

the Behavior Therapist

Contents

Original Research

M. Natalia Acosta Canchila, Sara Reyes, Sandra Mariely Estrada Gonzalez, Vanessa Dominguez, Laura M. Acosta, Roméo Guerra, Carmen Pulido, Olga Caicedo, Arthur R Andrews

The Role of Discrimination and Vaccine Distrust in Vaccine Uptake Among Latines in the Midwest • 117

Science Forum

Michael R. Gallagher, Amanda C. Collins, E. Samuel Winer

Quantifying Devaluation of Positivity Via Self-Report Measures: A Review and Directions for Future Research • 130

Clinical Practice Forum

Samantha Busa, Jeremy Wernick, John Kellerman, Elizabeth Glaeser, Kyle McGregor, Julius Wu, Aron Janssen

A Descriptive Case Study of a Cognitive Behavioral Therapy Group Intervention Adaptation for Transgender Youth With Social Anxiety Disorder • 135

Kevin O. Narine, Cindy J. Chang, Erica J. Ho, Christine Francis, Lindsey S. Davis, Catherine Vuky

Call to Action: Mobilizing Clinical Psychology Programs to Support AAPI Trainees Through an Anti-Racism Framework • 142

► Plus:

Call for Nominations: Champions • 148

Call for Applications, Fellows • 149

Digital Drop-ins • 150

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p. 149

Call for Applications **Fellows Status**

ORIGINAL RESEARCH

The Role of Discrimination and Vaccine Distrust in Vaccine Uptake Among Latines in the Midwest

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Arthur R Andrews, University of Nebraska-Lincoln

THE COVID-19 PANDEMIC illuminated widespread health inequalities. Latines¹ in the United States (U.S.) have experienced greater SARS-CoV-2 infections (the virus that causes COVID-19) throughout the entirety of the pandemic and during each of the two largest waves (Centers for Disease Control and Prevention, 2020). This holds true in many local contexts, including where the present study was con-

¹While less common in the United States, we use the term “Latine” as the pan-ethnic term for individuals from Latin America or of Latin American descent. Its pronunciation is more familiar and its usage more common within other Spanish-speak-

[continued on p. 119]

the Behavior Therapist

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A MESSAGE AND REQUEST FROM THE World Confederation of Cognitive and Behavioral Therapies

The WCCBT is deeply concerned about the unwarranted attack and aggression on Ukraine and the psychological impact this is having on all the people affected. The Ukrainian Association of Cognitive and Behavioral Therapy is a member of the EABCT and the WCCBT. We suggest you take a moment to listen to Valentyna Parobiv, the president of the UACBT, to hear first-hand her message:
<https://www.youtube.com/watch?v=j7dFEcqAdo8>



The WCCBT is in the process of collecting digital and written resources that can help therapists dealing with clients in war-torn areas and refugees in addition to materials to help therapists avoid burn out and take active self-care precautions. It is the wish of the WCCBT that the invasion and conflict to end as soon as possible for the Ukraine to be made safe again.

Please send your materials to: mjeimer@abct.org

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ducted. In Nebraska, Latines made up at least 21% of COVID-19 cases and 19% of COVID-19 hospitalizations in the state of Nebraska while only comprising 11.4% of the population (Nebraska Department of Health and Human Services, 2022). With this backdrop, many writers and public opinion polling organizations raised alarm regarding disparately high vaccine hesitancy among Latine populations prior to and during vaccine rollout (Lopes, 2021; McFadden et al., 2021). However, vaccine uptake statistics suggest this hesitancy may have evolved or that such hesitancy did not translate to lower uptake. As of February 2022, 77.8% of Latine adults in the U.S. reported being fully vaccinated, which is equal to the rate of non-Latinx Whites and second highest among racial/ethnic groupings assessed by the Centers for Disease Control and Prevention (Centers for Disease Control and Prevention; 2022). While inequalities may be lower than initially anticipated, exposure and risk inequities among Latines make it imperative to understand predictors of vaccine uptake. The incongruence between initial hesitancy inequalities and uptake also highlight the importance of directly testing the factors that influence uptake. Moreover, given that much of the unequal risk stems from workplace conditions (Do & Frank, 2021), which themselves result from economic inequality and insecurity (Burgard & Lin, 2013), expanding vaccine uptake to mitigate that risk clearly fits under human rights frameworks. The current study was part of a community-university partnership to understand and expand vaccine uptake among Latines in the local area. To understand factors that may influence uptake, it builds from the Health Belief Model, which is largely derived from cognitive and behavioral theories.

The Health Belief Model and COVID-19 Vaccine Uptake

The Health Belief Model has foundations in cognitive and behavioral theories to explain health behaviors and healthcare

utilization in particular. Its current iteration consists of six domains: (1) perceived susceptibility, (2) perceived severity, (3) perceived benefits, (4) perceived barriers, (5) cue to action, and (6) self-efficacy (Conner & Norman, 2017; Hochbaum et al., 1952).

These categories stem from foundational behavioral concepts of reinforcement (e.g., seeking care functions as negative reinforcement by avoiding a perceived harm or alleviating a harm). In this way, perceived susceptibility and perceived severity function together as perceived consequences of not seeking care or, alternately, the consequences that may be avoided by seeking care (i.e., negative reinforcement). Perceived benefits may work in conjunction with perceived susceptibility and severity to operate as negative reinforcement (e.g., avoiding or ameliorating an illness only occurs if an individual perceives they can avoid it). More simply, perceived benefits may also operate as positive reinforcement (e.g., interventions or behaviors that are enjoyable). Some perceived barriers function as punishment (e.g., anticipating negative experiences in a healthcare setting) while others represent structural barriers to help-seeking behaviors (e.g., cost or language). The latter may then lead to lower self-efficacy in receiving care, much like learned helplessness frameworks. In the case of COVID-19 vaccines, the lack of perceived benefits (e.g., thinking COVID-19 vaccines are not effective in reducing risk) has received substantial attention (Karlsson et al., 2021). However, structural barriers, perceived severity, perceived susceptibility, and self-efficacy in accessing vaccines have less often been examined as simultaneous predictors of vaccine uptake. Following the Health Belief Model, each factor may be critical in understanding vaccine uptake among Latine populations. That is, prior lived experiences (i.e., learning histories) likely contribute to each factor of the Health Belief Model, which in turn means that factors such as structural racism, related xeno-

phobia, and experiences within healthcare contribute to components of the Health Belief Model. As one example, Latines on average experience greater barriers to healthcare in general (Doshi et al., 2022; Palmer-Wackerly et al., 2020) and may therefore seek subsequent care less often. They also experience discrimination at high rates, both within and outside of healthcare contexts (Findling et al., 2019). Relatedly, prior studies utilizing the Health Belief Model framework have conceptualized that cultural beliefs in Latines may alter the perceived benefits and perceived barriers when health behaviors do not cohere with cultural beliefs (Scarinci et al., 2012). The inclusion of Latine lay health leaders has also been incorporated to ensure congruence with cultural values and provide education that enhances perceived benefits while reducing perceived barriers (Austin et al., 2002).

Based on the Health Belief Model, interpersonal discrimination may reduce vaccine uptake and function as a vaccine barrier in two important ways. In both cases, discrimination may occur for a variety of reasons and based on intersectional frameworks, even racial/ethnic discrimination may be perpetrated based on multiple identities simultaneously (Viruell-Fuentes et al., 2012). Relatedly, immigration-related discrimination typically occurs in a racialized fashion (Minero & Espinoza, 2016). As applied to the Health Belief Model, experiencing frequent discrimination across settings may generalize to expecting discrimination to occur in other settings (Burgess et al., 2008). This hypothesis is fundamental to recent advances in concepts like discrimination-related traumatic stress (e.g., Williams et al., 2018). Relevant for COVID-19 vaccine outreach, those who have experienced discrimination in several domains may carry expectations of discrimination when seeking the vaccine. From a behavioral learning perspective, expectations of discrimination may be an underappreciated perceived barrier, as experiencing discrimination would clearly represent an anticipated social stressor while seeking care. In this way, experiences of discrimination would act as a punishment that drives the avoidance of seeking care to avoid the negative experience. Experiencing discrimination may also reduce perceived benefits of a given treatment, including COVID-19 vaccines, given that prior discrimination appears to reduce trust in medical professionals, which in turn appears to lower perceived quality of care (Born et al., 2009; Glover et

[Footnote 1 continued from p. 117]

ing regions or countries. As examples, see popular press writing by LATV (2021) or Del Real (2020). While we disagree with some of the notions by Del Real (Latinx does not originate in English, but Brazilian Portuguese), we have intentionally selected the word “Latine” as it originates within feminist and LGBTQIA+ communities in Spanish-speaking countries. We also recognize that all pan-ethnic terms are problematic as they may lead to overgeneralizations and the flattening of identities. We, however, use pan-ethnic terminology because it is the best description of the unifying factor for those served by our community partner and much of the national data surrounding COVID-19 is framed in pan-ethnic terminology.

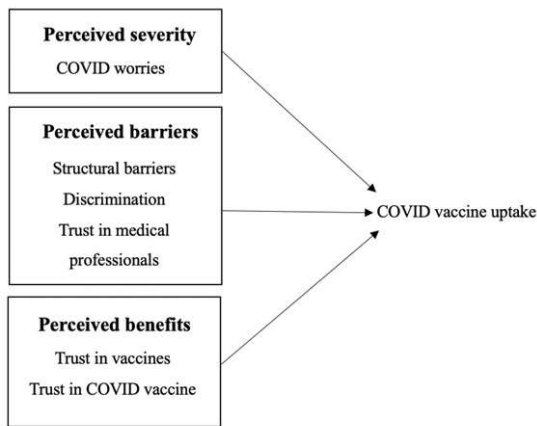


Figure 1. Study variables mapped into the Health Belief Model domains

al., 2017; Hong et al., 2018; Sutton et al., 2021). Together, prior experiences of discrimination may be associated with lower trust in medical professionals, which may in turn be associated with lower trust in COVID-19 vaccines, which then results in lower uptake. Despite previous studies examining discrimination in the context of mistrust in medical professionals for this population (Calo et al., 2015; Galvan et al., 2017; López-Cevallos et al., 2014; Oakley et al., 2018), the type of discrimination assessed is within the healthcare setting without inclusion of interpersonal discrimination in different contexts. Specifically, previous studies have found a strong association between medical mistrust and discrimination in healthcare settings for African Americans and Latines in the U.S. (Bazargan et al., 2021).

Finally, factors related to perceived susceptibility and perceived severity may also be critical in understanding COVID-19 vaccine uptake. Even prior to vaccine rollout, Latine populations on average experienced unequal exposure (Macias et al., 2020). Further, prior to widespread availability of COVID-19 vaccines, Latine populations experienced higher rates of hospitalization and death even after accounting for the higher rates of exposure (Macias et al.). However, few studies have directly tested the effects of worries related to exposure (susceptibility), one's own risk of hospitalization or death (severity), and the risk of passing along an infection that would result in a severe consequence for a loved one (severity).

Purpose and Hypotheses

The present study seeks to test predictors of COVID-19 vaccine uptake in

Latines based on the Health Belief Model. Figure 1 exemplifies how each of the proposed predictors are conceptualized. Following this model, we propose the following hypotheses:

Hypothesis 1: Discrimination will be negatively associated with trust in medical providers, such that those reporting higher levels of experiences of discrimination will be associated with lower trust in medical providers.

Hypothesis 2: Trust in medical providers will subsequently be associated with the probability of trusting COVID-19 vaccines, such that lower trust in medical providers will be associated with lower likelihood of trusting the COVID-19 vaccine.

Hypothesis 3: Greater trust in medical providers and trust in COVID-19 vaccines will cross-sectionally and prospectively be associated with greater likelihood of vaccine uptake.

Hypothesis 4: Perceived structural barriers, including cost, insurance, language, and travel, will be negatively associated with the likelihood of vaccine uptake.

Hypothesis 5: COVID-19-related worries will be associated with a higher likelihood of vaccine uptake.

Methods

Sample Description

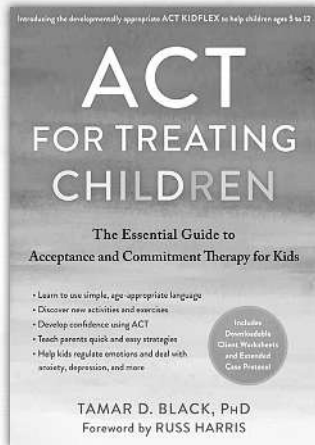
Participants were 137 adult Latine residents of Nebraska. The majority were cisgender women ($n = 106$, 77.4%). No participants reported identifying as transgender or other gender-diverse identity. The average age was 42.32 years ($SD = 14.23$, range = 19–82). The majority of participants completed the interview in Spanish at baseline ($n = 114$, 83.2%) and follow-up ($n = 52$, 38%), and were born outside the U.S. ($n = 116$, 84.7%). Of those born outside the U.S., the majority were born in Mexico ($n = 65$, 47.4%), other countries of origin included Guatemala ($n = 12$, 8.8%), Cuba ($n = 8$, 5.8%), Honduras ($n = 8$, 5.8%), Colombia ($n = 5$, 3.6%), Peru ($n = 4$, 2.9%), Venezuela ($n = 4$, 2.9%), El Salvador ($n = 4$, 2.9%), and Puerto Rico ($n = 2$, 1.5%). One participant each was born in Argentina, Ecuador, and Nicaragua. The average time in the US were 16.16 years ($SD = 9.11$, range = <1–40).

