ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

ISSN 0278-8403
VOLUME 42, NO. 5 • JUNE 2019

the Behavior Therapist

Contents

Contents continued on p. 146

PRESIDENT'S MESSAGE

Questions About Industry

Bruce F. Chorpita, *UCLA*

FOR THE PAST SEVERAL YEARS, I have found myself asking questions about industry and private enterprise at our big national mental health or education conferences—not just the wondering-in-my-head kind of questions, but increasingly the asking-others-aloud kind of questions. Lately, such questions have centered on the traditions and norms that govern both the scope of topics and the participant roles at our important gatherings. For instance, why do so few members from private industry attend our conventions? To the extent that there is such a presence, why is it confined almost entirely to an exhibitor bullpen? Why do talks about the most successfully scaled evidence-based programs overwhelmingly center on their effectiveness (of which there are thousands of peer-reviewed examples) rather than on the commercial models or business practices that may have led to their widespread impact (of which there are considerably fewer examples)? The most consistent response to my questions is simply that private industry is not an appropriate partner in our science and policy conversations. Although I understand some of the hesitation and concern and I am certainly not an unwavering advocate of industry myself, I am steadfastly in favor of more inclusive conversation about it. Thus, in the hopes of fostering such conversation at our November convention and beyond, while fully welcoming both dissent and controversy, I'd like to explore the next layer of our beliefs and attitudes—a "downward arrow," so to speak.

Many of these perspectives come from respected colleagues and friends, and a few are

[continued on p. 147]

[Contents Continued]

the Behavior Therapist
Published by the Association for Behavioral and Cognitive Therapies
305 Seventh Avenue - 16th Floor
New York, NY 10001 | www.abct.org
(212) 647-1890 | Fax: (212) 647-1865

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

At ABCT

ABCT

Election Results

David F. Tolin, Ph.D.
2019–2020 President Elect

Amie E. Grills, Ph.D.
2019–2022 Representative-at-Large Elect

INSTRUCTIONS *for* AUTHORS

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

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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

even my own. So, why are industry representatives more welcome as vendors than as peers in our professional activities? One point I hear frequently involves cost: the involvement of industry will introduce commercial models that become barriers to care, such as paywalls, licensing fees, or subscriptions. A corollary of that point is that commercialization runs counter to the deeply held values of our community, which is driven to help others. Thus, the hypothesis is that commercial activity is mutually exclusive of altruism or compassion, at least to a significant degree. Another concern often raised is that industry involvement could compromise the effectiveness of the products or services, prioritizing interests of business over that of the public. There are even the broader and long-standing arguments about the risks of dehumanization, loss of control, or alienation that could result from layers of industry between producers, workers, and consumers; and then there are the related concerns over whether industrially driven technologies will ultimately support human helpers (e.g., therapists and educators) or simply replace them. All of these questions are legitimate—and they likely have some evidence for them and some against them. Uncomfortable as it might be, should we talk more about them?

For a thought-provoking example of the pros and cons of industrialization, one can look to agriculture, which also serves the function of improving lives and provides what is valued by many as a basic human right. Agriculture has progressed through many revolutions, beginning with the transition from gathering to farming tens of thousands of years ago, to the introduction of carefully developed farming practices beginning in the 8th century, to the widespread use of simple machines (e.g., plows) over a thousand years ago, to powered machines in the past century (including the revolutionary invention of mechanical refrigeration), to radical innovations in seed yield and fertilizer production in the past few decades, for which the late U.S. agronomist Norman Bourlag was awarded a Nobel Peace prize and credited with saving over a billion people from starvation. Yes, these were initially engineering or scientific breakthroughs, but nearly all were commercially scaled. And we are fully in the midst of yet another agricultural revolution, in which seed varieties are optimally matched by computers to predicted climates, soil microbiomes, and water supplies; in which harvest times and yields are predicted with astonishing accuracy; and in which digital machines identify the most suitable grapes to press to produce superior wine (e.g., Liakos, Busato, Moshou, Pearson, & Boktis, 2018). Digital machines now decide which seedlings to water and which to kill, with tractor-fitted cameras streaming digital images to servers hosting massive agricultural data sets, allowing accurate prediction, in this case, of which lettuce sprouts will mature into the most food-worthy specimens and which will be unworthy of water and acreage. Such innovations undoubtedly introduce concerns about safety, ethics, food diversity, land development, equitable use of resources, conservation and so forth; but there is little debate that the course of human history would be dramatically different without an abundant and affordable food supply, which has depended not simply on these innovations but also on their commercialized, industrial-scale applications. Are there parallels within behavioral health? Certainly, we face similar issues of balancing global impact with high-quality, responsible practice. We should ask ourselves: What are our metaphorical horses and plows? What are our boutique farmer's markets? Who is not being nourished by our current food supply, and why?

There are no easy answers here. There is evidence of both promises and perils regarding how industry will play a role in our collective professional endeavors. But it will no doubt play a role. In fact, it already does. Many of the world's largest corporations are already well established in fitness, nutrition, and lifestyle commercial sectors, and thus are already poised to cross into behavioral health. Several are already there, but we are just not talking openly about it yet, or if we are, it is typically as an observer, not as a collaborator or driver (e.g., studying social media rather than designing it). Meanwhile, our legacy industries of publishing, teaching, training, consulting, administrative services, and clinical care continue to grow, innovate, and consolidate. As opponent or ally, or some mixture of both, big business will be a part of our future.

What might that future look like? We often imagine the future as some slightly more advanced version of things we already know: mobile phone treatment applications, electronic health records, or fitness activity trackers; but these are already the innovations of the past. Advances in social robotics suggest a possible future with digital therapeutic companions, who nudge or guide you based on machine-based predictive modeling using all relevant literature ever published, all relevant data from users similar to you, and your own history of speech and behavior. Or perhaps there will be a digital therapeutic presence embedded in the machines and objects we already use, from cars, to refrigerators, to furniture—making us safer, calmer, happier, more compassionate, or healthier. Perhaps clinical supervisors will be replaced by miniaturized digital assistants, who can whisper AI-derived wisdom in the ear of a service provider in real time. These things are as easy for us to imagine as web-enabled tractors with digital eyes and brains would have been for the 17th century farmer.

But something will come, and commercial enterprise along with it. To be clear, this is not just about technology, it is about business—the revenue models, production and distribution channels, licensing, incentive and competition structures, regulation, and standard setting that will nourish and scale those technologies and innovations so that they change the world. As has happened with agriculture, continued industrialization of health and wellness is inevitable. Given the potential benefits and costs, I would argue such development would benefit from having more of our members at the table to represent a perspective of empirical accountability and verifiability and to shape the goals and questions we feel are of greatest social value. We can even be the ones who set that table, by moving a few more of these conversations from the hotel lobby to the main stage, or from private email exchanges to the pages of our widely read journals. To that end, there will be at least one panel discussion at the ABCT 2019 Annual Convention taking on these issues formally. I encourage you all to attend, but more important, I encourage us all to consider more submissions of this nature as we continue to enrich the collective conversation that fosters the mission of ABCT.

Reference

Liakos, K. G., Busato, P., Moshou, D., Pearson, S., & Bochtis, D. (2018). Machine learning in agriculture: A review. *Sensors, 18*(8), 1-29.

. . .

Disclosures: I am employed full-time as a Professor in the Department of Psychology at UCLA, and I am also President and Partner/Owner of PracticeWise, LLC, a behavioral health consulting corporation.

Correspondence to Bruce F. Chorpita, Ph.D., Franz Hall 3227, Department of Psychology, University of California, Los Angeles, Los Angeles, CA 90095; chorpita@ucla.edu

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

Mary Jane Eimer, *Executive Director*

THE TRADITIONAL ELECTION of ABCT officers ended April 30. Congratulations are extended to David F. Tolin, 2019–2020 President Elect, and Amie E. Grills, 2019–2022 Representative-at-Large and liaison to Academic and Professional Issues. They each start their terms of office this November during our Atlanta Convention.

Wait! There is more on the election front. *We are shifting our election month to November* to encourage more of you to vote. We are seeking nominations now for the 2020–2021 President Elect and the 2020–2023 Representative-at-Large and liaison to Membership Issues. If you let us know you voted while attending the convention, we will give you an "I voted" sticker as a thank you. They will be available in the ABCT registration area. An article in this issue (p. 187) by incoming Leadership and Elections Chair Patricia DiBartolo includes a nomination form. Our website also has nomination and election information. Please keep in mind that only full and new member professionals can vote, so you will need to renew your dues for 2020. The candidates elected will start their terms of office in November 2020 during our Annual Convention in Philadelphia!

Is it time to get another stamp in your passport? Why not consider attending the 9th World Congress of Behavioural and Cognitive Therapies at the City Cube in Berlin, July 17–20. See ABCT's website for details: http://wcbct2019.org/Downloads/Preliminary_Programme.pdf

You are sure to know lots of colleagues attending the World Congress. Plus, ABCT will have a booth so you can hang out there and use our space as a meeting place to connect with colleagues. Pssst! ABCT is submitting a bid to host the World Congress in July 2025.

Tammy Schuler, Director of Outreach and Partnerships, resigned from ABCT to relocate to the West Coast to be closer to family and take a position at the Fred Hutchinson Cancer Research Center. Join me in thanking Tammy for her service and wishing her all the best in her new position. In the meantime, the Board and staff are revisiting the job description before advertising for the position. But who knows, one of you may be interested!

ABCT belongs to several coalitions (Consortium of Social Sciences Associations, Mental Health Liaison Group, and Coalition for the Advancement and Application of Psychological Science). ABCT appears on both the letter supporting the H.R. 2075/S.1013, the School-Based Health Centers Reauthorization Act of 2019—a bipartisan bill to increase young people's access to primary and mental health care services through school-based health centers, and the Comprehensive Addition Resources Emergency (CARE) Act of 2019.

Denise Sloan, Editor of *Behavior Therapy*, and Brian Chu, editor of *Cognitive and Behavioral Practice*, reported recently that Elsevier has instituted a new system for sending NIH-funded papers to NIH's archives. NIH requires that all papers emanating from NIH-funded studies be archived with them. Elsevier is now sending papers once they've been uploaded to ScienceDirect, before the authors have approved editorial revisions. The editors and staff think that this will cause multiple versions of paper, when only one authoritative text is wanted. It also adds work for the author. After further discussion, the committee charged staff to attempt to change this policy on how articles are submitted to NIH for archiving in order to ensure the identical authoritative text exists at both ScienceDirect and NIH.

Kate Wolitzky-Taylor, Editor of *the Behavior Therapist*, published a special issue, "CBT in Diverse Contexts and Professions," highlighting the work of ABCT members that goes beyond the traditional psychology professor or private practice model. This special issue (April *tBT*) should be of great interest to our student and new member professionals. You can heck out the issue here: http://www.abct.org/docs/PastIssue/42n4.pdf

Regine Galanti, our Web Editor, has been making lots of changes, with input from her Associate Editors, to make our website easier to navigate; they are also making content changes regularly. Immediate Past President Sabine Wilhelm's Presidential Address is now posted; and we have new additions to our Pioneer Series (Thomas Ollendick, Gail Steketee, Steven Hollon, and Alan Kazdin). Soon we will be posting the 2019 award recipients.

Staff continue populating the growing index of *tBT* issues available in PDF: http://www.abct.org/Journals/?m=mJournal&fa=TBT_Index

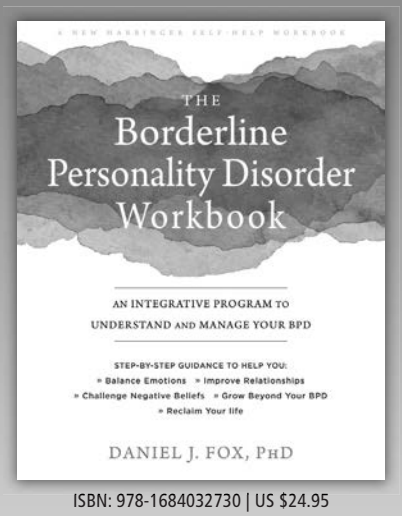
Have you checked our Self Help Book Recommendations listing lately? Thanks, yet again, to Erin Ward-Ciesielski and her committee, we just added 9 new titles that were approved by the Board of Directors. For a full listing, take a look: http://www.abct.org/SHBooks/. New titles welcomed.

Until next time!

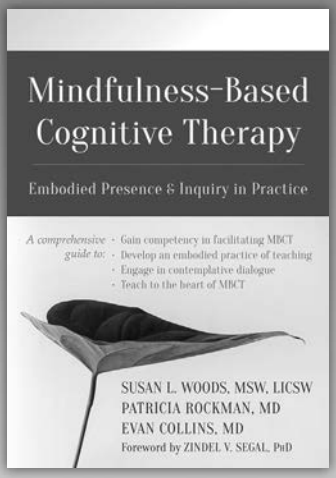
. . .

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

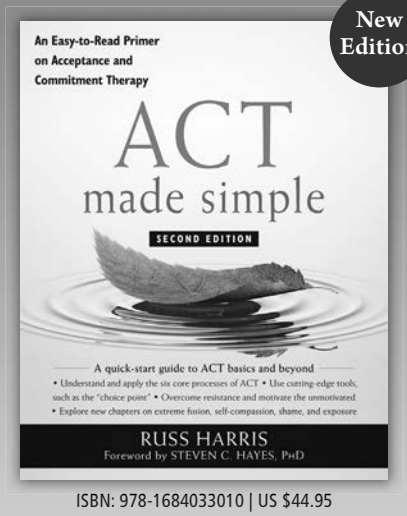
ESSENTIAL RESOURCES for YOUR PRACTICE



ISBN: 978-1684032730 | US $24.95

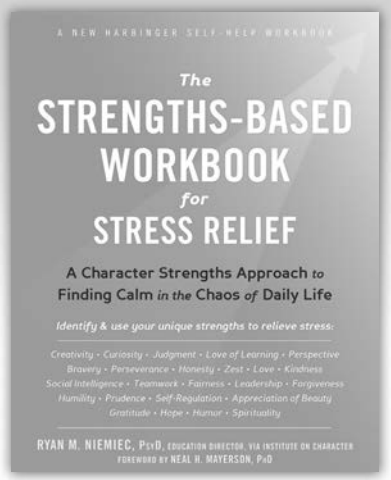


ISBN: 978-1684031504 | US $49.95

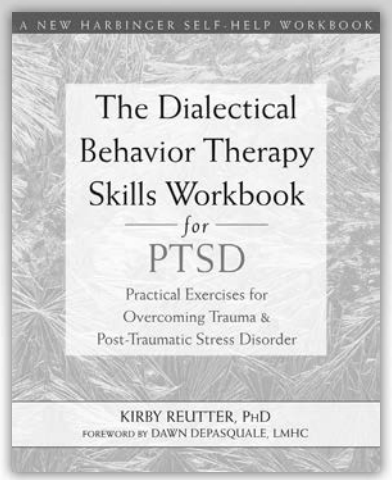


ISBN: 978-1684033010 | US $44.95

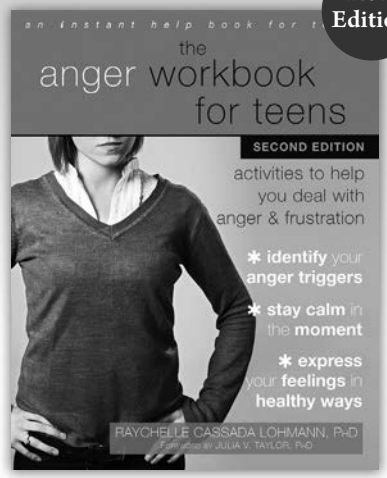
CONTEXT PRESS
An Imprint of New Harbinger Publications



ISBN: 978-1684032808 | US $24.95



ISBN: 978-1-684032648 | US $24.95



ISBN: 978-1684032457 | US $17.95

Instant Help Books
An Imprint of New Harbinger Publications

newharbingerpublications

1-800-748-6273 | newharbinger.com

QUICK TIPS for THERAPISTS Download a FREE e-book of our most popular tips: **newharbinger.com/quicktips**

Learn more about evidence-based continuing education and training with PRAXIS **praxiscet.com**

Brief Acceptance and Commitment Therapy With at-Risk Adolescents: A School-Based Preventive Intervention

Emily B. Kroska, *University of Iowa, University of Wisconsin, Madison*

Rosaura E. Orengo-Aguayo, *Medical University of South Carolina*

Michael W. O'Hara and James Marchman, *University of Iowa*

ADOLESCENTS REFERRED to alternative high schools are particularly vulnerable to depressive and anxiety disorders (Atkins, 2008; Lehr, Tan, & Ysseldyke, 2008). These students are more likely to have attempted suicide in the past year, consumed alcohol or drugs in the past 30 days, engaged in high-risk sexual behaviors (Grunbaum, Lowry, & Kann, 2001), and experienced chronic life stressors and adverse childhood experiences (Johnson & Taliaferro 2012). Preventive interventions that promote resilience and deter the development of psychopathology are critical (Kazdin, 2002; Merikangas et al., 2010).

Effective transdiagnostic processes should increase the efficacy of preventive interventions. One such process is experiential avoidance (EA)—attempts to avoid uncomfortable thoughts, emotions, urges, bodily sensations, or memories (Hayes, Strosahl, & Wilson, 1999)—which has been identified as a process underlying most maladaptive behavior and psychopathology (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013). Among children and adolescents, EA is associated with increased impulsivity, hyperactivity (Murrell, Steinberg, Connally, Hulsey, & Hogan, 2015), and worry (Laugesen, Dugas, & Bukowski, 2003). A high level of avoidance of thoughts and emotions has been found to mediate the relation between childhood maltreatment and adverse adult outcomes (e.g., psychological distress, internalizing symptoms), highlighting the detrimental role that EA can have across the lifetime (Marx & Sloan, 2002; Kroska, Miller, Roche, Kroska, & O'Hara, 2018). Existing evidence supports the potential utility of fostering openness and engagement among youth (Biglan, Hayes, & Pistorello, 2008).

Acceptance and Commitment Therapy (ACT) targets EA to facilitate connection with meaning, purpose, and vitality (Hayes et al., 1999). ACT is a mindfulness- and acceptance-based cognitive-behavioral therapy that aims to increase psychological flexibility by promoting values-based behavior. Psychological flexibility is the ability to engage in values-based behavior even in the presence of difficult thoughts, emotions, or other internal experiences. Adolescent research has been limited, but promising, in reducing depressive symptoms among depressed adolescents (Hayes, Boyd, & Sewell, 2011); high-risk sexual behavior among female adolescents (Metzler, Biglan, Noell, Ary, & Ochs, 2000); reduced depression, psychological inflexibility, stress, and anxiety, while increasing mindfulness, among adolescents screened for psychosocial problems in schools (Livheim et al., 2015); and improved problem-solving skills for peer conflict among seventh graders (Theodore-Oklota, Orsillo, Lee, & Vernig, 2014).

The present study aimed to build on previous research by testing the feasibility of a 1-day ACT intervention with alternative high school students. Attendance and grades were collected in addition to self-report data at pre- and post-intervention. Longitudinal change from pre-intervention to follow-up was examined, and the moderating role of traumatic experiences was tested. Authors expected to observe decreased avoidance and increased mindfulness from pre-intervention to follow-up, as well as decreased anxiety and depressive symptoms.

Materials and Methods

Procedure

Participants (N = 53) completed the baseline assessment 12.86 days (SD = 8.27) before completing the intervention (N = 46) and completed a pre-intervention assessment (N = 46) on the day prior to the intervention. Seven participants dropped out before completing the intervention. After the intervention, students completed 1-month (N = 38), 3-month (N = 16), 6-month (N = 20), and 12-month (N = 12) assessments. Multiple attempts were made to contact participants at each follow-up point, which proved challenging. Nearly all attrition was due to inability to contact participants. Attendance and grades were gathered at 1-month pre- and post-intervention.

Participants (N = 46) completed a single-session 5-hour group intervention with 5–7 students, led by two clinical psychology graduate students. The intervention consisted of experiential activities and discussions that addressed each of the ACT processes. See Table 1 for more detail.

Participants

Of the 120 alternative high school students enrolled during recruitment, 53 participated (see Figure 1). The majority were female (60.4%) and upperclassmen (11th grade: 45.3%; 12th grade: 17.0%). On average, participants were 16.29 years old (SD = 1.01). Participants were primarily African American (41.5%) or White, non-Hispanic (34%). The majority of students identified as heterosexual (66%). Importantly, about half of students reported that their family received food stamps (47.2%). See Table 2 for sample characteristics. The study was designed with school administrators who insisted that a control group not be utilized. The study was approved by the local university IRB. Participants under the age of 18 provided assent, and consent was obtained from guardians. Adult participants provided consent.

Measures

The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) was used to measure depressive symptoms, and Generalized Anxiety Disorder-7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) was used to measure anxiety symptoms. Both measures demonstrated good reliability (α =.92, .95, respectively).

The Early Trauma Inventory Self Report—Short Form (ETISR-SF; Bremner, Bolus, & Mayer, 2007) is a well-validated measure of traumatic experiences. Participants rate whether or not they have experienced 27 traumas, with higher scores indicating more trauma. Reliability of the total score in this sample was good (α =.87).

Earn 5 CE credits for reading books in the Advances in Psychotherapy book series

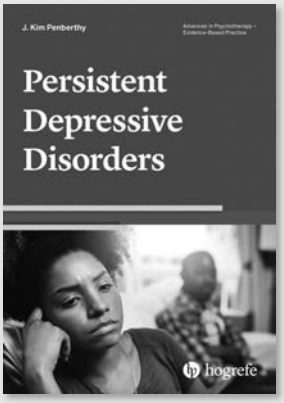
Psychologists and other healthcare providers may earn five continuing education credits for reading the books in the *Advances in Psychotherapy* series and taking a multiple choice exam. This continuing education program is a partnership of Hogrefe Publishing and the National Register of Health Service Psychologists.

The National Register of Health Service Psychologists is approved by the American Psychological Association to sponsor continuing education for psychologists. The National Register maintains responsibility for this program and its content.

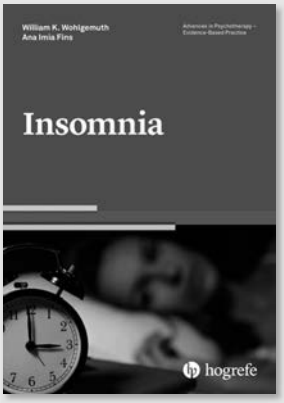
Readers who are not members of National Register can purchase each exam for US $25.00 or access to the entire series of exams for US $200.00. National Register members can take the exams free of charge.

Exams are available for 30 topics / books, with new titles being continually added.

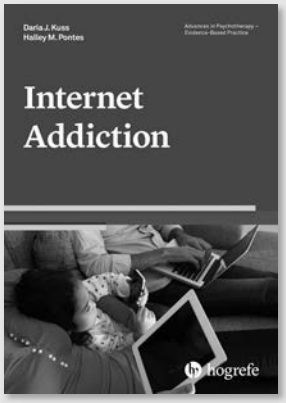
Learn more at **https://us.hogrefe.com/cenatreg**



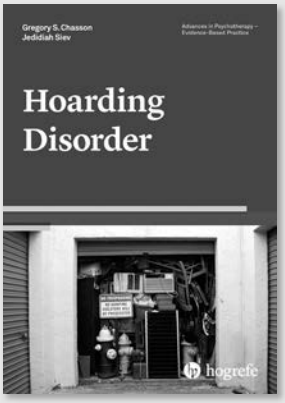
Vol. 43, 2019, vi + 106 pp.
US $29.80
ISBN 978-0-88937-505-5



Vol. 42, 2019, viii + 94 pp.
US $29.80
ISBN 978-0-88937-415-7



Vol. 41, 2019, iv + 86 pp.
US $29.80
ISBN 978-0-88937-501-7



Vol. 40, 2019, viii + 76 pp.
US $29.80
ISBN 978-0-88937-407-2

Hogrefe Publishing
30 Amberwood Parkway
Ashland, OH 44805, USA
Tel. 800 228 3749 (toll-free in North America)
Fax 419 281 6883
customerservice@hogrefe.com
www.hogrefe.com

hogrefe

The AFQ-Y (Acceptance and Fusion Questionnaire-Youth; Greco, Lambert, & Baer, 2008) is a 17-item measure of psychological inflexibility, cognitive fusion, and experiential avoidance in youth. Reliability in this sample was excellent (α = .97). The Child and Adolescent Mindfulness Measure-10 (CAMM-10; Greco, Baer, & Smith, 2011) measures mindfulness skills in youth. Reliability in the current sample was excellent (α = .96).

