the Behavior Therapist

Contents

Acting on the Recommendations of the ABCT Task Force for Equity, Inclusion, and Access: Updates and Next Steps

Laura D. Seligman, *University of Texas Rio Grande Valley*

IN THE SPRING of 2019, as ABCT members geared up for the upcoming convention in Atlanta, Georgia, Governor Brian Kemp signed into law a "heartbeat bill" that effectively ended women's and girls' right to choose whether to continue a pregnancy in the state of Georgia. Although I was not on the Board at that time, I was co-Chair of the Women's Issues in Behavior Therapy SIG. In that role, I was privy to the concerns being shared by our members about bringing our business and our members to Georgia. Against this backdrop, in the summer of 2019, then President Chorpita appointed a task force with the mission to begin the process of addressing equity, inclusion, and access throughout the organization. I, along with current Board member Sandra Pimentel, and former Board member Shireen Rizvi, were appointed as co-Chairs.

When viewed through the history of our field and the Association (Hall, 2006; Sockol & Girouard, 2014; Sockol et al., 2016), this was a long time coming. However, when we compare ourselves to similar organizations, ABCT could have been considered to be "ahead of the curve" back in the summer of 2019. Certainly, Presi-

ABCT 2022

2022 Annual Convention: Reviewer Data

The September 2022 issue of *the Behavior Therapist* will feature a special column by program chairs Dr. Rosaura Orengo-Aguayo and Dr. Emily Thomas. The program chairs will report on the 2022 convention abstract review and decision-making process in continued efforts toward promotion of transparency and membership engagement within the convention programming process.

In advance of the submission deadline, we shared with membership the criteria for peer review in the Town Hall and then made these documents public on the ABCT website. For the first time, peer review of abstracts was masked. Moreover, analysis of reviewer data was also masked, in that no author names were accessed during the peer review process or the decision-making process. To be further detailed in the forthcoming article, the final decisions were guided by an a priori plan, driven by analysis of reviewer data, and resulted in a program that stretches across topic areas. In this spirit, Drs. Orengo-Aguayo and Thomas look forward to sharing the peer review process with the membership and providing an open forum for ongoing discussion.

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, Richard LeBeau, Ph.D., at **rlebeau@ucla.edu.** Please include the phrase **tBT submission** and the author's last name (e.g., **tBT Submission - Smith et al.**) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

dent Chorpita's invited panel in Atlanta, "Realizing ABCT's Mission in a Politicized World" (Bufka et al., 2019, November), and the task force, with wide representation throughout the organization, should have placed ABCT in good stead to react to the events to come—the brutal killings of George Floyd and Ahmaud Arbery and many others who look like them, the racist attacks on Asian Americans, the release of the film *Conversion* (Caruso, 2022) detailing the role of ABCT in practices that pathologized the LGBTQ+ community, the consistent negative media portrayals of Hispanic/Latine individuals, the targeting of Jews and Muslims, and the persistent march toward eroding the rights of women and girls, particularly the rights of poor women and girls of color, to control their bodies and their future. Unfortunately, our progress has been slower than we had hoped, and we have failed to live up to our own aspirations. Thus, we must regretfully look back at missed opportunities for ABCT to be part of the solution, addressing inequities faced by those we serve through our research and practice in cognitive behavioral therapy and those we serve as a professional organization—you, our members.

In November 2020, the task force submitted its final report to the ABCT Board of Directors detailing eight major recommendations, the first of which was to hire a diversity officer and create a standing Equity, Inclusion, and Access Committee (Cho et al., 2022; Tolin, 2021; see also https://www.abct.org/about/abct-task-force-for-equity-inclusion-and-access/). In January of 2021, the Board of Directors voted to move forward with this recommendation, later amending this decision to follow a process in which a consultant was hired first to help guide the search and goals for the eventual hire of a Diversity

Manager. Regretfully, this goal has not yet been realized and members have brought to our attention the repercussions of this lack of action—erosion of faith in the organization's ability to follow through on our commitments to our members. Therefore, to ensure that we continue to move forward, I have asked a subcommittee of the Board—President-Elect Jill Ehrenreich-May and Representatives-at-Large Carolyn Becker and Katie Baucom—to work alongside our Executive Director, Mary Jane Eimer, to realize our goals. I am happy to report this action has already yielded some early success.

On April 6, a request for proposals for a consultant to guide our next steps was distributed and we are happy to report that we have received four high-quality responses and expect at least two more. Candidates were reviewed by the Board of Directors subcommittee on May 25, with finalists to be interviewed by the full Board of Directors May 31. Our goal is to hire the consultant in early June and for work to begin immediately and continue throughout the year.