Procedures and Sampling Strategy

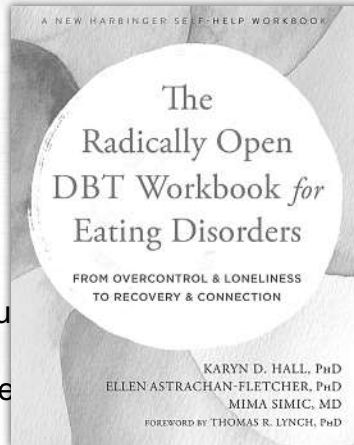
Participants were recruited via bilingual flyers and referral from local community centers, public health agencies, medical clinics, cultural organizations, faith organizations, and educational systems in rural, urban, and exurban areas of Nebraska. To do this, researchers from the University of Nebraska-Lincoln partnered with El Centro de las Américas (El Centro), a local Latine advocacy and social service organization. El Centro assisted with advertising and recruitment within the local area near the University as part of a larger community-based effort to enhance vaccination uptake. El Centro staff advertised the study to eligible clients (i.e., adults) and provided interested participants with contact information of the University team. University researchers and El Centro conducted outreach to other community organizations, though only University researchers conducted outreach beyond the communities near the University. During recruitment, it was emphasized to El Centro, other community partners and potential participants that participants did not need to be interested in receiving a vaccine and did not need to have direct exposure to COVID-19 in order to be eligible. Inclusion criteria included identifying as Latine or with heritage or emigration from a Latin American country, age of 19 years or older (age of majority in Nebraska), and currently residing in Nebraska. There were no additional exclusion criteria.

Regardless of outreach method, prior to participation, participants first contacted the University team by phone. Trained bilingual research assistants then conducted screening for eligibility and obtained verbal informed consent. Participants were reassured that all responses would remain confidential and the information from their responses would only be used in aggregate form. All study procedures were approved by the Institutional Review Board of the University of Nebraska-Lincoln prior to beginning data collection. Following informed consent, participants were able to either immediately complete the interview or schedule it for a later date and time of their choosing. The structured interview was completed, on average, in one and a half hours. Participants completed a baseline interview and a 3-month follow-up, and for both they were offered to complete the interview in Spanish or English. Recruitment occurred after vaccines had already been approved and had begun to be administered; however, 72

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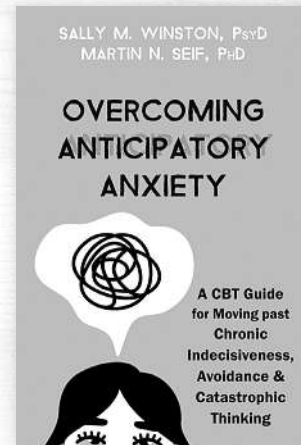


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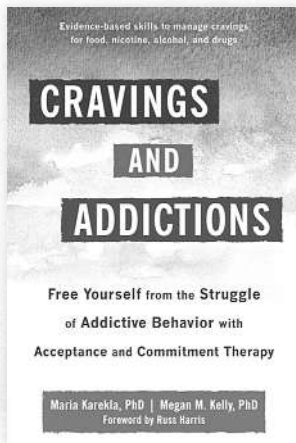


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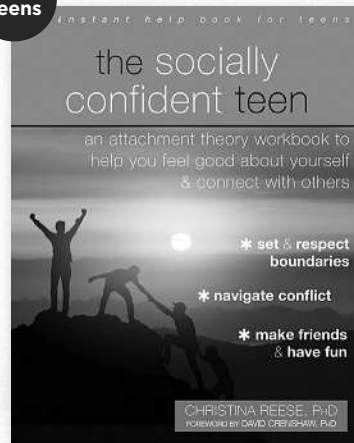


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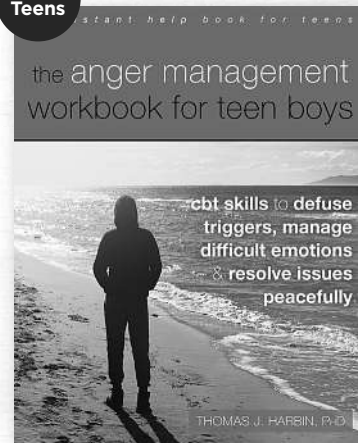
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(52.6%) participants completed the first wave of the interviews prior to open administration to all adults throughout the state, which did not occur until April 15, 2021. For the second wave, only 8 (13.8%) participants completed the interviews prior to open administration.

Members of the research team conducted the interview via phone and entered the data on the online platform Qualtrics. Participants completed self-report questionnaires regarding COVID-19 exposure, vaccine trust, COVID-19 vaccine trust, vaccine uptake, vaccine barriers, covid worries and exposure, everyday discrimination, trust in medical providers, and

demographics. Participants were informed that they may skip over any item or discontinue the interview at any time. Interviews were repeated at 3-month intervals and the current analyses included data from the first and second waves of data. Participants received \$30 in gift cards for the first wave of data collection and \$20 for subsequent waves. Slightly less than half of participants ($n = 58$, 42.34%) completed follow-up interviews 3 months after completing the initial interview. For re-recruitment, participants were called 1 week prior to their scheduled follow-up time. Participants were called up to three times after this if they did not respond.

Measures and Instruments at Baseline and Follow-up

• COVID-19 Vaccine Trust, Barriers, and Uptake

The interview utilized the COVID-19 Phenx toolkits (PhenX Toolkit: Covid19, n.d.). These assessed multiple dimensions of COVID-19 vaccine distrust, perceived barriers to access the vaccine, and vaccine registration/uptake. Vaccine barriers were assessed by asking participants whether specific barriers would prevent them from receiving the vaccine (yes/no). These included: lack of trust in vaccines overall, lack of trust in COVID-19 vaccines, and several perceived structural barriers (per-

Table 1. Demographics and Descriptive Information

			Follow-up (<i>n</i> = 58)			
			Vaccinated or registered		Vaccinated or registered	
			<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
Baseline (<i>n</i> = 137) Total			<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>n</i> (%)			<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Gender						
Cisgender women	106 (77.4)		62 (53)	29 (24.8)	35 (61.4)	13 (22.8)
Cisgender men	32 (22.6)		20 (17.1)	6 (5.1)	7 (12.3)	2 (3.5)
Born outside the U.S.						
Mexico	116 (84.7)		73 (71.6)	29 (28.3)	39 (68.4)	13 (22.8)
Caribbean	65 (47.4)		45 (44.7)	15 (14.9)	24 (40.1)	6 (10.5)
Central America	10 (7.3)		3 (2.9)	3 (2.9)	3 (5.3)	1 (1.8)
South America	25 (18.2)		16 (15.9)	7 (6.9)	7 (12.3)	5 (8.8)
	15 (10.9)		9 (8.9)	3 (2.9)	5 (8.8)	0
Education						
Less than high school	36 (26.3)		27 (23.1)	6 (5.1)	14 (24.6)	4 (7)
Completed high school	46 (33.6)		28 (24)	13 (11.1)	14 (24.6)	3 (5.3)
Some college or higher	50 (36.5)		26 (19.0)	15 (10.9)	14 (24.6)	7 (12.3)
General vaccine distrust (yes)	20 (16.1)		4 (5.7)	11 (31.4)	1 (2.6)	6 (40.0)
COVID-19 vaccine distrust (yes)	35 (28.2)		9 (12.9)	20 (57.1)	2 (5.3)	8 (53.3)
Structural Barriers (yes)	49 (39.5)		20 (28.6)	21 (60.0)	3 (7.9)	6 (40.0)
	<i>M(SD)</i>	<i>Min-Max</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Age	42.3 (14.2)	19-82	44.3 (14.5)	40 (15.2)	45.1 (11.1)	44.1 (15.1)
Years in the U.S.	16.2 (9.1)	<1-40	17.2 (9.1)	14.9 (7.7)	17.9 (9.2)	18.9 (8.7)
Household income (in USD) ¹	38 (35)	2 -140	36 (24)	20 (21)	27 (24)	18 (4)
Everyday Discrimination	5.26 (4.88)	0-20	5.19 (5.06)	5 (4.32)	10.7 (17.93)	3.7 (3.88)
Trust in Medical Professionals	12.09 (2.98)	4-20	12.33 (3.17)	11.46 (2.73)	12.3 (3.5)	10.9 (2.5)
COVID-19 worries	38.15 (9.21)	16-58	38.67 (9.38)	37.35 (8.16)	39.1 (9.3)	35.2 (10.3)

Note. Due to missing data, some percentages may not total to 100 and may not be equal across variables.

¹United States Dollars, values approximated to the nearest thousand.

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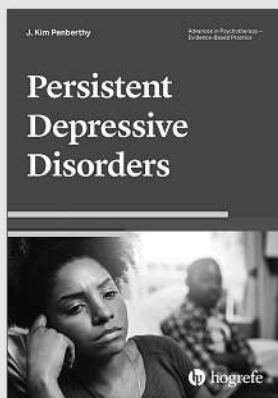
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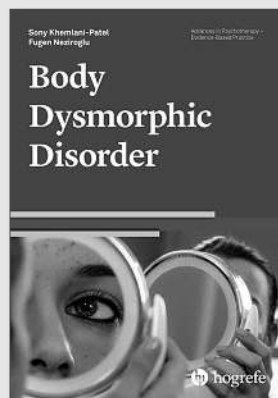
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ceived cost, insurance status, fears related to immigration status, language, and not having a place to receive them), for a total of 7 items. Additional items asked participants to identify whether they had been vaccinated (yes/no), whether they were registered to receive the vaccine (yes/no), and if they had not done either, whether they planned on receiving the vaccine (yes/no). Existing translation of this measure was forward and back translated in teams of three fully bilingual translators. The forward translator's first language was Spanish, the back translator's first language was also Spanish but was educated exclusively in English-language schools. The third translator helped resolve disagreements, has English as a first language, and a bachelor's in Spanish with extensive experience in translating psychosocial measures.

• COVID-19-Related Worries

Interviews also employed standardized measures of COVID-19-related distress (COVID Stress Scales; S. Taylor et al., 2020). The COVID Stress Scales contains 12 items regarding how the severity of worries regarding COVID-19 and SARS-CoV-2, the virus that causes it. In each case, it refers to these as "the coronavirus." Response items range from 1 ("strongly disagree") to 5 ("strongly agree"). Across each measure, symptoms are summed to

form an overall severity score. Existing translations were used for the COVID Stress Scale, the same translation procedure described above was implemented for this measure.

• Trust in Medical Providers

The Abbreviated Wake Forest Physician Trust Scale (A-WFPTS) was used to assess trust in medical providers. This 5-item scale has scores ranging from 1 ("strongly disagree") to 5 ("strongly agree"). This measure has demonstrated good internal consistency and structural validity (Dugan et al., 2005) when compared to other longer versions of measures assessing trust in medical providers (Müller et al., 2014). An existing Spanish version was used from a study in a Spanish-speaking population with the longer version of the scale (Vissman et al., 2013).

• Discrimination

The interview included the Everyday Discrimination Scale (Williams et al., 1997). This scale measures the frequency of common forms of mistreatment that occur more frequently to Black and Latine individuals. It assesses five types of mistreatment, ranging from 0 ("never") to 4 ("almost every day"). This measure includes items asking participants to identify why the discrimination occurred (e.g., race/ethnicity). We included all instances

of discrimination and not those ascribed to specific categories because using an intersectional approach, other forms of discrimination cannot be decoupled from race/ethnicity. Similarly, from the perspective of the Health Belief Model, the identity related to the experience of discrimination may be less relevant than the experience of unfair treatment. This is also a common scoring method used in other health behavior research (Bastos & Harnois, 2020; Kim et al., 2014). An existing Spanish language translation of the Everyday Discrimination Scale was used for the current study (Pérez et al., 2008; Stucky et al., 2011; R. Taylor et al., 2019).

Demographics

Several demographic variables were assessed, including age, gender/gender identity, country of birth, income, and education.

Data Analytic Strategy

First, all descriptive characteristics of all variables were examined to establish frequencies of barriers to vaccination, vaccine uptake, COVID exposure and worries, trust in medical providers, and discrimination in everyday life. Descriptive characteristics were examined within the overall sample and broken out by age, gender/gender identity, education, and U.S. nativity.

Table 2. Results from Generalized Linear Models

Predictor	Dependent Variables			
	Trust in Medical Providers	COVID-19 Vaccine Trust (Y/N)	Vaccine uptake ¹ baseline	Vaccine uptake ¹ Follow-up
	β (SE)	aOR (95% CI)	aOR (95% CI)	aOR (95% CI)
Age	-.06 (.09)	1.00 (0.96-1.05)	1.05 (1.01-1.09)*	1.05 (0.97-1.13)
Gender	.03 (.08)	0.60 (0.19-1.91)	0.41 (0.11-1.59)	0.41 (0.04-4.31)
April 15	.09 (.08)	1.25 (0.45-3.49)	0.85 (0.29-2.46)	2.30 (0.40-13.27)
Discrimination	.29 (.08)**	1.06 (0.95-1.19)	1.06 (0.93-1.20)	1.11 (0.92-1.34)
COVID-19 related worries	.09 (.08)	1.04 (0.98-1.10)	1.06 (0.99-1.13)	1.12 (0.99-1.26)
Trust in medical providers		0.92 (0.77-1.11)	1.16 (0.96-1.41)	1.00 (0.74-1.34)
General vaccine distrust (yes)		58.97 (11.58-300.38)**		
COVID-19 vaccine distrust (yes)			0.08 (0.02-0.25)**	0.12 (0.02-.70)*
Perceived structural barriers at baseline			0.26 (0.09-0.73)*	0.72 (0.12-4.34)
COVID-19 worries follow-up				0.98 (0.88-1.09)
Perceived structural barriers follow-up				0.11 (0.01-0.95)*

Note. * $p < .05$, ** $p < .01$; ¹Uptake was defined as having received one of the COVID-19 vaccines or having registered to receive one.

²Open registration for COVID-19 vaccines did not occur locally until April 15.