Attendance was quantified as the proportion of classes attended. GPA was measured at pre- and 1-month post-intervention on a 4.00 scale.

Intervention Adherence and Therapist Competency

Fidelity and competency checklists were created by the authors to assess facilitator adherence to the manual and competency in ACT, respectively. Two reviewers live-coded 57% of interventions. Reviewers were graduate students trained in the protocol. Exercises were rated on a 5-point Likert scale (1 = *Not at all adherent*, 5 = *Extremely adherent*). Mean adherence across all interventions was good (M = 4.85). The calculated value (K = .69) indicated good agreement. Competency of the co-facilitator team was rated on a 7-point Likert scale (0 = *Never true*, 6 = *Always true*). Mean competency across all interventions was good (M = 5.37). Kappa values indicated very good agreement among coders (K = .86).

Table 1. Description of Experiential Exercises, Metaphors, and Discussion Points During Intervention

Topic	Description of Activities
Introductions	Two Mountains metaphor; Facilitators told brief story of difficult time period during adolescence, followed by participants writing brief stories.
Values Identification and Clarification, Committed Action	Discussion of BIG life (life of meaning and vitality) versus small life (constricted life); Discussion of connection between values and pain; Identification of behaviors in service of values
Present Moment Awareness, Self-as-context	Distinguishing between internal and 5-senses experiences using mindfulness exercises (e.g., Leaves on a Stream; Hayes & Smith, 2005, p. 76); Use of specific emotion to distinguish between internal and 5-senses experience; Encourage contact with self-as-context by asking "who notices?"
Noticing Thoughts, Defusion	Noticing thoughts exercise; Defusion exercises (Milk, milk, milk; Clipboard; "I can't walk").
Creative Hopelessness, Unworkability of Experiential Avoidance	Digging metaphor (Hayes et al., 1999); The Uninvited Party Guest metaphor (Hayes et al., 1999); Tug-of-War exercise (Hayes & Smith, 2005, p. 32); Clean Pain/Dirty Pain exercise
Acceptance as an Alternative to Control	Chinese Finger Trap exercise (Hayes, Strosahl, & Wilson, 2011); Discussion of willingness—what it is and what it is not; Consider what they would be willing to have in service of values
Self-as-Context	Life is like exercise (participants are asked to create own metaphor for life, followed by discussion); Life as a Movie exercise
Mindful Committed Action (bringing it all together)	Passengers on a Bus exercise (Hayes & Smith, 2005, p. 153)
Conclusions	Final message: "choose to choose." This phrase means making mindful choices instead of letting internal experiences make choices for you.

Statistical Analyses

Descriptive statistics indicated that students reported a significant number of traumatic experiences (ETISR-SF M = 9.66, SD = 5.66). Participants reported mild depressive symptoms on the PHQ-9 (M = 8.29, SD = 7.87) and anxiety symptoms on the GAD-7 (M = 7.16, SD = 6.34). Mixed-effects modeling was used to analyze longitudinal change from pre- to post-intervention, with subject as a random effect, which accounts for individual variability. This approach is especially advantageous in datasets where missing data are expected because it allows participants with incomplete data to be included, thus increasing statistical power and reducing sampling bias. A longitudinal mixed-effects model was fit using the lme4 package (Bates et al., 2014) in R. Degrees of freedom were estimated using the lmerTest package in R (Kuznetsova, Brockhoff, & Christensen, 2014). Effect sizes were calculated using established procedures (Oishi, Lun, & Sherman, 2007).

Change over time was examined at the following time points: baseline (enrollment in the study), pre-intervention (day before intervention), and 1-month, 3-month, 6-month, and 12-month post-intervention. Given the observed high level of traumatic experiences in this population, additional analyses were conducted to examine the moderating role of trauma. Minimal item-level missing data were present and were imputed using mean imputation.

Results

Of the 46 students who began the 1-day intervention, all completed. Dropout at follow-up was substantial, with <50% completing the 3-month, 6-month, and 12-month assessments (see Figure 1). This school experiences quick turnover, and students who remained at school were able to be contacted for follow-up. Comparisons were conducted between those who completed the pre-intervention assessment and two or more follow-up assessments (N = 29) and those who did not (N = 22). No significant differences were found. The results are depicted in Tables 4 and 5.

Depressive symptoms decreased over time, $F(5, 106.31) = 12.91$, $p < .001$. There

Table 2. Descriptive Statistics of the Sample at First Completed Assessment

	***N* (%)**
Gender	
Male	21 (39.6%)
Female	32 (60.4%)
Age, M(SD)	16.29 (1.01)
Grade in School	
9	5 (9.4%)
10	15 (28.3%)
11	24 (45.3%)
12	9 (17.0%)
Race	
White, Non-Hispanic	18 (34.0%)
White Hispanic	6 (11.3%)
African American	22 (41.5%)
American Indian or Alaska Native	1 (1.9%)
Native Hawaiian or Pacific Islander	1 (1.9%)
Biracial or Multiracial	5 (9.4%)
Employment Status	
Full-time	3 (5.7%)
Part-time	26 (49.1%)
Unemployed	24 (45.3%)
Has children or currently pregnant	7 (13.2%)
Family receives food stamps	25 (47.2%)
In a Romantic Relationship	27 (50.9%)
Sexual Orientation	
Heterosexual	35 (66%)
Homosexual, Bisexual, Pansexual, or Other	15 (28.3%)
Missing	3 (5.7%)
English as first language	50 (94.3%)
Lives with biological parent(s)	43 (81.1%)
Moved homes in the last 6 months (# moves)	
0	37 (69.8%)
1+	16 (30.2%)

Table 3. Descriptive Statistics of Process, Moderator, and Outcome Variables at Pre-Intervention

Total Scores	***M(SD)***
Traumatic Experiences	9.66 (5.66)
General Trauma	11.00 (3.87)
Physical Punishment	5.00 (3.00)
Emotional Abuse	5.00 (2.04)
Sexual Abuse	5.00 (0.75)
Depressive Symptoms	8.29 (7.87)
Anxiety Symptoms	7.16 (6.34)
Avoidance	6.33 (8.23)
Mindfulness	25.59 (10.25)

were significant decreases in depressive symptoms between baseline and all follow-up points. The same pattern was reflected with decreases in anxiety, $F(5, 109.67) = 13.24$, $p < .001$, and avoidance, $F(5, 119.89) = 6.83$, $p < .001$, and increases in mindfulness, $F(5, 122.71) = 8.02$, $p < .001$. Differences in attendance approached significance from pre- ($M = 72\%$) to post-intervention ($M = 80\%$), $t(33.94) = 1.93$, $p = .06$. GPA did not significantly differ from pre- to post-intervention.

Moderation Analyses

Interaction analyses were conducted to determine if trauma moderated change in depressive and anxiety symptoms over time. Total trauma was centered at the mean. Simple effects were examined by centering trauma at one standard deviation above and below the mean (Table 5). Individuals who experienced a higher number of traumatic events showed greater change in depression, when compared to individuals with a lower number of traumatic events across depression, $t(139.11) = 5.11$, $p < .001$, $d = 0.87$, anxiety, $t(139.84) = 4.28$, $p < .001$, $d = 0.72$, avoidance, $t(142.77) = 2.74$, $p < .01$, $d = 0.46$, and mindfulness, $t(140.88) = -4.19$, $p < .001$, $d = 0.71$.

Discussion

Despite empirical support for ACT (Hayes et al., 2006), research with adolescents has been limited. The current study piloted a single-session, 5-hour ACT group with alternative high school students. Change in ACT processes was observed. From baseline through follow-up, significant reductions in depression and anxiety were observed at follow-up. Changes in attendance and GPA were not significant. The findings from this study are consistent with previous interventions at schools (Livheim et al., 2015).

The findings suggest that ACT may be a favorable preventive approach for at-risk adolescents. The results suggest that a single-session, 5-hour group ACT intervention may impact targeted therapeutic processes and internalizing symptoms among an at-risk, highly traumatized adolescent sample. The sample reported increased mindfulness and decreased avoidance, the targeted core processes, and though the sample did not report clinical levels of depression or anxiety at pre-intervention, significant reductions were observed and maintained. Further indicative of the appropriateness of ACT for preventive interventions, the findings demonstrated that adolescents reporting a greater history of trauma benefited most from the intervention, both in acquisition of the processes and in depressive and anxiety symptoms. Avoidance-targeting interventions may particularly be well-suited for trauma-exposed individuals, who may be more likely to engage in avoidance (Follette, Palm, & Pearson, 2006). The findings should be considered in light of the need for scalable, transdiagnostic interventions for youth that are both accessible and flexible. Single-session interventions offer the opportunity for brief, intensive interactions to create lasting change, and others have suggested the efficacy of this time-limited approach with youth (Schleider & Weisz, 2018). The findings herein warrant future randomized-controlled trials to examine the effectiveness of brief ACT interventions with this population.

These findings should be considered in light of significant limitations. Attrition was observed, as students at this school are transitory (i.e., changing schools, graduating) and difficult to reach, limiting ability to draw definitive conclusions. Forming a collaborative partnership was prioritized over strict methodological parameters (e.g., control group), and all observed findings could be the result of time, not the intervention. The study also has notable strengths. This is the first study to pilot ACT in an alternative high school. A brief intervention designed for delivery during one school day is promising for implementation and dissemination. The study was designed in collaboration with school administrators and represents a successful example of public engagement in research.

Despite being at risk (Grunbaum et al., 2001), alternative high school students are undertreated (Costello et al., 2014). These students are more likely to experience chronic life stress (Johnson & Taliaferro, 2012), and adverse childhood life experiences and chronic stressors robustly predict the development of mood and behavioral disorders among youth (Edwards, Holden, Felitti, & Anda, 2003). Alternative high school students are at risk to enter high school with an existing mental health disorder or to develop psychopathology during high school (Johnson & Taliaferro, 2012). Promoting acceptance- and values-based behavior preventatively has the potential to halt development of psychopathology (Biglan et al., 2008). Acknowledging its limitations, this study is encouraging when considering that students may benefit from just 5 hours of ACT. Future research would benefit from randomized controlled trials that examine the impact of mediating variables that impact longitudinal changes observed over time.

References

Atkins, T. (2008). Is an alternative school a school of choice? It depends. *Journal of School Choice, 2*(3), 344–347. doi:10.1080/15582150802371630

Bates, D., Maechler, M., Bolker, B., & Walker, S. (2014). *lme4: Linear mixed-effects models using Eigen and S4. R package version 1*.1-7, http://CRAN.R-project.org/package=lme4. R Package Version. http://doi.org/citeulike-article-id:7112638

Biglan, A., Hayes, S. C., & Pistorello, J. (2008). Acceptance and commitment: Implications for prevention science. *Prevention Science, 9*(3),139–152. doi:10.1007/s11121-008-0099-4

Bremner, J. D., Bolus, R., & Mayer, E. A. (2007). Psychometric properties of the Early Trauma Inventory-Self Report. *Journal of Nervous and Mental Disease, 195*(3), 211–8. doi:10.1097/01.nmd.0000243824.84651.6c

Costello, E. J., He, J., Sampson, N. A., Kessler, R. C., & Merikangas, K. R. (2014). Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey-Adolescent. *Psychiatric Services, 65*(3), 359–66. doi:10.1176/appi.ps.201100518

Edwards, V., Holden, G., Felitti, V., & Anda, R. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the adverse childhood experiences study. *American Journal of Psychiatry, 160*(8), 1453-1460. doi: 10.1176/appi.ajp.160.8.1453

Follette, V., Palm, K.M., & Pearson, A.N. (2006). Mindfulness and trauma: Implications for treatment. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 24*(1), 45–61. doi:10.1007/s10942-006-0025-2

Greco, L., Baer, R., & Smith, G. (2011). Assessing mindfulness in children and adolescents: Development and validation of the Child and Adolescent Mindfulness Measure. *Psychological Assessment, 23*(3), 606–614.

Greco, L., Lambert, W., & Baer, R. (2008). Psychological inflexibility in childhood and adolescence: Development and evaluation of the Avoidance and Fusion Questionnaire for Youth. *Psychological Assessment, 20*(2), 93–102.

Grunbaum, J. A., Lowry, R., & Kann, L. (2001). Prevalence of health-related behaviors among alternative high school students as compared with students attending regular high schools. *Journal of Adolescent Health, 29*, 337–343.

Hayes, L., Boyd, C. P., & Sewell, J. (2011). Acceptance and Commitment Therapy for the treatment of adolescent depression: A pilot study in a psychiatric outpatient setting. *Mindfulness, 2*, 86–94. doi:10.1007/s12671-011-0046-5

Hayes, S.C., Luoma, J.B., Bond, F.W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1–25. doi:10.1016/j.brat.2005.06.006

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change.* New York: Guilford.

Hayes, S., & Smith, S. X. (2005). *Get out of your mind & into your life: The new Acceptance & Commitment Therapy*. New York: New Harbinger.

Johnson, K. E., & Taliaferro, L. A. (2012). Health behaviors and mental health of students attending alternative high schools: a review of the research literature. *Journal for Specialists in Pediatric Nursing, 17*(2), 79–97.

Kazdin, A. E. (2002). Psychosocial treatments for conduct disorder in children and adolescents. In *A Guide to Treatments That Work* (2nd ed., pp. 57–85). New York: Oxford University Press.

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. doi:10.1046/j.15251497.2001.016009606.x

Kroska, E.B., Miller, M.M., Roche, A.I., Kroska, S.K., & O'Hara, M.W. (2018). Effects of traumatic experiences on obsessive-compulsive and internalizing symptoms: The role of avoidance and mindfulness. *Journal of Affective Disorders, 225*, 326-336.

Kuznetsova, A., Brockhoff, P. B., & Christensen, R.H.B. (2014). lmerTest: Tests for random and fixed effects for linear mixed effect models (lmer objects of lme4 package). R Package Version.

Laugesen, N., Dugas, M. J., & Bukowski, W. M. (2003). Understanding adolescent worry: The application of a cognitive model. *Journal of Abnormal Child Psychology, 31*(1), 55–64. doi:10.1023/A:1021721332181

Lehr, C. A., Tan, C. S., & Ysseldyke, J. (2008). Alternative Schools: A synthesis of state-level policy and research. *Remedial and Special Education, 30*(1), 19–32. doi:10.1177/0741932508315645

Livheim, F., Hayes, L., Ghaderi, A., Magnusdottir, T., Hogfeldt, A., Rowse, J., . . . Tengstrom, A. (2015). The Effectiveness of Acceptance and Commitment Therapy

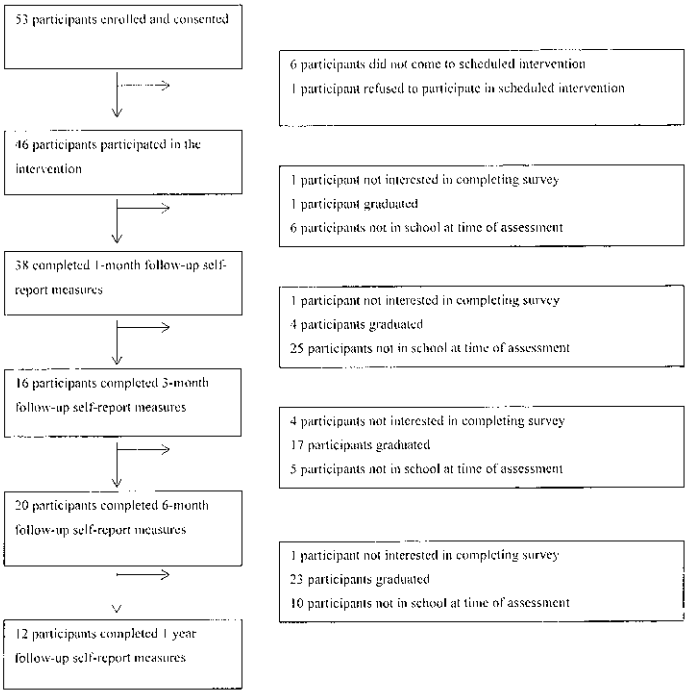


Figure 1. Participant flow chart

Table 4. Multilevel Modeling Results for Self-Report Data

Parameter	Estimate	Standard Error	*t* value	df	*p* value	*d* value
Outcome: Depressive symptoms						
Intercept	**8.58**	**1.15**	**7.48**	**139.55**	**<.001**	**1.27**
Pre-Intervention	-0.67	1.24	-0.54	119.41	0.59	-0.10
1-month follow-up	**-5.48**	**1.26**	**-4.35**	**116.23**	**<.001**	**-0.81**
3-month follow-up	-2.15	1.56	-1.38	113.86	0.17	-0.26
6-month follow-up	**-8.61**	**1.47**	**-5.84**	**115.98**	**<.001**	**-1.08**
1-year follow-up	**-5.99**	**1.68**	**-3.56**	**110.42**	**<.001**	**-0.68**
Trauma*Time	**1.03**	**0.20**	**5.11**	**139.11**	**<.001**	**0.87**
Outcome: Anxiety symptoms						
Intercept	**8.01**	**0.94**	**8.50**	**140.20**	**<.001**	**1.44**
Pre-Intervention	-1.23	1.02	-1.20	122.19	0.23	-0.22
1-month follow-up	**-5.48**	**1.04**	**-5.27**	**118.30**	**<.001**	**-0.97**
3-month follow-up	-2.94	1.29	-2.28	116.92	0.02	-0.42
6-month follow-up	**-7.38**	**1.23**	**-5.98**	**118.07**	**<.001**	**-1.10**
1-year follow-up	**-6.38**	**1.39**	**-4.59**	**113.91**	**<.001**	**-0.86**
Trauma*Time	**0.71**	**0.17**	**4.28**	**139.84**	**<.001**	**0.72**
Outcome: Avoidance						
Intercept	**2.54**	**0.65**	**3.88**	**142.67**	**<.001**	**0.65**
Pre-Intervention	-0.37	0.76	-0.48	126.69	0.63	-0.09
1-month follow-up	**-2.68**	**0.77**	**-3.48**	**123.60**	**.001**	**-0.63**
3-month follow-up	1.03	0.95	1.08	124.33	0.28	0.19
6-month follow-up	**-2.81**	**0.91**	**-3.12**	**125.83**	**0.002**	**-0.56**
1-year follow-up	**-2.10**	**1.04**	**-2.03**	**120.70**	**0.04**	**-0.37**
Trauma*Time	**0.31**	**0.11**	**2.74**	**142.77**	**0.01**	**0.46**
Outcome: Mindfulness						
Intercept	**36.34**	**0.73**	**49.55**	**140.79**	**<.001**	**8.35**
Pre-Intervention	0.80	0.85	0.94	128.48	0.35	0.17
1-month follow-up	**3.78**	**0.88**	**4.32**	**125.47**	**<.001**	**0.77**
3-month follow-up	-1.57	1.08	-1.45	127.22	0.15	0.26
6-month follow-up	**2.90**	**1.03**	**2.81**	**127.53**	**0.01**	**0.50**
1-year follow-up	**3.04**	**1.17**	**2.59**	**124.20**	**0.01**	**0.46**
Trauma*Time	**-0.54**	**0.13**	**-4.19**	**140.88**	**<.001**	**-0.71**

Note. Bolded rows indicate statistical significance.

for Adolescent Mental Health: Swedish and Australian Pilot Outcomes. *Journal of Child and Family Studies*, 1–15.

Marx, B.P., & Sloan, D.M. (2002). The role of emotion in the psychological functioning of adult survivors of childhood sexual abuse. *Behavior Therapy, 33*, 563-577.

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., . . . Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication—Adolescent Supplement. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(10), 980–989. doi:10.1016/j.jaac.2010.05.017

Metzler, C. W., Biglan, A., Noell, J., Ary, D. V., & Ochs, L. (2000). A randomized controlled trial of a behavioral intervention to reduce high-risk sexual behavior among adolescents in STD clinics. *Behavior Therapy, 31*, 27–54.

Murrell, A. R., Steinberg, D. S., Connally, M. L., Hulsey, T., & Hogan, E. (2015). Acting Out to ACTing On: A preliminary investigation in youth with ADHD and comorbid disorders. *Journal of Child and Family Studies, 24*(7), 2174–2181.

Oishi, S., Lun, J., & Sherman, G. D. (2007). Residential mobility, self-concept, and

positive affect in social interactions. *Journal of Personality and Social Psychology, 93*(1), 131–141. doi:10.1037/0022-3514.93.1.131

Schleider, J., & Weisz, J. (2018). A single-session growth mindset intervention for adolescent anxiety and depression: 9-month outcomes of a randomized trial. *Journal of Child Psychology and Psychiatry, 59*(2), 160-170.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine, 166*(10), 1092–1097. doi:10.1001/archinte.166.10.1092

Theodore-Oklota, C., Orsillo, S. M., Lee, J. K., & Vernig, P. M. (2014). A pilot of an acceptance-based risk reduction program for relational aggression for adolescents. *Journal of Contextual Behavioral Science, 3*(2), 109–116. doi:10.1016/j.jcbs.2014.03.001

. . .

This work was supported by a Graduate and Professional Student Government research grant from the University of Iowa. Work on this manuscript was supported in part by the National Institute of Mental Health (Grant N. T32 MH18869).

Acknowledgements: Lauren Clevenger, Ph.D.; Rebecca Grekin, Ph.D.; Michelle Miller, M.A.; Rebecca Neel, Ph.D.; Marianne Rizk, M.A.; Teresa Treat, Ph.D.; Julia Van Liew, Ph.D.; Xin Yu, B.A.; Mark Vander Weg, Ph.D.

