study, stronger beliefs that vaccines are dangerous were associated with less intent to get vaccinated. It may be that fears of the short-term side effects of vaccination outweighed the longer-term benefits of the vaccine against disease protection if those longer-term vaccine benefits (or conversely the longer terms costs of not being vaccinated) could not as readily be imagined with specificity.

There are several other noteworthy aspects of our findings. First, the hypothesized inverse association between PTSD symptoms and vaccination intent (r = -.44) approached but did not reach statistical significance. Given the significant inverse association between PTSD symptom severity and internal details on the future thinking task, it may be that lifetime history of PTSD symptoms indirectly influenced vaccination intent via reduced episodic future imagining. In a larger sample more varied in PTSD history, results possibly would have indicated a stronger association between PTSD symptoms and vaccination behavior. Second, in the context of conceptualizations of PTSD as a fear-based disorder, it is notable that a fear-based belief (i.e., that vaccinations are dangerous) was significantly associated with vaccination hesitancy and showed a nonsignificant trend in its association with PTSD severity. Finally, both future thinking and PTSD were assessed prepandemic. Although our study was observational, the prospective association of future thinking with vaccination intention argues against results being explained by pandemic/vaccination concerns influencing PTSD and/or future thinking.

Our findings, although preliminary, have potential clinical implications relevant to the COVID-19 pandemic. Specifically, our results suggest that interventions that would bolster episodic future imagining may reduce vaccine hesitancy. Relatedly, such interventions could further enhance the impact of future imagining on pandemic-related risk perception and health behavior decision making (cf. Sinclair, Hakimi, et al., 2021; Sinclair, Stanley, et al., 2021) even in populations diagnosed with disorders such as PTSD in which episodic future imagining may be attenuated. Our findings also reinforce the importance of identifying and treating PTSD in trauma-exposed populations.

Our study had several limitations, including a small sample that renders results as preliminary due to limited statistical power. Our findings are also not necessarily generalizable to the general community as our sample was comprised of predominantly male, White, U.S. military veterans. Limitations notwithstanding, this preliminary study provides provocative findings that may help inform public health efforts, including decreasing vaccination hesitancy, in the context of the ongoing COVID-19 pandemic.

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ACADEMIC FORUM

The Invisibilization of Asian American Women Psychologists in Academia: A Call to Action

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THE ASIAN AMERICAN population in the U.S. is projected to surpass 46 million by 2060, to become the largest immigrant group (36%) in the U.S. (Budiman & Ruiz, 2021). With an 81% growth rate over the past decade, there are 23 million Asians in the U.S., comprising 7% of the U.S. population (Budiman & Ruiz). They represent diverse ethnic/racial backgrounds from 20+ countries across East and Southeast Asia and the Indian subcontinent, and have significant variability in income, high and low educational achievement, and poverty rates (Budiman & Ruiz). More than half (57%) of the Asian American population in the U.S. is foreign-born—a group that includes documented and undocumented immigrants and those on temporary (nonimmigrant) visas as international students, scholars, and workers (Budiman & Ruiz). In this article, we use "Asian American" as antiracist terminology to include Asian Americans (by experience, citizenship, and/or nativity), Asian immigrants and Asian nonimmigrants in the U.S., all of whom experience Asian racialization in the U.S. regardless of their identification. We recognize that nativity and immigration history contribute to great variability, not only between those who are U.S. born and those who have migrated to the U.S., but also between generations within U.S.-born Asian Americans. In some points below, we include consideration of intersectional experiences of race and nativity, and particular barriers and discrimination faced by Asian international students and scholars in the U.S. Generally, however, our focus in this article is on resisting anti-Asian racism and discrimination and its intersection with gender. "Asian American" is a term rooted in the recognition of pan-ethnic racialization regardless of nativity, and was created to offer solidarity for the resistance that is our focus (Kambhampaty, 2020). We specify the citizenship, country of birth, or immigration status only where these distinctions may be particularly relevant.

Since the start of the COVID-19 pandemic, there has been an increase in anti-Asian American bias, discrimination, and violence across the nation. An early 2021 Pew Research Center poll found that a majority (70%) of adults in the U.S. perceived discrimination against Asian Americans, similar to public perception rates of discrimination against Black and Hispanic people (Daniller, 2021). In April 2021, a Pew Research Center poll was conducted with Asian American adults after the fatal shootings of six Asian American women and two other people in Atlanta (Ruiz et al., 2021). Of those surveyed, 81% stated that violence against Asian Americans is increasing and 45% endorsed having personally experienced fear of being threatened or physically attacked; people acting uncomfortable around them; being subjected to racial slurs or jokes; remarks they should go back to their home country; or, remarks that they are to blame for the coronavirus outbreak. Three-quarters of Asian Americans reported that they have experienced discrimination or been treated unfairly because of their race or ethnicity,

which is similar to prepandemic rates (Ruiz et al.). Tracking of media reports found 110+ incidents of anti-Asian American hate crimes in the past year across the U.S. (Cal et al., 2021). In large cities, anti-Asian American hate crimes have increased 145% since the start of the pandemic (Asher, 2021). The true number may be higher as hate crimes often go underreported.

Despite a long history of racism towards Asian Americans in the U.S., little attention has been paid to prejudice and discrimination directed against this group. The history and complexity of anti-Asian racism, the problematic positioning of Asian Americans as the "model minority," and intersectional discrimination experiences beyond gender such as specific ethnicity, sexuality, disability, or faith-based discrimination are beyond the scope of this article and are addressed elsewhere (e.g., Hall et al., 2010; Kiang et al., 2017; Kim et al., 2011; Li & Beckett, 2006; Liou, 2018; Marsden, 2015; Sue et al., 2007; Tawa et al., 2013). See also the *American Psychologist* special issue focused on a synthesis of theory, research, and policy on Asian Americans (Yip et al., 2021). Anti-Asian American prejudice and discrimination remains widespread, and research shows significant negative effects on standard of living, quality of life, depression, anxiety, substance use, and physical health (e.g., Carter et al., 2019; Lee & Ahn, 2011; Sue et al.).

In this call to action, we focus on the unique issues faced by Asian American academics in psychological science, and the intersectional identity of Asian American women academics in the U.S.. Sue et al. (2001) created a conceptual framework of cultural competence that examines the micro level (i.e., level of the individual) and macro level (i.e., level of profession of psychology, organizations, institutions, and broader society), which we utilize to explore issues in the academy. Historically, less emphasis has been placed on the macro level—the institutional barriers and ethnocentric monocultural policies, programs, structures, and practices that must be overcome to move towards equity. The lack of attention to macro-level barriers problematically places the responsibility on individuals to change their attitudes, beliefs, biases, and assumptions, and to develop culturally appropriate and adaptive interpersonal skills (Sue, 2001). Here, we propose recommendations for psychology departments and training institutions (e.g., psychiatry departments, internship training sites) to develop infrastructure for Diversity, Equity, and Inclusion (DEI) initiatives. We draw upon broader DEI initiatives for black, indigenous, and people of color (BIPOC) scholars and background literature highlighting structural barriers, and propose strategies to overcome them (see Bell et al., 2021; Buchanan et al., 2021; Galán et al., 2021).