Four generalized linear models (GLMs) were examined to test study hypotheses. First, three separate models examined predictors of trust in medical providers, vaccine distrust, and vaccine uptake at baseline. All models examined discrimination and COVID-19-related worries as predictors. Trust in vaccines in general and trust in medical providers were also added to the model predicting vaccine distrust. Of the 35 participants who reported distrust in the COVID-19 vaccines, 18 (51.4%) reported distrusting vaccines in general. Because of this substantial overlap that appeared to result in multicollinearity, only distrust in the COVID-19 vaccines was examined as a predictor in subsequent models. Vaccine distrust was then added to all of the aforementioned predictors with vaccine uptake at baseline as the outcome. Combined, these models tested hypotheses based on the Health Belief Model as vaccines had only started becoming available (January–April, 2021). Because the rollout of the COVID-19 vaccine was dependent on age and previous studies evidencing gender differences in vaccine hesitancy (Zintel et

al., 2022), age and gender were also used as covariates. Because vaccines were not readily available when many participants entered the study, participation date (prior to the date of full public release in the local area: yes/no) was used as a control covariate. For the fourth model, vaccine uptake at the 3-month follow-up was examined as the dependent variable. COVID-19 worries at follow-up, COVID-19 exposure at follow-up, and structural barriers to the vaccine at follow-up were added as predictors. This final model examined prospective and cross-sectional predictors of vaccine uptake once vaccines were widely available (April–July 2021). Table 2 outlines the predictors for each variable and their results.

Missing data were estimated using Full Information Maximum Likelihood, which has previously been shown to reduce biases relative to other missing data approaches (Enders & Bandalos, 2001). Within-wave, no variable had more than 10% missing data among participants who completed that wave. However, there was significant attrition with 79 participants (57.7%) com-

pleting baseline but not follow-up interviews. No demographic variables nor any other study variables were associated with attrition (p -values $> .05$). All GLMs were completed using robust maximum likelihood estimation. Additionally, data did not appear to evidence univariate or multivariate nonnormality.

Results

Vaccine Trust, Uptake, and Barriers

At baseline, 53 participants (45.3%, of those who responded) reported having received the COVID-19 vaccine and 37 (52.1%, of those who responded) had registered to receive it, meaning a majority had already taken steps to receive the vaccine ($n = 82$, 70.1%, of those who responded). At follow-up, approximately two-thirds reported having already received the vaccine ($n = 37$; 66.1%, of those who responded). Of the 19 who stated that they had not, 6 (31.6%) had registered to receive it. Thus, only 13 participants (22.8% of those who responded) reported

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not having received the vaccine and not having registered to receive it.

When asked about what would prevent them from receiving the vaccine, 35 (25.5%, of those who responded) reported not trusting the COVID-19 vaccine at baseline and 10 (18.9%, of those who responded) at follow-up. Structural barriers to vaccination were also identified by respondents, 25 (20.3%, of those who responded) at baseline and 6 (11.3%, of those who responded) at follow-up perceived cost as a barrier, 37 (30.1%, of those who responded) at baseline and 5 (9.4%, of those who responded) for follow-up reporting lack of insurance or not having insurance. Fears related to immigration status for them or someone they know was reported by 1 (4.3%, of those who responded) participant at baseline, but none at follow-up. Not having a place to go for vaccines was also identified by 28 (22.6%, of those who responded) at baseline and only by 5 (9.4%, of those who responded) at follow-up. Last, 16 (13.2% of those who responded) at baseline indicated language as a perceived barrier, with 2 (3.8%, of those who responded) at follow-up. Overall, participants identified less barriers at follow-up than baseline, with 49 (39.5%, of those who responded) at baseline reporting one or more structural perceived barriers while at follow-up only 9 (17%, of those who responded) did. COVID-19 exposure was also examined, considered as either testing positive for COVID-19 for having a loved one hospitalized or passed away due to the virus. Similar percentages of exposure were observed for both baseline ($n = 74$, 54%) and follow-up ($n = 30$, 52.6%).

Predictors of Trust in Medical Providers

Only discrimination predicted trust in medical providers ($\beta = .291$, $b = .18$, $SE = .05$, $p = .001$). Discrimination was negatively associated with trust such that greater experiences of discrimination were associated with lower trust, as expected (Hypothesis 1). Gender, age, COVID-19 worries, COVID-19 exposure, and date of participation were not significantly associated with trust in medical providers (p -values $> .05$).

Predictors of COVID-19 Vaccine Distrust

The only study variable that was significantly associated with COVID-19 vaccine distrust at baseline was distrust of vaccines in general ($aOR = 58.97$, $b = 4.08$, $SE = .83$, $p < .001$), such that greater distrust in vac-

cines in general was positively associated with greater distrust in COVID-19 vaccines. Discrimination, trust in medical providers, COVID-19 worries, and COVID-19 exposure were not significantly associated with distrust of the COVID-19 vaccine (p -values $> .05$).

Predictors of Vaccine Uptake During Initial Rollout (at Baseline)

At baseline, distrust in the COVID-19 vaccines ($aOR = .08$, $b = -2.59$, $SE = .61$, $p < .001$), perceived structural barriers ($aOR = .26$, $b = -1.35$, $SE = .53$, $p = .011$), and age ($aOR = 1.05$, $b = .05$, $SE = .02$, $p = .018$) were all associated with vaccine uptake (Hypotheses 3 and 4). Distrust and perceived structural barriers were negatively associated with vaccine uptake such that those who reported not trusting the vaccine and those who reported structural barriers were less likely to receive it or have registered to receive it. Nine of those who reported not trusting the vaccine had received it or registered to receive it, whereas 61 of those who did not report distrust had received the vaccine or registered to receive it. Of those reporting structural barriers, 20 had received the vaccine or registered compared with 50 who did not report structural barriers. No other study variable was significantly associated with vaccine uptake (p -values $> .05$).

Predictors of Vaccine Uptake Once Widely Available (at Follow-up)

At follow-up, only age was no longer a significant predictor of vaccine uptake (p -values $> .05$). Those reporting vaccine distrust (Hypothesis 3) remained less likely to have received the vaccine or have registered ($aOR = 0.12$, $b = -2.14$, $SE = .91$, $p = .018$). Additionally, perceiving structural barriers at follow-up was associated with lower vaccine uptake ($aOR = 0.11$, $b = -2.22$, $SE = 1.10$, $p = .044$), as expected (Hypothesis 4).

Discussion

We sought to understand relevant predictors of COVID-19 vaccine uptake utilizing the Health Belief Model as a framework. Results only partially supported our hypotheses. Higher experiences of discrimination were associated with lower trust in medical providers (Hypothesis 1); however, when considered alongside other factors, trust in medical providers was not associated with trust in COVID-19 vaccines or vaccine uptake (Hypotheses 2 and 3). In fact, the only factor associated with

trust in the COVID-19 vaccine was trust in vaccines in general. Even after removing this factor from the model, none of the other hypothesized variables were associated with vaccine trust. Hypothesis 3 did receive partial support as trust in COVID-19 vaccines did predict vaccine uptake at baseline and at follow-up. Hypothesis 4 was fully supported as structural barriers (cost, insurance, language, and travel) were also associated with lower likelihood of vaccine uptake at baseline and follow up. Contrary to our expectations, COVID-19 related worries were not associated with a greater likelihood of vaccine uptake (Hypothesis 5). Together, these results point to the importance of better understanding overall vaccine distrust and resolving even the perception of structural barriers as these were the only two factors that were consistently associated with vaccine uptake.

Our results highlight that attention to distrust in the COVID-19 vaccine is warranted, but that structural barriers must also be addressed. While not the focus of this article, perceived structural barriers were less often reported at follow-up compared with baseline (see Table 2). While barriers remained a significant predictor of vaccine uptake, the reduction in the perceptions of barriers and reduction of barriers themselves may have resulted in increased uptake. This is especially relevant, given that some of the perceived barriers, such as cost, were inaccurate. Said differently, the effect of perceived structural barriers remained the same, but a variety of interventions may have effectively reduced the presence of perceived structural barriers. This may be attributable to the various community intervention strategies to provide education about vaccine access and outreach efforts to take vaccines to where Latine community members reside. As one example, our community partner, El Centro, held multiple vaccine clinics at local churches and in workplaces. Anecdotally, we attribute part of that success to the combination of our baseline data with El Centro's on the ground expertise, which they then used to advocate more effectively with organizations that provided vaccines. These partnerships also allowed El Centro to reassure clients that the vaccine would be free, no or minimal travel would be required, that a trusted organization would be present, and that someone would be available to answer questions in Spanish.

Similarly, our results indicated that for Latines in Nebraska, overall vaccine dis-

trust was the largest correlate of COVID-19 vaccine distrust, which subsequently had significant associations with lower vaccine uptake. As such, education regarding vaccines in general is needed not only for current difficulties related to the COVID-19 pandemic, but generally for all vaccines. Similar to structural barriers, there did appear to be a reduction in vaccine distrust from baseline to follow up. This may also reflect the efficacy of expansive and urgent community intervention efforts to provide education surrounding the COVID-19 vaccine. This effect may also be greater in our sample given that El Centro assisted with recruitment and was simultaneously conducting extensive outreach.

Finally, while discrimination was not associated with vaccine uptake, our results still point to its importance in medical services overall. That is, everyday discrimination that is not specific to medical settings was associated with lower trust in medical providers. The effect of discrimination on mistrust in medical providers is likely compounded with the historical mistreatment of minorities in healthcare systems and research (Public Broadcasting Service, n.d.; Spector-Bagdady & Lombardo, 2019; Stern et al., 2017), as well as recent violence against immigrants, racist policies, and hateful rhetoric during and after the 2016 U.S. election (Huber, 2016). This serves as a reminder that working toward equitable healthcare access may necessarily entail working to eliminate discrimination in other domains, as it is the responsibility of the healthcare systems and its providers to mitigate mistrust (Jaiswal, 2019). This result has been replicated across multiple contexts including mental health (Born et al., 2009; Glover et al., 2017; Hong et al., 2018; Sutton et al., 2021).

Limitations and Future Directions

While the results hold insights for improving COVID-19 vaccination uptake among Latinas and understanding why many vaccination efforts were successful, there are significant limitations. First, our sample size is relatively small, evidenced high attrition, was geographically restricted, and had an overrepresentation of immigrant Latinas. These results may therefore not generalize to other Latine populations, such as non-immigrants. Our data was also collected via phone interviews, which may result in additional biases. Although attrition was not related to any study variables or demographics at baseline, attrition may have still altered the results at follow-up as it is still possible that

attrition was related to important unmeasured variables (e.g., documentation status). Additionally, our efforts were combined with substantial community outreach by our partners and follow-up results may have been influenced by that outreach.

Conclusion

While the current study provided only limited support for the Health Belief Model as applied to COVID-19 vaccine uptake among Latinas, results still offer important insights into vaccine uptake and service utilization overall. Our results point to the necessity of reducing structural barriers to care. This includes even perceived barriers, given that many of the perceived barriers were not fully accurate (i.e., vaccinations were free, but cost was a perceived barrier), and were possibly corrected by education provided by community partners. Cognitive behavioral therapists and scientists have a role in further elucidating the importance of learning histories in these contexts, by using their unique skill set and theoretical approaches in the understanding of how to expand health seeking and health care access. Specifically, this knowledge needs to be translated to application by connecting with community organizations and other institutions to guide meaningful actions based on cognitive behavioral perspectives. Our results and those of the field more broadly point to the importance of reducing structural barriers and supporting meaningful community outreach. This is particularly relevant in the context of the disproportionate effects the COVID-19 pandemic has had in the Latine community, adding to already existing inequalities. Mitigating the risk by increasing vaccine uptake is a pivotal necessity for the well-being of the Latine community.

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Quantifying Devaluation of Positivity Via Self-Report Measures: A Review and Directions for Future Research

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DEPRESSION is a heterogeneous construct with at least over 1,000 different symptom profiles (Fried & Nesse, 2015). Many clinical treatments have focused on downregulating the negative valence system, including reducing negative affect and cognitions. However, recent research has emphasized the role of the positive valence system in the development and maintenance of depressive symptoms. For example, meta-analytic findings from Winer and Salem (2016) suggest that individuals with depression exhibited an avoidance of positive stimuli, in comparison to neutral stimuli and in comparison to other clinical groups, on the dot-probe task. These findings may be explained by Reward Devaluation Theory (RDT; Winer & Salem, 2016), which posits that depressed individuals demonstrate an active avoidance of prospectively rewarding information. Repeated pairings of positive information with negative outcomes may result in individuals associating positivity with prospective danger. This coactivation of positive information with negative outcomes can result in a devaluation of positivity and avoidance of prospective positive information.

Studies have sought to operationalize the biases outlined in RDT through a variety of behavioral tasks examining different stages of processing. For example, Bartoszke and Winer (2015) examined the approach-avoidance mechanisms of RDT through the Approach-Avoidance Task. Participants were presented with valenced images on the screen and instructed to pull or push a joystick toward or away from themselves, which would respectively make the image bigger (i.e., participant is approaching image) or smaller (i.e., participant is moving away from image), depending on the color of the frame around the image. This task captured implicit approach and avoidance motivation given that participants were instructed to ignore the actual image. Findings sug-

gest that depressed individuals pulled the joystick for a shorter duration for positive images than neutral images, as well as in comparison to controls, suggesting that depressed individuals may freeze briefly in response to positivity or have difficulties sustaining motivation to approach positive information in a specifically meaningful manner.