Correspondence to Emily B. Kroska, Ph.D., 6001 Research Park Blvd., Madison, WI 53719; emilykroska@gmail.com

Table 5. Interaction Analyses With Traumatic Experiences as a Moderator

Parameter	Estimate	Standard Error	*t* value	df	*p* value	*d* value
Outcome: Depressive symptoms						
Simple effect: High trauma						
Intercept	**14.47**	**1.81**	**8.01**	**142.70**	**<.001**	**1.34**
Pre-Intervention	-2.72	1.87	-1.45	114.28	0.15	-0.27
1-month follow-up	**-9.68**	**1.91**	**-5.07**	**111.66**	**<.001**	**-0.96**
3-month follow-up	**-6.40**	**2.43**	**-2.63**	**116.16**	**0.01**	**-0.49**
6-month follow-up	**-13.46**	**2.10**	**-6.41**	**109.41**	**<.001**	**-1.23**
1-year follow-up	**-9.55**	**2.40**	**-3.97**	**110.99**	**<.001**	**-0.75**
Simple effect: Low trauma						
Intercept	**2.68**	**1.42**	**1.88**	**127.48**	**0.06**	**0.33**
Pre-Intervention	1.38	1.63	.84	120.02	0.40	0.15
1-month follow-up	-1.28	1.63	-0.79	116.44	0.43	-0.15
3-month follow-up	2.11	2.07	1.02	113.50	0.31	0.19
6-month follow-up	-3.75	1.95	-1.92	116.98	0.06	-0.36
1-year follow-up	-2.43	2.16	-1.13	108.29	0.26	-0.22
Outcome: Anxiety symptoms						
Simple effect: High trauma						
Intercept	**12.07**	**1.49**	**8.12**	**142.79**	**<.001**	**1.36**
Pre-Intervention	-2.41	1.55	-1.55	117.24	0.12	-0.29
1-month follow-up	**-8.20**	**1.58**	**-5.20**	**114.78**	**<.001**	**-0.97**
3-month follow-up	**-5.54**	**2.01**	**-2.76**	**119.11**	**0.01**	**-0.51**
6-month follow-up	**-9.85**	**1.73**	**-5.68**	**112.66**	**<.001**	**-1.07**
1-year follow-up	**-8.46**	**1.98**	**-4.27**	**114.22**	**<.001**	**-0.80**
Simple effect: Low trauma						
Intercept	**3.95**	**1.17**	**3.37**	**129.73**	**<.001**	**0.59**
Pre-Intervention	-0.05	1.34	-0.04	123.00	0.97	0.01
1-month follow-up	**-2.76**	**1.34**	**-2.06**	**119.02**	**0.04**	**-0.38**
3-month follow-up	-0.34	1.71	-0.20	116.56	0.84	-0.04
6-month follow-up	**-4.91**	**1.66**	**-2.95**	**118.01**	**0.004**	**-0.54**
1-year follow-up	**-4.29**	**1.78**	**2.41**	**112.15**	**0.02**	**0.46**

Table 5, continued

Parameter	Estimate	Standard Error	*t* value	df	*p* value	*d* value
Outcome: Avoidance						
Simple effect: High trauma						
Intercept	**4.34**	**1.04**	**4.16**	**142.81**	**<.001**	**0.70**
Pre-Intervention	-1.54	1.15	-1.34	122.27	0.18	-0.24
1-month follow-up	**-4.54**	**1.18**	**-3.86**	**119.12**	**<.001**	**-0.71**
3-month follow-up	-0.06	1.48	-0.04	128.88	0.97	-0.01
6-month follow-up	**-4.50**	**1.30**	**-3.47**	**117.48**	**<.001**	**-0.64**
1-year follow-up	**-3.35**	**1.48**	**-2.27**	**121.76**	**0.03**	**-0.41**
Simple effect: Low trauma						
Intercept	0.74	0.80	0.93	138.41	0.35	0.16
Pre-Intervention	0.81	0.99	0.82	126.74	0.42	0.15
1-month follow-up	-0.83	1.00	-0.83	123.18	0.41	-0.15
3-month follow-up	2.13	1.27	1.68	123.65	0.10	0.30
6-month follow-up	-1.11	1.19	-0.93	127.04	0.35	-0.17
1-year follow-up	-0.86	1.34	-0.65	117.39	0.52	-0.12
Outcome: Mindfulness						
Simple effect: High trauma						
Intercept	**33.24**	**1.17**	**28.36**	**140.82**	**<.001**	**4.78**
Pre-Intervention	**2.71**	**1.30**	**2.09**	**124.92**	**0.04**	**0.37**
1-month follow-up	**6.89**	**1.33**	**5.17**	**122.14**	**<.001**	**0.94**
3-month follow-up	-0.31	1.67	-0.19	131.29	0.85	-0.03
6-month follow-up	**5.96**	**1.47**	**4.06**	**120.91**	**<.001**	**0.74**
1-year follow-up	**5.40**	**1.67**	**3.23**	**125.11**	**.002**	**0.58**
Simple effect: Low trauma						
Intercept	**39.43**	**0.89**	**44.35**	**137.68**	**<.001**	**7.56**
Pre-Intervention	-1.11	1.12	-0.99	128.42	0.33	-0.17
1-month follow-up	0.68	1.14	0.60	124.55	0.55	0.11
3-month follow-up	-2.82	1.43	-1.97	126.59	0.05	-0.35
6-month follow-up	-0.17	1.38	-0.12	127.91	0.90	-0.02
1-year follow-up	0.68	1.51	0.45	121.23	0.65	0.08

Note. Bolded rows indicate statistical significance.

Scientific Skepticism and Critical Thinking About Therapy

Stephen Hupp and Cara Santa Maria, *Southern Illinois University Edwardsville and Fielding Graduate University*

RECENT ISSUES OF *the Behavior Therapist* have bravely tackled the thorny issue of pseudoscientific therapeutic practices—treatments that continue to be used despite considerable research showing them to be ineffective. As an introduction to a special issue dedicated to combatting this issue, Codd (2018) provided an overview of different approaches to dealing with pseudoscience. For example, articles address topics such as dealing with clients' beliefs about pseudoscience (Vyse, 2018), facing the challenges of exposing pseudoscience (Pignotti, 2018), and considering some legal remedies for combatting pseudoscience (Napolitano, 2018).

Emerging as an exciting debate within the pages of *tBT*, Strosahl (2018) later challenged the use of the word pseudoscience altogether, suggesting it is overused and can dampen investigation into promising but untested approaches. Lilienfeld and Gaudiano (2018) then responded by delineating appropriate and problematic uses of the term pseudoscience. However one chooses to define such approaches, the potential danger of utilizing untested, discredited, and/or non–bona fide therapies is very real. One idea, however, on which both sides of this debate appear to agree, is that blatantly harmful therapeutic practices do continue to be used. In addition to the harm caused directly to clients by these practices, they threaten the legitimacy and trustworthiness of licensed mental health practitioners. However, all hope is not lost. In his introductory article to the special issue, Codd (2018) ends with this encouragement:

> The problem of pseudoscience in mental health treatment is significant. Please do not read these articles and then fall into inaction. Allow these articles to stimulate action: Share them widely, execute the actionable items they suggest, and/or initiate a new line of empirical work based on their content. Numerous suffering human beings are counting on you. (p. 3)

Readers inspired by these words may also be motivated to learn more about the broader community of people engaging in scientific skepticism across a variety of disciplines. This community is one important place to share information that distinguishes between effective and ineffective approaches related to mental health. That is to say, there are many different outlets for dissemination (and de-implementation) beyond the typical resources within academic psychology.

Toward that end, this article provides a quick overview of resources that may be useful to skeptically minded mental health practitioners. The list opens with skeptical organizations and conferences, all of which commonly include a focus on therapeutic practices. Next, websites, blogs, and magazines also frequently contain information relevant to therapy. Podcasts, documentaries, and television shows often tackle therapeutic topics in entertaining ways. Finally, scores of books emphasize critical thinking related to therapy. Please keep in mind that this list is by no means exhaustive and is only meant to serve as an introduction to the ever-growing index of skeptical media sources.

Organizations

- *The Committee for Skeptical Inquiry (CSI)*. Since 1976, the CSI has been promoting scientific inquiry and using empirically based techniques to investigate extraordinary claims.
- *The Skeptics Society*. A nonprofit organization that seeks to investigate and expose pseudoscience of all stripes, the Skeptics Society also tackles many topics related to therapy and disseminates information about the psychology of belief in unsupported ideas.
- *Local skeptical organizations.* There are several local organizations dedicated to skepticism across the United States, spanning from the Bay Area Skeptics in San Francisco to the New York City Skeptics, and many cities in between.
- *International skeptical organizations.* Skeptical organizations span the globe, operating on nearly every continent. Prominent organizations include the Australian Skeptics, the Belgian Committee for the Critical Analysis of Parasciences, the Dutch Society Against Quackery, the Hong Kong Skeptics, the Science and Rationalists' Association of India, the Brazilian Society of Skeptics and Rationalists, and the Good Thinking Society in the United Kingdom.

Conferences

- *Committee for Skeptical Inquiry Conference (CSICon)*. This conference regularly includes skeptically oriented speakers from psychology and related disciplines, and it is currently held in Las Vegas on an annual basis.
- *The Amazing Meeting (TAM).* Hosted by the James Randi Educational Foundation, TAM was the premiere skeptical event for 13 years. Coinciding with James Randi's retirement, the foundation ceased operations; however, many of the conference's talks can still be found on YouTube.
- *Local conferences*. Local conferences occur across the United States. Covering topics related to medicine and related areas, for example, the Northeast Conference on Science and Skepticism (NECSS) is co-hosted by the New York City Skeptics and the New England Skeptical Society. Additionally, Dragon Con in Atlanta includes a "SkepTrack." Skepticon, Apostacon, the Skeptic's Toolbox, and SkeptiCamp are also held across the country. A common informal event, known as Skeptics in the Pub, utilizes an open-access format often run by smaller community-based skeptic organizations.
- *International conferences*. Global skeptic organizations are well-known for hosting international conferences. For example, QED (Question, Explore, Discover) is co-hosted by the Merseyside Skeptic Society and the Greater Manchester Skeptic Society of the United Kingdom. The European Skeptics Congress has been held throughout Europe since 1989. Many other organizations gather across the globe, drawing hundreds to thousands of participants per event.

Websites and Blogs

- *Child Myths.* A developmental psychology professor discusses pseudoscience related to infancy, childhood, and adolescence (http://childmyths.blogspot.com/).
- *Neurologica.* A clinical neurologist reviews questionable and harmful ideas in health, medicine, neuroscience, and media (https://theness.com/neurologicablog/).
- *Quackwatch.* Developed by a psychiatrist, Quackwatch documents issues related to consumer health (https://www.quackwatch.org/).
- *Science-Based Medicine.* Scrutinizing dubious claims related to medicine as well as clinical psychology, this site offers blog posts on a number of current pseudoscientific topics (https://sciencebasedmedicine.org/).
- *Skepchick.* A team of science communicators focus on women's issues, LGBTQ issues, education, art, parenting, and disabilities (http://skepchick.org/).
- *Skeptical Medicine.* This website critiques complementary and alternative medicine and other health-related claims (https://sites.google.com/site/skepticalmedicine/).
- *Skeptical Raptor.* An anonymous blogger with a background in biochemistry and endocrinology writes about pharmacology and other topics related to health (https://www.skepticalraptor.com/skepticalraptorblog.php/).
- *Snopes.* Garnering widespread appeal, Snopes investigates shocking claims that have gone viral on the internet (https://www.snopes.com/).
- *The Skeptic Magazine.* Not to be confused with the American magazine of a similar title, this United Kingdom–based website includes several contributors from mental health fields, and it also offers the coveted Ockham Awards to promote skeptical activism (https://www.skeptic.org.uk/).
- *What's the Harm?* This website (http://whatstheharm.net/) documents case reports of people experiencing significant harm from pseudoscientific interventions.

Magazines

- *Science et Pseudo-Sciences.* This quarterly French magazine, which has been in print since 1968, focuses on scientific skepticism.
- *Skepter.* This popular Dutch magazine is published by the skeptical foundation Stitching Skepsis.
- *Skeptic.* Published by the Skeptics Society, this American magazine covers a broad range of topics, many of which are related to psychology.
- *Skeptical Inquirer.* This magazine is published by the United States–based Committee for Skeptical Inquiry and often includes articles related to questionable practices in clinical psychology.
- *The Skeptic.* This Australian magazine covers most areas of skepticism.

Podcasts

- *Skepticality.* This podcast has been releasing fewer episodes in recent

years, but it has accumulated hundreds of episodes and is the official podcast of Skeptic magazine.
- *Skeptics with a K*. As the official podcast of the Merseyside Skeptics Society, this show discusses science, reason, and critical thinking with a Liverpool sensibility.
- *Skeptoid*. This popular weekly podcast examines pseudoscience and the paranormal in short, succinct episodes.
- *Talk Nerdy*.[2] The host of this podcast is a student in a Ph.D. program in clinical psychology. She interviews a scientist, author, and/or science communicator in every episode.
- *The European Skeptics Podcast*. This show covers skeptical issues and activism across Europe and features hosts from Latvia, Sweden, and Hungary.
- *The Prism Podcast*. A pediatrician and a dentist host this show, often covering topics related to psychology and critical thinking.
- *The Skeptic's Guide to the Universe*.[2] The hosts of this popular long-running podcast include a neurologist and several other skeptical "rogues."
- *The Skeptic Zone*. This Australian podcast broadly covers most areas related to skepticism.

Documentaries

- *An Honest Liar* (2014). This biographical portrait of noted skeptic, James "The Amazing" Randi, emphasizes his open use of deception as a magician.
- *Enemies of Reason* (2007). Originally broadcast in the United Kingdom, this two-part television documentary is hosted by Richard Dawkins and covers topics such as acupuncture, psychokinesis, and psychics.
- *Food Evolution* (2006). Focusing on the debate around genetically modified organisms, this film discusses the use of misinformation in campaigns to undermine evidence-based policy.
- *Here Be Dragons* (2008). Produced by skeptic Brian Dunning, this documentary provides an overview of critical thinking about pseudoscience.
- *Jabbed: Love, Fear, and Vaccines* (2013). Against a background of reason and evidence, this Australian-made documentary paints a nuanced picture of the global crisis of vaccine denialism.
- *Science Moms*[1] (2017). This documentary covers topics related to parenting such as vaccines, homeopathy, and genetically modified organisms.

Television Shows

- *A User's Guide to Cheating Death*. Hosted by health law expert Timothy Caulfield, this show investigates various health claims such as those related to sleep, sex, and dieting.
- *Adam Ruins Everything*. With a snarky sense of humor, comedian Adam Conover tackles misperceptions about many different topics.
- *Bill Nye Saves the World*.[2] Several episodes of this show are dedicated to critical thinking and feature noted skeptics.
- *Bullshit*. For many years, magicians Penn and Teller debunked many claims in this show (geared for adults only).
- *Mythbusters*. The first popular television show dedicated to busting myths, this show typically teaches critical thinking by focusing on myths that usually somehow involve explosions but occasionally attempts to answers questions related to psychology. Most recently a spinoff, called Mythbusters Jr., includes several myth-busting youth.

Books—Interdisciplinary Topics Related to Pseudoscience

- *Flim-Flam! Psychics, ESP, Unicorns, and Other Delusions* (Randi, 1987). This book covers topics such as fairies, levitation, and psychic surgery.
- *The Demon Haunted World: Science as a Candle in the Dark* (Sagan, 1995). This book covers specific topics such as visits from demons, alien abductions, and some notions by Sigmund Freud.
- *Why People Believe Weird Things: Pseudoscience, Superstition, and Other Confusions of Our Time* (Shermer, 2010). This book covers topics such as fallacies, pseudohistory, and evolution denialism.
- *Critical Thinking, Science, and Pseudoscience: Why We Can't Trust Our Brains* (Lack & Rousseau, 2016). This book covers critical thinking about pseudoscience.
- *Pseudoscience: The Conspiracy Against Science* (Kaufman & Kaufman, 2018). This book distinguishes science from pseudoscience.
- *The Skeptics' Guide to the Universe: How to Know What's Really Real in a World Increasingly Full of Fake*[2] (Novella, Novella, Santa Maria, Novella, & Bernstein, 2018). This book covers fallacies, biases, and several specific dubious claims.

Books—Broad Psychology Related to Critical Thinking

- *How We Know What Isn't So: The Fallibility of Human Reason in Everyday Life* (Gilovich, 1991). This book focuses on contributing factors leading to questionable beliefs.
- *Thinking, Fast and Slow* (Kahneman, 2011). This book focuses on understanding cognitive biases.
- *Believing in Magic: The Psychology of Superstition – Updated Edition* (Vyse, 2013). This book explains why people have superstitious beliefs.
- *Mistakes Were Made (But Not By Me): Why We Justify Foolish Beliefs, Bad Decisions, and Hurtful Acts* (Tavris & Aronson, 2015). This book covers cognitive dissonance and other factors leading to poor decisions.

Books—Clinical Psychology and Related Disciplines

- *Great Myths of Psychology Series*[1] (2010- 2019; Series edited by Lilienfeld & Lynn). This series includes books that focus on popular psychology, child development, adolescence, education, the brain, intimate relationships, and aging.
- *Brainwashed: The Seductive Appeal of Mindless Neuroscience* (Satel & Lilienfeld, 2013). This book covers dubious claims in neuroscience.
- *Alternative Psychotherapies: Evaluating Unconventional Mental Health Treatments* (Mercer, 2014). This book addresses specific dubious approaches such as regression therapies, energy therapies, and bodywork.
- *Science and Pseudoscience in Clinical Psychology, Second Edition* (Lilienfeld, Lynn, & Lohr, 2015). This book tackles questionable claims related to topics such as expert testimony, dissociative identity disorder, posttraumatic stress disorder, depression, and alcohol use disorder.
- *Science and Pseudoscience in Social Work Practice* (Thyer & Pignotti,

[1] The first author developed or made a major contribution to the resource.
[2] The second author developed or made a major contribution to the resource.

2015). This book highlights dubious claims in therapy for with youth and adults.

- *Pseudoscience in Child and Adolescent Psychotherapy*[1] (Hupp, 2019). This book reviews questionable claims related to every major type of mental health diagnosis facing youth.
- *Thinking Critically about Child Development, 4th Edition*[1] (Mercer, Hupp, & Jewell, 2020). This book examines common misunderstandings related to child development and was co-written by the first author of this article.

Admittedly, the above list is incomplete; however, any of these resources could provide a good starting point for those interested in learning more about scientific skepticism. There exists a wealth of information designed to encourage critical thinking skills for students, academics, professionals, and the public. We hope that this brief introduction has inspired you to investigate further and perhaps do your part to contribute to the skeptical community. If interested, we encourage you to find the nearest skeptical organization, attend a local meeting or national conference, subscribe to a podcast or magazine (or two!), and consider submitting a manuscript of your own to a skeptical outlet. The community only stands to benefit from the contributions of those who know all too well the deleterious effects of pseudoscience and quackery.

Ways to Participate in Scientific Skepticism

- *Engage on the internet*. Providing comments on one of the skeptical blogs can be a good way to share information. Similarly, social media can be another way to help disseminate scientific skepticism.
- *Submit an article.* Some blogs also accept outside submissions for entries. For example, the Science-Based Medicine blog includes a wide variety of authors. Skeptical magazines are also a great option for publishing ideas related to skeptical psychology.
- *Review books*. Journals often publish reviews for new books. Also, providing an online review of a skeptical book (e.g., on Amazon) can help increase the likelihood that others check it out.
- *Rate podcasts*. Simply providing ratings for skeptical podcasts (e.g., on iTunes) can help them reach larger audiences.
- *Edit Wikipedia*. Wikipedia is the first place a lot of people go to get information. Thus, many professionals have dedicated their time to making sure these entries include a healthy dose of scientific skepticism. Guerilla Skepticism on Wikipedia (GSoW) is one easily accessible group with this goal.
- *Speak at an event*. Getting involved with a local skeptical organization can involve making presentations during skeptical events. It's more challenging to get an invitation to speak at national or international skeptical conference; however, you can always reach out to the conference organizers and pitch an idea. Also, the CSICon includes a "Sunday Papers" session that accepts applications for speaker slots.
- *Provide financial support.* Skeptical podcasts are usually free but can often be supported through donations or memberships using subscription ser-

vices (e.g., Patreon). New skeptical ideas can even be supported using crowdfunding platforms (e.g., Kickstarter). Lastly, financial support can come in the form of membership to skeptical organizations.

References

Codd, R. T. III (2018). Introduction to the special issue: Pseudoscience in mental health treatment: What remedies are available? *the Behavior Therapist, 41*(1), 1-3.

Gilovich, T. (1991). *How we know what isn't so*. New York, NY: Free Press.

Hupp, S. (2019). *Pseudoscience in child and adolescent psychotherapy: A skeptical field guide*. Cambridge, UK: Cambridge University Press.

Kahneman, D. (2011). *Thinking, fast and slow*. New York, NY: Farrar, Straus, & Giroux.

Lack, C. W., & Rousseau, J. (2016). *Critical thinking, science, and pseudoscience: Why we can't trust our brains*. New York, NY: Springer.

Kaufman, A. B., & Kaufman, J. C. (2018). *Pseudoscience: The conspiracy against science*. Cambridge, MA: MIT Press.

Lilienfeld, S. O., & Gaudiano, B. A. (2018). Pseudoscience in behavior therapy: Concurrences, confusions, and clarifications – Response to Strosahl. *the Behavior Therapist, 41*(6), 273-280.

Lilienfeld, S. O., & Lynn (2010-2019). *Great Myths Psychology Series.* Malden, MA: Wiley-Blackwell.

Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (2015). *Science and pseudoscience in clinical Psychology* (2nd ed.). New York, NY: The Guilford Press.

Mercer, J. (2014). *Alternative psychotherapies: Evaluating unconventional mental health treatments*. New York, NY: Rowman & Littlefield.

Mercer, J., Hupp, S., & Jewell, J. (2020). *Thinking critically about child development: Examining myths and misunderstandings* (4th ed). Washington, DC: Sage.

Napolitano, L. A. (2018). Pseudotherapies in clinical psychology: What legal recourse do we have? *the Behavior Therapist, 41*(1), 47-51.

Novella, S., & Novella, B., Santa Maria, C., Novella, J., & Bernstein, E. (2018). *The skeptics' guide to the universe: How to know what's really real in a world increasingly full of fake*. New York: Grand Central Publishing.

Pignotti, M. (2018). Exposing pseudoscientific practices: Benefits and hazards. *the Behavior Therapist, 41*(1), 51-54.

Randi, J. (1987). *Flim-flam!: Psychics, ESP, unicorns and other delusions.* Buffalo, NY: Prometheus Books.

Sagan, C. (1995). *The demon-haunted world: Science as a candle in the dark.* New York: Random House.

Satel, S. L., & Lilienfeld, S. O. (2013). *Brainwashed: The seductive appeal of mindless neuroscience*. New York, NY: Basic Books.

Shermer, M. (2010). *Why people believe weird things: Pseudoscience, superstition, and other confusions of our time*. New York: St. Martin's Griffin.

Strosahl, K. (2018). Some reflections on the stormy marriage of science, would-be science, and "pseudoscience." *the Behavior Therapist, 41*(5), 237-247.

Tavris, C., & Aronson, E. (2015). *Mistakes were made (but not by me): Why we justify foolish beliefs, bad decisions, and hurtful acts*. Boston, MA: Mariner Books.

Thyer, B. A., & Pignotti, M. (2015). *Science and pseudoscience in social work practice*. New York, NY: Springer.

Vyse, S. A. (2013). *Believing in magic: The psychology of superstition.* New York, NY: Oxford University Press.

Vyse, S. (2018). What's a therapist to do when clients have pseudoscientific beliefs? *the Behavior Therapist, 41*(1), 36-39.

. . .

The authors disclose that they developed or otherwise contributed to some of the resources mentioned in the article, and they have identified these resources within the text. *Note*: [1] = the first author developed or made a major contribution to the resource; [2] = the second author developed or made a major contribution to the resource.

Correspondence to Stephen Hupp, Ph.D., Professor of Psychology, Southern Illinois University Edwardsville, Alumni Hall, Box 1121, Edwardsville, IL 62026-1121; sthupp@siue.edu

Making a Difference, Starting With Me: Mindfulness, Values-Based Self-Care, and Self-Compassion for Psychologists Who Work With Children and Families

Amy R. Murrell, Teresa C. Hulsey, Leyla Ergüder, and Ethan G. Lester,
University of North Texas

PSYCHOLOGISTS PLAY MANY IMPORTANT roles in the lives of children, adolescents, and their families. These caring individuals may function as school psychologists—conducting assessments, prevention programs, and consulting with parents, teachers, and administration (Helgoth & Sobansky, 2008)—or as pediatric psychologists, providing psychological treatment for problems related to a child's physical health as part of an interdisciplinary treatment team in medical settings (Wahass, 2005). Psychologists may also work with youth and their families in private practice as clinical child psychologists (Wahass), providing trauma treatment or therapy for childhood bipolar disorder. They may also be counseling psychologists (Wahass), for example, helping families through divorce. They could be forensic clinical psychologists, conducting evaluations with youth in the juvenile justice system (Borum & Otto, 2004). These motley examples are just a small representation of potential roles and responsibilities that psychologists who work with youth may hold. Many of these varied positions are accompanied by barriers that place psychologists at risk for psychological distress, compassion fatigue, and burnout (Craig & Sprang, 2010; Sodeke-Gregson, Holttum, & Billings, 2013).