The Problem: Macro Level

At the macro level, institutionalized racism is defined as differential or restricted access to the goods, services, and opportunities of society based on ethnicity or race, and a lack of policies, procedures, and practices to ensure inclusion and justice (Jones, 2000; Prilleltensky, 2012). This structural racism that encapsulates inequitable access to education, employment, resources, accumulation of wealth, and representation in positions of power perpetuates racial disparities for all BIPOC groups, including Asian Americans. For example, Asian Americans are underrepresented in and excluded from leadership positions due to stereotypes of Asian Americans as lacking in leadership potential or communication skills (Johnson & Sy, 2016). Further, this stereotype threat can decrease the motivation to lead among Asian Americans, which can further reinforce the view that they are not good leaders (Johnson & Sy). In an analysis of U.S. Equal Employment Opportunity Commission workforce data, Asian Americans are the least likely racial/ethnic group to be promoted to management roles, and given little priority in diversity programs because they are not considered members of underrepresented minority groups (Gee & Peck, 2018). It is unsurprising that Asian Americans are not promoted as they are stereotypically represented as a nameless and faceless homogeneous group, referred to as the "interchangeable Asian," "invisible Asian," or "you've got the wrong Asian" phenomenon (Chen, 2021). In fact, 42% of people in the U.S. were unable to name a single famous Asian person, despite Kamala Harris being the Vice President of the U.S. (LAAUNCH, 2021). One-tenth named actor Jackie Chan, who is famous for a stereotyped Asian role as "kung fu master" (LAAUNCH).

Disparities are also evident in mental health and funding to address mental health issues. Asian American graduate/professional students and those from minority backgrounds have higher rates of depression than White students (Posselt, 2020). Furthermore, clinical research focused on Asian American, Native Hawaiian, and Pacific Islander populations funded by the U.S. National Institutes of Health (NIH) comprised only 0.17% of the total NIH budget—a disproportionately low percentage that is 1/29 times the proportion of these groups in the U.S. population (Doàn et al., 2019).

Asian American women academics experience intersectional oppression. Stereotypes of Asian American women include being passive, subservient, sexually compliant, and exotic (Kawahara et al., 2013). These stereotypes conflict with the dominant American view of leadership (Kawahara et al., 2007), creating further barriers to promotion and leadership opportunities. Within academia, Asian American women typically occupy junior faculty positions and have one of the lowest tenure rates (Li & Beckett, 2006). Moreover, Asian American and Black women Ph.D.s and M.D.s are less likely than White women to receive R01-level funding, considered an indicator of an established investigator in the clinical and health sciences (Ginther et al., 2016). White female Ph.D.s and M.D.s are as likely as White male Ph.D.s and M.D.s to receive R01-level funding (Ginther et al.). In psychology, Asian American women make up only 1.5% of department heads, compared to 2.5% for Asian American men (Bichsel et al., 2019, as cited in Taylor et al., 2020), and ethnographic research reveals multiple challenges faced by Asian American women graduate students (Wang et al., 2020) and faculty (Li & Beckett).

International students and scholars may experience the intersectional oppression of immigrant status, lack of citizenship privilege, and greater discrimination due to multiple indicators of "foreignness" (e.g., speaking with non-American accent, cultural stereotypes associated with countries outside North America and Western Europe). Barriers faced by international students and work visa holders include U.S. immigration policy limitations on program of study, eligibility for grants, fellowships, clinical internships, and jobs, and restricted educational and work opportunities in the U.S. for those unable to demonstrate individual financial resources or documentation of institutional commitment (NIH, 2021; USCIS, 2021). Additionally, as only 7% of employment-based green cards are granted to individuals per-country annually, applicants from large countries such as India and China have long wait times due to a high volume of applicants from these countries (Kandel, 2018). The U.S. immigration policy for sci-

ence, technology, engineering and math (STEM) fields granting Optional Practical Training (OPT) after completion of academic studies is 3 years whereas non-STEM fields are limited to 1 year of OPT (USCIS, 2021). In our experience, the classification of psychology as a STEM or non-STEM field for OPT purposes has been an opaque process that varies across subfield (e.g., clinical, developmental), institution, and time (i.e., due to changes in classification). This lack of clarity adds to the burden that international students already face in keeping pace with visa-related paperwork and policy changes. Furthermore, the immigration policies that impact international students or scholars often come with substantial financial burden to cover work visa or green card application and processing fees necessary for postdoctoral or faculty positions, expenses that may not be fully borne by the hiring institution.

The extant literature illustrates the barriers Asian American women face in advancing into the senior ranks of academia, as well as their exclusion from leadership positions. Factors contributing to this bamboo ceiling in psychology are likely to be consistent with previous research of both structural racism and stereotype

Table 1. Incidents of Anti-Asian American Racism Experienced by the Authors, Colleagues, and Other Asian American Women Academics

Experience Type 1: Racism against Asian Americans that are shared by Asian American Women	**Experience Type 2: Gendered racism/racialized sexism**
Applies Across Levels of Academic Seniority or Backgrounds -Having name incorrectly spelled or pronounced, repeatedly -Not being considered "the right type of minority" or included in diversity initiatives -Being "the token Asian," feeling more visible and "put on display" -Seen as overrepresented (e.g., told there are "too many Asians") -Being viewed as other/foreign (e.g., asked about citizenship status or country of origin, complimented for speaking "good English") -Assumptions regarding exoticized and non-American cultural customs, values, and food preferences brought up by colleagues and supervisors -Being bullied for race and cultural background by perpetrators with tenure or in positions of authority -Seen as lacking in social skills -Facing misperceptions of one's identity and role in the organization -Being underemployed and overused by departments and/or institutions **Applies Primarily to Students/Trainees** -Having to educate supervisors, colleagues, others about discrimination/racism -Being discriminated against or having competence questioned by White clients **Applies Primarily to Faculty** -Being called on to advise BIPOC scholars due to scarcity of BIPOC faculty -More emotional labor, service, burden associated with DEI initiatives -Being evaluated worse than White instructors **Applies Primarily to International or Foreign-Born Academics** -Speaking with a non-American/non-European accent being equated with lack of intelligence -Bias against those who did not attend undergraduate universities in the U.S. -Emotional and financial toll from changing international student/scholar regulations (e.g., unrealistic limits on years of visa, fear of not being allowed to enter or re-enter the U.S., especially during the pandemic) -Stress over disclosing international status during graduate school, internship, and job interviews, due to limited funding opportunities	**Applies Across Levels of Seniority or Backgrounds** -Being mistaken for another Asian American woman -Not being seen/heard, being spoken over, on behalf of, or dismissed in professional settings -Not getting credit for work because of expectations for Asian American women to be collaborative/submissive -Male colleagues receiving preferential treatment -Comments made regarding Asian features passed off as compliments -Lack of respect for personal space or unwanted touching -Sexual harassment or comments from supervisors, colleagues, or patients -People's first reaction is that one is an Asian American woman, not a scientist or a competent individual -Stereotype threat and model minority myth exacerbating imposter syndrome and leading to underperformance -Considered good at technical but not leadership roles -Feeling more pressure to conform, to make fewer mistakes -Finding it harder to gain credibility -Being more likely to be excluded from informal peer networks, leading to isolation -Having limited sources of power through mentorship or sponsorship -Being referred to as "young" or "way too young" -Having experiences with discrimination minimized or denied **Applies Primarily to Faculty** -Assumed to be in a junior role (e.g., research assistant, graduate student) -Needing to accomplish more than White male colleagues to achieve same goals with tenure and promotion -Having one's authority challenged by students more often than White male professors -Being the only tenured Asian American woman in home department

threat in Asian American women. First, Asian American women are stereotypically represented as a nameless and faceless monolithic group; perceived as submissive, lacking in leadership qualities and communication skills; penalized for acting assertively; and are excluded from diversity initiatives (Chen, 2021; Kawahara et al., 2013; Kawahara et al., 2007; Gee & Peck, 2018). Second, Asian American women scientists experience greater gender bias regarding perceived lack of competence than White women, greater workplace pressures to fulfill traditionally feminine roles, and greater backlash if they deviate from these traditional roles, as compared to women of other racial and ethnic backgrounds (Williams et al., 2014). Third, Asian American women's awareness of the bamboo ceiling, stereotype threat, lack of role models, and internalized racism can disincentivize pursuit of leadership and promotion opportunities, further perpetuating the cycle of underrepresentation, and perception of such exclusion as justified (Aronson et al., 1998; Johnson & Sy, 2016). Finally, lack of representation in leadership positions could discourage Asian American women from entering psychology. This leads to several negative downstream effects: a dearth of Asian American psychologists at all career stages, underrepresentation of Asian Americans in higher education and mental health research, and a disproportionately small number of Asian American clinicians.