Importantly, one overarching goal of the Board is to increase transparency with our members about both our successes and our setbacks. This month's column is the first step toward achieving this goal. To keep our members up to date, we will be communicating with our SIG leaders, so we encourage members to remain active in our 45 SIGs (or to join one or more of our SIGs please visit https://www.abct.org/membership/special-interest-groups-sig/) and to reach out to your SIG leadership with any questions.

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Webinar

JUNE 24, 2022

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Addressing Discrimination Stress in the Context of CBT
— Brittany Hall-Clark, Ph.D.

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

In recent years, the impact of stress due to racism, sexism, heterosexism, and other forms of identity-related discrimination has received greater attention at a national level. This presentation will discuss how to broach the topic of discrimination, provide practical strategies for assessment, and discuss tailoring cognitive and behavioral interventions across multiple mental health conditions with cultural sensitivity.

Telemental Health: It's Here to Stay, What Can We Do Better for Future Trainees?

Danielle I. Berman, Nicole E. Mahrer, Sarah Duffy, Noelle Huffman, Rachel Cohen, *University of La Verne*

IN SPRING 2020, as the world shut down in fear of the growing COVID-19 pandemic, mental healthcare was forced to quickly pivot to a format of service delivery different from what had been the norm for decades. Due to health concerns and the related need for social and physical distancing, in-person services were often no longer feasible or safe (Koonin, 2020). Many providers shifted to delivering services virtually either via videoconferencing, telephone, or texting, hereafter referred to as telemental health (Hilty et al., 2013). This shift came with little to no preparation and providers were often left to navigate on their own, or with support from colleagues/supervisors similarly new to virtual care.

At the time of this shift, established clinicians reported concerns about a lack of training in telemental health, that they preferred face-to-face appointments, and that they experienced stress related to virtual appointments (Perry et al., 2020). Newer clinicians were in a unique situation during this time, having recently entered the field. Although these newer clinicians were likely trained with a traditional approach to service delivery, they may be less "set in their ways" and open to an updated way of service. According to the APA, 97% of psychologist surveyed say that telemental health should be here to stay (Clay, 2022), which speaks to the importance of optimizing care in this format. The researchers in this present qualitative study sought to understand new clinician experiences with telemental health at the start of the pandemic and utilize the data to find ways to improve the use of telemental health for both clients and clinicians moving forward. The present study sought to learn about what went well and what did not in order to enhance future training endeavors that can better meet the needs of the ever-changing mental health landscape.

Starting even before the pandemic, research has been conducted to assess the effectiveness of telemental health. Barriers have been identified related to cost, technology, privacy, and confidentiality (Kruse et al., 2018). Despite those difficulties, the main barrier to telemental health has been clinician resistance and hesitation, often related to a belief that telemental health treatment is not as effective as traditional in-person care (Kruse et al.; Wind et al., 2020). The pandemic, however, has forced clinicians to change how they think about mental healthcare and its delivery (Wind et al.). We have seen an increase from 17.1% daily telemental health use, to 40.6%, but only half of clinicians surveyed report feeling comfortable in this mode of therapy (Zhou et al., 2020). Further, with the global mental health crisis related to the COVID-19 pandemic, there is a growing need for mental health services, and there is an opportunity for greater access through telemental health (Figueroa & Aguilera, 2020; Zhou et al.). Therefore, it is crucial that we learn how to increase a clinician's comfort and confidence while utilizing telemental health, particularly for new clinicians who will be the future of this field.

A handful of studies have examined telemental health since the start of the COVID-19 pandemic. In a recent commentary, Madigan and colleagues (2021) outlined the benefits and disadvantages to telemental health they observed in service delivery in Canada. They highlighted the ability of telemental health to protect the safety of both clients and clinicians and to increase access to services both from a location and cost perspective. They also discussed client populations that may be more receptive to telemental health versus in-person care, such as individuals with anxiety disorders or those experiencing high levels of COVID-related stress. Disadvantages included geographical limitations related to licensing and systemic inequities with lower income populations having less access to the needed technology. From a clinical perspective, they discussed concerns about privacy and confidentiality, as well as the greater difficulty reading non-verbal cues in therapy. Additionally, Bunnel and colleagues (2021) reviewed surveys completed by practicing mental healthcare providers to better understand how telehealth works and identify the patient populations who benefit. Through their research, they reported that the effectiveness of telemental health is dependent on age and diagnosis. They explain that if we attempt to utilize telemental health the same across all populations, it can pose a risk for the most vulnerable patients.