Avoidance of positivity may also contribute to the development of individual depressive symptoms, specifically anhedonia. For example, due to past experiences in which seemingly positive situations (e.g., spending time with friends) are coupled with negative outcomes (e.g., consistently being made fun of or excluded by those friends), one may learn to fear and preemptively avoid positive situations. Thus, one may be conditioned to anticipate or experience negative emotions (e.g., sadness) whenever certain prospective positive situations are introduced. This may result in one avoiding positive situations (e.g., spending time with friends) to decrease the prospective negative emotions that may occur. As a result, the avoidance behaviors are negatively reinforced as they decrease one's experience of negative emotions in response to prospective positivity. Over time, the avoidance of positivity may lead to one experiencing a lack of positive affect in their lives and a decrease or devaluation of previously enjoyable activities (see Bryant et al., 2017; Winer et al., 2017).

Affective neuroscientific research has previously investigated the role of anhedonia and deficits in positive affect through the lens of underlying neurobiological systems. Recent reviews have emphasized the distinct roles of reward motivation and reward learning in the development and maintenance of anhedonia and depression (Rømer Thomsen et al., 2015; Winer et al., 2019). Deficits in reward motivation represent a reduced ability to seek out or want reward. In other words, individuals with decreased reward motivation may not seek

out positive experiences because they are evaluated as unimportant, thus contributing to the development of anhedonia. Deficits in reward learning, however, represent a learned association that rewards (i.e., positive experiences) have been associated with negativity (e.g., threat, disappointment), thus resulting in a devaluation or avoidance of reward. Moreover, deficits in reward learning may also represent an inability to learn from and develop a response bias to reward, as measured by the probabilistic reward task (Pizzagalli et al., 2005, 2008). Parsing apart motivation and learning, the former represents a passive decrease in wanting to experience positivity and the latter represents an active devaluation or avoidance of positivity, in line with RDT (see Bryant et al., 2017). For example, neuroimaging findings suggest that blunted responses in the striatum and midbrain may be associated with deficits in reward learning and anhedonia (Gradin et al., 2011; Kumar et al., 2008). Thus, future research examining the neurobiological underpinnings of reward learning may continue to provide important information as to how depressed individuals come to devalue reward.

Self-Report Measures Quantifying Devaluation of Positivity

Along with the behavioral and neuroscientific evidence noted above, self-report measures contribute to the overall understanding of avoidant behavior associated with positive stimuli. Self-report measures also allow for quick acquisition of data, and thus may be used in research settings wherein behavioral or neurobiological measures are not indicated or feasible.

Self-report measures have long been used as one of the metrics to track treatment progress and outcomes in clinical settings (Uher et al., 2012) via changes in depressive symptomatology with measures such as the Patient Health Questionnaire and Quick Inventory of Depressive Symptomatology Self-Report (Löwe et al., 2004; Rush et al., 2005). Tracking positive and negative affect using the Positive and Negative Affect Scale (PANAS; Watson et al., 1988) is also potentially useful, especially when examining the impact of personalized treatments attempting to act on anhedonic symptomatology. Positive affect treatments demonstrate increases in positive affect and decreases in negative affect from pre- to post-intervention (Craske et al., 2019; Dunn et al., 2019; Taylor et al., 2017).

Thus, the PANAS appears to demonstrate clinical relevance and can capture changes in the experience of positive affect as a result of the given treatment over time. However, the PANAS was not designed to determine what person-based, motivational, or behavioral elements might contribute to one's affective state, and may thus not be suitable for measuring avoidance of positivity. As evidence continues to accumulate suggesting that avoidance of positivity may be a specifically relevant clinical target even when accounting for mere self-reported positive affect, self-report measures that have been developed to measure avoidant positivity biases may also become integral to tracking mechanisms that underly treatment progress. For example, an individual seeking treatment for depression may experience an overall reduction in symptomology and severity of negative affect and a mild-to-moderate uptick in the experience of positive affect, but continue to avoid and fear positive and rewarding situations, thus limiting treatment gains or contributing to future relapse. Therefore, self-report measures that specifically address aversion to positivity might have particular clinical utility for those individuals for whom devaluing reward is crucial to their self-understanding.

Fear of Happiness Scales

Some individuals have learned to fear happiness (Gilbert et al., 2012), potentially due to past pairings of positive experiences with negative outcomes (Winer & Salem, 2016). For example, a person may have become excited and felt happy about first dates in the past; however, if they have experienced repeated negative outcomes, such as being stood up or having a bad date, they may learn to associate first dates with rejection and despair. This may result in the person fearing the positive anticipatory emotions that have previously been associated with potential first dates as they expect to be stood up or have a bad date, and the experience of negative affect in response to the prospectively rewarding date. This fear of positivity and particularly charged experience of negative affect may result in the individual entirely avoiding first dates. In line with this explanation, it is important to note that individuals who fear happiness do not necessarily have difficulties processing positive emotions, as seen in individuals with alexithymia (Gilbert et al., 2012), but they instead experience negative affect in response to positivity and may

eventually avoid positive situations to decrease their negative affect or ambivalence.

Two self-report measures currently exist to measure fear of happiness. The first is the Fear of Happiness Scale (FHS) by Gilbert et al. (2012). The FHS is a 9-item self-report measure that assesses feelings about happiness and positive emotions. The 9 items represent statements made during therapy by clients. Examples of statements include "I am frightened to let myself become too happy." Items are scored on a 5-point Likert scale with scores ranging from 0 (*Not at all*) to 4 (*Extremely like me*). Items in the FHS largely represent anticipatory fears or avoidance of happiness. Specifically, they denote statements that happiness-averse individuals may make in response to prospective positivity. Using the example above, a person who has learned that first dates will result in negative or disappointing outcomes may say "I am frightened to let myself become happy" when they have a prospective first date.

In the initial development paper of the FHS, the authors utilized a nonclinical sample (Gilbert et al., 2012), and FHS scores were negatively correlated with types of positive affect (e.g., safe, relaxed, and active) and positively correlated with self-criticism and symptoms of psychopathology (e.g., depression, anxiety, and stress). In a subsequent depressed sample (Gilbert et al., 2014), individuals with clinical levels of depressive symptoms endorsed higher scores of FHS ($M = 23.96$, $SD = 9.09$) compared to a nonclinical sample ($M = 11.63$, $SD = 8.31$). Further work has investigated the relationship between fear of happiness and depressive symptoms, using the current FHS, and has demonstrated a positive relationship between the two constructs (Barkus, 2021; Collins et al., 2021; Jordan et al., 2021), consistent with findings of Gilbert et al. (2014).

The second self-report measure is the Fear of Happiness Scale (FHS) by Joshanloo (2013). The FHS is a 5-item self-report measure that assesses the beliefs that happiness is a sign of negative outcomes. Examples of statements include "Disasters often follow good fortune." Items are scored on a 7-point Likert scale ranging from 1 (*Strongly disagree*) to 7 (*Strongly agree*). This version of the FHS shares similarities with the FHS by Gilbert et al. (2012); however, the statements in the FHS by Joshanloo place more emphasis on the negative outcomes, bad fortunes, and

unhappiness that one may experience as a result of increased happiness and joy.

Existing studies have largely examined the relationship between FHS and well-being and have suggested a negative relationship between the two constructs (Joshanloo, 2018). Research investigating negative affect, dampening (Joshanloo et al., 2014), and depressive symptoms (Bloore et al., 2020) suggests a positive relationship between fear of happiness and constructs representing psychopathology symptoms and negative affect. Thus, the extant literature provides evidence regarding the negative impact fearing happiness has on clinical outcomes.

One study has examined changes in fear of happiness in relation to an intervention. Lambert et al. (2019) examined the effect of a 14-week positive psychology intervention on well-being and beliefs about happiness. They found that, in the positive psychology intervention group, participants reported a decrease in fear of happiness scores from pre- to post-intervention ($d = 0.36$), and this decrease was maintained 3 months after the intervention. Moreover, they did not observe a change in scores in the control group. Thus, this study demonstrates that fear of happiness is a construct that may be targeted by positive psychology interventions. Given the clinical relevance of fear of happiness regarding its influence in reducing positive affect or avoiding pleasurable situations, further clinical research is needed to better inform the role fearing happiness plays as a mediating variable in treatment outcomes.

Negative Affect Interference

Negative affect interference (NAI) is a subscale of the Hedonic Deficit and Interference Scale (HDIS; Frewen et al., 2012) and assesses the experience of negative emotions in response to positivity. The HDIS is a 21-item self-report form assessing anhedonic behavior and its association with negative and low positive affect. Items are scored from 0 (*Not at all or never true*) to 10 (*Completely true or very frequent*). The NAI subscale specifically quantifies the degree to which individuals experience elevated negative emotionality in response to positive affect. Examples of items include "When positive events happen in your life, do you experience fear or panic?" Research has shown that some individuals, typically those who have experienced traumatic events, do not derive enjoyment from apparently pleasurable situations (Frewen et al.). Rather than feeling happiness or

enjoyment during previously pleasurable activities, some experience elevations in negative emotions (Frewen et al.). The emergence of negative emotions in response to positive, pleasurable experiences has recently been linked to depression and is in line with the tenets of RDT (DePierro et al., 2018).

Although similar in nature, NAI and FHS are both unique and integral concepts that contribute to the processing of positivity. FHS assesses anticipatory avoidance of situations that evoke positive emotions, whereas NAI assesses the frequency of negative affect in response to experienced positive affect. Therefore, although FHS and NAI are independent constructs, they contribute to the development and maintenance of one another in the cycle of positivity processing.

Given the relation between FHS and NAI, Jordan et al. (2021) examined both of these constructs in relation to depressive symptoms. Jordan et al. found that both NAI and FHS, as measured by Gilbert et al. (2012), independently predicted depressive symptomology, suggesting they are two separate constructs that uniquely contribute to the development of depression. Since NAI plays a unique role in understanding cognitive biases in depression, it is vital that a self-report measure exists that enables clinicians and researchers to operationalize such a bias. Within a clinical setting, the HDIS can be utilized to track and monitor anhedonic behaviors with the NAI subscale serving as a mechanism to specifically assess the direct experience of negative affect in response to positivity (Barkus, 2021).

Response to Positive Affect

Similar to the trend in the experimental psychopathology literature, many self-report measures were initially developed to assess response styles to negative information, including rumination. In response to this gap in the literature in which response styles to negative information were the main focus, Feldman et al. (2008) created a measure complementary to existing rumination scales to assess responses to positive affect: the Response to Positive Affect questionnaire (RPA; Feldman et al.). The RPA is a 17-item self-report measure, containing statements that ask participants to indicate how often they engage in certain responses to positive emotions from 1 (Almost never) to 4 (Almost always). The RPA consists of three subscales: (1) emotion-focused, (2) self-focused rumination,

and (3) dampening. The subscale most theoretically relevant to RDT, the dampening subscale, involves reducing positive affect in the moment.

Whereas FHS largely assesses an anticipatory fear of positivity, the dampening subscale of the RPA is purely a responsive concept. It quantifies the extent to which an individual downplays or destroys their happiness with negative thoughts. Although FHS and dampening are different in their temporal proximity of positivity processing, they are inherently connected. An individual who devalues or avoids positivity will likely also seek to dampen positive emotions in the moment when they are unable to avoid experiencing positive affect. Therefore, the RPA provides valuable data when operationalizing the cognitive biases outlined in RDT.

Studies that have used the dampening subscale of the RPA generally examine it in relation to various prospective facets of depression: dampening is positively related to depressive symptoms (Feldman et al., 2008), is predictive of future depressive symptoms over time (Raes et al., 2012; Raes et al., 2014), and is positively related to other constructs assessing devaluation of positivity, including the Fear of Happiness Scale (Joshani et al., 2014). Therefore, the dampening subscale of the RPA is a useful tool to use with depression populations and may act as a valuable measure in tracking mechanisms involved in treatment outcomes.

Discussion

The positivity biases outlined in Reward Devaluation Theory (RDT; Winer & Salem, 2016) are avoidant and ambivalent in nature and have been examined experimentally to establish their ontological and discriminant value when conceptualizing depression and positive valence processing more generally. However, there are a number of relevant self-report measures that allow for the assessment of reward devaluation in a more accessible and translatable way. Herein we reviewed four self-report measures that may be used to examine thoughts and behaviors related to devaluation or avoidance of positivity. Although this does not represent an exhaustive review, these are the self-report measures that have been commonly used to assess facets of RDT or affective changes after positivity treatments, encompassing anticipatory and responsive positivity avoidance behaviors and thought processes.

Clinical Implications

Avoidance of positivity is a maintenance factor that may be able to be targeted by traditional treatments, such as cognitive behavioral therapy (CBT), if adapted to consider the ambivalent relationship that some individuals have with prospective positivity. Being able to properly measure these biases through self-report measures is a strength, as monitoring maintenance factors that are integral in depression will aid in the assessment of treatment outcomes. Understanding how and why certain individuals avoid positivity can also inform novel interventions.

Indeed, previous work has demonstrated that reductions in the positive valence system (PVS) are related to poor treatment response and future relapse of depressive symptoms (Dunn et al., 2020; McMakin et al., 2012). Positive Affect Treatments (PATs) aim to upregulate the PVS and demonstrate positive outcomes for depressed individuals. Examples of PATs that have demonstrated effectiveness in decreasing depressive symptoms and increasing positive affect or well-being include Augmented Depression Therapy (Dunn, Widnall, Reed, Owens, et al., 2019; Dunn, Widnall, Reed, Taylor, et al., 2019), Positive Affect Treatment (Craske et al., 2016; Craske et al., 2019), and Positive Affect Intervention (Taylor et al., 2017; for a review of these treatments, see Winer et al., 2019). In addition, positive CBT is another standalone treatment that incorporates traditional CBT methods with those of positive psychology to further target deficits in positive affect (Geschwind et al., 2020). Whereas these treatments are effective for anhedonic individuals, or those who have experienced a lack of positive affect, how individuals who specifically devalue and avoid positivity may respond to these treatments has not yet been widely investigated in a clinical population. Previous research has demonstrated a decrease in responses on the Fear of Happiness Scale in response to a positivity psychology intervention; however, this study included a nonclinical student population (Lambert et al., 2019). Thus, we suggest that future research examine how individuals with higher levels of devaluation or avoidance of positivity, as measured by the above-mentioned self-reports, respond to PATs.