The Problem: Micro Level

Personal incidents of racism and discrimination experienced by Asian American women academics in psychological science are pervasive and prevalent. Table 1 presents a nonexhaustive list of incidents of racism in professional settings experienced by the authors, Asian American women colleagues, or others who documented their lived experiences in the literature (Aronson et al., 1998; Asher, 2010; Dancy & Jean-Marie, 2014; Mukkamala & Suyemoto, 2018; Reid, 2010; Seo & Hinton, 2009; Turner; 2002; Wang et al., 2020). We organized Asian American women's experiences of racialized sexism by Experience Type as previously identified by Mukkamala and Suyemoto: Experience Type 1 being racism against Asian Americans of all genders shared by Asian American women; and Experience Type 2 being gendered racism/racialized sexism that particularly applies to Asian American women apart from Asian American men and women of other ethnic or racial groups. We also indicated which experiences apply primarily to subgroups of Asian American women in psychology (e.g., students/trainees, faculty, international/foreign-born academics).

Potential Solutions

Psychology departments should provide adequate structural support to address the barriers and disparities experienced by Asian American women and other BIPOC academics at both macro and micro levels. At a foundational level, this includes change in departmental culture and practices. Many institutions and departments have existing DEI initiatives and programs spearheaded by various committees and task forces. Here, we highlight potential initiatives to support Asian American women psychologists and others in marginalized groups more broadly. In Table 2, we provide recommendations to guide the development of DEI strategic plans for addressing the needs of Asian American women academics. Strategies to address sexism (Gruber et al., 2021) and to integrate antiracism and BIPOC solidarity in psychological science more generally (Bell et al., 2021; Buchanan et al., 2021; Galán et al., 2021; Turner, 2002) are detailed elsewhere.

Providing DEI-Related Training and Seminars

Institutions should aim to ensure that DEI-related training and seminars are provided in order to increase support for members from marginalized groups, as well as provide the skills and knowledge to those in majority groups on issues concerning race and gender to help with advocacy. Possible training topics include racial and cultural responsiveness, bystander intervention to support Asian American women when macro and microaggressions occur, and training for mentors and faculty on structural barriers faced by students and trainees who are Asian American women or international scholars. Professional development seminars—involving colleagues, supervisors, and peers—on the heterogeneous identities and experiences of Asian American women scholars are warranted to address how intersectionality influences negotiation, authorship, service, and career opportunities for Asian American women at the graduate and junior faculty levels.

Of note, research indicates that training may not effectively address all DEI-related issues. In particular, implicit bias training is often used organization-wide but may not be effective (Onyeador et al., 2021). In addition, such training may lead to defensive responses from dominant group members (see Dovidio et al., 2017, for a review on implicit bias and aversive racism). An alternative strategy involves educating those making decisions on recruitment, promotion, and tenure about their personal susceptibility to implicit biases, and increasing their investment and understanding of the work necessary to meaningfully address aversive bias (e.g., see Dovidio et al.). To address the specific issues raised above, biases that individuals may have on the competency or suitability of Asian American women to take on leadership roles should be addressed. For example, Cavanaugh and Green (2020) published a case study on implementing an institutional training on racial and ethnic diversity in hiring and highlighted the significant resources and service allocations needed to launch such a program. Along with implicit bias training, decision-makers need to broaden their definition of effective leadership to encompass behaviors more commonly associated with Asian Americans and women, including leadership styles that are less hierarchical, more cooperative, and more collaborative (e.g., see Kawahara et al., 2007; Neilson & Suyemoto, 2009; Suyemoto & Ballou, 2007). Studies have found that women executives with such cooperative leadership styles outperform their male counterparts on performance measures as rated by peers, supervisees, and supervisors alike (Sharpe, 2000).

Integration of DEI Into Curriculum

Departments should aim to provide resources for faculty and instructors on how to increase DEI in psychological science coursework and research. Research by Bertolero and colleagues (2020) showed that women of color were significantly less likely to be cited than White scholars or men of color. By providing reference lists that contain research by Asian American women and other women of color, departments may contribute to increased diversity in research that students are exposed to, and increase student citations of work by Asian American women. Additionally, institutions should consider integrating antiracism courses or courses related to DEI into the curriculum to help increase students' understanding of race and increase solidarity between members from different marginalized groups and major-

Table 2. Recommendations for DEI Strategic Plan With Focus on Asian American Women Issues

Proposed efforts/initiatives	Issues/problems addressed specific to Asian American women
DEI-related training and seminars	
1. Training for bystander intervention for when aggressions/ microaggressions against Asian American women occur 2. Educate mentors and faculty on structural barriers for Asian American women in psychology and international students 3. Educating those on committees around promotion and tenure about their susceptibility to implicit biases against Asian American women	1. Negative mental health outcomes of Asian American women resulting from bias and microaggressions from peers and faculty 2. Lack of support for early-career Asian American women academics from mentors 3. Lack of awareness of biases around Asian American women's ability or suitability to take on leadership roles
Integration of DEI into curriculum and training	
1. Provide resources for faculty on decolonizing curriculum syllabi (e.g., reference lists for courses containing papers written by Asian American women) 2. Integrate anti-racism courses, courses related to DEI or multicultural psychology courses into the curriculum	1. Invisibility of scholarship by Asian American women 2. Lack of solidarity between members from different marginalized groups and majority groups
Create infrastructure to support marginalized groups	
1. Cultivate safe spaces for Asian American women - affinity groups, spaces led by mental health professionals 2. Promote safe reporting of experiences of discrimination and bias and protection from potential retaliation 3. Masked review process for grants and journal publications 4. Organize special issues and action plans devoted to DEI 5. Increase diversity in leadership (e.g., editorial advisory board, tenure review committee) 6. Objective evaluation metrics on performance and tenure 7. Hire external consultant to conduct needs assessment and progress tracking for DEI efforts 8. Regular and transparent assessment of racial climate and DEI efforts to inform concrete steps 9. Training to educate faculty and mentors about linguistic bias and anti-immigrant discrimination, and financial and immigration-related barriers, for international students and scholars 10. Mentors to provide guidance on job search and negotiations, including for immigration-related costs 11. Mentors to connect mentees to resources and other academics with shared identities and experiences	1. Negative mental health outcomes resulting from bias and microaggressions; stigma around mental health specific to Asian American women 2. Lack of institution-specific needs assessment and outcome monitoring 3. Difficulties in publishing experienced by Asian American women, some who may be non-native English speakers 4. Lack of support as well as barriers for international students/scholars to obtaining training fellowships, clinical internships, postdoctoral positions, and faculty positions
Requirement of service from all members	
1. Encourage everyone to participate in specific task forces to advance DEI efforts rather than rely on BIPOC scholars 2. Requirement of service from all members 3. Leverage allyship to advocate for marginalized groups	1. Greater emotional labor/service/burden of Asian American women and other BIPOC scholars
Collaboration with different stakeholders	
1. Collaborate with existing resources within institution to identify university-wide mechanisms for receiving support 2. Collaborate across institutions on DEI initiatives and create networking opportunities for Asian American women and other BIPOC scholars 3. Engage community resources and partnerships 4. Encourage candid conversations about shared difficulties with racism and sexism, and informal mentorship beyond the department	1. Negative mental health outcomes of Asian American women resulting from bias and microaggressions from peers and faculty

ity groups. Research suggests that multicultural psychology courses can increase multicultural awareness and knowledge for both students in dominant and marginalized groups (Soto et al., 2021). Such coursework may have implications for Asian American women's own development of their ethnic identities, positive racial socialization, and related leadership strengths.