Burnout is defined as "a prolonged response to chronic emotional and interpersonal stressors on the job" (Maslach, Schaufel, & Leiter, 2001). The barriers psychologists face can include being subjected to unrealistic expectations or demands and requirement of functioning in complicated contexts. For example, school psychologists experience pressures from teachers and principals to allocate large amounts of time on prevention, counseling, consultation, and in-service training (Farrell, Jimerson, Kalambouka, & Benoit, 2005). Due to competing job demands, school psychologists often feel too overwhelmed to carry out these services (Watkins, Crosby, & Pearson, 2001). It is understandable that many school psychologists experience ethical dilemmas when they must balance

opposing requests between children's rights, and anticipation of parents' and school's objectives (Knauss, 2001).

Results of a systematic review indicated that emotional exhaustion was the most commonly reported aspect of burnout among psychologists (McCormack, MacIntyre, O'Shea, Herring, & Campbell, 2018). According to Maslach, Schaufeli, and Leiter (2001), emotional exhaustion is the stress component and "central quality" of burnout. Interestingly, Dreison, White, Bauer, Salyers, and McGuire (2016) found that psychologists reported greater levels of emotional exhaustion as compared to other mental health professionals working in disciplines such as addictions and psychiatry. However, there is some contradictory evidence. A review by Rössler found negative impact is worse for psychiatrists, who tend to not disclose their problems to others (Rössler, 2012). Still, McCormack and colleagues (2018) posited that overinvolvement with a client could be a burnout risk more specific to psychologists as opposed to other professions. A meta-analysis conducted by Lee, Lim, Yang, and Lee (2011) found that overinvolvement with clients and work-related distress in clinicians were significantly related to dimensions of burnout, including emotional exhaustion and related decreases in job satisfaction. Similarly, Rupert, Miller, and Dorociak (2015) indicate that many stressors psychologists face result from the nature of therapy itself, or from the organizational and contextual factors inherent in being a psychologist.

A related example of context complication has to do, specifically, with treating youth. Providing treatment to youth almost always involves balancing the legal rights of the adults who consent to treatment and the best needs and wishes of the child who assents. This is potentially stressful, especially in cases for which there is a forensic issue. Think about treatment of a child in the midst of a custody evaluation as an example. Consider, as a more complicated case, a custody evaluation where a trauma, such as abuse, is being evaluated as well. The clinician needs to be mindful of exactly who the identified client is, what the boundaries between treatment and assessment are (APA, 2002), who has legal and physical custody, and several other related issues (APA, 2010). Similarly, a pediatric psychologist who is treating a child diagnosed with serious illness needs to be mindful of the family's and the hospital's needs (Rae, Brunnquell, & Sullivan, 2009).

Having few, or no, colleagues to consult with makes these ethical ambiguities more difficult to navigate (Huhtala, Kaptein, & Feldt, 2016). The Rössler review mentioned earlier (2012) found that mental health professionals from all fields tend to report lower levels of job satisfaction if they report low support within and outside of their work organizations. One reason a psychologist may have few or no colleagues with whom to consult is high vacancy rates in the workplace. To address high vacancy rates of psychology positions in North Carolina prisons, Mackain, Myers, Ostapiej, and Newman (2010) discovered that feelings of being valued by the organization and satisfaction with the work atmosphere and relationships with supervisors, but not colleagues, significantly predicted job satisfaction. Similarly, Brough and Pears (2004) identified that the type of support an individual receives plays a significant role in job satisfaction outcomes. More specifically, they determined that greater job satisfaction was significantly predicted by perceived supervisor support but not by colleague support (Brough & Pears, 2004). These findings suggest that job satisfaction differs dependent upon the type of perceived support individuals experience. Furthermore, psychologists, at times, interact with complex cases that are not covered by practical guidelines or ethics codes. When this occurs in the context of economic restrictions, it can be particularly stressful. These stressors can manifest as rumination, sleep loss, higher levels of reported stress and exhaustion, and decreased well-being (Huhtala et al., 2016). One undesirable outcome is burnout. Burnout can negatively influence the quality of the provision of psychological services (Rossler, 2012; Rupert et al., 2015).

These symptoms not only impact service provision effectiveness, but also impact the professional's personal life. For instance, trauma treatment providers report feeling impatient with clients and within their interpersonal relationships outside of work (Killian, 2008). Clinicians also report physical pain, sleep problems, difficulties concentrating, and burnout as the direct result of treatment provision (Killian). Thus, mindfulness, self-care, and self-compassion skills are important across settings.

Mindfulness and Acceptance-Based Approaches

Mindfulness is a rapidly growing area of research and practice in psychology. The term is often defined as regulating one's attention, with purposeful awareness, to immediate experiences while being open, curious, and accepting (Bishop et al., 2004). Positive outcomes related to mindfulness include decreased reactivity and increased self-knowledge, patience, and compassion (Bishop et al.). These skills are useful and meaningful in professional and personal capacities.

Mindfulness has been used therapeutically to foster effective emotional and behavioral response to distress (Bishop et al., 2004). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999, 2011) is a transdiagnostic acceptance and mindfulness-based cognitive-behavioral treatment. In ACT, experiential exercises, metaphoric language, and paradox are used to help individuals relate differently to their histories and their internal experiences in order to increase their psychological flexibilities (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

Psychological flexibility refers to coming in contact with the present moment, fully, with a conscious awareness, and based on the contingencies present in the context, choosing to continue to do a behavior, or to stop it, depending on which choice best serves what you care about (Hayes et al., 2006). The work is accomplished through six core processes: acceptance, defusion, contact with the present moment, self-as-context, values, and committed action.

Holt and Cottone (2014) noted the trend of mindfulness-based psychotherapy techniques being used to address concepts such as psychological flexibility, as opposed to symptom reduction. They reviewed the benefits and limitations of these therapies, including ACT. They concluded that cognitive-behavioral treatments, including mindfulness, are more beneficial than harmful, and noted the need for behavioral health providers to be well trained in mindfulness and to have a practice of their own (Holt & Cottone, 2014). Several researchers have looked at the utility of mindfulness-based interventions (MBIs) for those who work specifically with youth. In a study implementing mindfulness integrated in health and academic settings, Poulin and colleagues demonstrated that MBIs were effective in reducing emotional exhaustion, and increasing relaxation and overall life satisfaction among human service providers (Poulin, Mackenzie, Soloway, & Karayolas, 2008).

While not conducted with psychologists, Hülsheger et al. (2013) found that

mindfulness was negatively related to exhaustion and positively correlated with job satisfaction among individuals in "helping professions," many of whom worked with children; the results indicated that MBIs could manipulate these factors. In a randomized controlled trial for human service professionals, which compared piloted mindfulness to *metta* (loving-kindness), researchers found no immediate differences between the two groups. However, the piloted mindfulness group demonstrated increases in mindfulness and self-compassion at 1- and 4-month follow-up periods (Pidgeon, Ford, & Klaassen, 2014).

There is evidence that using mindfulness and acceptance can foster more meaningful engagement and increase connections with others, in both professional and personal roles. This may be a value-consistent action. Further, social connection is associated with higher well-being in mental health professionals (Killian, 2008). Whether working in a school, a private practice, a medical center, university, or a community health center, taking a mindful moment can help psychologists reengage in work and respond with more psychological flexibility (Flaxman, Livheim, & Bond, 2013). In the midst of a stressful day that is full of responsibilities at work and home, it can help to practice mindful moments. Here are five mindfulness skills that can be implemented to help with life stressors that come with being a psychologist, especially one who works in youth- and family-focused settings.

1. Be Mindful of Transitions

In between the tasks you do, take a mindful moment to notice the transitions you make between your responsibilities and/or environments. What tells you that you are transitioning? For example, do you have to physically move; and, if so, how does that feel in your body? Where do you feel it? How quickly or slowly do you transition? Do you notice the space between two activities, and can you be fully present—without a need to fill a void—in the "in-betweens"? You might want to ask yourself, "What is happening in the moment just before I greet the student with whom I have the best therapy sessions?" Likewise, a good activity would be to do a quick body scan immediately after writing a progress note.

2. Be Mindful of Systems

See if you can become aware of how your presence as a psychologist works within, and in some cases outside of, a system (e.g., hospital, group practice, professional discipline). Are there any personal shifts you experience as related to these systems? Are there any emotional/mental/physical states you embody as a function of these systems? A good question might be, "How am I standing in front of my fellow psychology colleagues, and is that different than how I present myself during an interdisciplinary treatment team meeting?" Notice if you have any strong thoughts or feelings about your role as part of the system. What about outside of the system? Where does your personal life fit in? Notice any changes in your own behavior (including your thoughts, feelings, and bodily sensations)—in the moment—as you think about your personal roles in relation to the system in which you work.

3. Be Mindful of Presence

Ask yourself, "Where am I in this moment?" Consider if you are "in between your ears," or if you can be aware of what is going on within and around you. If you had to gauge in distance (e.g., feet, meters, miles) how far away you are from your own presence right now, where would you be? If you are with another person when you are practicing this skill, you might want to ask if you are able to listen and notice subtle shifts in their behavior. You might also ask, "Can I notice, without judgment, the experience of how I am showing up to serve?"

4. Be Mindful of Intention

See if you can be aware of your intentions as you serve. Ask yourself, "How am I serving others, as well as myself, right now?" What is your purpose, at this time, and in this place? How might an awareness of your intention change your behavior? How does your intention, either spoken or unspoken, fill the space that you are in?

5. Be Mindful of Your Breath

Simply noticing that your body is doing what it is capable of doing on its own can be very powerful. You have everything you need. You don't need to change anything. Take 5 minutes or less to become aware of your breathing. You don't have to change anything. Just notice the temperature of your breath, how your chest rises and falls when you breathe, and now, your belly.

Drop the Balance and Live One Life: Valuing for Prevention of and Response to Burnout

As previously noted, child psychologists may have many roles: therapist, researcher, employee, confidant, parent, partner, and the list goes on. Our society often tells us to divvy up these roles and their related responsibilities. Further, we are to weigh them on the work-life balance, a metaphor used to characterize how we should manage work and the rest of our lives (Guest, 2002). This balance is highly subjective, context dependent, and not clearly defined (Guest). Inherent in the term work-life balance is the idea that imbalance is not desirable (Guest). This notion thus forces individuals to take efforts to achieve balance. The obligatory tilting plays out in undesirable ways. We often make uncomfortable decisions, feeling forced to pit multiple important life areas against one another.

Quick Tip If you find yourself feeling overloaded, unsupported, uninformed OR if you notice that you are acting distant from your clients, that you don't like them, or feel like they won't ever get better OR if you are just plain exhausted. . . . First, get really present to that. Notice where that shows up in your body and what thoughts are linked to those sensations. Next, think back to the day you decided to do what you do for a living. Jot down a quick list of why you wanted your current job. Does it feel different, nicer? Now, take a moment to reflect on a time that you were really successful at this same job. Do the same reflection for this moment. Notice you are the same you who was present in all situations—then and now. You are more than how you feel in any one moment. More than how you feel about others, or how you perform.

The perception of time seems to be an important consideration in the understanding of work-life balance and burnout (Maslach et al., 2001; Shanafelt, Boone, & Tan, 2012). For example, Shanafelt and colleagues conceptualized work-life balance as the work-schedule leaving an individual enough time for personal and/or family life. This focus may be indicative of a missing component in the work-life balance and burnout literature. The idea of work-life balance suggests we need to prioritize our values (i.e., what we care about) by ranked importance. The metaphor of a balance further implies that when we are feeling as if our life is not balanced, our values are conflicting. For example, a school psychologist may not feel she has enough time to administer assessments, write reports, individually meet with students, and participate in fun activities with her family. This school psychologist may then feel as if these two significant aspects of life, work and family, are conflicting with each other. This view of values conflicting is a perspective that is maintained by many psychologists, but there is another perspective to consider.

In the ACT model, values are neither feelings nor things. Values are defined as life directions with no endpoints (Wilson & Murrell, 2004). Commonly held value domains include education/training, relationships, spirituality, and physical well-being (Wilson, Sandoz, Kitchens, & Roberts, 2010). An important component of ACT is determining if a person is living consistently with their identified values. If someone is choosing and doing behaviors that match their values, it is termed "committed action." Committed action involves concrete goals that can be achieved (Hayes et al., 2006). We believe that there are no true values conflicts, but that goals associated with committed actions may involve time-related conflicts.

Quick Tip Take a moment to consider how true these items are of you; items taken from the Meta-Valuing Measure (MVM; Taravella & Murrell, 2010):

- I have considered what I want my life to be about.
- I must express my values in a specific way.
- When I'm upset, it's more difficult to make decisions about what is important.
- I have trouble balancing different areas of my life.
- I see myself as someone who has many things that are important to me.
- I am willing to stick to things that matter to me even when there are obstacles in my way.

Returning to the school psychologist example, we propose that focusing on how much time one does or does not have is ineffective. It is more important to consider if individuals hold rigid beliefs about how their time should be spent (i.e., we often have ideas about how we think our lives should look). Through structural equation

modeling, Major and colleagues (2002) found that amount of time spent at work contributes to psychological distress, but choices made about how to spend time was more important in predicting distress and family interference.

Let's say that same school psychologist values meaningful connections with others. Because she is rigidly thinking about how that value must look in her personal relationships (e.g., "I must be home by 5 P.M. to see my children") and as a psychologist (e.g., "I must take on every assessment and consulting case I'm called about each week"), she feels overwhelmed and guilty that she is not able to do it all. As she spreads herself thin, she may get burned out and not do any of these tasks well, or she may get too exhausted to engage in meaningful activities with her family, friends, coworkers, and clients. Helping her see her values in a flexible manner will allow her to see that her value of meaningful connection can be achieved in multiple contexts, in varied ways. As opposed to focusing on the idea that the psychologist's life directions of work and family conflict with each other, we can identify the behaviors that the school psychologist can engage in that are consistent with both professional and personal life. In this case, perhaps staying late to chat with colleagues at work provides emotional and intellectual stimulation that makes her able to openly express emotion with her children at home, all related to meaningful connection with others. Take a few moments to look back at your answers to the MVM questions. Were you already thinking flexibly about your values and committed actions? If not, what specific goals can you commit to that meet multiple values? How does this flexible, meta-valuing, feel?

When we have identified values-consistent behavior, another important component is how we engage in the behavior. For example, the school psychologist may be able to spend time with her family, but she won't feel good about it if her mind is at her place of employment. Practicing mindfulness will allow individuals to experience their time with their families fully. It will help make effective use of the time they have.

Compassion and Care: It Starts With Me

Mindfulness affords us the opportunity to more actively choose our behaviors. Humans have the capacity to speak very negatively to themselves. As the common saying goes, we can be our own worst enemies. This can occur when we find ourselves having difficulty managing the expectations and pressures of our own life. Over time, treating oneself harshly can negatively impact one's work with others (Henry, Schacht, & Strupp, 1990). When we are mindful, however, we have the opportunity to be kind to ourselves and choose healthy adaptive coping skills such as self-compassion (Coleman, Martensen, Scott, & Indelicato, 2016).

Self-compassion is being open to and experiencing personal suffering as it is, and responding to that suffering with kindness (Neff, 2003). Self-compassion is comprised of three components, which include self-kindness, common humanity, and mindfulness (Neff, 2003). Self-kindness involves recognizing your own human flaws and being understanding, gentle, and supportive toward yourself in response to when life does not go as expected (Neff, 2011). Common humanity emphasizes that all humans experience suffering; and that we all, in our own way, relate to this shared experience (Neff, 2011). Last, mindfulness provides the opportunity for self-compassion to occur, because action can only occur in the present moment (Neff, 2011).

Quick Tip Here is a way to develop self-compassion in an experiential and ACT-consistent way— If you catch yourself taking shallow breaths, feeling your temperature rise, tensing your muscles, getting forgetful or inattentive, or if you notice you are anxious, angry, guilty, or sad:

Give those bodily sensations and feelings, and any related thoughts or memories, a name—just one will do. Do your best to just name them and not judge or evaluate, simply label without opinion or qualifiers. For example, you could say, "This is stress," or you could even say, "I am noticing stress."

Next, imagine what you would do if someone you loved very much was experiencing that same thing. And, whatever you would do for them, do that for yourself. If you need some prompting, think of a child you really want to help, maybe a client, maybe your own child, maybe yourself as a child. Would you give that child a hug? Tell them that they will be okay? Wish them peace, or strength, or both?

Now, put your hand on a part of your body that often feels tension (your neck, your shoulder, your stomach, or maybe hold it gently over your heart). Take a strong and solid breath in and briefly hold your breath before you let it out. Slowly exhale. As you breathe in, imagine that you are breathing in love and acceptance, and as you breathe out, let go of attempts to control how you feel.

As you do this, remember that everyone has struggles, and everyone, including you, has the capacity to be kind.

Self-compassion relates to greater psychological well-being (Zessin, Dickhäuser, & Garbade, 2015), less self-critical judgment (Beaumont, Irons, Rayner, & Dagnall, 2016), and less compassion fatigue and burnout (Beaumont, Durkin, Hollins Martin, & Carson, 2016) in individuals in helping professions. There are therefore many reasons to engage in self-compassion. Sometimes, though, self-compassion is hard. These are the times when a person can hold onto their identified values. Being self-compassionate takes practice and care.

As Richards, Campenni, and Muse-Burke (2010) indicated, the literature has not established a clear, agreed-upon definition of self-care. Therefore, for the purposes of this article, self-care will be defined as actively implementing practices for the purpose of promoting one's own psychological and physical health. Sometimes self-care is acted upon as a last resort. Why is this? Mills, Wand, and Fraser (2015) asserted that self-care can be stigmatized as selfish, and viewed as counter to helping others. There is merit, however, to acknowledge, accept, and care for yourself. For example, Killian (2008) found that debriefing, or processing, with colleagues is important to effectively work through difficult information such as hearing about trauma, or seeing signs of child abuse. This is important, because difficult information can manifest as intrusive thoughts or images when at home with family or with one's significant other (Killian). Therefore, debriefing allows professionals—especially those who work with youth and families in difficult situations—to share and be validated in their experience of being affected (Killian). Debriefing also helps professionals to realistically assess their own levels of feeling burdened and overwhelmed by their work (Killian).

Many times self-care may feel counterintuitive. Specific self-care strategies, which can be provided in trainings, include:

- Seeking support and advice from other professionals and keeping your door open at work to help foster a friendly atmosphere (Puterbaugh, 2008)
- Other self-care strategies suggested by Patsiopoulos and Buchanan (2011) are:
  - Eating nutritious meals and scheduling time to mindfully eat with others at work and home
  - Exercising, including walking, participating in sports, running up and down the stairs at work, doing exercises in your office, and/or working out or taking classes at the gym; exercising with others can be especially beneficial
  - Sleeping enough: putting your children to bed earlier, going to sleep earlier, watching caffeine intake, and making a valued-consistent choice to stop working at a certain time
  - Seeking support from family and friends can involve spending quality time with individuals close to you, talking about important topics (work or non-work related)
- Additional self-care strategies include scheduling leisure time, engaging in activities in the community (e.g., book clubs), meditating, getting massages, spending time in nature, going to therapy, participating in spiritual/religious practices, and engaging in creative projects (e.g., painting, adult coloring, photography)
- Setting strict boundaries on the number of difficult cases on your caseload and the number of hours you work per week (Killian, 2008), designating specific hours during the week for administrative tasks, and changing your job or career (Figley, 2002)
- Formal self-compassion meditations, journaling exercises, experiential exercises, and the like
  - Kristin Neff and Paul Gilbert both have excellent websites to check out as resources.

Conclusion

Self-compassion, self-care, valued living, and mindfulness are clearly important for psychologists who work with youth and families. Taking care of ourselves can make all the difference for the children and families we serve. Risk of distress, compassion fatigue, and burnout can be further lowered through mindfulness-based interpersonal and institutional support. Small daily practices may make monumental changes for our clients, for us, and ultimately, for our profession.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060–1073. doi: 10.1037/003-006X.57.12.1060

American Psychological Association. (2010). Guidelines for child custody evaluations in family law proceedings. *American Psychologist, 65*, 863-867. doi: 10.1037/a0021250

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey, *Midwifery, 34*, 239-244. doi:10.1016/j.midw.2015.11.002

Beaumont, E., Irons, C., Rayner, G., & Dagnall, N. (2016). Does compassion-focused therapy training for health care educators and provides increase self-compassion and reduce self-persecution and self-criticism. *Journal of Continuing Education in the Health Professions, 36*, 4-10. doi:10.1097/CEH.0000000000000023

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., ... Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice, 11*, 230-241. doi:10.1093/clipsy.bph077

Borum, R., & Otto, R. (2004). Evaluation of youth in the juvenile justice system. In W. T. O'Donohue & E. R. Levensky (Eds.), *Handbook of forensic psychology: Resource for mental health and legal professionals* (pp. 873-895). New York, NY: Elsevier Science.

Brough, P., & Pears, J. (2004). Evaluating the influence of the type of social support on job satisfaction and work related psychological well-being. *International Journal of Organisational Behavior, 8*, 472-485.

Coleman, C., Martensen, C., Scott, R., & Indelicato, N. A., (2016). Unpacking self-care: The connection between mindfulness, self-compassion, and self-care for counselors. *Counseling & Wellness Journal, 5*, 1-8. Retrieved from http://self-compassion.org/wp-content/uploads/2016/06/Coleman_etal_2016.pdf

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping, 23*, 319–339. doi: 10.1080/10615800903085818

Dreison, K. C., White, D. A., Bauer, B. A., Salyers, M. P., & McGuire, A. B. (2016). Integrating self-determination and job demands-resources theory in predicting mental health provider burnout. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-10. doi: 10.1007/s10488-016-0772-z

Flaxman, P. E., Livheim, F., & Bond, F. W. (2013). *The mindful and effective employee: An Acceptance and Commitment Therapy training manual for improving well-being and performance.* Oakland, CA: New Harbinger.

Guest, D. E. (2002). Perspective on the study of work-life balance. *Social Science Information, 41*, 255-279. doi.org/10.1177/0539018402041002005

Gutkin, T. B., & Conoley, J. C. (1990). Reconceptualizing school psychology from a service delivery perspective: Implications for practice, training, and research. *Journal of School Psychology, 28*, 203-223. doi:10.1016/0022-4405(90)90012-V

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes, *Behaviour Research and Therapy, 44*, 1-25. doi:10.1016/j.brat.2005.06.006

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change*. New York: Guilford Press.

Helgoth, S., & Sobansky, R. R. (2008). The roles and functions of school psychologists: A global perspective. *International Journal of Psychology: A Biopsychosocial Approach, 1*, 85-96. Retrieved from https://www.oalibrary.org/papers2/ac28f037-228e-45ee-8eef-9304a5e1520e/ on Dec. 4, 2017.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology, 58*, 768-774. doi:10.1037/0022-006X.58.6.768

Holt, R. W., & Cottone, R. R. (2014). Mindfulness: An Overview for Human Service Professionals. Journal of Human Services, 34. Retrieved from ERIC, EBSCOhost (accessed December 4, 2017).