These research teams have weighed in on the pros and cons of telemental health, but better understanding of the experiences of both clinicians and clients is still needed. This brief report describes the themes emerging from two focus groups with psychology trainees and new clinicians who spoke about their experience in quickly shifting to telemental health services at the start of the COVID-19 pandemic, and the perceived client experiences as well. Themes related to what went well and what did not from both clinician and perceived client perspectives are discussed and supported by direct quotes from the participants. We conclude with a discussion of what these findings mean for clinicians moving forward as telemental health becomes a permanent part of the mental health field.

Methods

The current qualitative study aims to explore how clinicians and clients responded to telemental health and hopes to improve future training and practice. This study is based on two focus groups conducted with psychology trainees and new clinicians providing telemental health services during the pandemic. Participants were eligible if they were a United States resident over the age of 18, had experience delivering virtual therapy, and had a strong internet connection. Focus groups included nine clinicians who had delivered telemental health therapy during the 2020–2021 year (8 female, 1 male). Participants' age ranged from 25 to 39 years old (M = 30.78, SD = 5.07), and 11% identified as Asian/Asian American, 22% as Hispanic or Latino, and 67% as White or Caucasian. Most participants (n = 6) were in training in a graduate-level doctoral program (Psy.D. or Ph.D.) and the remaining participants (n = 3) had 1–5 years of experience (postgraduate). Areas of specialty ranged from young children to older adults, and clinicians worked with various mental health diagnoses in both inpatient

and outpatient settings. All clinicians worked with individual clients and the majority (*n* = 6) also worked with families. Clinicians reported seeing at least several clients a week and reported delivering telemental health through video, telephone, and hybrid formats.

Once enrolled, clinicians participated in one of two 1-hour focus groups conducted virtually via a HIPAA-compliant Zoom platform. Focus groups were led by a psychology trainee who asked clinicians open-ended questions about their personal responses and their clients' responses to telemental health. The focus group leader facilitated discussion and encouraged participants to build upon each other's ideas, promoting full participation. Participants talked about what worked well and what did not as compared to in-person care. Focus groups were audio recorded and the recordings were transcribed using an external transcription service. Participants received a $10 gift card for participation.

Consensual qualitative coding was done by four graduate students to identify themes. Each coder engaged in open coding to identify units of data that were independently meaningful. They then shifted to analytic coding, grouping the notes into categories. Several rounds of data reduction were conducted to ensure that all categories were responsive to the research question of how clinicians and clients responded to telemental health, and were sensitive, exhaustive, mutually exclusive, and conceptually congruent (Merriam & Tisdell, 2015, p. 186). Once complete, an auditor (second author) checked the coding to make sure it was comprehensive and accurate (Hill et al., 2005). The final categorization divided themes into two separate sections: clients' response (six themes) and clinicians' response (seven themes) to telemental health. The final themes were mapped directly onto the questions from the focus group leader.

Themes/Results

The coders identified 210 individual idea units that were captured by six themes for clients and seven themes for clinicians. Percentages presented demonstrate the proportion of ideas represented by each of these themes. Direct quotes from the participants further exemplifying the themes found can be seen in Table 1.

Discussion

Telemental health appears to be a fixed entity in the future of mental healthcare,

and targeted training of future clinicians is needed. Nine clinicians early in their training shared their experiences during the transition to telemental health at the start of the pandemic. Results of the current study can be utilized to inform better therapeutic experiences for both clinicians and clients. The themes reveal both useful aspects and barriers associated with telemental health and identify matters of telemental health that require further attention and improvement. The following discussion aims to link the identified themes with possible solutions for clinicians moving forward. Clinician and client themes are discussed together when they are related.

For both clinicians and clients, the theme of convenience and accessibility was commonly identified. Consistent with prior findings (Madigan et al., 2021), our research showed that, according to clinician perception, the convenience of telemental health increased client attendance and decreased tardiness, as clients did not have to commute to therapy sessions. This accessibility allowed clinicians to reach clients who may not have had access to therapy (e.g., ill patients who could not commute or patients from rural areas); and increased their productivity (e.g., allowed them to utilize their breaks more efficiently by getting things done at home between sessions).