Creating Infrastructure to Support the Well-Being of Scholars From Marginalized Groups

To address issues in publishing and grant funding experienced by BIPOC researchers and nonnative English speakers, psychological distress resulting from chronic exposure to bias (such as repeated microaggressions), and mental health stigma specific to Asian American communities, institutions should provide resources to ensure the well-being and success of individuals in marginalized groups. One model is to create affinity groups within and across institutions, which can provide a shared, safe space for Asian American women and other members of marginalized groups to gather, process their experiences of marginalization, and provide support for one another. Additionally, to address the lack of understanding of institution-specific needs and progress, consistent and transparent assessment is vital to inform concrete actions (Galán et al., 2021). Racial and ethnic minority groups experience greater practical (e.g., time) and emotional burden related to service, mentorship, and teaching, which may increase disparities in research output. Hiring external consultants to conduct needs assessments (Gassam & Salter, 2020) and requiring service from all members (see University of Wisconsin's model, Nunes, 2021) may reduce the burden of marginalized faculty and students within the department. There is a need for measuring justice and well-being at the individual and organization levels (see Prilleltensky, 2012); although Asian Americans and other minority group scholars may be productive and successful despite longstanding systemic racism, it is unjust to assume their experience is positive and unscathed. Administrators can signal support and value for service around DEI and foster allyship and advocacy for Asian American women.

To address systemic challenges faced by international scholars applying for academic jobs, beneficial infrastructure within departments and institutions includes training to educate faculty and mentors about the needs and barriers for international students and scholars, including limited funding opportunities due to non-U.S. citizenship status, immigration barriers and costs, linguistic bias, and immigration based discrimination. In turn, mentors could provide guidance on the job search and negotiation process for international scholars, such as identifying institutions, labs, or practice settings likely to sponsor international scholars and negotiating covering immigration-related costs. Mentors can also more intentionally connect their mentees with international scholars in mentors' own professional networks who can offer guidance and personal perspectives. Additionally, universities should consider making legal consultations/immigration services available for international scholars to help them navigate immigration policies.

Collaboration With Other DEI-Related Efforts

In many institutions, there are already existing resources for DEI-related efforts. Departments should seek out other institutional resources and offices to collaborate and identify university-wide mechanisms for receiving support. Additionally, collaborations across institutions may be beneficial for furthering DEI in academia, as well as build supportive networks for Asian American women psychologists as well as other psychologists in marginalized groups. One example is BRIDGE in Clinical Psychology (bridgepsychology.org), which aims to connect students working to develop DEI initiatives at their home institutions to foster collaboration, improve initiatives, and build supportive networks. The Society for Research in Child Development (SRCD) has caucuses to integrate diversity into the society, with the purpose to provide support, networking opportunities, and dissemination venues for research by and about members of marginalized groups. The SRCD Asian Caucus aims to support the career development of Asian and Asian American researchers, as well as promote research with Asian populations. Providing information on these networking resources can be beneficial, especially for graduate students and faculty from marginalized groups. In particular, it may provide opportunities to find mentors across institutions with shared identities. Finally, engaging in community resources and creating partnerships can help improve the lived experience of marginalized students and faculty, build an inclusive learning and research environment, and contribute to promoting DEI in the community.

Conclusions

We have highlighted disparities, discrimination, and racism faced by Asian American academics—particularly women—at the macro and micro levels, and we have described the barriers we encounter towards professional advancement. In this call to action, we propose recommendations for Psychology Departments and training institutions for DEI initiatives to address the needs of Asian American women scholars. Through our focus on Asian American women psychologists, we also hope to illustrate unique challenges faced by marginalized groups with intersecting identities and the specific recommendations that may be needed to promote a more diverse, equitable, and inclusive psychological science.

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TREMENDOUS STRIDES have been made to make your ABCT membership experience more beneficial to you.

By now, most of you are aware that we have transitioned from a list serve to forums. Forums permit us to communicate and network with other ABCT members more easily. Currently we have forums for general use, referrals, and job postings. Users of the ABCT forums will receive email notifications whenever a new thread is created and have the ability to subscribe to threads and receive email notifications whenever a new post is made on that thread. Users of the ABCT forums will also have the ability to create new topics of discussion and message other ABCT members privately.

You can access the ABCT forums by visiting abct.org and clicking on ABCT Forums link, or by logging in to your ABCT account. If you have not already set up your ABCT forums profile, you will be prompted to do so. Our forums are an "opt in" option for members. Once that has been set up you will have complete access to the forums.

Like many new software programs, there is a learning curve and a few tweaks are required. We are working to have the system available in a digest format and allow members to choose whether to receive notifications or not. Forums content will always be available for review by thread.

We are working to expand the scope of our forums topics over the coming months. For now, we encourage you to share any job/internship opportunities, clinical referrals, or general discussion topics to the forums. If you have any questions, please reach out to membership@abct.org.

One tremendous benefit of transitioning to a new database has been the ease for members to access *Behavior Therapy* and *Cognitive and Behavioral Practice* without having to know your username and password with ScienceDirect. All members can now easily access our journals from the ABCT website once they log in.

Speaking of the website, we continue to make adjustments to the site to make it more user friendly. We recently added an accessibility menu to the home page. There is an icon on the middle of the left-hand side that, when clicked, immediately brings the user to the options available. Options include contrast, font size, rulers, and even fonts that help dyslexics navigate.

The usefulness of our database rests entirely on you. Members can look up members on the membership directory, participate in our Speakers Bureau, or Mentorship Directory. Members can also be listed in our Find a CBT Therapist if licensed and pay an optional fee that highlights more information that is useful to the public when seeking professional help. While on the website, visit our job bank (https://www.abct.org/for-professionals/job-bank/); there are sections for job seekers (free to add your resume) and those looking to fill positions (attractively priced, and reaching only the target audience).

We made many changes to our database to capture more information and help ABCT be more inclusive and diverse in all areas of our activities. We are working to capture KPIs for our awards program, presentations, submissions, and governance. If you haven't done so recently, please take a moment to look at your record and make sure it is accurate. We won't know how we are doing with our efforts to be inclusive without your input.

We now have an astonishing 40+ Special Interest Group program. Take a look at our website to see the full listing. Only ABCT members can participate in our SIGs. Many are quite active at the Annual Convention, having individual meetings, participating in the SIG Expo Friday night, and managing their own awards programs. Many are also active throughout the year producing newsletters or presentations.

April 7 is World CBT Day. David Barlow, ABCT Past President, will deliver a keynote address. Please take a look at our website for updates on how you can take advantage of some of the offerings. We are an active member of the World Confederation of Cognitive and Behavioral Therapies. Plans are underway for the 2023 World Congress to be held in Seoul, Korea.