Huhtala, M., Kaptein, M., & Feldt, T. (2016). How perceived changes in the ethical culture of organizations influence the well-being of managers: A two-year longitudinal study. *European Journal of*

Work and Organizational Psychology, 25, 335-352. doi:10.1080/1359432X.2015.1068761

Hülsheger, U. R., Alberts, H. M., Feinholdt, A., & Lang, J. B. (2013). Benefits of mindfulness at work: The role of mindfulness in emotion regulation, emotional exhaustion, and job satisfaction. *Journal of Applied Psychology, 98*, 310-325. doi:10.1037/a0031313

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*, 32-44. doi:10.1177/1534765608319083

Knauss, L. K. (2001). Ethical issues in psychological assessment in school settings. *Journal of Personality Assessment, 77*, 231-241. doi:10.1207/S15327752JPA7702_06

Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice, 42*, 252-258. doi: 10.1037/a0023319

Luken, M., & Sammons, A. (2016). Systematic review of mindfulness practice for reducing job burnout. *American Journal of Occupational Therapy, 70*. doi:10.5014/ajot.2016.01695

Mackain, S., Myers, B., Ostapiej, L., & Newman, R. A. (2010). Job satisfaction among psychologists working in state prisons: The relative impact of facets assessing economics, management, relationships, and perceived organizational support. *Criminal Justice and Behavior, 37*, 306-318. doi: 10.1177/0093854809357420

Major, V. S., Klein, K. J., & Ehrhart, M. G. (2002). Work time, work interference with family, and psychological distress. *Journal of Applied Psychology, 87*, 427-436. doi:10.1037/0021-9010.87.3.427

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*, 397-422. doi:10.1146/annurev.psych.52.1.397

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause(s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology, 9*,1897. doi: 10.3389/fpsyg.2018.01897

Mills, J., Wand, T., & Fraser, J. A. (2015). On self-compassion and self-care in nursing: Selfish or essential for compassionate care? *International Journal of Nursing Studies, 52*, 791-793. doi:10.1016/j.ijnurstu.2014.10.009

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*, 223-250. doi:10.1080/15298860390209035

Neff, K. D. (2011). Self-compassion, self-esteem, and well-being. *Social and Personality Psychology Compass, 5*, 1-12. doi:10.1111/j.1751-9004.2010.00330.x

Patsiopoulos, A. T., & Buchanan, M. J. (2011). The practice of self-compassion in counseling: A narrative inquiry. *Professional Psychology: Research and Practice, 42*, 301-307. doi:10.1037/a0024482

Pidgeon, A. M., Ford, L., & Klaassen, F. (2014). Evaluating the effectiveness of enhancing resilience in human service professionals using a retreat-based mindfulness with metta training program: A randomised control trial. *Psychology, Health & Medicine, 19*, 355-364. doi:10.1080/13548506.2013.806815

Poulin, P. A., Mackenzie, C. S., Soloway, G., & Karayolas, E. (2008). Mindfulness training as an evidenced-based approach to reducing stress and promoting well-being among human services professionals. *International Journal of Health Promotion and Education, 46*, 72-80. doi: 10.1080/14635240.2008.10708132

Puterbaugh, D. T. (2008). Spiritual evolution of bereavement counselors: An exploratory qualitative study. *Counseling and Values, 52*, 198-210. doi:10.1002/j.2161-007X.2008.tb00104.x

Rae, W. A., Brunnquell, D., & Sullivan, J. R. (2009). Ethical and legal issues in pediatric psychology. In M. C. Roberts & R. G. Steele (Eds.), *Handbook of pediatric psychology* (4th ed., pp. 19 –34). New York, NY: Guilford Press.

Richards, K., Campenni, C., & Muse-Burke, J. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness, *Journal of Mental Health Counseling, 32*, 247-264. doi:10.17744/mehc.32.3.0n31v88304423806

Rössler, W. (2012). Stress, burnout, and job dissatisfaction in mental health workers. *European Archives of Psychiatry and Clinical Neuroscience, 262*(Suppl 2), 65–69. https://doi.org/10.1007/s00406-012-0353-4

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice, 46*, 168-174. doi: 10.1037/a0039297

Shanafelt, M. D., Boone, M. D., & Tan, L. (2012). Burnout and satisfaction with work-life balance among U.S. physicians relative to the general U.S. population. *Archives of Internal Medicine, 172*, 1377-1385. doi:10.1001/archinternmed.2012.3199

Sodeke-Gregson, E. A., Holttum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology, 4,* 1-10. doi: 10.3402/ejpt.v4i0.21869

Taravella, C. C., & Murrell, A. R. (2010). *The meta-valuing measure*. Unpublished measure as part of the first author's dissertation work, available from either author.

Wahass, S. H. (2005). The role of psychologists in health care delivery. *Journal of Family & Community Medicine, 22*, 63-70. Retrieved from MedLINE, EBSCOhost (accessed December 4, 2017).

Watkins, M. W., Crosby, E. G., & Pearson, J. L. (2001). Role of the school psychologist: Perceptions of school staff. *School Psychology International, 22*, 64-73. Retrieved from ERIC, EBSCOhost (accessed December 4, 2017).

Wilson, K. G., & Murrell, A. R. (2004). Values work in Acceptance and Commitment Therapy: Setting a course for behavioral treatment. In S. C. Hayes, V. M. Follette, & M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 120-151). New York: Guilford Press. Ebook retrieved from PSYCINFO, EBSCOhost (accessed December 4, 2017).

Wilson, K. G., Sandoz, E. K., Kitchens, J., & Roberts, M. E. (2010). The Valued Living Questionnaire: Defining and measuring valued action within a behavioral framework. *The Psychological Record, 60*, 249-272. Retrieved from ERIC, EBSCOhost (accessed December 4, 2017).

Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. *Applied Psychology: Health and Well-Being, 7*, 340-364. doi:10.1111/aphw.12051

. . .

The authors have no conflicts of interest or funding to disclose.

Correspondence to Amy R. Murrell, Ph.D., Associate Professor, Department of Psychology, University of North Texas, 1155 Union Circle #311280, Denton, TX 76203-1280; amy.murrell@unt.edu

Gender-Affirming Services in Treatment of Transgender Patients: Understanding Gender Variance and Current Issues

Jack Lee, *Hofstra University*

Clark R. Goldstein, *Growth Psychology*

Literature Review

Increased public consciousness of gender variance has greatly shifted the gender paradigm in the U.S in recent years. Understanding the evolving nature of the transgender community has become imperative for many mental health professionals as substantial changes are taking place in the cultural and societal perceptions of the population. Understanding the demographic characteristics, identifying barriers to treatment, and using appropriate transgender-related terminology are all essential in training culturally competent clinicians. It's important to note that the National Institute of Health only recently designated sexual and gender minorities a health disparities population, further contributing to the lack of available clinical resources and research in this area on a federal scale (Fredriksen-Goldsen et al., 2014).

National surveys have rarely included items to identify transgender respondents; this has been an obstacle to understanding the demographic composition of the transgender population. However, local and state-level survey samples have been helpful in estimating the national average of self-identified transgender individuals. When it comes to the demographic characteristics of transgender individuals in the United States, the best data come from surveys of transgender adults, and less is known about the percentage of youth that identify as transgender. Behavioral Risk Factor Surveillance System (BRFSS) is a national survey system that collects data from all 50 U.S states regarding health-related risk behaviors, and it has identified transgender individuals to among the at-risk populations. According to BRFSS, 1.4 million U.S. adults (0.6%) and nearly 150,000 youth (0.7%), ages 13 to 17, identify as transgender. In addition, the data show that individuals between the age of 15 and 17 are most likely to identify as transgender (Herman et al., 2017). While the numbers may be good estimates of the demographic composition, the term "transgender" is an umbrella term that encompasses individuals who do not fit into the binary gender category (Maguen, Shipherd, & Harris, 2005). For example, many respondents who did not identify as transgender in the study may identify as being on the non-gender-conforming spectrum. As more transgender individuals are able to affirm their unique identities outside the bounds of the traditional binary gender norms, the longstanding assumption that using surgical and hormonal interventions are necessary to live a fulfilling life is changing drastically (Carroll, Gilroy, & Ryan, 2002).

The term transgender can be used inclusively, describing individuals who identify in a multitude of ways on the spectrum of gender. Important distinctions that many professionals often find difficult to understand lie between sex and gender, and gender identity and gender expression. The American Psychological Association (APA) has worked diligently in recent years to publish documents that accurately define terms related to sexual orientation and gender diversity. While the evolving nature of the constructs and changing usage of terms often result in varying definitions, certain gender constructs have stayed consistent among APA documents published in the past 5 years. According to the APA, sex usually refers to the biological aspects of one's identity based on the appearance of external genitalia, whereas gender can include the psychological, behavioral, and cultural aspects associated with one's biological sex (APA, 2012, 2015). This distinction has been particularly prominent in the legal discourse of American society over the last decade. According to Currah (2006), transgender activists believe a ban on same-sex marriage fails to promote inclusivity and equal rights by inappropriately using sex as a legal category. The author states that many activists hope to deconstruct the concept of gender and stop the state's use of sex as an identification marker for legal documents, suggesting that this will weaken the cultural pressure to amalgamate gender identity with biological sex. According to APA, another important distinction lies between one's gender expression and one's gender identity. APA states that gender identity refers to one's sense of self on the gender spectrum, and gender expression refers to how one communicates gender in a given culture regardless of its association with gender identity (APA, 2012, 2015). For example, someone who identifies as transgender may not express their gender identity publically even if their identity has been fully established internally. This type of social inhibition and repression of gender expressions often stems from internal or external transphobia and the cost of transitioning (Mizock & Mueser, 2014). It is particularly important for clinicians not to assume the gender identity of their patients for this reason.

The concept of gender identity has been scrutinized by the mental health community for many decades. Historically, gender-nonconforming individuals have often been pathologized and diagnosed as having an identity disorder using the traditional model of gender (Chen-Hayes, 2001; Lev, 2013). While the concepts of the third gender and gender diversity have been popular in many ancient cultures as well as modern India, the predominant view on the human gender spectrum in North America has largely been dominated by dichotomous systems in which one's gender identity only exists in a binary fashion: male and female (Herdt, 2012). In terms of diagnostic tools, DSM and ICD have been used to assess gender nonconformity and associated distress, but a significant revision of diagnostic categories has been made in the recent editions (DSM-5 and ICD-11) to reflect a balance between stigmatization concerns of such disorders and the need for diagnostic labels to facilitate and access health care (Drescher et al., 2012; Vargas-Huicochea et al., 2018). Drescher and his colleagues state that the stigmatization of being labeled mentally ill can create a particularly dangerous situation for transgender individuals as culturally bound gender norms render them vulnerable to additional stressors. Vargas-Huicochea and his colleagues assert that this could adversely influence transgender children in particular, suggest-

ing that because their gender identities have not fully been developed, children are more susceptible to labels and stigmatization. Therefore, ICD's adaptation to employ Gender Incongruence of Childhood (GIC) as the new classification helped prevent medical communities from pathologizing nonconforming gender identities in childhood. According to Drescher, the medical communities initially adapted the psychopathological model of gender developed largely in the 1940s to explain gender nonconformity. They suggest that the psychopathological model of gender is largely based on outdated studies conceptualizing sexual deviance and that a new model is required for best mental health practices, advising that the new model be based on current scientific evidence, needs and experiences of the population, and high-quality health care services. Bartlett, Vasey, and Bukowski (2000) supported this idea by rejecting the psychopathological model, stating that future editions of DSM advocate not including GID, particularly concerning the evaluation of transgender children who struggle with the culturally prescribed gender role of their sex but do not experience discomfort with their biological sex. In an attempt to improve definitional criteria for disorders relating to human sexuality and gender, scientific and mental health communities must not rely on traditional models of morality to inform and pathologize functionally established gender identities.

With the increased attention and empirical research on transgender health, many studies focus on minimizing health disparities between the transgender and cisgender populations and on advancing public awareness of issues relevant to gender, particularly in the field of mental health services. Many transgender individuals, especially transgender youth, are often exposed to discrimination, marginalization, and a lack of supportive resources (Toomey et al., 2013). Transgender individuals may engage in gender-atypical behavior that could lead to negative reactions from others, and they often struggle with understanding their gender identity and sexual orientation (Grossman & D'augelli, 2008). High rates of suicidal ideation and self-injurious behavior among gender-nonconforming individuals have been noted in research, and analyses suggest that gender identity is a unique risk factor for these concerning thoughts and behaviors (Dank et al., 2014; Gross & D'augelli, 2007). According to the Gender Minority Stress and Resilience (GMSR) model by Testa et al. (2015), four external and three internal stressors have been identified. The external stressors consisted of rejection, lack of affirmation, victimization, and discrimination, and the internal stressors consisted of internalized transphobia, negative expectations, and nondisclosure. Both external and internal stressors contributed to the prevalence of suicidal ideation (Testa et al., 2017). Studies by Liu and Mustanski (2012) present similar findings, suggesting that lesbian, gay, bisexual, and transgender (LGBT) youth are at risk for suicidal ideation and self-harm due to prospective victimization, low support, and a sense of hopelessness. According to the study, the transgender group and childhood gender nonconformity were at particular risk factors for self-harm. Social and cultural stressors significantly influence transgender individuals, and the high prevalence of suicidal ideation and self-harm has been well documented to indicate this difficulty along with the escalating mental health awareness in recent studies. With the high prevalence of suicidality and self-harm in transgender individuals, many qualify for clinically significant depression and anxiety. Numerous studies indicate that for both transgender women (male to female) and transgender men (female to male), depression and anxiety symptoms are observed a lot more frequently compared to the general population (Nemoto, Bödeker, & Iwamoto, 2011; Rotondi et al., 2012). The study by Budge, Adelson, and Howard (2013) in particular shows that 51.4% of transgender women and 48.3% of transgender men present with clinically significant depressive symptoms and 40.4% of transgender women and 47.5% transgender men present with clinically significant anxiety symptoms, suggesting that these symptoms can interact with the specific environment of the transgender individual to exacerbate their risk behaviors.

While the population often requires adequate mental health treatment due to the aforementioned external and internal stressors, some studies have identified potential barriers to seeking mental health services. In their study, Shipherd, Green, and Abramovitz (2010) stated the potential barriers consist of the cost of treatment, negative previous experiences, and stigma concerns. The study emphasized the role of providers in minimizing barriers to treatment for transgender clients, encouraging clinicians to tailor their approaches in a patient-centered and culturally sensitive framework as fears related to mental health services substantially hinder the transgender community. Erickson-Schroth and Carmel (2016) reviewed the effects of discrimination and violence on transgender mental health to examine the barriers further. Similar to other marginalized groups, the Minority Stress Model was used to understand maladaptive coping patterns and difficulties in seeking mental health services for the transgender community. The study showed that transgender patients could benefit greatly by having affirming providers, drawing a comparison to racial minority groups.

Available Clinical Services and the Training Model

While more gender-nonconforming individuals are seeking better mental health care, many mental health professionals rarely receive adequate training in providing services for this particularly disenfranchised population. In addition, the National Institute of Health only recently designated sexual and gender minorities a health disparities population, further contributing to the lack of available clinical resources and research in this area on a federal level (Fredriksen-Goldsen et al., 2014). In his study, Lurie (2005) identified several barriers for clinicians in providing adequate transgender services in his study on treatment and care of transgender patients. According to his study, many clinicians admitted discomfort and a lack of resources in assessing and treating transgender patients. While most clinicians desire to treat transgender patients, many are frustrated with relative lack of research findings and treatment guidelines for this population. The study also suggests that many clinicians mistakenly believe that only transgender providers can perform sufficient training on transgender issues. With more clinicians trained in transgender care, more sophisticated training models have been developing in available clinical services for transgender communities. It is a general consensus that an affirmative and integrative approach consisting of multicultural and sociopolitical awareness results in the best therapeutic outcomes for this population (Chavez-Korell & Johnson, 2010).

In school settings, professional workshop models such as Gay Lesbian Straight Education Network (GLSEN) Houston training and the Gender Infinity practitioner training to teach pedagogical strategies in gender diversity have been successful for educators and counselors (Case & Meier, 2014). Such models focus on train-

ing transgender allies and assisting gender-nonconforming youth. According to Munoz-Plaza et al. (2002), despite the effort to expand services for transgender students, many transgender high school students report little or no family support on their gender issues and lack of school resources to cope with their specific stressors. One interesting finding of the study is that more students had higher perceived support from nonfamily members such as their peers and school affiliates. This finding is consistent with the study by Koken, Bimbi, and Parsons (2009), which states that higher levels of family rejection are observed in gender-nonconforming children. A study by Nuttbrock et al. (2009) further supports the idea, indicating school resources as a major theme in supporting transgender students through their social and personal difficulties.

Transgender programs have largely been successful in university settings as well due to increasingly more transgender young adults seeking campus resources and assistance. Campus climate is particularly important for LGBT students as the level of sexual and gender diversity and acceptance can shape the affirming campus environments. Woodford et al. (2014) examined many LGBT ally training programs on individual and institutional level and accentuated the importance of understanding the unique experience of a minority student in the context of heterosexism and transphobia. The study states that creating a visible network of affirming students, staff, and faculty is essential in ally training programs. Another study (Case et al., 2014) suggests that campus activism challenging gender-conforming privilege and a faculty-student partnership are essential in promoting nondiscrimination policies and ally trainings. The aforementioned professional workshop model can be applied in higher education as well, using pedagogical practices and strategies to promote collaborative relationships between faculty and students. According to Pryor (2015), the faculty-student partnership in ally training programs is particularly important as most transgender students experience incidents of marginalization from instructors and peers. More research is encouraged in honing the efficacy of such programs as most studies are limited to case studies in a small number of universities.

Studies show that while services for transgender patients have been increasing, particularly in the field of mental health, there is still a lack of adequate LGBT training in the area of senior care and aging services (Knochel et al., 2012). According to the study by Knochecl et al., out of 320 existing aging agency samples, only a few agencies provided transgender services or outreach and more than 70% of these agencies did not have staff members who received any form of transgender training. The study shows that mental health care services have largely been less accessible for older transgender adults, with the exception of urban-based agencies, which tend to provide better staff training, promote LGBT outreach and services, and address LGBT assistance requests. Studies by Page et al. (2016) revealed similar findings, stating that older transgender communities struggle the most in accessing these specialist services, increasingly due to cognitive and psychosocial impairment relating to dementia and other mental disorders.

As with senior care and aging services that often lack adequate services for transgender individuals, the United States Department of Veterans Affairs (VA) has experienced its share of difficulties with accessibility and quality of care transgender veterans receive. In terms of its history, despite the previous administration's repeal of "Don't Ask Don't Tell" in 2011, transgender individuals remained barred from serving openly in the military until the ban was lifted in 2016. In addition, the current administration has indicated its intent to ban transgender individuals from serving in the military since 2017, bringing up significant implications such as access to health care, transgender mental health, and willingness to engage in services (Zucker, 2017). According Rosentel et al. (2016), transgender veterans were eligible to receive transition-related care since 2011 through the Veterans Health Administration (VHA). However, their study showed that most transgender veterans experienced insensitivity and harassment among providers. The study indicated a general lack of knowledge regarding transgender patients while accessing transition-related care and other services though VHA, highlighting the importance of additional patient-centered interventions in the implementation of transgender protections and care coverage. Similarly, Chen et al. (2017) investigated the experiences of transgender veterans, and the results showed that provider training for gender-affirmative health care is imperative in the VA setting.

Gender-Affirming Therapy

With various practices and approaches in transgender health care, many professionals look to empirical studies and gauge the efficacy of different treatment modules. While the focus of treatment typically revolves around mental health services, the clinical model is often multidisciplinary, consisting of medical care, research, education, and community work. Some professionals believe that the role of gender affirmation is minimal in the multidisciplinary framework; however, recent studies reveal that gender affirmation is central to treatment of transgender patients, particularly in children and ethnic minorities.

Two main bodies of research exist surrounding the gender affirmation framework: the Identity Threat Model of Stigma and the objectification theory (Sevelius, 2013). According to the Identity Threat Model of Stigma, when an individual's stigmatized identity faces a threatening situation, the individual will respond with attempts to decrease the threat and increase the resources to cope (Varas-Diaz et al., 2005). Gender affirmation relates to this framework as the individual's stigmatized identity can recover with increased resources for social validation. Another important component of gender affirmation is derived from the objectification theory, which states that an individual's sense of self is largely defined by gender socialization and sexual objectification. According to Hill and Fischer (2008), human bodies are often sexualized and objectified in a culturally acceptable fashion, and this can lead individuals to treat themselves as objects. The study shows that cultural sexual objectification and self-objectification are highly correlated and that the more frequent the reports of sexualized gaze and harassment, the more likely the victim would develop their own self-objectification. When one's gender is not affirmed, both transgender and cisgender individuals tend to focus on their biological sex and monitor their bodies against dominant cultural standards of beauty by engaging in body surveillance (Sevelius, 2013). Gender affirmation can help individuals focus on their gender identity rather than their bodies and prevent the self-objectification process that often leads to body shame and anxiety disorders.

According to Reisner et al. (2015), the gender-affirming approach must consist of tailored practices that aim to meet specific clinical needs with cultural responsivity and advocacy. While different treatment

modules exist, it's particularly important for clinicians to modify their practices to promote affirmative attitudes and examine personal biases. Treatment of transgender patients can vary greatly, depending on a multitude of cultural factors, such as societal norms and differing levels of transgender advocacy; however, all affirmative clinicians are able to elicit the patient's preferences regarding names and pronouns by adopting affirmative language. Clinicians must adopt the language of their transgender patients, but not rely on their patients to provide them with an affirmative lexicon (Austin & Craig, 2015). Tailored practices are particularly important for transgender patients who are going through changes in their gender identity and preferences. Understanding the evolving nature of the patient's preferences is essential in the therapeutic alliance and rapport building, leading to a collaborative relationship rather than the clinician serving as an evaluator (Heck, Flentje, & Cochran, 2013). The clinician's collaborative role is particularly important as an assessment by mental health professionals is often required for transgender patients before they gain access to hormone replacement therapy and surgical procedures (Sanchez et al., 2009). As many U.S. states allow policies that do not protect transgender individuals, the alliance a clinician creates with the patient is helpful in coping with unique challenges such as altering legal documents and receiving coverage for medications and medical procedures from insurance companies (Fraser, 2009).

The study by Heck et al. (2013) highlighted the importance of adopting affirmative language, particularly during the intake process, suggesting that the initial client contact can determine the trajectory of developing a solid working alliance. For example, if a client uses the word "partner," the service provider must immediately adopt the client's language and reflect the word "partner" instead of assuming a specific gender for the individual. It's important to use open-ended and gender-neutral questions for this reason. Hunter and Hickerson (2003) further support this idea, stating that replacing the term "sexual intercourse" with "sexual activity" is appropriate as it attends to the heteronormative bias, taking a more inclusive view. Heck and his colleagues also suggest that openly expressing affirmation is imperative, especially when clients are specifically seeking providers who identify as transgender. The study acknowledges that questions regarding sexuality can feel invasive to providers and suggests that openly expressing their affirmation can assure the clients of their support without having to disclose any personal information.

In addition to taking an affirmative approach, providers can create an environment that is visibly affirming. Radkowsky and Siegel (1997) discussed several ways affirmative providers can minimize subtle homophobic undertones in the office space. According to the study, considering something as simple as keeping a rainbow sticker or subscribing to LGBT-focused magazines can be helpful in creating an affirming environment. In addition, providers can place community resources or books related to psychotherapy with transgender clients in a prominent position on the bookshelf to implicitly communicate interest, acceptance, and affirmation. In terms of the paperwork, providers must use respectful, inclusive, and gender-neutral language that captures the broad range of gender identity and expression (Hunter & Hickerson, 2003). Heck and his colleagues suggest that it's important to provide clients with opportunities to write in their gender on a blank line instead of having binary options of "male" and "female" for gender. Furthermore, many psychological measures are not gender inclusive and may use outdated language, rendering modification of these measures essential.