Conclusion

The way in which we understand and measure RDT will continue to develop as advancements in technology, such as facial morphing and eye-tracking, are used in

concert with tasks that assess the cognitive and behavioral biases that are associated with ambivalent responses to positivity. These future investigations of devaluation of positivity will benefit from also including the self-report measures outlined above, to provide evidence of how and why depressed individuals devalue reward that cuts across levels of analysis. Future clinical trials should also examine how responses on the self-report measures outlined in this paper change over time in response to clinical treatments, particularly with PATs. This would provide crucial information as to which mechanisms are specifically targeted by this type of treatment, allowing for further personalization of these novel and promising therapeutic approaches.

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A Descriptive Case Study of a Cognitive Behavioral Therapy Group Intervention Adaptation for Transgender Youth With Social Anxiety Disorder

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TRANSGENDER and gender-expansive (TGGE) youth have a gender identity that differs from their sex assigned at birth and often meet criteria for gender dysphoria (GD), the psychological distress due to the mismatch of one's gender identity from their assigned sex at birth (American Psychiatric Association, 2013). TGGE youth with GD have high rates of co-occurring mental health diagnoses, including social anxiety disorder (de Vries et al., 2011). Social anxiety disorder is the fear of social situations and social evaluation that causes clinically significant impairment (American Psychiatric Association).

Cognitive behavioral therapy (CBT) focuses on the relationship between thoughts, feelings, and behaviors, and has been proven to be an effective treatment for social anxiety disorder in children, adolescents, and adults (Albano et al., 1995; Gallagher et al., 2004; Hayward et al., 2000; Khalid-Khan et al., 2007). Despite the documented effectiveness of CBT, there has been sparse research investigating the impact of CBT on TGGE individuals specifically. For TGGE individuals, it has been proposed that tailoring CBT treatment to specific minority groups makes these treatments more effective and acceptable for marginalized groups (Austin & Craig, 2015). These recommendations are aimed to address minority stress theory, which was originally developed using a systems theory approach to explain how structural, economic, and interpersonal factors contributed to mental health dis-

parities among women with minoritized sexual orientations (Brooks, 1981). Minority stress theory posits that being a member of a marginalized or oppressed group exposes individuals to unique, identity-related stressors which may in turn contribute to increased rates of psychopathology among members of that group. It has been applied to conceptualize identity-based stress across diverse samples, including racial minority individuals and TGGE populations (Bockting et al., 2013; Cohen et al., 2016; Mustanski et al., 2010; Puckett et al., 2016; Williams, 2018). Meyer (2003) conceptualized these stressors as unique, chronic, and socially mediated across domains through experiences of systematic discrimination and includes chronic exposure to and threat of verbal and physical violence, high rates of homelessness and underemployment, and poor medical care for TGGE people (James et al., 2016). In TGGE youth specifically, the majority report social exclusion, parental rejection, and high levels of discrimination, bullying, and violence (Bauer et al., 2015). As a result, mental health disorder rates for TGGE individuals are high and TGGE individuals experience more anxiety when compared to the general population (Bouman et al., 2016; Carmel & Erickson-Schroth, 2016; Dhejne et al., 2016; Millet et al., 2016). More specifically for TGGE youth, reports of the prevalence of social anxiety disorder range from 9.5% to 31.4%, which is higher than the general population estimate of 7% (American Psychiatric

Association, 2013; Bergero-Miguel et al., 2016; de Vries et al., 2011).

Distress related to GD may contribute to and exacerbate symptoms of social anxiety disorder. Incongruence between one's experienced and expressed gender and one's outward appearance may contribute to general discomfort in social environments where there is a risk of being misgendered or treated as a member of a gender that is incongruent with identity (Galupo et al., 2019). Lived experiences and worries about being misgendered or misperceived may prompt additional social concerns that generalize to a broader range of anxious symptoms, including fear of being evaluated and corresponding avoidance of social situations. Recent research has identified "interruption of social functioning" as a common feature of GD among transgender individuals (Galupo et al., 2020). Social situations can trigger symptoms of dysphoria, including distress related to speaking voice, appearance, and being appraised by strangers. For some, discomfort speaking in social situations or interacting with unfamiliar people due to concerns about gender-related appraisal may appear similar to symptoms of social anxiety. For individuals with both social anxiety disorder and GD, avoidance behavior may serve to reduce anxiety as well as dysphoria and treatment approaches that do not consider both functions may be less effective in addressing maintaining factors for social anxiety.

The experiences of TGGE youth complicate the presentation of social anxiety disorder. The definition of social anxiety disorder assumes that an individual's worries related to social situations are out of proportion to the true threat (American Psychological Association, 2013). For TGGE youth, anticipatory and in-vivo anxiety are many times not out of proportion to actual threats posed by social encounters or the sociocultural context. Distress related to social interactions and fear of social judgment and discomfort are normative responses to the minority stressors (e.g., discrimination, stigma, marginalization) experienced by TGGE youth. Hendricks and Testa (2012) outline the importance of integrating minority stress for clinical approaches with TGGE clients. Specifically, they recommend that assessment and treatment explicitly discuss minority stress and focus on promoting resilience (Hendricks & Testa, 2012). Further, high levels of internalized transphobia and incongruence of identity appearance are both related to major depressive disorder

der and generalized anxiety disorder among youth (Chodzen et al., 2019). This suggests that both external and internal minority stressors could impact presentations of social anxiety. As such, it is important to consider the effects minority stress may have on social anxiety when choosing treatment. In particular, recent literature has provided a framework for understanding social anxiety through a minority stress framework in TGGE youth by specifically addressing coping with distal stressors (e.g., being misgendered, being dead-named) and proximal stressors (e.g., negative self-evaluation, internalized transphobia; Coyne et al., 2020; Deloizer et al., 2020).

Evidence suggests that GD may function as a proximal, internal source of minority stress (Galupo et al., 2020; Lindley & Galupo, 2020). Experiences of GD can increase in response to stressful social situations and avoiding social situations may help decrease gender dysphoria symptoms in a way that contributes to and perpetuates social anxiety. Additionally, high levels of GD are correlated with greater anticipated stigma (Lindley & Galupo). Individuals with greater dysphoria may use social avoidance due to anticipation of discrimination, further demonstrating the importance of adapting existing social anxiety treatment protocols to specifically consider and address the ways in which GD contribute to and interact with social anxiety among TGGE individuals.

When assessing the presentations of GD and social anxiety disorder, there are many situations that might trigger symptoms of both diagnoses. For youth who experience social anxiety and GD, the distress and impairment associated with social fears may be exacerbated by specific worries related to how others interpret their gender based on observable characteristics such as their body shape/size or tone of voice. These youth may fear negative evaluation as well as worry that others will perceive their identity inaccurately or with judgment, leading to experiences of misgendering, bullying, or violence (Grossman & D'Augelli, 2006). The authors argue that the interaction of social anxiety and GD calls for a thoughtful approach to treatment that both utilizes evidence-based practices and addresses the experience of minority stress. Current research on evidence-based treatments for social anxiety disorder does not speak to the impact of experiences of minority stress on treatment outcomes. In order to reduce the distress and impairment associated with social anx-

iety disorder and GD among TGGE individuals, mental health professionals must adapt evidence-based practices to meet the treatment needs of this population.

For cisgender youth with social anxiety disorder, CBT is the gold standard of treatment. Treatment is structured and addresses psychoeducation regarding cognitive restructuring of unrealistic thoughts, problem solving, and exposure-based methods to help children, teens, and adults approach anxiety-provoking situations. The use of a group setting allows teens to have in-vivo practice of social interactions that individual CBT does not provide. Group CBT is an effective treatment for social anxiety disorder in children, adolescents, and adults (Albano et al., 1995; Hayward et al., 2000; Khalid-Khan et al., 2007).

While the need for mental health services for TGGE youth is well-documented, providers do not have a strong basis for systematically adapting services for TGGE youth (Spivey & Edwards-Leeper, 2019). Adaptations may be particularly important for this population given that limited access to gender-affirming and culturally competent care are unique and substantial barriers to care for TGGE youth (Pampati et al., 2021; The Trevor Project, 2021). The guidelines that exist for the treatment of TGGE populations endorse gender affirmative therapy, calling for mental health providers to educate themselves on TGGE health, advocacy, and terminology when providing mental health care to this population (American Psychological Association, 2015; World Professional Association for Transgender Health, 2011). As a result, researchers are advocating for a gender affirmative model of behavioral health care (Chen et al., 2018; Spivey & Edwards-Leeper, 2019).

Despite the aforementioned recommendations, there are currently no published instances of CBT for TGGE youth with social anxiety disorder (Chen et al., 2018). This paper focuses on the rationale and adaptations of group CBT to meet the unique needs of TGGE youth with social anxiety disorder and co-occurring GD using a descriptive group case study in a clinic setting. Establishing the acceptability of an adapted treatment protocol is an essential first step to ensuring that treatment is gender-affirming. This paper does not reflect a formal research protocol or a full treatment adaptation study; however, this descriptive case study provides an example of how a standard group CBT protocol can be adapted to meet the needs of TGGE youth and provides preliminary evi-

dence for acceptability and client satisfaction.

Group CBT Protocol Adaptation

The aim of this section is to provide an overview of the writers' approach to adapting an existing EBT approach for implementation with a group of TGGE youth and to provide specific examples of gender-affirming changes to the established protocol to maximize acceptability. The modifications made to the existing treatment protocol for social anxiety were not intended to target symptoms of GD. However, the procedures aimed to consider how symptoms of GD may contribute to social anxiety symptoms and may affect the efficacy and experience of individual components (e.g., exposures, cognitive restructuring) of group therapy for social anxiety.

Intervention

• Adaptation Process

The writers adapted and ran the group in a clinical setting, which mirrors the process of many providers who are on the front line of clinical work. While this was not a formal community-based participatory research framework, transgender youth and volunteers within the clinic had input in this adaptation. This intervention was adapted from a researched and standardized group CBT program for social anxiety disorder developed first for adults (Hope et al., 2006) and then adapted for teens where it demonstrated efficacy (Albano et al., 1995; Hayward et al., 2000). In the authors' clinical setting (a large child psychiatry faculty group practice), there was an existing group using this protocol for both cisgender and TGGE socially anxious youth that was not meeting the needs of TGGE youth. This was revealed through collaboration with two transgender high school students who participated in a CBT group for social anxiety and expressed frustration with the treatment not being adapted for TGGE youth and their unique needs. Of note, both teens did not complete the standard group and left the group prematurely (i.e., before half of the group was completed). They reported that while they felt affirmed by treatment providers, they felt invalidated when asked to restructure their thoughts around microaggressions within the community. Further, they felt that it was difficult to discuss their anxiety with cisgender youth who might not understand their experience. As a result, the authors discussed the importance of

Week	Topic of Adapted Group	Aligning sessions of Albano & DiBartolo (2007) group
0	Individual Screening Session <ul style="list-style-type: none"> Review rationale of social anxiety group for transgender youth Review screening measures 	Assessment Session 1: Treatment Rationale
1	<ul style="list-style-type: none"> Introductions Psychoeducation: Nature of Social Anxiety, Discussion of Minority Stress as it relates to Social Anxiety Treatment Rationale (review tripartite model of anxiety, discuss relationship between thoughts feelings and behaviors) Goals/Hierarchy brainstorming 	Session 2: Treatment Rationale, Psychoeducation
2	<ul style="list-style-type: none"> Thinking Realistically (review concept of automatic negative thoughts, thinking traps, and how to restructure thoughts to be more realistic) Managing Genuine Fears Related to the World (provide explicit acknowledgement that teens in group experience distressing situations such as discrimination in the world where cognitive restructuring might not be effective, psychoeducation regarding minority stress) 	Session 3 and 4: Cognitive Restructuring
3	<ul style="list-style-type: none"> Acceptance based approaches to address discrimination, rejection, shame, and victimization Distress tolerance (review distraction, self-soothe, and self-validation skills) 	Session 5 and 6: Assertiveness Skills
4	<ul style="list-style-type: none"> Review concept of exposure (provide psychoeducation regarding science of exposure, review of engaging assertively with the world) Refine Fear Hierarchies and Exposure 	Session 9 through end of group: Exposure
5	<ul style="list-style-type: none"> Exposure 	Session 9 through end of group: Exposure
6	<ul style="list-style-type: none"> Exposure 	Session 9 through end of group: Exposure
7	<ul style="list-style-type: none"> Exposure 	Session 9 through end of group: Exposure
8	<ul style="list-style-type: none"> Exposure Graduation Review of skills learned and celebration of successes 	Session 9 through end of group: Exposure

Figure 1. Session by Session Outline of Group. This figure describes the general sessions and structure for each week of the group as well as session overlap with Cognitive Behavioral Therapy for Social Phobia in Adolescents Group (Albano & DiBartolo, 2007). Homework was reviewed from the week prior and assigned for the following week, each week of the group. Please reach out to first author to learn more about the group protocol.

meeting the needs of TGGE teens who are socially anxious in the clinic and began a new group specifically for TGGE teens.

Authors worked with two transgender college summer interns sponsored by the authors who edited the manual to improve protocol acceptability for a group of TGGE

teens. The group protocol was condensed into eight sessions to decrease attrition, which was an issue in other CBT groups in the clinic. Figure 1 shows a week-by-week group outline in comparison to the Cognitive-Behavioral Therapy for Social Phobia in Adolescents protocol (Albano & DiBar-

tolo, 2007). Information about treatment rationale was provided by group leaders prior to the initiation of the protocol. Therefore, sessions from the original protocol that focused on treatment rationale were removed from the present adaptation. Sessions that focused on assertiveness skills

and coping strategies were condensed and modified to target TGGE youth specifically and practiced during in-vivo exposures. Sessions 7 and 8 were also removed as they focused on review of skills and psychoeducation regarding the second half of treatment. Further, to maximize feasibility given the ratio of staff to group members, number of exposure sessions were reduced as each exposure session prescribed at least three exposures for each individual.