ABCT has many opportunities for members to get involved. If interested, please let me know. Members can also visit https://www.abct.org/membership/get-involved/ to learn more about the amazing work of our committees and how members can get involved. Although we just completed the Program Committee sign-up, we also need more members to assist us with membership, student membership, social media, and other areas of governance. Announcement for volunteers are made in *tBT* or on our Forums. But always feel encouraged to let me know of your interest at mjeimer@abct.org

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Correspondence to Mary Jane Eimer, CAE, Executive Director, ABCT, 305 Seventh Ave., Suite 1601, New York, NY 10001; mjeimer@abct.org

World CBT Day

April 7, 2022

Celebrate World CBT Day!
ABCT is collaborating with the WCCBT to promote and disseminate CBT presentations from thought leaders around the globe.

Visit www.abct.org for more information and to register for these prerecorded sessions:

David Barlow, Ph.D.
Neuroticism and Disorders of Emotion: A New Synthesis and Approach to Treatment

Freedom Leung, Ph.D.
Doing CBTs With the Help of Neuroscience

Minutes of the ABCT Annual Meeting of Members

Saturday, November 20, 2021 — via Zoom

Call to Order

President David Tolin called the meeting together at 12:17 p.m. EST.

Minutes

Secretary-Treasurer Sandra Pimentel presented the minutes of the November 21, 2020, Annual Meeting of Members, which can be found in the February 2021 issue of the Behavior Therapist (pp. 99-102) https://www.abct.org/journals/the-behavior-therapist-journal/ They were unanimously approved as submitted.

Expressions of Gratitude

President Tolin thanked Martin Antony, rotating off as Immediate Past President; Shireen Rizvi, Representative-at-Large; Kathleen C. Gunthert, Coordinator of Membership Issues; Michelle G. Newman, Publications Committee Coordinator; Gail Steketee, ending her term as our Development Committee Chair; Shannon Sauer-Zavala, Research Facilitation Committee Chair; Shannon M. Blakey, Student Membership Committee Chair; Daniella C. Cavenagh, Clinical Directory & Referral Issues Committee Chair; Shari A. Steinman, Social Networking Media Committee Chair; Denise M. Sloan, Editor, Behavior Therapy; Emily L. Bilek, Public Education and Media Dissemination Committee Chair; Brian R.W. Baucom, Advanced Methodology and Statistics Seminars Chair; Cole D. Hooley, Research and Professional Development Committee Chair; Amanda M. Raines, Local Arrangements Committee Chair; Elizabeth Katz, Associate Program Chair; Gregory S. Chasson, Program Committee Chair, who worked first on an in-person meeting before transitioning to the virtual program we're attending now.

President Tolin thanked the members of the Program Committee, without whom this program would not have life. Reviewers are listed below, with super-reviewers identified by asterisks:

*Nicholas Allan, Lauren Alloy, Drew Anderson, *Lisa Anderson, Joye Anestis, Fabiana Araujo, *David Austern, Alisa Bahl, Amanda Baker, *Miya Barnett, *Kimberly Becker, Stephen Becker, *Emily Becker-Haimes, *Nancy Beckman, Kathryn Bell, Christopher Berghoff, Noah Berman, Jennifer Block-Lerner, Heidemarie Blumenthal, Christina Boisseau, *Maya Boustani, Elle Brennan, *Timothy Brown, *Wilson Brown, *Lily Brown, Steven Bruce, *Taylor Burke, Teresa Burrell, Amber Calloway, Will Canu, *Nicole Caporino, *Erin Cassidy-Eagle, Nadine Chang, *Gregory Chasson, Torrey Creed, Jennifer Dahne, Kristy Dalrymple, Charlie Davidson, Thompson Davis, Alessandro De Nadai, *Thilo Deckersbach, *Tamara Del Vecchio, Gretchen Diefenbach, Linda Dimeff, *Laura Dixon, Keith Dobson, *Deidre Donaldson, Alex Dopp, Sheila Dowd, *Anthony Ecker, *Flint Espil, *Jamal Essayli, Martha Falkenstein, Kiki Fehling, Julianne Flanagan, Nicholas Forand, Elisabeth Frazier, Steven Friedman, Patti Fritz, Matthew Gallagher, *Richard Gallagher, *Frank Gardner, Sarah Garnaat, Brandon Gaudiano, *Emily Georgia Salivar, Meredith Ginley, *Jeffrey Goodie, Andrea Graham, *Amie Grills, John Guerry, *Cassidy Gutner, Arryn Guy, Lindsay Ham, *David Hansen, *Rochelle Hanson, Audrey Harkness, Trevor Hart, Tae Hart, Cynthia Hartung, Jumi Hayaki, Sarah Helseth, Craig Henderson, Juventino Hernandez Rodriguez, *Kathleen Herzig, *Melanie Hetzel-Riggin, Michiyo Hirai, Daniel Hoffman, Laura Holt, Janie Hong, Cole Hooley, *Debra Hope, *Joseph Hovey, Kean Hsu, Christopher Hughes, Megan Hughes Feltenberger, Anna Jaffe, Amanda Jensen-Doss, D. Gage Jordan, *Kathryn Kanzler, Heather Kapson, *Elizabeth Katz, Amy Keefer, Lourah Kelly, Connor Kerns, Elizabeth Kiel, Hanjoo Kim, *Katharina Kircanski, *Evan Kleiman, Nancy Kocovski, Emily Kuschner, Sara Landes, David Langer, *Jennifer Langhinrichsen-Rohling, Penny Leisring, Greg Lengel, Matthew Lerner, Cheri Levinson, Kristen Lindgren, Danielle Lindner, Sandra Llera, Patricia Long, Sam Lookatch, *Joshua Magee, *Abby Mandel, *Patrick McGrath, *Joseph McGuire, *Carmen McLean, *Alison McLeish, Daniel McNeil, Elizabeth Meadows, Douglas Mennin, *Robert Meyers, Jamie Micco, Alec Miller, John Mitchell, Kelly Moore, *Michael Moore, *Angela Moreland, Taryn Myers, *Brad Nakamura, *Amie Newins, *Michelle Newman, Roisin O'Connor, Kelsie Okamura, Bunmi Olatunji, *Thomas Olino, *Camilo Ortiz, Julie Owens, Mandy Owens, *David Pantalone, *Laura Payne, *Andrew Peckham, Nicholas Perry, *Jacqueline Persons, Sandra Pimentel, Lillian Polanco-Roman, Mandy Porter, Mark Prince, Jae Puckett, Cara Pugliese, *Amanda Raines, Elizabeth Raposa, Carla Rash, Judy Reaven, Simon Rego, Elizabeth Reichert, Lillian Reuman, *Kelly Rohan, Halle Ross-Young, Adam Rubenis, Lauren Rutter, Dustin Sarver, Steven Sayers, *Sonja Schoenwald, *Kelli Scott, Ilana Seager van Dyk, *Kathy Sexton-Radek, Ashley Shaw, *Nicholas Sibrava, Matthew Skinta, Colleen Sloan, Moria Smoski, Laura Sockol, Matt Southward, *Amanda Spray, *Susan Sprich, Shari Steinman, Gail Steketee, *Eric Storch, *Lauren Stutts, Sarah Tannenbaum, *Kimberli Treadwell, *Emily Treichler, *Shona Vas, *Clorinda Velez, Bianca Villalobos, *Jason Vogler, *Anka Vujanovic, Debbie Warman, Alia Warner, Laura Watkins, Christian Webb, Hilary Weingarden, Jeremiah Weinstock, Lauren Weinstock, *Brandon Weiss, Susan Wenze, Michael Wheaton, *Kamila White, Kate Wolitzky-Taylor, Courtney Wolk, *Erica Woodin, Sheila Woody, Edward Wright, Peggilee Wupperman, *Brian Wymbs, *Ilya Yaroslavsky, *Matthew Young, Chelsie Young, Alyson Zalta, and Laurie Zandberg.