Another important skill to have as an affirming clinician is the ability to assess the relationship between gender and current challenges. That is, it is important to note that transgender clients, particularly those who are posttransition, may enter treatment for reasons unrelated to their gender identity. Martell, Safren, and Prince (2004), suggesting that clinicians must not assume sexual orientation or gender identity as the primary reason for why a client is seeking treatment, encouraged open expression of affirmation while preventing premature conclusions. An affirming clinician not only creates an affirming environment, but also seeks to improve it. According to Bockting, Robinson, Benner, and Scheltema (2004), patient satisfaction is largely dependent on efforts by the providers to improve services. In their study, 180 transgender individuals were provided various university-based services and surveys were conducted to assess their health outcomes and satisfaction ratings. Results indicated that despite inherent challenges in providing transgender care, client satisfaction can improve greatly, depending on quality assurance and opportunities for patients to provide feedback.

Among many orientations of psychotherapy, cognitive behavioral therapy has often been integrated into the gender-affirming approach. As a result of being exposed to transphobic attitudes, transgender patients may develop maladaptive patterns of thinking, which in turn influence emotional and behavioral responses (Austin, Craig, & Alessi, 2017; Nadal et al., 2014). Based on the aforementioned minority stress model and the objectification theory, transgender patients often require alternate ways of thinking that prompt emotional and behavioral changes. Cognitive behavioral therapy has largely been adapted to incorporate the gender-affirming approach for this reason and clinicians are encouraged to differentially engage dimensions of risk and resilience by recognizing the diversity within the transgender community based on client circumstances (Austin & Craig, 2015).

Conclusion

This article explores the importance of gender-affirming services for transgender patients, highlighting the benefits of cultural responsivity and advocacy in treatment of transgender patients. In addition, the literature is reviewed to examine available mental health services for transgender communities and their potential effect on patients' initial care and developmental outcomes. While increased public consciousness helps us understand the evolving nature of the transgender community, it is still up to mental health professional to apply this knowledge in a gender-affirming environment. Mental health and related communities must not rely on traditional models of morality to inform and pathologize functionally established gender identities.

Gender-affirming services highlight the benefits of cultural responsivity and advocacy in treatment of transgender patients. A thorough literature review finds that gender affirmation can help both transgender and cisgender individuals, shifting the focus from the biological sex to the gender identity, effectively reducing self-objectification and body dysphoria. By examining available mental health services for transgender communities and their potential effect on patients' initial care and developmental outcomes, clinicians learn that surgical and hormonal interventions may not be necessary for transgender individuals to

affirm their functional identities. While increased public consciousness helps us understand the evolving nature of the transgender community, it is still up to mental health professional to apply this knowledge in a gender-affirming environment. It is our hope that scientific and mental health communities will explore more ways to promote and affirm functioning identities in the realm of gender and sexual diversity by continuing to conduct research on these topics.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67*(1), 10–42. doi: 10.1037/a0024659

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832-864.

Austin, A., & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. *Professional Psychology: Research and Practice, 46*(1), 21.

Austin, A., Craig, S. L., & Alessi, E. J. (2017). Affirmative cognitive behavior therapy with transgender and gender nonconforming adults. *Psychiatric Clinics, 40*(1), 141-156.

Bartlett, N. H., Vasey, P. L., & Bukowski, W. M. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles, 43*(11-12), 753-785.

Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient satisfaction with transgender health services. *Journal of Sex & Marital Therapy, 30*(4), 277-294.

Budge, S. L., Adelson, J. L., & Howard, K. A. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology, 81*(3), 545.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling & Development, 80*(2), 131-139.

Case, K. A., Kanenberg, H., "Arch" Erich, S., & Tittsworth, J. (2012). Transgender inclusion in university nondiscrimination statements: Challenging gender-conforming privilege through student activism. *Journal of Social Issues, 68*(1), 145-161.

Case, K. A., & Meier, S. C. (2014). Developing allies to transgender and gender-nonconforming youth: Training for counselors and educators. *Journal of LGBT Youth, 11*(1), 62-82.

Chavez-Korell, S., & Johnson, L. T. (2010). Informing counselor training and competent counseling services through transgender narratives and the transgender community. *Journal of LGBT Issues in Counseling, 4*(3-4), 202-213.

Chen-Hayes, S. F. (2001). Counseling and advocacy with transgendered and gender-variant persons in schools and families. *Journal of Humanistic Counseling, Education and Development, 40*(1), 34-48.

Chen, J. A., Granato, H., Shipherd, J. C., Simpson, T., & Lehavot, K. (2017). A qualitative analysis of transgender veterans' lived experiences. *Psychology of Sexual Orientation and Gender Diversity, 4*(1), 63.

Currah, P. (2006). Gender pluralisms under the transgender umbrella. In P. Currah, R. Juang, & S. Minter (Eds.), *Transgender rights* (pp. 3-31). Minneapolis, MN: University of Minnesota Press.

Dank, M., Lachman, P., Zweig, J. M., & Yahner, J. (2014). Dating violence experiences of lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence, 43*(5), 846-857.

Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry, 24*(6), 568-577.

Erickson-Schroth, L., & Carmel, T. C. (2016). Transgender mental health. *Psychiatric Annals, 46*(6), 330-331.

Fraser, L. (2009). Psychotherapy in the world professional association for transgender health's standards of care: Background and recommendations. *International Journal of Transgenderism, 11*(2), 110-126.

Fredriksen-Goldsen, K. I., Simoni, J. M., Kim, H. J., Lehavot, K., Walters, K. L., Yang, J., ... Muraco, A. (2014). The health equity promotion model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry, 84*(6), 653.

Grossman, A. H., & D'augelli, A. R. (2006). Transgender youth: Invisible and vulnerable. *Journal of Homosexuality, 51*(1), 111-128.

Grossman, A. H., & D'augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37*(5), 527-537.

Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Intake interviewing with lesbian, gay, bisexual, and transgender clients: Starting from a place of affirmation. *Journal of Contemporary Psychotherapy, 43*(1), 23-32.

Herdt, G. (2012). *Third sex, third gender: Beyond sexual dimorphism in culture and history*. New York: Zone Books.

Herman, J. L., Flores, A. R., Brown, T. N., Wilson, B. D., & Conron, K. J. (2017). *Age of individuals who identify as transgender in the United States*. Los Angeles, CA: The Williams Institute.

Hill, M. S., & Fischer, A. R. (2008). Examining objectification theory: Lesbian and heterosexual women's experiences with sexual-and self-objectification. *The Counseling Psychologist, 36*(5), 745-776.

Hunter, S., & Hickerson, J. (2003). *Affirmative practice: Understanding and working with lesbian, gay, bisexual, and transgender persons*. New York: NASW Press.

Knochel, K. A., Croghan, C. F., Moone, R. P., & Quam, J. K. (2012). Training, geography, and provision of aging services to lesbian, gay, bisexual, and transgender older adults. *Journal of Gerontological Social Work, 55*(5), 426-443.

Koken, J. A., Bimbi, D. S., & Parsons, J. T. (2009). Experiences of familial acceptance: Rejection among transwomen of color. *Journal of Family Psychology, 23*(6), 853.

Lev, A. I. (2013). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Routledge.

Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *American Journal of Preventive Medicine, 42*(3), 221-228.

Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. *International Journal of Transgenderism, 8*(2-3), 93-112.

Maguen, S., Shipherd, J. C., & Harris, H. N. (2005). Providing culturally sensitive care for transgender patients. *Cognitive and Behavioral Practice, 12*(4), 479-490.

Martell, C. R., Safren, S. A., & Prince, S. E. (2004). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York: Guilford Press.

Munoz-Plaza, C., Quinn, S. C., & Rounds, K. A. (2002). Lesbian, gay, bisexual and transgender students: Perceived social support in the high school environment. *The High School Journal, 85*(4), 52-63.

Mizock, L., & Mueser, K. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia

among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 1*(2), 146.

Nadal, K. L., Davidoff, K. C., Davis, L. S., & Wong, Y. (2014). Emotional, behavioral, and cognitive reactions to microaggressions: Transgender perspectives. *Psychology of Sexual Orientation and Gender Diversity, 1*(1), 72.

Nemoto, T., Bödeker, B., & Iwamoto, M. (2011). Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. *American Journal of Public Health, 101*(10), 1980-1988.

Nuttbrock, L. A., Bockting, W. O., Hwahng, S., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2009). Gender identity affirmation among male-to-female transgender persons: A life course analysis across types of relationships and cultural/lifestyle factors. *Sexual and Relationship Therapy, 24*(2), 108-125.

Page, S., Burgess, J., Davies-Abbott, I., Roberts, D., & Molderson, J. (2016). Transgender, mental health, and older people: an appreciative approach towards working together. *Issues in Mental Health Nursing, 37*(12), 903-911.

Pryor, J. T. (2015). Out in the classroom: Transgender student experiences at a large public university. *Journal of College Student Development, 56*(5), 440-455.

Radkowsky, M., & Siegel, L. J. (1997). The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review, 17*(2), 191-216.

Reisner, S. L., Bradford, J., Hopwood, R., Gonzalez, A., Makadon, H., Todisco, D., & Boswell, S. L. (2015). Comprehensive transgender healthcare: the gender affirming clinical and public health model of Fenway Health. *Journal of Urban Health, 92*(3), 584-592.

Rosentel, K., Hill, B. J., Lu, C., & Barnett, J. T. (2016). Transgender veterans and the veterans' health administration: Exploring the experiences of transgender veterans in the veterans affairs healthcare system. *Transgender Health, 1*(1), 108-116.

Rotondi, N. K., Bauer, G. R., Travers, R., Travers, A., Scanlon, K., & Kaay, M. (2012). Depression in male-to-female transgender Ontarians: results from the Trans PULSE Project. *Canadian Journal of Community Mental Health, 30*(2), 113-133.

Sevelius, J. M. (2013). Gender affirmation: A framework for conceptualizing risk behavior among transgender women of color. *Sex Roles, 68*(11-12), 675-689.

Sharon, N. (2016). Psychiatry's role in supporting healthy development in gender diverse children. *Psychiatric Annals, 46*(6), 355-360.

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2013). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: school victimization and young adult psychosocial adjustment. *Developmental Psychology, 46*, 158-159.

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health, 14*(2), 94-108.

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65.

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*(1), 125.

Vargas-Huicochea, I., Robles, R., Real, T., Fresán, A., Cruz-Islas, J., Vega-Ramírez, H., & Medina-Mora, M. E. (2018). A qualitative study of the acceptability of the proposed ICD-11 gender incongruence of childhood diagnosis among transgender adults who were labeled due to their gender identity since childhood. *Archives of Sexual Behavior,* 1-12.

Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health, 99*(4), 713-719.

Varas-Díaz, N., Serrano-García, I., & Toro-Alfonso, J. (2005). AIDS-related stigma and social interaction: Puerto Ricans living with HIV/AIDS. *Qualitative Health Research, 15(*2), 169-187.

World Health Organization. (1992). *The International Statistical Classification of Diseases and Related Health Problems* (10th revision). Geneva, Switzerland: Author.

Woodford, M.R., Kolb, C.L., Durocher-Radeka, G., Javier, G. (2014). Lesbian, gay, bisexual, and transgender ally training programs on campus: Current variations and future directions. *Journal of College Student Development, 55*(3), 317-322.

Zucker, B. (2017). Transcending limitations: Obstacles to benefits for transgender veterans. *Federal Circuit Bar, 27*, 321.

. . .

The authors have no conflicts of interest or funding to disclose.

Correspondence to Jack Lee, 1810 Front St. Apt. 39, East Measow, NY 11554; jacklee1dp@gmail.com

Addressing Depression Stigma Through the Arts Using a Play Inspired by the TV Show *Friends*

Joseph D. Mango, Elizabeth Lizaola, Lily Zhang, and Bonnie T. Zima,
UCLA Center for Health Services and Society, UCLA Semel Institute for Neuroscience and Human Behavior

DEPRESSION IS THE LEADING CAUSE of disability worldwide, with an estimated 350 million persons affected by the illness. This has led to over 800,000 suicides each year, making it the second leading cause of death in 15- to 29-year-olds (Friedrich, 2017; WHO, 2018). The devastating impact of major depression could be potentially mitigated through improving prevention, early detection, and better access to evidence-based treatment (Beardslee et al., 2013; Gilbody et al., 2006; Kroenke et al., 2009). Nevertheless, individuals living with major depression, especially those in underresourced communities, are presented with many barriers to care, including lack of resources, poor access to care, and high out-of-pocket cost; even if accessing care, it takes time to find the right combination of therapy and medication (Miranda et al., 2013).

One of the biggest challenges of major depression, though, is the stigma, or shame, of living with the disorder (Bromley et al., 2016). Especially among young adults, the loneliness experienced while suffering with major depression is often further exacerbated by worsening of social withdrawal, energy level, hopelessness, and helplessness (Chang et al. 2008). It is within this context that sustained support, along with understanding from family and friends, is heavily important to aid in the recovery.

In an effort to destigmatize major depression, creative individuals often turn to theatre, film, or television to show the positive impact of the arts in relation to mental health, and essentially, like cognitive behavioral therapy and medication, how the arts aid in the healing process. When family and friends are scarce, individuals may depend more heavily on a parasocial relationship with a television character they may relate to or gain validation from a scenario that resonates with one's experience (Cohen, 2004; Rubin & McHugh 1987). Although films, television shows, plays, poetry, and music have been a powerful platform in moving audiences through compelling narratives and while numerous productions advocate to reduce stigma or inform using the arts (Dupere, 2016; Morandi, 2018; Nutt, 2016; see also Friends of the Semel Institute for Neuroscience and Human Behavior, www.friendsofnpi.org/open-mind-series), there is very little research that examines the impact the arts or arts events have on audiences, specifically in times of stress and/or depression.

To raise awareness about major depression, a play was written to reflect an accurate and hopeful portrayal of a person living with major depression and how human connection, support, and the comfort of the arts contribute in the healing process. The context of the play was the TV show *Friends*, a sitcom that would be familiar to a wide audience in promoting dialogue among characters that was direct and delivered with compassion and understanding, especially since the sitcom revolves around six characters connecting and becoming best friends over 10 seasons. We conducted a study to systematically assess the impact of the play on depression stigma using a pre-, posttest study design. The aims of this study were to (a) describe the sociodemographic characteristics and prior experience with major depression among the audience members by performance site; and (b) examine change in attitudes about depression stigma and whether watching TV is comforting or the arts promote the healing process, within performance sites and in the overall sample.

Methods

The Play

The One With Friends, the feature-length play written by playwright Joseph Mango (co-author), takes place in a Los Angeles coffee shop and follows two characters living with depression—Lucy is going through a depressive episode after the sudden death of her parent while Callum has been diagnosed with major depressive disorder and has suicidal ideation and self-injurious behavior. Lucy recently lost her mother to cancer and isolates herself from friends and family in order to not be a burden to others or be let down by their inattentiveness. Callum, a struggling actor on a visa from England, who has lived with depression since he was a teenager, recently lost many friends from his blind-sided divorce and is looking for connection. On an assignment from his therapist to help with his social anxiety, Callum tries his best to initiate a conversation with a perfect stranger and introduces himself to Lucy. The interaction goes well and Callum learns that Lucy is writing a reunion episode for the beloved and universally known sitcom *Friends* as a fun side project. She enthusiastically shares her love of *Friends*, which piques Callum's interest.

The next day, Callum is now confident enough to have another conversation with Lucy, but this time Lucy ignores him, causing Callum to blame himself and revert back to a depressive state. Callum decides to open up to Lucy about his depression and she takes the time to listen. He also informs Lucy that he binge-watched a dozen episodes of *Friends*, which provided solace and much needed laughs. Lucy reveals that she has isolated herself from friends and family and views the characters on *Friends* as her friends, especially since they are easily accessible through streaming, DVDs, and syndication. She explains to Callum her reasoning for not wanting to be friends with him and for taking on parasocial relationships. She expresses that she is unable to attach to anything because she inevitably experiences loss so she holds on to those TV characters because they are always accessible and will not take advantage of her or brush her off.

In the end, Lucy comes to a realization that human connection is important in a world of social media and smartphones. Callum reveals that he is actually American and he used the British visa to try to be someone new and forget about the depressed person he always was; he also makes the decision to go back on his antidepressants. While neither character is cured by the end of the play, they are both left with a great sense of hope and are shown putting their own issues aside to help a depressed stranger, demonstrating that those who live with depression are still capable of helping others.

The play not only showcases struggles of depression and the resources/help avail-

able, but also uses the arts, in this case *Friends* and live theatre, as therapy and a healing resource. Lucy recalls an important episode from *Friends* when Phoebe (played by Lisa Kudrow) helps a complete stranger who is considering suicide and ends up saving the stranger's life. This scene was included in the play to give an example of how the arts, and a sitcom no less, can also be an educational source for its audience as well as leave the viewer with hope.

While the play veers through some heavy scenes, including Callum detailing an uncompleted suicide and showing his stomach covered in bandages from self-harm, another character, the Warm-up Comedian (Locker, 2015), breaks the fourth wall and interacts with the audience between scenes, unnoticed by Lucy and Callum, to check on the audience's mental health, provide light-heartedness, and engage the audience in mindfulness activities. The Warm-up Comedian mainly plays the role of a therapist for the live audience and offers support and comfort throughout the play.

Implementation

After 6 weeks of rehearsal, five performances of the 100-minute play were produced through the UCLA Narratives Project, with funding from the California Center of Excellence for Behavioral Health and supported by the Mental Health Services Act (MHSA). The first two performances were staged during Mental Illness Awareness Week at the Tamkin Auditorium located in the Ronald Reagan UCLA Medical Center on October 7 and 9, 2016, hereafter referred to as the "Los Angeles" site. All performers/production team were paid a stipend for the performances. To increase sample size in another community, the play was performed two times in New York City at New York University's Goldberg Stage on December 4 and 5, 2016, and hereafter is referred to as the "New York" site. One final performance took place at the Santa Monica Playhouse in Santa Monica, CA, on January 27, 2017, to improve outreach to a wider, community-based audience, and hereafter is referred to as the "Santa Monica" site. Due to limited funding, the producing team sought venues that were no cost to rent or provided nonprofit discounts. The play was performed free of charge in all three venues.

Study Design

To examine change in attitudes, we created a pre- and posttest study design, using a convenience sample of audience members from three different venues across the 5 performances (Los Angeles: $n = 2$; New York: $n = 2$; Santa Monica: $n = 1$) between October 7, 2016, to January 27, 2017.

Participant Recruitment

Participants were recruited via e-mail invitations (sent to thousands of faculty and staff at UCLA) and public postings on the UCLA Center for Health Services and Society's social media accounts (Facebook, Instagram, Twitter), which included a statement detailing the optional research study component. The play was summarized as "an aspiring writer and a struggling actor both living with depression are about to find out that one TV show and six 'Friends' can change their lives." Articles about the event appeared in *The Huffington Post*, *UCLA Daily Bruin*, *The Mighty,* and the *Santa Monica Daily Press* with links to reserve free tickets. Interviews with the writer and research team appeared on Los Angeles' KPCC radio station. Nonprofit organizations, such as Bring Change to Mind and UCLA Friends of the Semel Institute, promoted the play on their social media accounts; e-mails about the play were sent to numerous student groups in Los Angeles and New York City. An EventBrite link to reserve tickets was provided in all advertisements as well as a website created for the play (www.theonewithfriends.com).

Participants

In total, 298 of 354 audience members, or participants (84%) completed the pre- and post- surveys. The participation rate is conservative because the total audience included a few members under the age of 18 years who accompanied an adult audience member at the Los Angeles/Santa Monica performances. The audience sizes differed across performance sites, such that almost two-thirds of the total audience members attended the Los Angeles–based performance ($n = 198$; 66.4%), 20.8% ($n = 62$) attended the play at the New York site, and the remaining 12.8 % ($n = 38$) attended the final performance in Santa Monica.

Study Procedures

As audience members checked in, they were reminded about the research component and upon agreeing to participate in the study, were given a two-sided paper version of the anonymous survey, along with a pencil. They were asked to complete 15 questions before and 13 questions after the play to measure their attitudes about depression (28 questions total). A short announcement was made prior to the play to remind attendees to complete the pre-survey along with an announcement after the play reminding attendees to complete the post-survey. A research study information sheet with study details as well as rights, benefits, and risks, was made available to all audience members before and after the performances. Study procedures were approved by the Institutional Review Board of UCLA.

Measures

The survey questions were selected to align with the trajectory of the main characters' attitudes throughout the course of the play. The questions explored whether audience members have used the arts to get through a stressful/depressed period, identified depression among themselves or loved ones, felt comfortable around persons with depression, and minimized persons with depression. For example, the post-survey included these questions: Has the play moved you in feeling less likely to minimize a person who has self-harmed themselves? How willing would you be to make friends with someone suffering from depression?

To assess the therapeutic benefit of the play, two survey questions were developed for this study that inquired about the extent of agreement with the following statements: (1) watching TV is comforting; and (2) arts promote the healing process. For each question, audience members were asked to rate their extent of agreement using a 5-point Likert scale (1= *strongly disagree*; 2 = *disagree*; 3 = *neither*; 4 = *agree*; 5 = *strongly agree*). To assess change in depression stigma, we asked four of six social distance questions from the MacArthur Mental Health module of the 1996 General Social Survey (GSS). In the GSS, these questions are posed to participants after reading vignettes describing a person with mental illness, including major depression (Pescosolido et al., 2000). We adapted this component of the survey instrument for assessing participant attitudes toward interacting with someone suffering from depression before and after the play. For each stigma survey item, attitudes were rated using a 4-point Likert rating scale (1 = *definitely unwilling*, 2 = *probably unwilling*, 3 = *probably willing*, 4 = *definitely willing*). In addition, we calculated the mean score for these ratings using the total sum to create continuous variables.

Data Analysis

To examine differences in sociodemographic characteristics and prior experiences with depression by performance site, chi-square tests of proportions for dichotomous variables and student's *T* tests for continuous variables were conducted. For independent variables that significantly varied across three sites, pairwise comparisons were also conducted. For the belief and depression stigma ratings, dichotomous variables were created to examine pre- and postperformance change. Agreement with the statements related to comfort from TV watching or promotion of healing through the arts was defined as ratings of agree or strongly agree. For depression stigma, perceived stigma was classified as reporting definitely unwilling or unwilling to make friends, socialize, work or have a person with depression marry into one's family. For the total sample and for each performance site, change in beliefs and stigma pre- and postperformance was examined using two approaches: (a) assessing whether there was a significant difference in the proportion of audience members with more positive attitudes toward TV watching and the arts and reduced stigma following the play compared to prior to watching the play; and (b) examining whether the mean score on these ratings significantly improved after the play compared to before the performance. To explore predictors of change within the Los Angeles–based audience, logistic regression models examining each covariate one by one was conducted given small sample size.

Results

Sociodemographic characteristics and prior experience with depression among the participants by performance site are summarized in Table 1. Overall, the audience age averaged 38.6 years (*SD* = 16.8), and ranged from 18 to 81 years. Slightly more than one half of the total participants identified themselves as non-White (*n* = 154; 52.7%), 65.4% (*n* = 191) were female, and 81.4% (*n* = 223) had a bachelor, master, or doctoral college degree. Almost 4 out of 5 audience members reported annual incomes of $25,000 or greater (*n* = 191; 79.3%), and 26.1% (*n* = 63) reported annual incomes of $100,000 or more. Sociodemographic characteristics did not vary by performance site, but given the relatively small sample sizes at the New York and Santa Monica sites, the analysis was likely underpowered to detect differences.

Among the total participants, 60.2% (n = 177) reported personally suffering from depression during their lifetime, but only 36% (*n* = 107) reported receiving any depression care. In addition, 86.8% (*n* = 257) of participants reported having at least one family member or friend who suffered from depression and slightly more than one half (*n* = 153, 51.9%) reported family or friends receiving any depression care. The performance in New York City attracted an audience with the largest proportion of persons who endorsed personally suffering from depression (*n* = 43; 69.4%) or having a family or friend who suffered depression (*n* = 60, 96.8%).