• *Adaptation in Group Description*

Group leaders explicitly marketed this group as gender-affirming and that group leaders were committed to providing gender-affirming treatment. During the initial assessment, group leaders used gender-affirming language, validated clients' experiences and identity, and assessed the impact of transgender-specific issues on well-being, as recommended in the literature (Austin & Craig, 2015). Group leaders asked for affirmed name and pronouns at the start of group and during assessment.

• *Addition of Minority Stress as a Concept*

In line with recommendations from prior research groups, the authors also changed the content of the groups to be more gender-affirming (Austin & Craig, 2015). Group leaders incorporated minority stress into the group curriculum by explicitly acknowledging and teaching about minority stress theory to help group members better understand their experiences in the world. Clinicians allowed for group discussion about each youth's experience with minority stress by providing a validating framework around how distal and proximal stressors may impact TGGE youth and how these stressors may contribute to social anxiety (Coyne et al., 2020; Deloizer et al., 2020). Because many participants had similar experiences related to minority distress (e.g., misgendering in school or school ID card not having affirmed name), validation was inherently provided and teens encouraged resilience within one another. Group leaders also facilitated problem solving.

• *Combination of Cognitive Restructuring and Distress Tolerance*

Addressing cognitive distortions within the group was individualized based on the type of thought. In order to address some cognitive distortions, cognitive restructuring was used as an intervention as it would with cisgender youth. Cognitive techniques for these socially anxious thoughts focus on

combating thought distortions that lead to the unreasonable fear that people will react to or evaluate an individual negatively.

Acceptance and distress tolerance skills were added to the group to complement cognitive restructuring. This change was made because restructuring cognitions that are feared and potentially realistic outcomes can be perceived as invalidating. TGGE individuals have genuine fears (i.e., a high probability of threat for rejection or violence towards them), and cognitive restructuring may be ineffective or invalidating. To counter this, treatment adaptations allowed time for teaching and practicing distress tolerance skills. These skills helped youth tolerate negative emotions related to realistic fears in the world and included acceptance techniques for group members to be more accepting of themselves. Group leaders taught group members to differentiate between automatic negative thoughts that are realistic outcomes versus unrealistic thoughts and to use distress tolerance and cognitive restructuring, respectively. Group leaders were explicit that it is not necessary for group members to restructure thoughts related to minority stress.

One example of using both cognitive restructuring and distress tolerance follows. One common fear for cisgender and TGGE teens is giving presentations and "being judged for being a loser while giving a presentation in school." A TGGE teen might think "everyone will think I am a loser," and at the same time think "they will know that I am transgender" or "they will judge the sound of my voice because I am trans." By using both cognitive restructuring and distress tolerance, group leaders could coach the group members in generating realistic thoughts related to others not thinking they are "a loser" and use distress tolerance to tolerate worries that others might judge them for being transgender.

In other situations, group leaders could help TGGE group members generate more realistic coping thoughts in situations where someone might misgender them. Coping thoughts might include, "I might be misgendered, and I know how to correct that person" or "I might be misgendered, and I know I can handle it." At the same time, group leaders could also encourage youth to use distress tolerance skills to reduce pain associated with the experience. An example of a hypothetical situation provided in group to practice both coping thoughts and distress tolerance is shopping in a clothing section associated with a patient's affirmed gender. Anxious

thoughts could include, "I can't shop in the boy's section of the store, people will judge me," and group leaders would help this teen restructure and cope with these thoughts to be more accurate with statements like, "I can shop in the boy's section, and if someone judges me, I can handle it by using a distress tolerance skill."

• *Adaptations Made to Hierarchy Development and Exposures*

Hierarchy development focused on information collected during the assessment, including the initial screening session. Each hierarchy was highly individualized based on the individual's needs and was completed within session and included at least 10 items to address. Group members would list items that are anxiety-provoking and provide both subjective units of distress (SUDS) and avoidance ratings. Group leaders focused on both gender-specific exposure ideas (e.g., using affirmed name and pronouns, using affirmed bathrooms, shopping for and wearing affirmed clothing) as well as non-gender specific social exposures (e.g., presentations, maintaining conversations, ordering at a coffee shop). If a teen needed practice in assertiveness skills, this was also included within exposure preparation. Many exposures that were non-gender-specific also addressed cognitions related to an individual's tone of voice not aligning with their gender identity or worries that others would judge the individual's gender presentation. Group leaders and youth collaboratively chose which exposure to complete.

Group leaders led exposures within the clinic and out in the community. Within the clinic, exposures were led in "safe settings" where youth would introduce themselves or talk about their TGGE identity. Youth also practiced correcting one another if pronouns were used incorrectly, and doing so in an assertive way. As youth became less anxious in clinic, group leaders began to engage in real-world practice. Some unique examples included going to a shoe store in the community and asking for shoes of the individual's affirmed gender, going to a coffee shop and using affirmed name and pronouns to order, and youth role-playing conversations with confederate therapists who acted as teachers or other authority figures. Youth encountered both affirming and nonaffirming individuals in the community, and group leaders processed each exposure with group members to discuss potential use of cognitive

restructuring or distress tolerance skills as needed.

Single Group Acceptability Pilot

General Procedure

Authors ran this group at an academic medical center's clinic. A retrospective chart review was approved by the Institutional Review Board to review group data collected as routine parts of clinical practice. Each group met for 75 minutes once every week for eight sessions. Group length was determined by space availability within the clinic. Services were provided at a fee for service and providers offered a sliding scale for families who could not afford the full fee of the group. Group members completed postmeasures at the end of the group. All group members attended at least six of eight groups ($M = 7.00$, $SD = 0.82$).

Therapists

Sessions were conducted by a cisgender licensed psychologist and a cisgender licensed social worker who have expertise in working with TGGE youth, along with two cisgender clinical psychology externs who served as exposure coaches. We invited transgender volunteers to be in the group, though they had a scheduling conflict and did not participate.

Participants

Requirements for group participation were a diagnosis of GD and social anxiety disorder. Rule-outs for participation were autism spectrum disorder and psychosis as these are consistent with rule-outs for the clinic's social anxiety group for cisgender youth. Eight individuals, ranging from grade 9 to 11, aged 14 through 16, were enrolled in group for treatment of social anxiety disorder during spring 2018 (see Table 1 for demographics). Data only existed for seven of eight individuals who participated in the group, as one participant did not attend the last session or complete measures. All participants identified as transgender and were recruited via list-serv, mass email, and word of mouth. Recruitment was aimed towards youth ages 13 through 18 in grades 8 through 12 who experience GD and social anxiety disorder within our in-house clinic and with gender-affirming community health providers. All members of the group met criteria for GD and social anxiety disorder confirmed by clinical interview in the screening session. Participants were also asked about current stressors in their lives related to their gender including family

support, school, peers, and places where they are comfortable and not comfortable expressing their gender identity. All participants had other co-occurring disorders and were in individual therapy.

Measures

• Client Satisfaction Questionnaire-8

The Client Satisfaction Questionnaire-8 (CSQ-8) was used to measure self-report satisfaction with the group (Larsen et al., 1979). The CSQ-8 is a brief, 8-item validated measure that is on a 4-point Likert-type scale to self-report satisfaction with healthcare services. Participants were asked to rate each item from 1 to 4, with 4 indicating the highest level of satisfaction. Participants rate satisfaction statements including, "How satisfied are you with the amount of help you have received?" Summing the responses yields a single score

indicating service satisfaction, with a higher score correlating to higher satisfaction. The CSQ-8 also allows for a comment section on the printed version given to participants. Participants were also verbally asked to write feedback they had about the group on the form.

Acceptability

Preliminary results from the pilot group suggest that the adapted protocol was acceptable and perceived as gender-affirming. Although the sample was limited, there was no attrition across group members, and all members attended at least 75% (6 of 8 sessions) of the groups. Only one participant did not complete the final session, which conflicted with school exams. In assessing acceptability of the group, we looked both at the CSQ-8 scores and at open-ended feedback. CSQ-8 scores were

Table 1. Demographic Characteristics

Age, <i>M</i> (<i>SD</i>)	15 (0.82)
	Range: 13-17
Assigned Sex at Birth	
Male	1 (14%)
Female	6 (86%)
Gender, <i>n</i>	
Transgender Male	6 (86%)
Transgender Female	1 (14%)
Race, <i>n</i>	
White	5 (71%)
Biracial	2 (29%)
Ethnicity, <i>n</i>	
Latinx	2 (29%)
Not Latinx	5 (71%)
Transition Status, <i>n</i>	
Gender Affirming Hormones	2 (29%)
Social Transition in School	5 (71%)
Social Transition at Home	7 (100%)
Psychiatric Diagnoses, <i>n</i>	
Social Anxiety Disorder	7 (100%)
Gender Dysphoria	7 (100%)
Co-occurring Diagnosis ¹ , <i>n</i>	7 (100%)
Major Depressive Disorder	5 (71%)
Generalized Anxiety Disorder	5 (71%)
ADHD	4 (57%)
PTSD	1 (14%)
Panic Disorder	1 (14%)

¹Diagnosis in addition to Social Anxiety Disorder and Gender Dysphoria

high, with a mean score of 29.5 ($SD = 2.40$; out of a maximum of 32). No participant rated below a 3 (*mostly satisfied*) out of 4 (*very satisfied*) on any item. This indicates that participants were generally satisfied with the care they received. When asked for open-ended feedback and suggestions for improving the acceptability of the group protocol, none of the group members suggested modifications. The few written responses received expressed gratitude and satisfaction with the group. Anecdotally, members also appeared to benefit from social support in the group. Most group members were early for the group and sat together within the waiting room. Many group members commented independently to group leaders that they have built friendships with one another after the group, despite going to different schools. Finally, multiple youth asked to join the group again.

This descriptive case study aims to illustrate an example of an intervention that has been adapted to meet the unique needs of TGGE youth with social anxiety disorder and co-occurring GD using a minority stress framework. This paper aims to highlight the importance of adapting evidence-based treatments for TGGE youth and to present preliminary acceptability of this adapted intervention. Establishing acceptability is an essential first step in adapting gender-affirming treatments, and future research will examine the efficacy of the adapted intervention. Preliminary data yielded promising markers indicative of acceptability, including high rates of group participation and participant satisfaction following the conclusion of the protocol.

Conclusions

It is well documented that there is a need for psychotherapy adaptations for TGGE youth with mental health concerns (Chen et al., 2018; Spivey & Edwards-Leeper, 2019), though there are few published models of this work. We believe that it is important for clinical providers to evaluate ways in which they can adapt treatments to become more affirming by following recommendations of other groups, as this paper has done (Austin & Craig, 2015; Austin et al., 2018). Given preliminary acceptability of the adapted intervention protocol, the treatment should be further refined through a larger open trial to examine both acceptability across a larger, more diverse sample and to examine efficacy of the intervention. Specifically, addressing the unique minority stress fac-

tors related to nonbinary youth would also be essential in further adaptation of this group. Nonbinary youth experience unique challenges that are based in society's deeply rooted sense of the gender binary in restroom labels, sports, and pronouns (Thorne et al., 2019).

Effectively adapting evidence-based practices to meet the needs of marginalized populations requires input from community member participants. This group was adapted after discussions with TGGE youth who were displeased with services that they had been provided in the past. This brings to light the importance of having TGGE voices as part of treatment development and adaptations. Ideally, this work would be done through use of community-based participatory research which involves engaging community members and stakeholders at all stages of the research, including hypothesis generation, adaptation of programming, implementation, and dissemination of information. Future refinement and implementation of the adapted protocol will continue to include input from TGGE individuals. For clinicians working with TGGE youth, it is important to consider ways in which evidence-based practices can be modified to be more gender-affirming. Training clinicians to provide affirming treatment that incorporates a minority stress framework to conceptualize and address the difficulties facing TGGE youth is an important step in closing the treatment gap for this vulnerable population. Concerns about finding an LGBTQ+ competent provider represent a major barrier to treatment for TGGE youth (The Trevor Project, 2020). Clinics that provide gender-affirming care should make efforts to communicate and advertise that they provide affirming care and, if possible, should offer programming specifically to address the unique needs of TGGE youth. Importantly, we advocate for gender-affirming groups that address minority stress and discrimination that TGGE youth experience daily and that allow youth to provide social support to one another.

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Call to Action: Mobilizing Clinical Psychology Programs to Support AAPI Trainees Through an Anti-Racism Framework

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... minor feelings: the racialized range of emotions that are negative, dysphoric, and therefore untelegenic, built from the sediments of everyday racial experience and the irritant of having one's perception of reality constantly questioned or dismissed.... Minor feelings are also the emotions we are accused of having when we decide to be difficult—in other words, when we decide to be honest.

—Cathy Park Hong, *Minor Feelings: An Asian American Reckoning* (2020, pp. 55–57)

ASIAN AMERICAN and Pacific Islanders (AAPI) is an umbrella term referring to diverse communities of Asian or Pacific origin in the United States. AAPI individuals experience significant mental health inequities, including underutilization of mental health services due to stigma and shame and more mental health difficulties such as increased suicide risk in older women and greater rates of posttraumatic stress disorder (PTSD) in refugees (Sue et al., 2012). Although AAPI people comprise 7.2% of the total population in the United States, AAPI individuals represent only 4% of psychologists in the workforce (U.S. Census Bureau, 2015). In addition to perceiving AAPI therapists as more credible and culturally sensitive (Cabral & Smith, 2011; Gim et al., 1991), AAPI patients tend to experience lower rates of premature terminations (Flaskerud & Liu, 1991) and higher treatment satisfaction (Gamst et al., 2003) with AAPI therapists. Therefore,

recruiting, retaining, and affirming AAPI trainees in clinical psychology programs is imperative to delivering culturally responsive mental health services.