Dr. Tolin also thank and salute our Student Reviewers, who represent our future: Tamara Abu-Ramadan, Emily Barnes, Gina Belli, Olivia Bolts, Morgan Boyle, Charlotte Corran, Ecem Demirli, Joseph Diehl, Katherine Escobar, Robert Fite, Staci Grant, Cayla Hari, Lauren Jones, Clara Law, Brigid Marriott, Ilayna K. Mehrtens, Miriam Ortiz, Claudia Paszek, Kesley Ramsey, Angela Richardson, Taylor R. Rodriguez, Tammy Rosen, Jennifer Schild, Taylor Stacy, Nazaret C. Suazo, Debbie Torres, Holly Turner, John Vasko, McKenzie Watson, Julia Yasser, and Rebeca Zapata.

Appointments

David Tolin announced the appointments: Shari A. Steinman, Membership Issues Coordinator; Lillian Reuman, Student Membership Committee Chair; Amanda McGovern, Clinical Directory and Referral Issues Committee Chair; Alexandra Long, Social Networking Media

Committee Chair; Susan W. White, Publications Committee Coordinator; Erin Kang, Public Education and Media Dissemination Committee Chair; Rosaura Orengo-Aguayo, 2022 Program Chair; Emily B. Kroska, 2022 Associate Program Chair; Emily L. Bilek, 2023 Program Chair; Krystal M. Lewis, 2023 Associate Program Chair; Miryam Yusufov, AMASS Committee Chair; Amanda M. Raines, Research and Professional Development Seminars Committee Chair; Ryan J. Jacoby, Research Facilitation Committee Chair; W. Edward Craighead, Development Committee Chair.

Finance Committee Report

Secretary Treasurer and Finance Committee Chair Sandra Pimentel thanked her committee members Ana Bridges, Brian Chu, Laura Seligman, ex-offico members David Tolin, and staff members Mary Jane Eimer and Kelli Long for their input and work over the past year. She reported that our finances are stable and, for the most part, we weathered the pandemic well despite the many challenges we all faced. Yes, we have taken hits with the last two conventions being virtual, which are our bread and butter. The Finance Committee credited past leadership and staff for building our reserves; and current leadership and staff efforts to develop new sources of revenue while keeping a close watch on our expenses. She asked that people view ABCT's Twitter for a proper thank you of Mary Jane, Kelli, and the rest of the Central Office.

She reported that our Financial Advisor, Brian McGrath, from Boenning and Scattergood, noted that our portfolio remains strong. She reported that the Finance Committee approved a moderate-risk profile that has performed well for us over the years.

She informed the membership that this year's move to a fully virtual convention could have cost the organization a full million dollars, but Central Office staff has cut this down significantly, including renegotiating more than $600,000 in penalties that will be forgiven by rebooking New Orleans Hyatt Regency in 2025 and 2027.

The Finance Committee Chair reminded the membership that ABCT continues to have three main sources of revenue: membership, publications, and convention. Forecasting for 2022 we are looking at approximately $608,000 in membership fees; $637,000 from convention registration; and $574,000 for publications income. She noted that publications are tied to membership as the journals are bundled with membership. The Director of Communications and the Publications Committee are exploring an open access journal at the bequest of Elsevier as part of our journal contract renegotiation process. It is difficult to make forecasts with so much still in flux due to the pandemic. We are hopeful that we will do better than projected in terms of membership and convention registration. She reported that we received a PPP Loan of $174,390, which was applied to fiscal 2021, and it was forgiven.

The Finance Committee is working in tandem with the Board's direction to aim for diversity equity, and inclusion, and, to that end, we added $50,000 for a Diversity and Inclusion consultant in 2022.

She noted that there are pluses and minuses presenting our convention virtually or in person. We are all optimistic that we can meet in person next year in New York City. She noted that we spent money this year on transitioning to a new database and website in 2020 and 2021. We expect to add a few more refinements now that staff has "hands-on" experience; they will complete the necessary work to be in compliance with GDPR, PIPEDA and emerging US spam compliance regulations. We are investing resources toward increasing our cybersecurity coverage. There are no major expenses required to repair or upgrade items in the office. It is a given that members of governance and staff will continue to keep a close eye on expenses. We hope you take a look at the new website and start using all the new elements of the new database that Dakota McPherson, our Membership and Marketing Manager, and David Teisler, Director of Communications and our Deputy Director, have worked so hard to bring to fruition.

We look to the membership to continue to support our efforts by renewing your membership and participating in our offerings. We will get through this pandemic, girded by a large reserve fund built up for contingencies just like we're experiencing, as unimaginable as it might have been 2 years ago.

Development Committee

Chair Gail Steketee reported the Development Committee's purpose is to support ABCT activities. Her term is ending, and Ed Craighead will be succeeding her as the new chair. We are working to develop a culture of giving that is larger than awards. We encouraged funds that can be applied to underrepresented members this past year by creating the Francis C. Sumner Award of Excellence and adding a second Student Travel award specifically for underrepresented candidates. She noted that the membership should be pleased that our fundraising outcomes are good. She thanked David and Beverly Barlow for their new innovative research award in addition to colleagues, family, and friends who help fund the newly created Michael J. Kozak award. She thanked Mary Jane Eimer and Kelli Long for the constant help on the tasks they undertake with regards to fundraising and their investments.

Coordinators Reports

Academic and Professional Issues

Nathaniel Herr reported that the Awards Committee, chaired by Sara Elkins, oversaw a very successful 2021 awards program. As noted in the Development Committee Report, we have added three new awards over the past year (Barlow, Kozak, and Sumner) and added a second Student Travel Award. The call for 2022 awards is up on the ABCT website with a deadline of March 1, 2022. The Academic Training and Education Standards Committee, chaired by Monnica Williams, oversees several subcommittees. One of the subcommittees identified three recipients for our Spotlight on Mentor awards and added a new category, Spotlight on Graduate Student Mentor. Another group sent a manuscript to *Training and Education in Professional Psychology,* an APA journal, on training competencies on master's-level students, a subcommittee continues to add teaching resources to our website, and are working on a tBT paper on culturally informed best practices; our newest committee, the Committee on Dissemination, Implementation, and Stakeholder Engagement, chaired by Erum Nadeem, has been tasked with identifying areas for ABCT to address and oversee our Champions program. They are refining their agenda for 2022. The Coordinator reported that International Associates Committee, chaired by Lata McGinn, has initiated the "International Influencers," a project highlighting our international members on the web; and gave wings to WCCBT. Mark your calendars that the next World Congress will be held in Seoul, Korea in early June 2023. The Committee on Research Facilitation, chaired by Ryan Jacoby, oversees the Student Research Grant program and focus on expanding the pool, and working to create

a Find a Research Directory for our website. They also oversee our Spotlight on a Researcher program. The Committee on Self-Help Book Recommendations, chaired by Chris Bergdorf, reviewed and recommended 19 books, which are listed on ABCT's website. Our recommended listing of self-help books is heavily used by the public and it is an incredible amount of work by the committee.

Convention and Education Issues

Katharina Kircanski reported things are going well with our second virtual convention, made possible by dedicated and creative leadership; registration and revenue both exceeded expectations; on-demand content will be posted on the website and CE credits will be available for both virtual and later on-demand sessions.