Sociodemographic characteristics and prior experience with depression did not vary by performance site, with three exceptions. Perceived unmet need for depression care in self was significantly higher in the Los Angeles and New York audiences compared to the Santa Monica audience (LA: 24.1% vs. 5.6%, $p = .012$; NY: 35.5% v s. 5.6%, $p < .001$). For reported experience of a family member or friend with depression, New York participants were more likely to endorse this experience compared to Los Angeles–based participants (96.8% vs. 84.7%, $p = .012$), and participants at the Santa Monica performance (96.8% vs. 81.6%, $p = .010$). Further, unmet need for depression care among family or friends was more likely to be reported among the New York audience compared to the audience at the Los Angeles performances (36.8% vs. 29.9%, $p = .015$).

Change in the proportion of audience members with positive attitudes or improved willingness to associate with persons with a history of depression by performance site are summarized in Table 2. Overall, at baseline most participants reported positively about how watching TV was perceived as comforting (*n* = 256; 87.7%) and that the arts promoted the healing process (*n* = 280, 95.9%). In addition, the majority of participants reported little depression stigma as indicated by willingness to make friends (*n* = 274; 94.8%), socialize (*n* = 273, 94.5%), and work with a person who suffers from depression (*n* = 267; 92.4%). Even among the most sensitive stigma survey item, 84.1% (*n* = 243) of participants reported a willingness to have someone with a history of depression marry into their family.

For each of the attitudes, there was significant positive change following the performances in the Los Angeles audience, with only one exception (making friends). Although the absolute number of persons endorsing disagreement with the positive influence of TV or the performing arts was small, among these participants, 63% (14/22) and 58% (7/12) shifted to perceiving these mediums as comforting or healing, respectively. In addition, perceptions of stigma positively shifted for more than one half of the participants who arrived at the performance with feelings of depression stigma (making friends: change in 50% [5/10]; socialize: 64% [7/11]; work: 50% [7/14]; marry: 52% [17/33]).

Change in mean scores for attitude and stigma ratings is summarized in Table 3. With only three exceptions at the Santa Monica performance, there was significant change in positive attitudes toward comfort received from watching TV, the belief that the arts promote the healing process, and improved willingness to make friends, socialize with, work with, and marry a person with a history of depression. At the Santa Monica performance, improvement in belief about the healing impact of the arts and willingness to work with someone with depression approached but did not attain statistical significance ($p = .07$), and there was no significant change in willingness to socialize with a person who had a history of depression. These findings should be interpreted carefully because of the small sample size.

Exploratory analyses using logistic regression did not find significant predictors of change in attitudes among the Los Angeles audience. Although there was no statistically significant change in attitudes at the New York City or Santa Monica performance sites, differences may have not been detected given smaller sample sizes. In addition, significant changes among the total participants should be interpreted cautiously because they are likely confounded by significant differences in change at the Los Angeles performance site.

Discussion

Findings from this study suggest that it is feasible to implement an innovative study to create and perform a play that sought to communicate an accurate and hopeful portrayal of a person living with major depression. The play also engaged the audience in participating in a study to examine change in attitudes using a pre-, posttest design across the five performances. In addition, this play attracted audiences with 10 times higher reported rates of major depression compared to estimated national prevalence rates of 6.7%

Table 1. Sociodemographic Characteristics and Prior Experience With Depression by Performance Site

	Total N = 298		***Los Angeles N = 198***	***New York City N = 62***	***Santa Monica N = 38***	
Variables	Analytic *N*	*N* (%)	*N* (%)	*N* (%)	*N* (%)	*p*-value
Age, Mean (SD)	298	38.6 (16.8)	40.6 (18.0)	35.2 (14.2)	33.9 (12.6)	0.015
Race/Ethnicity	292					0.247
White/Caucasian		138 (47.3)	86 (44.3)	34 (56.7)	18 (47.4)	
Non-White/ Caucasian		154 (52.7)	108 (55.7)	26 (43.3)	20 (52.6)	
Gender	292					0.896
Female		191 (65.4)	128 (65.6)	40 (66.7)	23 (62.2)	
Male		101 (34.6)	67 (34.4)	20 (33.3)	14 (37.8)	
Education	274					0.089
High school/some college		51 (18.6)	38 (20.8)	4 (7.0)	9 (26.5)	
Bachelor Degree		86 (31.4)	55 (30.1)	19 (33.3)	12 (35.3)	
Master/Doctoral		137 (50.0)	90 (49.2)	34 (59.6)	13 (38.2)	
Income	241					0.192
<$25,000		50 (20.7)	32 (20.0)	9 (17.3)	9 (31.0)	
$25,001-$40,000		40 (16.6)	26 (16.3)	7 (13.5)	7 (24.1)	
$40,001-$99,000		88 (36.5)	54 (33.8)	24 (46.2)	10 (34.5)	
$100,000 or up		63 (26.1)	48 (30.0)	12 (23.1)	3 (10.3)	
Prior experience with depression						
Personally suffered depression	294					0.203
Yes		177 (60.2)	115 (58.7)	43 (69.4)	19 (52.8)	
No		117 (39.8)	81 (41.3)	19 (30.6)	17 (47.2)	
Received care for depression	297					0.482
Yes		107 (36.0)	69 (35.0)	21 (33.9)	17 (44.7)	
No		190 (64.0)	128 (65.0)	41 (66.1)	21 (55.3)	
Unmet need for depression care	293					0.004
Yes		71 (24.2)	47 (24.1)	22 (35.5)	2 (5.6)	
No		222 (75.8)	148 (75.9)	40 (64.5)	34 (94.4)	
Family/friends suffered depression	296					0.029
Yes		257 (86.8)	166 (84.7)	60 (96.8)	31 (81.6)	
No		39 (13.2)	30 (15.3)	2 (3.2)	7 (18.4)	
Family/friends received care for depression	295					0.364
Yes		153 (51.9)	106 (54.4)	31 (50.0)	16 (42.1)	
No		142 (48.1)	89 (45.6)	31 (50.0)	22 (57.9)	
Family/friends unmet need for depression care	294					0.033
Yes		103 (35.0)	58 (29.9)	29 (46.8)	16 (42.1)	
No		191 (65.0)	136 (70.1)	33 (53.2)	22 (57.9)	

Pairwise Comparisons

	Los Angeles vs. New York	***Los Angeles vs. Santa Monica***	***New York vs. Santa Monica***
Unmet need for depression care	$\chi^2 = 3.10$, $p = 0.078$	$\chi^2 = 6.26$, $p = 0.012$	$\chi^2 = 11.03$, $p < 0.001$
Family/friends suffered depression	$\chi^2 = 6.33$, $p = 0.012$	$\chi^2 = 0.23$, $p = 0.630$	$\chi^2 = 6.64$, $p = 0.010$
Family/friends unmet need for depression care	$\chi^2 = 5.97$, $p = 0.015$	$\chi^2 = 2.18$, $p = 0.140$	$\chi^2 = 0.21$, $p = 0.649$

Table 2. Change in Attitudes and Depression Stigma by Performance Site

Variables	*Overall*				*Los Angeles N=198*				*New York City N=62*				*Santa Monica N=38*			
	Overall	*Pre*	*Post*	*P*	*N*	*Pre*	*Post*	*P*	*N*	*Pre*	*Post*	*P*	*N*	*Pre*	*Post*	*P*
Attitudes																
Watching TV is comforting	292			<.001	193			<.001	62			0.031	37			0.125
Strongly disagree/disagree/ neither		36 (12.3)	12 (4.1)			22 (11.4)	8 (4.1)			9 (14.5)	3 (4.8)			5 (13.5)	1 (2.7)	
Agree/strongly agree		256 (87.7)	280 (95.9)			171 (88.6)	185 (95.9)			53 (85.5)	59 (95.2)			32 (86.5)	36 (97.3)	
Arts promote the healing process	286			0.022	189			0.039	61			1.000	36			1.000
Strongly disagree/disagree/ neither		15 (5.2)	6 (2.1)			12 (6.3)	5 (2.6)			1 (1.6)	0 (0.0)			2 (5.6)	1 (2.8)	
Agree/strongly agree		271 (94.8)	280 (97.9)			177 (93.7)	184 (97.4)			60 (98.4)	61 (100)			34 (94.4)	35 (97.2)	
Depression stigma																
Make friends	289			0.057	191			0.227	61			0.500	37			1.000
Definitely unwilling/unwilling		15 (5.2)	7 (2.4)			10 (5.2)	5 (2.6)			3 (4.9)	1 (1.6)			2 (5.4)	1 (2.7)	
Probably willing/definitely willing		274 (94.8)	282 (97.6)			181 (94.8)	186 (97.4)			58 (95.1)	60 (98.4)			35 (94.6)	36 (97.3)	
Socialize	289			0.012	191			0.039	62			1.000	36			1.000
Definitely unwilling/unwilling		16 (5.5)	7 (2.4)			11 (5.8)	4 (2.1)			2 (3.2)	1 (1.6)			3 (8.3)	2 (5.6)	
Probably willing/definitely willing		273 (94.5)	282 (97.6)			180 (94.2)	187 (97.9)			60 (96.8)	61 (98.4)			33 (91.7)	34 (94.4)	
Work	289			0.002	192			0.039	61			0.500	36			0.250
Definitely unwilling/unwilling		22 (7.6)	10 (3.5)			14 (7.3)	7 (3.6)			3 (4.9)	1 (1.6)			5 (13.9)	2 (5.6)	
Probably willing/definitely willing		267 (92.4)	279 (96.5)			178 (92.7)	185 (96.4)			58 (95.1)	60 (98.4)			31 (86.1)	34 (94.4)	
Marry into family	289			<.001	192			<.001	62			0.250	35			0.250
Definitely unwilling/unwilling		46 (15.9)	23 (8.0)			33 (17.2)	16 (8.3)			8 (12.9)	5 (8.1)			5 (14.3)	2 (5.7)	
Probably willing/definitely willing		243 (84.1)	(92.0)			159 (82.8)	176 (91.7)			54 (87.1)	57 (91.9)			30 (85.7)	33 (94.3)	

(continued from p. 178)

Table 3. Change in Mean Rating Scores of Attitudes and Depression Stigma by Performance Site

	Overall N=298					Los Angeles N=198					New York City N=62					Santa Monica N=38				
Variables	N	Pre Mean(SD)	Post Mean(SD)	Post-Pre Mean(SD)	p-value	N	Pre Mean(SD)	Post Mean(SD)	Post-Pre Mean(SD)	p-value	N	Pre Mean(SD)	Post Mean(SD)	Post-Pre Mean(SD)	p-value	N	Pre Mean(SD)	Post Mean(SD)	Post-Pre Mean(SD)	p-value
Attitudes																				
Watching TV is comforting	292	4.26 (0.81)	4.57 (0.65)	0.32 (0.62)	<.001	193	4.26 (0.81)	4.58 (0.65)	0.31 (0.64)	<.001	62	4.24 (0.84)	4.52 (0.7)	0.27 (0.55)	<.001	37	4.24 (0.75)	4.62 (0.55)	0.41 (0.64)	<.001
Arts promote the healing process	286	4.54 (0.64)	4.73 (0.49)	0.18 (0.52)	<.001	189	4.48 (0.67)	4.69 (0.52)	0.19 (0.52)	<.001	61	4.71 (0.49)	4.84 (0.37)	0.13 (0.46)	0.031	36	4.61 (0.59)	4.78 (0.48)	0.19 (0.62)	0.07
Depression stigma																				
Make friends	289	3.55 (0.65)	3.74 (0.5)	0.19 (0.52)	<.001	191	3.55 (0.64)	3.73 (0.5)	0.18 (0.52)	<.001	61	3.55 (0.64)	3.79 (0.45)	0.23 (0.56)	0.002	37	3.58 (0.68)	3.76 (0.6)	0.19 (0.46)	0.017
Socialize	289	3.58 (0.63)	3.76 (0.5)	0.17 (0.47)	<.001	191	3.55 (0.62)	3.75 (0.48)	0.18 (0.5)	<.001	62	3.66 (0.6)	3.82 (0.43)	0.16 (0.45)	0.006	36	3.55 (0.76)	3.69 (0.67)	0.11 (0.4)	0.103
Work	289	3.52 (0.68)	3.71 (0.55)	0.19 (0.52)	<.001	192	3.49 (0.66)	3.69 (0.54)	0.19 (0.52)	<.001	61	3.58 (0.64)	3.77 (0.46)	0.2 (0.48)	0.002	36	3.53 (0.86)	3.69 (0.75)	0.19 (0.62)	0.07
Marry into family	289	3.3 (0.8)	3.56 (0.69)	0.27 (0.57)	<.001	192	3.26 (0.8)	3.53 (0.69)	0.27 (0.6)	<.001	62	3.39 (0.75)	3.65 (0.63)	0.26 (0.48)	<.001	35	3.32 (0.91)	3.57 (0.78)	0.26 (0.56)	0.01

(Kessler et al., 2005), and an even larger proportion of persons who had at least one family member or friend who had suffered from major depression. Since the play was produced through a research center dedicated to improving access and quality of mental health care, there was likely a positive selection bias towards attracting audience members who felt more comfortable disclosing experiences with depression. The reported unmet need for depression care also was relatively high (self: 64%; family/friends: 48.1%), also consistent with national estimates (Wang et al., 2005). These findings were consistent across performance sites, suggesting that a free-of-charge play related to major depression may be an effective mechanism to bring together a critical mass of persons that understand the significance of public advocacy efforts to improve access to care for mood disorders.

Overall, the majority of persons attending the play endorsed positive attitudes about watching TV and the healing capacity of the arts as well as reducing depression stigma. Although limited to a few audience members, significant improvement in the proportion of audience members with positive change in these attitudes was identified at one site (Los Angeles). When examining change using the mean scores, the impact of the play was further strengthened. There was significant improvement in positive attitudes toward watching TV and the healing impact of the arts as well as reduced depression stigma, with only a few exceptions at the performance site with the smallest sample size. Together, these findings suggest that the impact of the play to reduce depression stigma was promising.

Whether a person has a favorite go-to film, TV show, book, or music album, the arts seem to inspire positive feelings and escapism. In the 2017 documentary *Spielberg*, which details the life and films of director and film enthusiast Steven Spielberg, he states in the film, "Movies are my therapy" (Meslow, 2017). Further, in a 2016 interview, actress Jennifer Aniston, who portrayed the character of "Rachel Green" on *Friends*, reflected on the impact *Friends* specifically has had: "It's comfort food and it makes people feel better when they're feeling down and when they want to distract themselves, they can always [turn it on], because it is always on." She summarizes the show as ". . . just friends sitting, communing together. I hope that it actually will inspire people to remember that connection and speak with each

other" (Aniston, 2016). While we do not suggest that movies and TV shows are a replacement for mental health care or are a suitable escape, these activities may be used in adaptive ways such as providing comfort, especially during times of loneliness.

This play was purposively written to stimulate hope and emphasize the role primary support, directly from others, has in one's recovery. While it was important to the playwright to accurately portray an individual living with depression and anxiety, no suicide attempts or self-harm are depicted on stage. The play ends with hope for all the characters along with formation of new friendships. The goal was to avoid triggering a depressive episode as well as provide anyone experiencing depression with a sense of hope.

In the play, we modeled social support skills and demonstrated their role in helping persons living with depression (Krull, 2018; Smith, Hill, & Kokanovic, 2015). Specifically, many scenes in the play show the characters listening to each other, especially when sharing their feelings, struggles, and symptoms (lack of sleep, loneliness, fatigue) with the intent of modeling how to react when a family member or friend expresses they are depressed and/or suicidal. There are also scenes of the characters providing encouragement to one another, whether it is continuing therapy, reaching out to friends, or taking medication. In one scene, Lucy commends Callum for reaching out to a friend and seeking help when he shares a time he had suicide ideation.

The main limitation of the study is that it is a pilot test using a convenience sample of audience members and a measure developed to align with the themes of the play. Additional research would be needed to establish the psychometric properties of the attitude measure. Another limitation is that the venues selected for the performances were at or close to major universities, thus attracting a highly educated audience. An important next step would be to examine the impact of this play using larger, more diverse audiences. The authors also recognize that given the proximity of the Santa Monica venue to the Los Angeles venue, these sites could be merged for analysis; however, the sites were kept separate as the venues were different—a community playhouse in Santa Monica as opposed to a hospital auditorium on UCLA's campus, where the play may have attracted more health care professionals and students, especially since it was heavily advertised through UCLA and the UCLA Health System. The Santa Monica Playhouse promoted the play to their members/community via social media. Nevertheless, our early findings suggest that the impact of the play on further reducing depression stigma at two performances were promising. In the play, we combined television with theatre to engage an audience around a beloved TV show as a way to disseminate education around depression, the stigma surrounding it, the resources available, and to reinforce empathy and kindness.

References

Aniston, J. (2016). Jennifer Aniston talks friends reunion, office christmas party, and Justin Theroux. In Lorraine, edited by Lorraine Kelly. ITV.

Beardslee, W. R., Brent, D. A., Weersing, V. R., Clarke, G. N., Porta, G., Hollon, S. D., . . . Iyengar, S. (2013). Prevention of depression in at-risk adolescents: longer-term effects. *JAMA Psychiatry, 70*, 1161-1170.

Bromley, E., Kennedy, D. P., Miranda, J., Sherbourne, C. D., & Wells, K. B. (2016). The fracture of relational space in depression: Predicaments in primary care help seeking. *Current Anthropology, 57*, 610-631.

Chang, E. C., Sanna, L. J., Chang, R., & Bodem, M. R. (2008). A preliminary look at loneliness as a moderator of the link between perfectionism and depressive and anxious symptoms in college students: Does being lonely make perfectionistic strivings more distressing? *Behaviour Research and Therapy, 46*, 877-886.

Cohen, J. (2004). Parasocial break-up from favorite television characters: The role of attachment styles and relationship intensity. *Journal of Social and Personal Relationships, 21*, 187-202.

Dupere, K. (2016, October). Black visual artists are bravely addressing mental health in their work. In *Mashable*. Retrieived from https://mashable.com/2016/10/10/black-mental-health-art.

Friedrich, MJ. (2017). Depression is the leading cause of disability around the world. *JAMA, 317*, 1517.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine, 166*, 2314-2321.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617-627.

Kroenke, K., Strine, T. W., Spitzer, R. L., Williams, J. B. W., Berry, J. T., & Mokdad, A. H. (2009). The PHQ-8 as a measure of current depression in the general population. *Journal of Affective Disorders, 114*, 163-173.

Krull, E. (2018). Social support is critical for depression recovery. *Psych Central.* Retrieved from https://psychcentral.com/lib/social-support-is-critical-for-depression-recovery/

Locker, M. (2015). *Warm-up comics: The funniest people in TV who are never on TV*. Retrieved from https://www.vanityfair.com/hollywood/2015/10/tv-warm-up-comics?verso=true

Meslow, S. (2017). *How HBO's Spielberg find the unknown side of the world's best-known filmmaker*. Retrieved from https://www.gq.com/story/hbo-spielberg-documentary-review

Miranda, J.,Ong, M. K., Jones, L., Chung, B., Dixon, E. L., Tang, L., . . . Wells, K. B. (2013). Community-partnered evaluation of depression services for clients of community-based agencies in under-resourced communities in Los Angeles. *Journal of General Internal Medicine, 28*, 1279-1287.

Morandi, J. N. (2018). *The Suicide Musicals: Combating the stigma of mental illness*. Retrieved from https://www.thecrimson.com/column/the-might-of-musicals/article/2018/11/6/TheSuicide-Musicals/

Nutt, A. (2016). *Turning madness into music: A former psychiatric patient's life is now an opera*. Retrieved from https://www.washingtonpost.com/news/to-your-health/wp/2016/09/16/turning-madness-into-music-a-former-psychiatric-patients-life-is-now-an-opera.

Pescosolido, B. A., Martin, J. K., Link, B. G., Kikuzawa, S., Burgos, G., Swindle, R., & Phelan, J. (2000). *Americans' views of mental health and illness at century's end: Continuity and change.* Bloomington, IN: Indiana Consortium for Mental Health Services Research.

Rubin, R. B., & McHugh, M. P. (1987). Development of parasocial interaction relationships. *Journal of Broadcasting & Electronic Media, 31*, 279-292. doi: 10.1080/08838158709386664

Smith, L., Hill, N., & Kokanovic, R. (2015). Experiences of depression, the role of social support and its impact on health outcomes. *Journal of Mental Health, 24*(6), 342-346.

Wang, P. A., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 629-640.

WHO. (2018). *World Health Organization—Depression fact sheet.* Retrieved from https://www.who.int/en/news-room/fact-sheets/detail/depression

. . .

This study was supported by the California Center of Excellence for Behavioral Health (SB852). The authors would like to thank: Kenneth Wells, MD, MPH, Bowen Chung, MD, MSHS, Sheryl Kataoka, MD, MSHS, Armen Arevian, MD, PhD, Eugene Gillespie, PhD, Consuelo Garcia, Sophie Feller, MD, Rosalinda Cardenas, and Erika Orellana for their research and/or administrative/production support; Ashley Griggs, MFA for her dramaturg work, direction, production assistance, and support; Actors: Nick McLoughlin, Miranda Wynne, Chloé Hung, and Lindsey Moore Ford; and donors of the UCLA Spark campaign.

Correspondence to Joseph D. Mango, MFA, UCLA Center for Health Services and Society, 10920 Wilshire Blvd., Suite 300, Los Angeles, CA 90095; jdmango@mednet.ucla.edu

Spotlight on a Mentor • **Betsy D. Kennard, Psy.D.**

Dr. Kennard is a Professor in the Department of Psychiatry at UT Southwestern Medical Center and Children's Health, Dallas. She has expertise in pediatric depression and has served as a site co-investigator in three NIMH-funded multisite treatment studies of adolescent depression and suicide, and co-authored CBT treatment manuals for these three studies. She also developed a CBT sequential treatment strategy to prevent relapse in youth with depression and was Principal Investigator in the NIMH-funded trials of this relapse prevention CBT intervention (since published by Guilford Press). More recently, Dr. Kennard is conducting an R34, "Brief Intervention for Suicide Risk Reduction in High Risk Adolescents," in collaboration with David Brent at the University of Pittsburgh. This project aims to determine the efficacy of an inpatient intervention and a smartphone app for suicidal adolescents to reduce suicide attempts following hospital discharge. The expansion of this project was recently funded by the American Foundation for Suicide Prevention. In addition, she is the Principle Investigator on a project to adapt and implement an effective adolescent suicide prevention intensive outpatient program for community mental health clinics that serve low-income, culturally diverse suicidal youth, funded by Texas Health and Human Services. She is also the Program Director of an intensive outpatient program for suicidal youth at Children's Health, Dallas, and the Program Director of an APA-accredited doctoral program and internship in clinical psychology.

Dr. Kennard is interested in developing treatment interventions, specifically for child and adolescent depression and suicidality, as well as youth with HIV and depression. Her work includes developing treatment strategies to reduce relapse rates in youth with major depressive disorder. In addition, she has been active in the dissemination of evidence-based practice in community settings, as well as using technology to enhance treatment interventions.

For how long have you been a member of ABCT?
Six years— elected as a fellow in 2015

For how long have you engaged in the type of mentoring that you engage in now?
I have been fortunate enough to work with graduate students and interns for over 30 years. That said, I believe I am always learning and developing my skills as a mentor. I have learned much from my colleagues, as well as my mentees, on how to improve my ability to help others reach their career goals.

What type of mentor do you aspire to be? Do you have a mentorship philosophy?
My goal is to create a comfortable learning environment, and to that end, I see my role as a collaborator in helping mentees to reach their own career goals.