Doctoral students are at a critical stage in their personal and professional development as they explore and establish their clinical styles, determine career goals and trajectories, and build supportive networks (Maton et al., 2011). However, there are several obstacles that impact AAPI trainees, including exposure to race-related stress in predominantly White doctoral programs. AAPI trainees commonly experience ethnoracial microaggressions, which are intentional or unintentional statements or behaviors that are brief and commonplace and convey hostile ethnoracial messages (Sue et al., 2007). While microaggressions are commonly misunderstood to suggest benign cultural error, microaggressions represent hostility and aggression that are interpersonally unacceptable behaviors towards targeted individuals (Kendi, 2019; Williams, 2021). In particular, racial microaggressions are commonly enacted through (1) subtle verbal or nonverbal slights or deliberate, derogatory messages (e.g., referring to an AAPI trainee as an “Oriental” or “terrorist”); (2) insults or concealed messages that belittle an AAPI trainee (e.g., requesting AAPI trainees adopt dominant cultural ideals to be more verbal and emotive); and (3) invalidating messages that disregard the experiences of AAPI trainees and convey intolerance (e.g., dismissing AAPI trainees when they share

race-based stress in clinical practice). These stressful experiences can negatively impact AAPI trainees' perceived belongingness and psychological functioning (Clark et al., 2012) and, consequently, their decision to pursue a career in clinical psychology.

Specific to AAPI people, the *model minority myth* asserts that AAPI individuals (particularly those of East Asian descent) are the prototypical immigrants who are highly successful, conscientious, diligent, submissive, and intelligent (Chao et al., 2013). The model minority myth may contribute to expectations that AAPI trainees will conform to unrealistic standards in academic performance or clinical practice, or require less academic support, compared to trainees of other ethnoracial groups. Consequently, this myth minimizes anti-AAPI racism, erases the diversity within the AAPI umbrella, and negatively impacts academic functioning (Cheryan & Bodenhausen, 2000). This myth also drives a wedge between AAPI and other people of color by suggesting that the challenges of other people of color must be due to their own failings as opposed to systemic oppression, while simultaneously invalidating marginalization experienced by AAPI individuals (Tran et al., 2018), especially during the civil rights movement and war on drugs. Thus, the model minority myth may impact AAPI trainees' potential to connect with members of other minoritized ethnoracial groups in their academic and training sites who might share their similar experiences of racism.

In *Minor Feelings*, Cathy Hong (2020) coined “minor feelings” to describe the unique marginalization and stress that AAPI individuals experience in their daily lives and the invalidating reactions they receive when discussing their experiences. The purpose of this article is to shed light on the unique experiences and challenges of AAPI clinical psychology trainees, in order to develop and sustain effective methods of support. We hope that this article will benefit AAPI trainees by educating and empowering clinical supervisors, instructors, staff and administrators, and academic advisors to support AAPI trainees through an actionable and culturally affirming antiracism framework. For AAPI trainees reading this, we hope that this article can add to the voices assuring you that you are not alone, that you are valued for your presence and the insights and experiences that you uniquely bring, and that *we need you* in this field. To that end, the recommendations we provide here are informed by our personal experiences in various contexts as

well as research evidence on AAPI individuals.

Of note, the AAPI umbrella is highly heterogeneous and comprises multiple subgroups including East Asians, Southeast Asians, Pacific Islanders, and South Asians, with various other intersecting identities (e.g., age, developmental disabilities, acquired disabilities, religion, ethnicity, sexual orientation, socioeconomic status, indigenous group membership, nationality, and gender). Intersectionality refers to attending to multiple, interconnected identities and associated power dynamics in privilege and marginalization (Rosenthal, 2016). AAPI trainees may experience stress and/or resilience at the crossroad of their intersecting identities (Nadal & Corpus, 2012; Nakamura et al., 2013). For example, LGBTQ+ AAPI trainees may experience microaggressions based on their intersecting identities in race/ethnicity, sexual orientation, and/or gender identity within an interlocking racist and queerphobic context. Although Asian Americans (AA) and Pacific Islanders and Native Hawaiians (PI/NH) often share experiences and challenges discussed in this article, we also acknowledge that PI/NH have unique experiences from AA that have been understudied (Kwan et al., 2020). Historically, the term “Asian American” was developed in 1968 to unify various communities in opposition to the pejorative term “Oriental” (Maeda, 2012). Currently, AAPI is commonly used as an aggregated label to unite several communities and amplify their voices; however, it may conceal the unique experiences of subgroups. We also acknowledge that Asian international trainees may differ in ethnoracial identification and experiences from AA trainees. Therefore, AAPI trainees cannot be reduced to a monolith, and the ideas and recommendations in this article must be considered from an intersectional stance.

Positionality Statement

We represent a diverse range of identities, backgrounds, and experiences, which influence how we navigate the world. Kevin Narine (he/him) is a queer, first-generation Indo-Guyanese who is currently a second-year Psy.D. student. Cindy Chang (she/they) is a bisexual/pansexual Taiwanese American genderqueer woman who is currently a fifth-year Psy.D. student and predoctoral intern in clinical psychology. Erica Ho (she/her) is a second-generation (child of immigrants) Taiwanese American and is currently a sixth-year

Ph.D. student and predoctoral intern in clinical psychology. Christine Francis is a child of Indian American immigrants and is currently a second-year Psy.D. student. Lindsey Davis (she/her) is a White American early-career clinical forensic psychologist with academic appointments at William James College and Harvard University. Catherine Vuky (she/her) is a first-generation Vietnamese refugee who is currently Assistant Professor and Director of the Asian Mental Health Program at William James College.

AAPI Trainees' Experiences of Aggression in Professional Settings

Common Microaggressions by Supervisors and Mentors

• *Stereotyping/Tokenizing*

Many AAPI trainees have had experiences of being confused for another AAPI person, having their names mispronounced repeatedly, or being asked to speak on behalf of an AAPI community. They may also be expected to speak Asian languages fluently and be treated as perpetual foreigners, regardless of their place of birth. I (Kevin) have been asked about where I was “really” from, how to pronounce specific words in Guyanese Creole, and whether I could speak on behalf of other LGBTQ+ AAPI individuals. These experiences communicate to AAPI trainees that we are only seen for our race and not as individuals.

• *Pathologizing and Punishing Non-White Coded Behaviors*

One of the most insidious ways that supervisors microaggress against AAPI trainees is by criticizing aspects of interpersonal style or deportment if they do not reflect those that are valued in mainstream White culture. Some examples are being criticized for being not assertive enough, not outgoing enough, not professional enough, and not expressive enough. Although supervisors may mean to provide helpful feedback (e.g., “You need to be less tender with your patient or else they may not disclose things to you”; “You just need to take control of the session”), these messages localize the problem within the trainee as opposed to larger systems of racism, sexism, and other forms of oppression. Additionally, this feedback relies on and perpetuates stereotypes, rather than constructively identifying specific behaviors that can then be examined and understood together in supervision.

• *Erasure of AAPI Identity*

Due to the model minority myth, our identities are often erased. AAPI identity is often overlooked or excluded in discussions about race and ethnicity, promoting the invisibilization of AAPI trainees in various settings. In the wake of the racial reckoning in 2020, I (Cindy) was pleasantly surprised to see some of my professional communities speak about racism. However, in an attempt to acknowledge the lack of diversity on our teams, more than one staff psychologist has said, “I want to acknowledge that our staff is all White.” This assertion, although meant to acknowledge a very real need for greater representation of people of color, led to the erasure of my identity as an AAPI person.

Microaggressions From Patients

Clinicians from marginalized groups are disproportionately the targets of patients' bias and discriminatory behavior, leading to workplace distress and likely also contributing to burnout (Chandrashekar & Jain, 2020). The harmful consequences of patient microaggressions are arguably even more pronounced for students, who may fear retribution from supervisors and their training programs for not “properly” managing patient interactions. Because psychology faculty and student bodies are predominantly White, trainees are often taught a blanket approach of “exploring” or “processing” interpersonal dynamics that arise in the therapy room with clients, including racism. It can thus be perceived as a moral or character failing of the targeted trainee if they are not able or willing to engage with perpetrators of microaggressions. However, it is deeply misguided and beyond the reasonable scope of psychotherapy training to expect individual students to have to fix manifestations of systemic racism, or to have to continue subjecting themselves to harm. Instead, everyone deserves a training experience that is respectful and affirmative of their whole selves.

Educational Settings

Historically, the field of psychology has engaged in oppressive practices towards marginalized ethnoracial groups and imposed a predominantly Eurocentric worldview on trainees, impacting educational attainment and training satisfaction in AAPI trainees (Brown et al., 2022). Faculty members in clinical training programs are the product of the same culturally limited education that students currently experience, which means many are not familiar with AAPI cultures and mental health. This

puts undue strain on AAPI trainees and their allies to explain or justify Asian ways of being, thinking, and behaving. Particularly exacerbated by the model minority myth, AAPI trainees are accustomed to their experiences of oppression being dismissed, invalidated, and silenced. Therefore, a culturally responsive approach is needed to support AAPI trainees in classroom settings.

One important way to enact cultural responsiveness is to actually respond to sociopolitical events, which are often very personal to trainees, rather than to treat them as extraneous to our profession. As suggested by Galán and colleagues (2021), programs should acknowledge and denounce hate crimes when they occur. Hate crimes pose an existential threat to members of the targeted group because the only risk factor may be their identity—which is immutable and thus a risk that cannot be managed (e.g., Iganski, 2001). As Kang (1993) wrote of anti-Asian hate crimes, “psychologically, they evoke a feeling of helplessness, because race—the only characteristic that could be changed to prevent future attacks—is immutable” (p. 1928). Unfortunately, many of us co-authors found it challenging to bring awareness to anti-AAPI violence and its potential effect on AAPI trainees and clients in classroom settings. We were also dismayed by the silence and lack of acknowledgment that followed discussions in settings with predominantly non-AAPI trainees and instructors. In attempting to discuss anti-AAPI hate in the classroom, faculty may be surprised to face silence, confusion, misdirection, or even direct opposition, due in large part to the general lack of attention to anti-AAPI bias. The silence around anti-Asian violence juxtaposed against greater national attention to racism reinforces messages that anti-Asian racism is unimportant, or even acceptable, in American society.

As a result, there is a secondary impact of trauma that spreads throughout the targeted community, not only experienced by our AAPI clients, but also by students and colleagues. In clinical training, faculty and supervisors should be aware that a trauma-informed treatment during a wave of violence toward a particular identity group cannot focus merely on a singular traumatic event experienced directly by a client, but also on the context in which the client is expected to function. In my (Lindsey) clinical work with a Korean woman who was the victim of an anti-Asian hate crime, I concluded that my client’s fears and

avoidant behaviors were not pathological; they were reasonable responses to a legitimate ongoing threat in her community. These same considerations also apply to AAPI trainees, who may be traumatized or otherwise negatively impacted by hate crimes occurring on a national level. Educators and clinicians operating from a privileged, White American perspective may overpathologize the fears of AAPI trainees and clients or contribute to further erasure of AAPI racism if they do not remain aware of their biases and engage in perspective-taking.

Creating Safe and Supportive Training Structures for AAPI Students

Systems-Level Actions for Programs and Training Sites to Support AAPI Trainees

The only way to undo racism is to consistently identify it and describe it—and then dismantle it. —Dr. Ibram X. Kendi, *How to Be an Antiracist* (2019)

Racist policies and inequity are prevalent in society, and higher education institutions are not immune. To commit to supporting AAPI trainees, programs should take a holistic approach, beginning with: (1) leadership, e.g., Do program leaders model a shared commitment to dismantling anti-AAPI racism? (2) power and voice, e.g., Are AAPI people represented in leadership roles? (3) teaching and learning, e.g., Does the curriculum challenge inequity and value inclusion? (4) well-being and belongingness, e.g., Is AAPI trainees’ well-being seen as a priority and are there supportive spaces for AAPI trainees in the program? and (5) continuous critical self-reflection, e.g., In what ways are policies, procedures, and practices upholding anti-Asian racism?

It is crucial that training programs take systemic actions to (1) recruit, support, and retain AAPI educators, supervisors, and faculty leaders; (2) require that all psychologists in the program complete continuing education on current practices for providing culturally responsive mentorship and supervision to AAPI trainees; and (3) compensate AAPI psychologists who access their internal resources and invest their labor in organizing educational events and spearheading diversity, equity, and inclusion (DEI) initiatives (Alegria et al., 2019). I (Catherine) have advocated for the standardized inclusion of a DEI statement for instructors to include in syllabi to acknowledge the impact of racism in various people-of-color subgroups, including AAPI communities, and develop a safe and sup-

portive community within the classroom for AAPI trainees. It is important to provide courses on AAPI mental health in the curriculum, recruit and support AAPI faculty, and underscore AAPI scholars and issues in course readings. Additionally, a bias incident reporting system with an option for anonymous feedback may be helpful for allies and AAPI trainees to share negative bias-related situations either witnessed or directly experienced in their programs. These systems foster accountability that addresses anti-AAPI bias to promote a safe and respectful environment. Moreover, microaggression trainings should be made mandatory and offered several times in programs. Given the erasure that AAPI communities face, trainings specific to anti-AAPI racism should be offered. It may also be beneficial to include practicum site supervisors in separate trainings to reinforce the program’s commitment to addressing anti-AAPI racism (Galán et al., 2021). These trainings should secure consultants and use authentic vignettes from the personal experiences of trainees to bring awareness to the experiences of AAPI individuals.