She applauded Greg Chasson, Program Chair; Liz Katz, Associate Program Chair; Shireen Rizvi, Board Liaison; Christina Boisseau, Workshops Chair; Samantha Farris, Institutes Chair; Tejal Jakatdar, Master Clinician Seminars Chair; Brian Baucom, Advanced Methodology and Statistics Seminars Chair; Cole Hooley, Research and Professional Development Seminars Chair; Amanda Raines, Local Arrangements Chair; Patrick McGrath, Sponsorship Chair; and the essential work of the entire Program Committee. She also thanked Mary Jane Eimer, Executive Director, and Stephen Crane, Convention Manager, for their great work in making this happen. She introduced Rosaura Orengo-Aguayo and Emily Thomas, 2022 Program Chair and Associate Program Chair, who will oversee our 2022 Convention in NYC, November 17–20. She noted that the portal opens for ticketed sessions January 7 and general sessions February 7. She encourages all to submit work and provide feedback on this year's convention. She also thanked Lily Brown, Chair, and all on the Continuing Education Committee, for developing timely, well-rounded, and well-received webinars with well-qualified presenters.

Membership Issues

Coordinator Kathleen Gunthert reported that we're doing much better this year than last; we're currently at 3,565; we're down from where we usually are, in large part because membership is so tied to the convention and the impact of the pandemic.

Seven committees comprise Membership Issues. All of the committees are doing great work on DEI; the Membership Committee, under Rebecca Skolnik, has been doing well in recruiting new members and working to expand benefits to our members. The focus this past year has been on outreach to master's programs, clinicians, and other licensed professionals. The Committee on Student Members, under Shannon Blakey, generated a tremendous amount of useful content, professional development sessions on ABCT's YouTube, and expanded our Featured Labs program. Lillian Reuman will now be transitioning to the chair position. The Special Interest Groups Committee, chaired by Broderick Sawyer, has added two new SIGs: Psychedelic Research and Therapy and Master's-Level Training. There's also a SIG in formation focusing on climate change.

Coordinator Gunthert acknowledged Daniella Cavanaugh, rotating off as Chair of the Committee on Clinical Directory & Referral Issues, for the great work the committee did over her 3 years. We're excited to have Amanda McGovern taking over. This group has been active with the design and functionality of the web site's clinical directory; working on the Pioneers feature on the website and adding International Influencers to the Pioneers in collaboration with our International Associates Committee. In the coming year, they plan to develop best practices for telehealth.

Patricia DiBartolo chairs the Committee on Leadership and Elections; this committee worked diligently to get a slate of qualified candidates to run for office. She encouraged members to vote, and this is the first year ABCT is using its own database for voting. Members can now renew and vote in one seamless transaction. Over the coming year, the committee is identifying alternatives for our election process. Chair Linda Sobell and the Fellows Committee overhauled policies and procedures, focusing on equity for clinical members. Eleven new members received ABCT Fellows status, acknowledged at the Friday ABCT Awards ceremony. Shari Steinman, Chair of our Social Network Media Committee, is completing her term and Alexandra Long is taking the Chair spot. Coordinator Kathleen Gunthert proclaimed, "You don't need me to tell you what this committee is doing; it's all in plain sight on every social media platform our members use. Shari will be taking over my slot, and you'll be well served. I've very much enjoyed serving as the Membership Issues Coordinator and want to take this opportunity to thank all of my committee chairs for their dedication and hard work and the ABCT staff who have been a delight to work. I thank those who have renewed their membership and are active and encourage the membership to get their friends and colleagues to join and get involved in our professional home."

Publications Committee

Michelle Newman, Coordinator, thanked the committee, including Denise Sloan, current *Behavior Therapy* Editor, and Jon Comer, incoming *Behavior Therapy* Editor; Nikolaos Kazantzis, *Cognitive and Behavioral Practice* Editor; Richard LeBeau, *the Behavior Therapist* Editor; Laura Payne, Web Editor; Emily Bilek, outgoing Public Education and Media Dissemination Chair; Joshua Magee, who handled video outreach and helped develop ABCT's very strong YouTube presence; David DiLillo, Fact Sheets Editor who expanded our library, had many translated into Spanish and a few into digital recordings; and Mitchell Share, who oversaw Book Series with OUP and Hogrefe. She welcomed her successor, Susan White, incoming Publications Coordinator; Erin Kang, incoming Public Education and Media Dissemination chair; and Shannon Blakey, Catherine Carlson, and Stephen Schueller, incoming committee members.

Coordinator Newman reported that *Behavior Therapy* review time and the number of unsolicited manuscripts remains comparable to recent years; our impact factor is at an all-time high of 4.183, up from 3.243 last year. Five-year impact factor is also at an all-time high of 5.425; journal's ranking is 31st/131 journals, comparable to last year 28/131 journals. *Cognitive and Behavioral Practice*'s impact factor is at an all-time high of 2.946, up from 2.096 last year; 5-year impact factor is also at an all-time high of 3.271; the journal is ranked 62/131, same as last year. She thanked the editors and associate editors for their outstanding work on our behalf.

She reported that we need a new *tBT* editor identified by end of 2021, with no viable candidates yet. Richard LeBeau is willing to extend his term by a year. Unsolicited submissions have been down but review times steady relative to last year. Even with fewer unsolicited submissions, *tBT* has been thick with great articles and special series.

Regarding our web, the major accomplishment this past year was the redesign, re-organization, and launch of the new

website! This included a tremendous amount of work. It is tied to a new database, also demanding lots of work to implement. We're reviewing ongoing feedback from other committees/members. The Web Committee will continue to work with Clinical Directory and Referral Issues committee to streamline search terms and functionality of clinical directory search.

Josh Magee's video outreach committee experimented with fact sheet videos, which was a great success based on its ability to attract viewers. Views are originating in a more balanced fashion across ABCT.org, Google, social media, internal YouTube recommendations, etc. Best of all, numbers of views and average view time are strong.

We added a new Race-Based Trauma (Jayson Mystowski) fact sheet; two existing fact sheets, Phobia and Stress, were translated into Spanish; and two additional sheets are translated but need a final review.

She noted that the contract between ABCT and Hogrefe is fully executed and that the contract between Hogrefe and series editor remains to be executed; our Oxford University Press series continues to expand. We have two recently submitted proposals for books and three under contract (including Cultural Competency in Psychological Assessment); that is in addition to six published titles (including *Managing Microaggressions: Addressing Everyday Racism in Therapeutic Spaces*). We continue to encourage editors to seek social justice issue submissions from diverse authors.

The Public Education and Media Dissemination Committee completed two Briefing Books, aimed at arming lay people, and especially journalists, on the basics of various topics of concern in CBT. The first is the ABCT Suicide Briefing Book and the second is on Gun Violence. The committee also provided ongoing support to members of the press and members related to media.

Coordinator Newman thanked ABCT staff who created a completely new Association Management System (AMS) in partnership with Internet for Associations with more features and functions and launched a new streamlined website that is easier to navigate and that is fully integrated with the AMS.

Executive Director's Report

Mary Jane Eimer reported that we continue to expand content on the web and refine fields in the database. We are mindful of the European Union's General Data Protection Requirements (GDPR) and Canada's Personal Information Protection and Electronic Documents Act (PIPEDA), meant to safeguard your privacy and protection.