What practices do you engage in that foster your mentorship style?
I think it is important to always put yourself in the position of the trainee and to fully understand their perspective before sharing your own.

What are your strengths as a mentor?
I actually think my years of experience, or my age, has become my most important strength. I have a lot of compassion for the trainee, given the challenges of that time of career, and a lot of patience. I try to meet trainees where they are in their career journey and do not feel the need to impose my own career path or ideals on them.

Whom do you perceive to be your most influential mentors? Describe the main lessons that you have learned from your mentors.
The people whom I have admired the most are the women who have been very successful in academics, yet have matched that success with a noncompetitive spirit and an equivalent lack of arrogance.

What do you tend to look for in potential mentees (recognizing that this varies depending on context [e.g., clinical supervision, research advising])?
I look for individuals with a strong work ethic, who work well with team members.

What advice would you give to other professionals in your field who are starting out as mentors?
Be nice to everyone and do not take yourself too seriously. Also, remember that everything you achieve is because of others' hard work—science is a team sport.

What do you enjoy doing for fun/relaxation?
I mostly enjoy traveling with my family. I love to read and exercise.

. . .

Correspondence to Betsy D. Kennard, Psy.D., Department of Psychiatry, UT Southwestern, Medical Center, 5323 Harry Hines Blvd., Dallas, TX 75390-8589; Beth.kennard@utsouthwestern.edu

Spotlight on a Mentor interviews are presented by ABCT's Academic Training and Education Standards Committee. The purpose of the Spotlight on a Mentor program is to highlight the diversity of excellent research mentors within the membership ranks of ABCT. Its goal is to spotlight promising early career and well-established mentors across all levels of academic rank, areas of specialization, and type of institution. To read about all of our spotlighted mentors, visit www.abct.org/Resources/?m=mResources&fa=spot_Mentor. To add your mentorship profile to the ABCT Mentorship Directory, please visit www.abct.org/mentorship/

Questions? Contact Aleksandra Foxwell: aleksandra.foxwell@utsouthwestern.edu

Michael J. Kozak (1952–2019)

Martin E. Franklin, *University of Pennsylvania School of Medicine*

Jonathan S. Abramowitz, *University of North Carolina*

THE FIELD OF COGNITIVE BEHAVIORAL therapy and obsessive-compulsive disorder recently lost an outstanding theorist, master clinician, painstaking scholar, and brilliant mentor with the passing of Michael J. Kozak, Ph.D., on March 18, 2019, after a brief and sudden illness. Everyone who encountered Michael for more than a short time likely walked away with a clear sense of his keen intelligence, his uniqueness, his generosity and generativity, and his kindness. Michael was born in Northeast Philadelphia in 1952, son of a Philadelphia firefighter; he attended Father Judge High School in Northeast Philadelphia and, like so many in the region, had his heart broken by the collapse of the Philadelphia Phillies in the final week of the 1964 regular season. Michael went on to the University of Pennsylvania, where he received his bachelor's degree in 1974. Michael's first immersion into clinical psychology occurred at Penn when he served as a research assistant in the laboratory of Martin Seligman, Ph.D., who at the time was studying learned helplessness in rats (e.g., Seligman, Rossellini, & Kozak, 1975). From there Michael entered the clinical psychology Ph.D. program at the University of Wisconsin–Madison. It was in the laboratory of Dr. Peter Lang where Michael undertook study of the psychophysiology and expression of human emotion and the tripartite model, and where he became interested in anxiety in particular (e.g., Lang, Kozak, Miller, Levin, & McLean, 1980; Lang, Levin, Miller, & Kozak, 1983). Michael's early contributions to understanding the unique physiology and treatment of blood-injury fear with applied tension represented but one of many seminal contributions he made to the field of clinical psychology (e.g., Kozak & Miller, 1985).

It was in Madison where Michael made some lifelong friendships with other future psychologists, including Drs. Gregory Miller and Robert Simons; the lab in Madison also served as a springboard for Michael's serious study of and collecting of wines, a passion that remained a source of great joy for Michael throughout his life. Indeed, Michael would receive myriad requests about wines from those of us who knew him well, and typically would respond quickly with a variety of choices, price ranges, and advice about food pairings. Like most everything he did, Michael came at this process with great enthusiasm and serious thought, and a desire to share his knowledge with others. Dinner out with Michael was always an enjoyable experience, with hand-picked venues arrived at only after careful consideration, detailed knowledge of the menu, and obvious relish in the nuances of the dining experience. Michael once strongly endorsed a particular restaurant with the memorable proclamation: "We should go here: the chef takes chances!" As was often the case, Michael's recommendation in that case proved prescient.

After completing internship and a teaching year at the University of British Columbia, Michael returned to Philadelphia to take a position as a clinical psychologist in the lab of Dr. Edna Foa, then at Temple University. Michael and Edna began a long collaboration focused on anxiety theory, phenomenology, and treatment, and wrote one of the most important papers in the history of clinical psychology. The paper, entitled "Emotional Processing of Fear: Exposure to Corrective Information" by Foa and Kozak, was published in 1986 in *Psychological Bulletin*, and has influenced the thinking of virtually every scholar studying anxiety disorders since then. Indeed, the paper has been cited over 3,200 times in the literature since 1986, and remains a crucial starting point for those interested in understanding how pathological anxiety is maintained and, by extension, how it can be ameliorated.

Michael's substantive contributions to the lab and to the field certainly did not end with that paper, however: Michael was the study coordinator, clinical supervisor, and/or co-investigator for many seminal trials examining the efficacy of exposure plus response prevention conducted by Foa and colleagues in the 1980s and 1990s (e.g., Foa, Kozak, Steketee, & McCarthy, 1992; Foa et al., 2005; Franklin et al., 1998). While at the Medical College of Pennsylvania/Eastern Pennsylvania Psychiatric Institute (MCP/EPPI), Michael also provided clinical supervision to many new faculty members, clinical psychology interns, and research assistants who rotated through the Center for the Treatment and Study of Anxiety during his 17-year stint there (1982–1999). Michael's true talent for mentoring and influencing future clinical psychologists was most evident in this role. Supervision with Michael could be overwhelming at times: he often imparted so much wisdom and knowledge in a single session that it was not possible to take it all in; nevertheless, you were made better by whatever part of it you could retain. Michael took the time to get to know his supervisees well and, by extension, understand their strengths and weaknesses as therapists. A common refrain from Michael in supervision was that he did not wish to simply rehash what was going well but was interested instead, for the sake of efficiency, in discussing the problems encountered in treatment. And he was especially gifted at identifying such problems, and offering suggestions to address them. Michael's overarching goal was precision in communication, and his logic was always evident; at the same time, Michael expected, and indeed demanded, that supervisees treat their patients with compassion for the circumstances and vulnerabilities that put them in the position to need our assistance. As Jason Isbell once put it in one of his songs, in supervision Michael's questions were like directions to the truth, a truth that Michael usually saw long before the rest of us could. He was patient throughout the process, but stayed on message until such time that he could count on us to see it all as clearly as he did. All these years later, many of us still feel strongly that we try to channel Michael's cogent and compassionate approach in supervision, and that his influence on the field shall continue on indefinitely in the work we do with patients, trainees, and colleagues.

Michael moved on from the CTSA on July 14, 1999, when he took a position as a Scientific Review Administrator at the National Institutes of Health. Michael's talent for organization and desire for fairness served the agency well, and quickly Michael's abilities were recognized with his being named as Chief of Extramural Review at the National Institute of Mental Health in 2001. Michael served in this role for several years, but Michael's logical

mind and ability to encourage scientists to create and submit fundable proposals led NIMH to move him over to the Program side in 2005, where he served as NIMH's Chief of Adult Psychopathology and Psychosocial Intervention Research Branch in its Division of Adult Translational Research and Treatment Development until his retirement in 2017. Those whose applications came in under Michael's program were quickly acquainted with his capacity to see the holes in arguments faster than most; indeed, in the circles in which he traveled professionally, to be "Kozaked" became a verb that conveyed that the specious and less defensible aspects of your arguments would be immediately identified and quickly laid to waste. Indeed, Dean McKay, an OCD expert at Fordham University quite familiar with Michael's style and work, said that his presence in the audience at a conference talk led many to fear his incredible and penetrating questions. These questions, once the recipient of his feedback recovered, invariably made the work far better for those who took them to heart, and crafted their articles from the talks in which Michael offered his suggestions. Indeed, to be "Kozaked" was a badge of honor, and offered an opportunity to improve your thinking and, by extension, your own contribution to the field. Michael was forever encouraging his supervisees, often ushering them into the very academic spotlight that he so fastidiously avoided himself. For many of us, Michael's gentle hand on our backs served as a springboard to clarity of purpose, improved confidence, and career success, and we remain forever in his debt. We recognize that Michael's efforts to alleviate suffering in those with OCD and in taking the time to carefully train others who would continue this important work shall live on. At the same time, the world is already a far less interesting place without him in it, and we will miss him dearly.

References

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*(1), 20-35.

Foa, E. B., Kozak, M. J., Steketee, G. S., & McCarthy, P. R. (1992). Treatment of depressive and obsessive-compulsive symptoms in OCD by imipramine and behaviour therapy. *British Journal of Clinical Psychology, 31*(3), 279-292.

Foa, E. B., Liebowitz, M. R., Kozak, M. J., Davies, S., Campeas, R., Franklin, M. E., . . . Tu, X. (2005). Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *American Journal of Psychiatry, 162*(1), 151-161.

Franklin, M. E., Kozak, M. J., Cashman, L. A., Coles, M. E., Rheingold, A. A., & Foa, E. B. (1998). Cognitive-behavioral treatment of pediatric obsessive-compulsive disorder: An open clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(4), 412-419.

Kozak, M. J., & Miller, G. A. (1985). The psychophysiological process of therapy in a case of injury-scene-elicited fainting. *Journal of Behavior Therapy and Experimental Psychiatry, 16*(2), 139-145.

Lang, P. J., Kozak, M. J., Miller, G. A., Levin, D. N., & McLean, A. (1980). Emotional imagery: Conceptual structure and pattern of somato-visceral response. *Psychophysiology, 17*(2), 179-192.

Lang, P. J., Levin, D. N., Miller, G. A., & Kozak, M. J. (1983). Fear behavior, fear imagery, and the psychophysiology of emotion: The problem of affective response integration. *Journal of Abnormal Psychology, 92*(3), 276-306.

Seligman, M. E., Rosellini, R. A., & Kozak, M. J. (1975). Learned helplessness in the rat: Time course, immunization, and reversibility. *Journal of Comparative and Physiological Psychology, 88*(2), 542-547. doi:http://dx.doi.org/10.1037/h0076431

"Expanding the Tent": Looking for the Next Generation of ABCT Leadership in 2020

Patricia Marten DiBartolo, *Chair, Leadership and Elections Committee*

EVERYWHERE I TURN recently, it seems that institutions and organizations have been talking about the importance of advancing science in order to address society's challenges. Given ABCT's mission to foster human well-being through evidence-based principles, I imagine this mindset resonates with you as it does with me.

Indeed, compelling data show that effective discovery and creative problem-solving require a multitude of backgrounds and perspectives. Good science must necessarily be diverse and inclusive in order to tackle today's problems. The same can be said for strong organizations like ABCT that work to tackle complicated matters.

Every year, ABCT's Leadership and Elections Committee works hard to shepherd our elections with an exciting slate of candidates. Our goal for the slate is to represent the diverse and dedicated membership of the organization. We encourage individuals with diverse backgrounds to run. On the committee, we view diversity in a variety of ways—from discipline to geographic region, career stage to gender, clinical speciality to race and ethnicity. In this way, we seek to propel one of ABCT's central strategic initiatives: to "expand the tent" of those who feel they belong to our community.

One measure of whether we have hit our mark as a committee is the percentage of members who cast votes in the election. We continually strategize about how to increase rates of membership participation in the voting process and are excited to introduce a change to the timing of our election in this year's cycle with that goal in mind. In 2019, the election will run in the fall, overlapping with the annual convention. Look for onsite opportunities to exercise your right to vote in Atlanta.

So, as ABCT gears up for our 2020 election, we ask you to consider: Where is the talent we're missing? What about you? What about now?

For the upcoming 2020 election, we seek nominations for ABCT's next President-Elect (2020–21; President, 2021–22; Immediate Past President, 2022–23) and for a Representative-at-Large (RAL; 2020–23). Each RAL serves as a liaison to one of the governing branches of the association. The representative position open for 2020 will connect and coordinate with the Membership Issues Coordinator and committees. The bylaws of the organization require two candidates for the position of President-Elect and three for the position of Representative-at-Large. You can nominate any full member in good standing in the organization and there is no limit to the number of nominees you can put forward for any position. Candidates with the most nominations will be the only official names on the ballot once voting commences.

Membership on the Leadership and Elections Committee, approved by ABCT's Board of Directors, includes a chair and two members. We would like to take this opportunity to thank David Pantalone, from the University of Massachusetts Boston, for his thoughtful leadership of the committee for the previous 3 years. The incoming Chair, Patricia DiBartolo (pdibarto@smith.edu), from Smith College, has served on the committee since 2016. Kristen Lindgren, of the University of Washington School of Medicine, is a continuing member (kpl9716@u.washington.edu), and we welcome to our committee L. Kevin Chapman (lkevinchapman@icloud.com), who has a private practice in the Louisville, KY, area. Any one of us, as well as ABCT's Executive Director, Mary Jane Eimer (mjeimer@abct.org), would be happy to answer your questions and encourage your involvement in the organization.

For many of us, ABCT is an intellectual home. We relish its annual convention and feel like we belong, both professionally and personally. If this describes your relationship with ABCT, then this call is definitely for you. Nominate and then vote in November 2019. Even if it does not, this call is definitely for you as well. Let's all work together to "expand the tent" and realize the organization's loftiest goals: to enhance and promote human health and wellness. We look forward to hearing from you, in the voting "booth" and outside it, to know whether you feel we're achieving success.

I Nominate

▶ **PRESIDENT-ELECT (2020–2021)**

_____

_____

▶ **REPRESENTATIVE-AT-LARGE (2020–2023)**
and Liaison to Membership Issues Coordinator

_____

_____

Name

_____

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years.

Only full and new member professionals can nominate candidates. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions. Candidates for the position of President-Elect shall ensure that during his/her term as President–Elect and President of the ABCT, the officer shall not serve as President of a competing or complementary professional organization during these terms of office; and the candidate can ensure that their work on other professional boards will not interfere with their responsibilities to ABCT during the presidential cycle. Please complete and sign this nomination form. **Only those nomination forms bearing a postmark on or before September 3, 2019, will be counted.**

Send your form to Patricia DiBartolo, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 by Sept. 3, 2019. Or email to membership@abct.org (Subject line: Nominations)

ABCT

Wisdom of Purpose and Perspective: Extending the Social Impact of Cognitive Behavioral Science

53rd Annual Convention

November 21–24, 2019 | Atlanta, GA

Plan to attend Thursday Ticketed Sessions

■ INSTITUTES

Jonathan S. Abramowitz, Ph.D., Ryan J. Jacoby, Ph.D., & Shannon M. Blakey, M.S.
Desirable Difficulties: Optimizing Exposure Therapy for Anxiety Through Inhibitory Learning

Nate Mitchell, Ph.D., Daniel McNeil, Ph.D., & Trevor Hart, Ph.D.
Motivational Interviewing for Health Behavior Change

Denise Sloan, Ph.D., & Brian Marx, Ph.D.
Written Exposure Therapy:
A Brief Treatment for PTSD

Cheryl B. McNeil, Ph.D.
Parent-Child Interaction Therapy: A Robust Intervention for Early Childhood Mental Health

David M. Fresco, Ph.D., & Douglas S. Mennin, Ph.D.
Emotion Regulation Therapy for Chronic Worry, Rumination, and Self-Criticism

Anne Marie Albano, Ph.D., Shannon Bennett, Ph.D., Lauren Hoffman, Psy.D., & Schuyler Fox, B.A.
Anxiety and Emerging Adults: Incorporating Caregiver Involvement and Enhancing Exposures in the Treatment of Adolescents and Young Adults With Anxiety Disorders

Martin E. Franklin, Ph.D.
Treating OCD in Children and Adolescents: A Cognitive Behavioral Approach

Michael W. Otto, Ph.D.
Tricking Coyote: Cutting-Edge Strategies for Harnessing Motivation and Achieving Goals

Cory F. Newman, Ph.D., & Danielle A. Kaplan, Ph.D.
Supervision Essentials in CBT

■ CLINICAL INTERVENTION TRAININGS (*1-Day*)

Adele M. Hayes, Ph.D.
Applying Exposure Principles to the Treatment of Depression: Exposure-Based Cognitive Therapy

Andrew Christensen, Ph.D., & Brian D. Doss, Ph.D.
Integrative Behavioral Couple Therapy: Acceptance and Change in Couple Therapy

Philip Kendall, Ph.D.
Working With Anxious Youths: Clinical Strategies Within Empirically Supported Treatment

■ AMASS

Jessica Schleider, Ph.D., & Michael Mullarkey, M.A.
Open Science Practices for Clinical Researchers: What You Need to Know and How to Get Started

Friday and Saturday Ticketed Sessions

■ WORKSHOPS

Carla K. Danielson, Ph.D., & Zachary Adams, Ph.D.
Risk Reduction Through Family Therapy: An Evidence-Based Treatment for Co-Occuring Substance Use Problems and PTSD Among Adolescents

Colleen A. Sloan, Ph.D., & Danielle S. Berke, Ph.D.
How to Apply Cognitive Behavioral Principles to Transgender Care: An Evidence-Based Transdiagnostic Framework

PROGRAM SUBJECT TO CHANGE

Dawn M. Eichen, Ph.D., & Kerri N. Boutelle, Ph.D.
Regulation of Cues Treatment: Using Appetite Awareness Training and Cue-Exposure Treatment to Treat Binge Eating, Overeating and Obesity

Kim S. Slosman, M.S., LMHC, Clara M. Bradizza, Ph.D., & Paul R. Stasiewicz, Ph.D.
Emotion Regulation Training for Alcohol Use Disorders: Helping Clients to Manage Negative Emotions

Kirk Strosahl, Ph.D., & Patricia J. Robinson, Ph.D.
When Time Matters: A Process-Based Approach for Delivering Powerful Brief Interventions

Dean McKay, Ph.D.
Assessment and Case Conceptualization of Disgust in Anxiety Disorders and OCD

Sean M. Barnes, Ph.D., Lauren M. Borges, Ph.D., Nazanin Bahraini, Ph.D., & Robyn D. Walser, Ph.D.
ACT for Life: Using Acceptance and Commitment Therapy to Prevent Suicide and Build Meaningful Lives

Stefan G. Hofmann, Ph.D., & Steven C. Hayes, Ph.D.
Functional Analysis in Process-Based CBT

Richard Gallagher, Ph.D., Janelle Nissley-Tsiopinis, Ph.D., & Margaret Sibley, Ph.D.
Practical and Effective Treatment Methods for Functional Deficits in Children and Teens With ADHD: Paths to Improving Home and School Functioning

Scott H. Waltman, Psy.D., Brittany C. Hall, Ph.D., & Lynn McFarr, Ph.D.
Supervision and Clinical Case Consultation Strategies: Guided Discovery, Strengthening the Supervisory Relationship, and Experiential Teaching Techniques

Terri L. Messman-Moore, Ph.D., & Noga Zerubavel, Ph.D.
Trauma-Informed Mindfulness: Integrating Mindfulness-Based Practices Into Psychotherapy With Traumatized Clients

Carla Rash, Ph.D., & Jeremiah Weinstock, Ph.D.
Designing and Implementing Contingency Management Interventions for Health Behaviors

Jasper Smits, Ph.D., Mark Powers, Ph.D., & Michael W. Otto, Ph.D.
A Transdiagnostic Approach to Exposure-Based Treatment: A Memory-Centric Perspective

R. Trent Codd III, Ed.S., Dennis Tirch, Ph.D., Laura Silberstein-Tirch, Psy.D., Joann Wright, Ph.D., & Martin Brock, MSc, M.A.
Self-Practice and Self-Reflection: Developing Personal and Professional Mastery of Acceptance and Commitment Therapy Through Self-Practice of Core ACT Processes

Craig J. Bryan, Psy.D.
Means Safety Counseling for Suicide Prevention

Jennifer Sayrs, Ph.D., & Shireen L. Rizvi, Ph.D.
Case Formulation and Treatment Planning in DBT

■ MASTER CLINICIAN SEMINARS

Robert L. Leahy, Ph.D.
You Are Not Supposed to Feel That Way: Making Room for Difficult Emotions

Linda W. Craighead, Ph.D.
Appetite Monitoring in Individual and Family-Based Healthy Weight Coaching

Mary A. Fristad, Ph.D., & Eric A. Youngstrom, Ph.D.
Evidence-Based Assessment and Treatment of Bipolar Disorder and Mood Dysregulation in Youth and Early Adulthood

Todd J. Farchione, Ph.D. & Shannon Sauer-Zavala, Ph.D.
In Depth Analysis of the Unified Protocol in Clinical Practice: Transdiagnostic Case Conceptualization and Application

Steven A. Safren, Ph.D., & Sylvie Naar, Ph.D.
Integrating Motivational Interviewing With Cognitive-Behavioral Interventions to Maximize Client Outcomes

Fugen Neziroglu, Ph.D.
CBT for Body Dysmorphic Disorder

Alec L. Miller, Psy.D.
Helping Suicidal Teens Build Lives Worth Living: Key Elements to Orienting and Committing Teens to DBT

Douglas W. Woods, Ph.D. & Michael B. Himle, Ph.D.
Comprehensive Behavioral Intervention for Tics

PROGRAM SUBJECT TO CHANGE

ABCT's 2019 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 interventions and who have thereby advanced the mission of ABCT. Champions may not be members of ABCT at the time of their nomination.

▶ Potential Candidates

When considering making a nomination, think about decision-makers, funders, government officials, business people, consumers, or well-known people who have shared their struggles and benefited from CBT treatment.

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). Briefly, ideal candidates should have demonstrated one or more of the following: (1) an enduring commitment to the application and impact of one or more evidence-based intervention; (2) the promotion of innovation, even in the face of social or organizational indifference or resistance, (3) a willingness to risk reputation as a result of a commitment to change, (4) leadership in the service of the broad mission of positive social change, and (5) a willingness to go above and beyond their regular professional duties.

▶ Recognition

Nominees will be reviewed in March, June, and October by the ABCT Awards & Recognition Committee and those meeting criteria will be forwarded to the ABCT Board of Directors for approval. Recipient 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 2019ABCTAwards@abct.org (nomination form available at http://www.abct.org/Awards/docs/2019_Champions_Nomination_Form.pdf). Be sure to put "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 and followed up with an ABCT staff member for a final review of the copy to be posted on the ABCT website.

CBT Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.

2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.

3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Shona Vas at svas@yoda.bsd.vchicago.edu and include "Medical Educator Directory" in the subject line.

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this directory serve strictly in a volunteer capacity.

ABCT's Medical Educator Directory

http://www.abct.org
Resources for Professionals
Teaching Resources
CBT Medical Educator Directory

Find a CBT Therapist

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

We urge you to sign up for the ***Expanded Find a CBT Therapist*** *(an extra $50 per year). With this addition, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars.*

To sign up for the Expanded Find a CBT Therapist, click MEMBER LOGIN *on the upper left-hand of the home page and proceed to the ABCT online store, where you will click on "Find CBT Therapist."*

For further questions, call the ABCT central office at 212-647-1890.

the Behavior Therapist
Association for Behavioral
and Cognitive Therapies
305 Seventh Avenue, 16th floor
New York, NY 10001-6008
212-647-1890 | www.abct.org
ADDRESS SERVICE REQUESTED

Call for 2020 Officers

Happening Now!

Vote November 1–30

Nomination form on p. 187