In programs and training settings, discussions on anti-AAPI racism can be viewed as potentially threatening interactions in relationships with power dynamics, can reveal differences in perspectives, trigger negative emotional responses, and can unmask biases and prejudices (Sue & Constantine, 2007). If these conversations are handled poorly by faculty and staff, such dialogues may result in irreparable harm such as anger, hostility, silence, complaints, misunderstandings, and blockages of the learning process to address anti-AAPI racism. These interactions can trivialize and invalidate the experiences of AAPI individuals, reinforcing racist messages that their experiences do not matter and are unbefitting of spaces for processing and healing as minoritized individuals. However, if these conversations are handled skillfully, they present an opportunity for growth, improved communication, and learning (Young, 2003). These are some considerations in handling difficult conversations related to AAPI issues, including (1) seeking clarification about what was said, e.g., asking “what I hear you saying is...?”; (2) using “I” statements to take responsibility and accountability for your own words, feelings, and emotions; and (3) focusing on mutual contribution and not on who to blame for the situation, e.g., asking, “how did we each contribute to this problem or conflict that we are experiencing?” The pur-

pose of underscoring contribution is to take a nonjudgmental stance and identify appropriate actions to prevent issues in the future.

While programs and practicums may value DEI, many engage in short-term actions that fall short of long-term structural changes and practices. The willingness of programs to engage minimally in social justice practices (e.g., sending an email supporting Black Lives Matter while doing little to change policies supporting Black students), while failing to speak out on anti-Asian racism, highlights to all minoritized trainees that these efforts are little more than virtue signaling. It is also important to note that, because of the model minority myth, advocating for AAPI people is often equated to diminishing the importance of Black Lives Matter. However, these criticisms delegitimize experiences of racism in AAPI people and divert attention away from systemic racism targeting AAPI people by creating an “oppression olympics” (Hancock, 2011) that increases misunderstanding and hinders empathy between communities of color (Tran et al., 2018). To directly combat the ways in which White supremacy attempts to “divide and conquer” communities of color (Tran et al.), we wish to explicitly note that we wholeheartedly and unequivocally support Black Lives Matter and believe that efforts to combat anti-Black racism remain critically important. We call on our programs to avoid falling into the trap of segmenting different minoritized ethnoracial groups from one another, and to commit to the development and sustainability of anti-AAPI racism initiatives. In fact, research suggests that there is much to be gained by finding connection in shared experiences of oppression (Cortland et al., 2017).

• *Activism Strain and Burnout*

In addition to AAPI trainees experiencing race-based stress (e.g., bias, prejudice, and discrimination related to their ethnoracial identity) and invalidation and invisibilization of their marginalized experiences in their daily lives (Yip et al., 2021), they also experience activism strain from institutional reliance on their “expertise” as minoritized ethnoracial individuals to educate non-AAPI individuals on AAPI-issues in discussions, workshops, and events (Eaton & Warner, 2021). These complex stressors may lead to overcommitment and burnout symptoms in AAPI trainees (Eaton & Warner, 2021). Given the unrealistic high standards related to success and diligence imposed upon AAPI individuals (Chao et al., 2013), this burnout may not be acknowl-

edged or taken seriously by others. I (Christine) experience activism burnout and am frequently told that my additional work at clinical practicum or in the classroom is “just part of the training process” or to simply “practice self-care” in my own time. It is important to acknowledge the responsibilities and commitments of AAPI trainees, as educating others is an added responsibility that non-AAPI individuals, instructors, and supervisors do not have to undertake. Therefore, it is essential for non-AAPI individuals to (1) take responsibility for independently educating themselves on AAPI-issues and engaging in anti-racist efforts, (2) encourage self-care in AAPI trainees, and (3) compensate trainees for their expertise to respect their valued contributions.

Actions That Supervisors and Mentors Can Take to Support AAPI Trainees

It is important for supervisors and mentors to practice cultural humility. Cultural humility is a lifelong process of learning about and from others, of self-reflection and self-awareness, willingness to confront biases, commitment to challenging negative power dynamics, and engagement with compassion, dignity, and respect for AAPI trainees (Hook et al., 2016). It is a guiding framework for establishing culturally sensitive parameters for maintaining supportive relationships.

• *Setting the Stage*

It is important to proactively foster a safe and supportive mentorship and supervisory relationship, rather than waiting until adverse events occur.

1. *Create a safe environment.* As with any trainee, begin your supervisory relationship with an open conversation about your respective identity characteristics and how these factors may impact both your work together as well as interactions with patients.

2. *Acknowledge power dynamics.* Given the power differential between supervisor and trainee, it is critically important for you as the supervisor to take the lead in starting this conversation (e.g., Falicov, 2014) and to open the door for your trainee to bring these issues to you. For example, “I understand that sharing your experiences may be challenging at times due to differences in privilege or power with my identities and roles, but I am committed to fostering a safe and supportive environment for you to share.”

3. *Be consistent.* It is important to keep discussing the role of sociocultural identities in shaping differences in experiences and perspectives. For example, “I can see how my understanding of how to appear confident may be different as a White man,” and check in with your trainee: “Given recent events, I wanted to provide space to talk about how it is impacting you if you would like to talk about it.”

• *Receiving Feedback*

While supervisors and advisors tend to provide feedback to AAPI trainees, it is also crucial that there is a parallel process for AAPI trainees to feasibly provide feedback to supervisors and advisors on experiences of AAPI-related bias. The following are recommendations for receiving feedback:

1. *Actively solicit feedback.* In addition to the power differential between supervisor and trainee, modesty and respect for authority may be culturally valued for your trainee. Therefore, supervisors should proactively ask what is working well and what they can be doing differently.

2. *Practice nondefensiveness and express gratitude for feedback.* Although receiving feedback may provoke feelings of shame, anger, and guilt, receiving feedback indicates your trainee is being vulnerable to share with you a suggestion that may help you grow as a supervisor. Acknowledging feedback without defensiveness can bolster your supervisory relationship.

3. *Commit to action and monitor your progress over time.* Describe how you will incorporate their feedback and monitor your progress.

• *Giving Feedback*

As an advisor or supervisor, there are several considerations to make before and during giving feedback. Before giving constructive criticism, ask yourself: (1) whether your feedback is entrenched in a stereotype or a harmful assumption towards an AAPI trainee, and (2) whether your feedback would be appropriate to share with a non-AAPI trainee.

1. *Consider the impact of systemic factors.* A common microaggression towards AAPI individuals is undermining or disproving of their communication styles and cultural values. For example, well-meaning supervisors may intend to help their AAPI trainees by encouraging them to act more dominant and assertive. However, it is important to frame this feedback in a way that does not locate the flaw within the

trainee (“You are too passive”) but rather in systemic factors (“I want to acknowledge that academia and society at large often unfairly rewards those who are loudest about their own preferences. How has that impacted you, and how I can help you navigate it?”).

2. *Be behaviorally specific.* Rather than using labels (“You’re too cold and distant with your patient”), describe (“I noticed you looked away often when you were speaking with your patient this morning”).

3. *Approach with curiosity.* The role of a supervisor is to help your trainee become the best version of themselves as a clinician, not necessarily adopt your exact therapeutic style. If your trainee has a different style from your own, approach with curiosity: “I noticed you use more metaphors than I do in my own practice. How has that worked for you? What feels effective and genuine for you?”

• *Formulating a Plan for Supporting Your AAPI Trainee With Microaggressions*

Proactively discuss a plan with your supervisee about how they would like you to handle inevitable instances of racism from patients and other people involved in clinical training. Some trainees may prefer their supervisor, as both the bystander (if applicable) and the authority in the room, to immediately step in. In contrast, other trainees may prefer to handle racist encounters on their own. Still others may prefer to simply move on and request that the patient be transferred to the care of another therapist. Any of these choices are valid, and the trainee should not be shamed or humiliated for their decision.

It is also important to check in with your trainee after any racist encounters about the affective impact it may have had. Supervisors may sometimes feel pulled to comment on what next steps would be most helpful for the patient, but doing so may signal to the trainee that the patient’s well-being is more important than the harm that the patient enacted on the trainee. Instead, we suggest prioritizing the trainee’s immediate needs in the aftermath of the racist encounter (Wheeler et al., 2019). A simple and surprisingly powerful intervention is explicitly labeling any microaggressions that you witness or that your supervisee informs you about (Wheeler et al.). This intervention directly combats pervasive messages that AAPI trainees receive from society that their experiences of racism are not real or valid. Therefore, labeling experiences as racism is a form of using your power and status responsibly, and of letting

your trainees know that you do not condone their mistreatment.

• *Case Example of Supervisor Supporting an AAPI Trainee Following Patient Microaggression*

A common microaggression is physical appearance stereotypes that confuse AAPI trainees with someone else. I (Erica) was working as a predoctoral psychology intern on an inpatient specialty medicine unit, and I had a patient who seemingly deliberately confused me with a medical provider who also happened to be Asian American. These microaggressions occurred in the presence of my supervisor during co-therapy. Because of the high-risk nature of the patient’s medical treatment, as well as other significant psychological concerns that I thought were more pressing, I initially chose not to address the microaggressions with the patient, and I informed my supervisor as such. I am sure that I was also feeling a cultural aversion toward “rocking the boat.” Finally, however, when it became clear that these behaviors were interfering with not only psychotherapy but also medical treatment, I determined it was time to have a frank conversation with the patient (e.g., Wheeler et al., 2019).

For my personal edification, I decided that I myself had to be the one doing the confronting, as doing so would help me feel that I was addressing the issue head-on. My supervisor and I collaboratively formulated the following plan: (1) that he would accompany me to this session; (2) that I would steer the conversation, to further signal my agency and professional expertise; (3) that I would invite my supervisor to share his personal reflections about the microaggressions I had experienced; and (4) in recognition of the cognitive and affective burden of such an encounter, that my supervisor would jump in as needed to provide backup (e.g., Wheeler et al., 2019). As it happened, further microaggressions against me did in fact occur during our initial conversation with the patient. However, as agreed upon in advance, my supervisor stepped in to handle those instances for me, allowing me to focus on the task of communicating the impact that the patient’s behaviors had on his medical and psychological treatment.

As this example illustrates, the most important aspect of addressing patient microaggressions is to let the trainee decide what course of action would be most empowering for them. That decision may also shift over time, whether due to personal factors or new developments in the patient’s

overall care, so please also continue to check in with your trainee as therapy progresses. In this particular case, I was only able to navigate these hard conversations so successfully because of the safe, nonjudgmental learning environment and mentoring relationship that my supervisor fostered. His unconditional support for me transformed one of the most challenging clinical experiences I have had into one of the most therapeutically effective and personally rewarding.

Conclusion

This article focused on bringing awareness to the unique experiences of AAPI trainees in clinical psychology doctoral programs and collating actionable strategies to address their concerns on individual and systemic levels. AAPI trainees occupy an often invisibilized ethnoracial identity and experience anti-AAPI stress in clinical psychology doctoral programs. Training programs often overlook their specific needs, which may negatively impact the number of AAPI providers joining the health service psychology workforce and decrease the number of providers uniquely positioned to understand AAPI patients. In popularizing the term “minor feelings,” Cathy Park Hong brought awareness to experiences that many of us shared—experiences that we knew deep down were wrong but could never explain. This paper was inspired by many challenging experiences in our professional roles before we recognized the systemic nature of these problems. We collectively hope to remind AAPI trainees that they are not “making things up” when they feel like they do not quite belong; that they are not alone in this feeling of alienation; that they are valued and vital in this field; and that their experiences matter in fostering culturally responsive training and supervision.

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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/

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>

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Digital Drop-Ins

ABCT and One Mind PsyberGuide have been collaborating on casual and interactive bimonthly sessions in which we discuss how digital tools can be leveraged in mental health. At the Drop-Ins, we welcome people no matter what brings them to an interest in digital mental health: clinicians who are exploring integrating apps into their practice; people with lived experience who are looking for digital solutions to mental health needs; researchers who are hoping to share their knowledge; and app developers who want to share their product ideas.

Upcoming sessions, March–June:

- **Using Public Forums and Social Media for Mental Health** (3/2/22, 4:00 p.m. EDT)
- **Digital Tools and Women's Mental Health** (3/16/22, 4:00 p.m. EDT)
- **Digital Tools for Stress Management** (4/6/22, 4:00 p.m. EDT)
- **Digital Mental Health for the Latine/Latinx Community** (4/20/22, 4:00 p.m. EDT)
- **Digital Mental Health for the AAPI Community** (5/4/22, 4:00 p.m. EDT)
- **CBT Apps and Digital Tools** (5/18/22, 4:00 p.m. EDT)
- **Digital Mental Health Tools for the LGBTQIA+ Community** (6/1/22, 4:00 p.m. EDT)

Sessions are flexible, varied, and relevant. We've had conversations around how digital mental health can be of help through current events like COVID and its effect on mental health. We've also covered digital mental health resources for specific groups, like LGBTQIA+ and BIPOC communities.

Whether you need a tool to address what's keeping you up at night, or if you need a VR solution for a spider-phobic client—we look at how digital tools can be helpful across a broad range of needs.

TO REGISTER: <https://psyber.guide/dropins>

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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

The ABCT Forums have replaced the list serve. The Forums are a place to communicate and network with other ABCT members. Users of the ABCT Forums will receive email notifications whenever a new thread is created, and have the ability to subscribe to threads and receive email notifications whenever a new post is made on that thread. Users of the ABCT Forums will also have the ability to create new topics of discussion and message other ABCT members privately.

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

How to receive posts in digest form: Emails received from the Forums will include an option at the bottom of the message to switch to the digest format. Users can also sign into their ABCT account and navigate to the Forums, and change their settings to receive emails in the digest format.

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

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