She reported that over the past several years, ABCT has sponsored several think tanks. The broad purpose of ABCT organizing think tanks is to bring together influential experts in a CBT-related field to consider ways in which the area of inquiry can be advanced. Think tanks are intended to enhance ABCT members' knowledge and skill sets related to the issue(s) in question. Think tanks' products, including, but not limited to publications and webinars, will credit ABCT as a thought leader in the field of cognitive and behavioral therapies. Our first think tank, "Digital Technologies to Provide Care to Difficult-to-Reach and Underserved Populations" had many positive outcomes:

a. Members presented 2 ABCT webinars and a Clinical Intervention Training at last year's convention

b. They worked to have a special series in Cognitive and Behavioral Practice, "Digital Interventions in Mental Health: Reviews and Recommendations for Application in Clinical Practice and Supervision" (in press): Muniya Khanna and Raphael Rose, Guest Editors

c. They have invited our Technology SIG to participate so the work will continue, and they have presentations at this convention addressing this area of dissemination

d. They put together a document for a potential "Expert in Digital Mental Health" video series.

e. ABCT has a collaborative relationship with Digital Drop Ins, a monthly digital discussion on a specific topic using technology and apps. ABCT members are encouraged to suggest topics and volunteer as speakers

She thanked Think Tank facilitator, Stephen Schueller, and members Courtney Beard, Denise Chavira, Adam Haim, Muniya Khanna, Ricardo Munoz, Jordana Muroff, Ralph Rose, and Bethany Teachman.

Our second think tank, Adapting Neurocognitive Methods for the Clinic, is also concluding its work and has proved productive in addressing this issue by:

a. Providing the membership each year at the Annual Convention with an update, including this year's Invited Panel, "Toward an Intersectional Model of Translational Neuroscience: Engaging Marginalized Community Partners to Adopt Neuroscience in Psychology Clinics"

b. Creating a series of videos addressed to clinicians to understand the benefits of using cognitive neuroscience in their practice (see ABCT's YouTube channel for the series)

c. Putting together several articles on standards and psychometrics for neurocognitive assessments in tBT with more papers in the works for us and other publications

d. Conducting outreach to funders regarding the importance of incorporating stakeholders (patients and clinicians) into translational research. This was touched on in our student research grant call for submissions as well

Happily, their work will continue with the Neurocognitive Therapies/Translational Research Special Interest Group. She gave special thanks to Greg Siegle, Facilitator, and members Kristen Ellard, Angela Fang, Phillippe Goldin, Stefan Hofmann, Marlene Strege, Sabine Wilhelm, and NIH Consultant Lisa Onken.

Executive Director Eimer noted that ABCT governance and staff are addressing diversity and inclusion. Requests for proposals have been solicited from several companies to hire a diversity and inclusion consultant to help us address IDEA in a meaningful and concrete manner. This past year, the Board and staff addressed expanded goals and possible outcomes in our Strategic Intent with creativity and consideration and generated a list of new revenue-stream possibilities. The Board is in the process of reviewing the outcomes and prioritizing them. Expect to hear more about this over the coming months in *the Behavior Therapist*. She noted that ABCT handles the administrative needs of the World Confederation of Cognitive and Behavioral Therapies, including hosting their Executive and Board of Directors Meetings. Member Keith Dobson serves as President and Lata McGinn as Secretary. ABCT was instrumental in getting the WCCBT incorporated in New York this year as a 501c3 organization. April 7, 2022, has been designated World CBT Day and Past-President David Barlow will give a 1-hour keynote workshop on the Unified Protocol. Other presentations (workshops) in the works include Mark Dadds of Australia and Freedom Laung of Hong Kong.

The next World Congress will be held in Seoul, South Korea in early June 2023. She

Find a CBT Therapist

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

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

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

encouraged the membership to consider submitting when the call for papers is announced in 2022. ABCT will be hosting the 2026 World Congress.

Executive Director Eimer shared, "As you can hear, I am quite excited about the work we are doing in the Central Office. I would like to take this opportunity to thank and acknowledge my colleagues: David Teisler, Deputy Director and Director of Communications; Stephanie Schwarz, Managing Editor; Stephen Crane, Convention Manager; Dakota McPherson, Membership and Marketing Manager; Kelli Long, Bookkeeper; Tonya Childers, Executive Assistant, Convention Registrar, and Exhibits Manager; and Amanda Marmol, Administrative Secretary."

She noted that staff are very much aware that ABCT is your association: "Let us hear from you with suggestions or feedback. GET INVOLVED!" The Executive Director thanked those members whose service has ended, noting ABCT is a vital organization because of the skill sets, interest, and commitment of our volunteer leaders.

President's Report

David Tolin opened his remarks with thanks to the Central Office staff: "In particular I'd like to acknowledge Mary Jane Eimer for all her knowledge and dedication to the organization. I will miss our weekly meetings. A big thank you to David Teisler, Stephen Crane, and Dakota McPherson, for all your hard work, and everyone else at the Central Office. I gained a great deal of appreciation for the amount of work that's required and how much time staff puts into every endeavor for our benefit. I've enjoyed a collaborative and collegial relationship between the Board and staff. We revised our Strategic Intent document. It had originally been a strategic plan. This is meant to be a living document with potential outcomes we deem important to ABCT and the field at large."

Dr. Tolin further enumerated recent efforts: a performance review of the Executive Director; a partnership with APA for more jointly sponsored webinars; and think tanks (noting that he would like ABCT to create a think tank on diversity issues). Dr. Tolin also addressed ABCT's election process, noting that it is notoriously difficult to get people to run for office, and even more so for minoritized individuals to run. He conjectured whether we should keep elections as they are, or transition to a system where officers are appointed by a committee.

Transition of Officers

President Tolin introduced our incoming officers, with Jill Ehrenreich-May, President-Elect; Katherine J.W. Baucom, Representative-at-Large and liaison to Convention and Education Issues; Barbara Kamholz, Secretary Treasurer-elect for 2022-2025; and Laura D. Seligman, President.

With that he turned over an imaginary gavel.

President Seligman quipped, "Technically, I have the most important task, to adjourn the meeting." She noted that she is looking forward to working with the Board, and especially our newest Board members. She thanked Katharina, Greg, Stephen, Dakota, MJ, and all those who had a hand in putting together this outstanding meeting under trying circumstances. In a normal year, this is a phenomenal program, but this is not a normal year. Active allyship and climate change are among those topics that she highlighted. She thanked President Tolin for his leadership. She recalled the difficult decision made by the Board to choose making this a remote meeting. She noted how President Tolin led the meeting and made sure we understood the implications for members and attendees. Dr. Seligman stated, "I want to thank the membership; I think change brings opportunity; and I want to thank the membership for giving me this opportunity."

Adjournment

President Seligman commented that, were this meeting in person, she would be handing President Tolin a plaque to thank him for his leadership and dedication to ABCT over the past year. "And with my pencil cup serving as gavel, I hereby adjourn this meeting at 1:20 p.m." ■

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/

Are you following ABCT on social media?

Join the conversation!

Facebook: Association for Behavioral and Cognitive Therapies
Twitter: @ABCTNOW
Instagram: @abct_insta

NOTE: The Forums replaced the list serve last November.
To check out the Forums discussion, go to the ABCT website, log in to your account through "My Membership," and click on "Forums."

Want to get more involved? If you are interested in joining the Social Network & Media Committee or want to learn more about what we do, please contact Alex Long at Long.AlexandraD@gmail.com

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- Enhances one's qualifications as an expert witness; facilitates applying to insurance companies' networks
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1. Submission of educational/training materials.
2. Review of a practice sample or senior option (≥ 15 years of experience, there are alternatives for a practice sample).
3. Collegial exam.

- We encourage diversity of all types and we recognize diversity has breadth
- We offer a discounted application fee for graduate students, interns, and postdoctoral residents
- We conduct exams at APA and ABCT conferences, and other locations as possible (virtual and face-to face)
- We offer a free workshop at the ABCT conference and free mentoring.
- Online application: **https://abpp.org/Applicant-Information/Specialty-Boards/Behvioral-Cognitive.aspx**

ABCT ASSOCIATION *for* BEHAVIORAL *and* COGNITIVE THERAPIES

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

APPLICATION DEADLINE:
July 1, 2022

the Behavior Therapist
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