Although telemental health is more convenient and accessible, it also increases distractions for clients and decreases control over the therapeutic environment for clinicians. Focus group participants reported that clients were interrupted and distracted more often because they were at home. Since clinicians could not control the client's therapy setting, increased distractions affected the delivery of services. Burgoyne and Cohn (2020) highlighted screen-related cues as distractors and suggest that clinicians and clients pause computer notifications (e.g., text messages, emails, etc.) before every telemental health session to ameliorate this problem. Our results also showed that clinicians felt a lack of control during telemental health sessions. Clinicians may consider having open problem-solving discussions with clients (or client's parents) prior to sessions in order to help sessions run smoother (i.e., creating plans of what to do in case of connection issues, distractions, etc.; Maier et al., 2021). Even if addressed prior to a session, technology issues may still arise. This was the second most common client theme and could have been accountable for some attrition problems reported. The technol-

ogy issues included delays, cutting out, screen fatigue, and other problems. Madigan et al. (2021) explain how telemental health is unveiling a digital divide as some clients do not own the necessary devices or know how to navigate technology. They suggest that, for some clients, therapists consider conducting therapy via telephone to reduce the stress that internet issues may cause. Although telephone-based therapy is typically not as effective as video-based therapy, it can be effective if sessions are clearly structured and clients are given homework tasks (Leach & Christensen, 2006).

The most common lament by clinicians was the loss of nonverbal communication. Burgoyne and Cohn (2020) suggest that clinicians practice where to look to ensure the best eye contact and guide their clients where to sit during sessions (e.g., further back so you can see their body language or closer to better see their facial expressions). If it is difficult to observe a client's physical responses, it is appropriate and important to ask them to describe their body's feelings. They also explain how it is vital for clinicians to also be more expressive and animated during telemental health since this can encourage clients to do the same. Last, they suggest the importance of checking in with clients to see how they are experiencing the sessions and understanding the context. These additional questions can help provide feedback that is missed through loss of nonverbal cues and communication.

On the other hand, clinicians appreciated that telemental health gave them the ability to observe patients in their natural environment. However, Madigan et al. (2021) pointed out that the glimpse into the home environment of patients is just that—a glimpse. What we are seeing during sessions is a snapshot of family dynamics and interactions that may not include clinically important details to fully understand the situation. Additionally, Burgoyne and Cohn (2020) point out that it allows for clients to enter the home of the clinician as well. For some clients, this may help to build rapport, but for others, this can be problematic and force a client to interact with a clinician's personal life in ways that they are not comfortable. It is important for clinicians to be aware of the therapy setting prior to sessions so that clients are not exposed to anything that can be distracting or damage the therapeutic relationship.
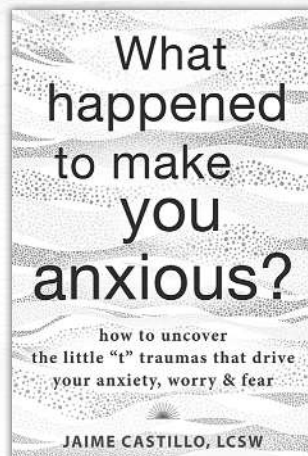
Confidentiality problems that threaten therapeutic spaces were also discussed by

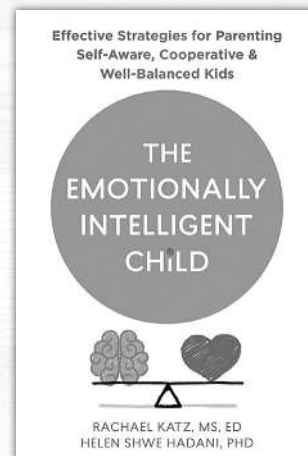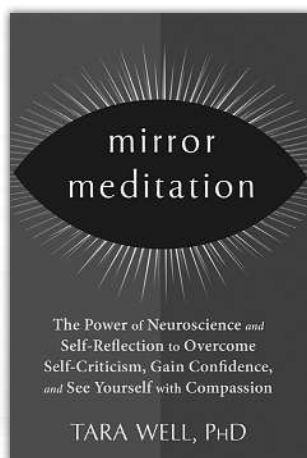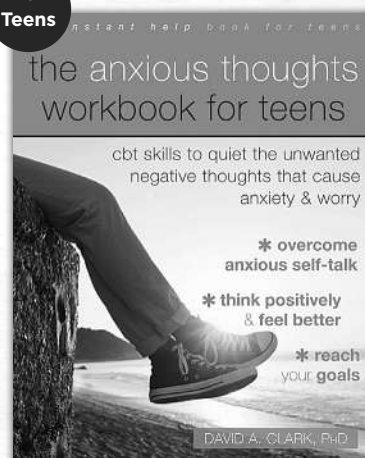Table 1. Themes With Explanations and Quotations

Client Themes	Explanations	Quotations
More convenient/accessible (31%)	● Clients appreciated ease of not having to commute ▪ Resulted in increased patient engagement ● Beneficial for those in rural communities or ill patients who struggled to get to appointments	"...for folks with some medical conditions, they actually liked it or said that it was easier because…they didn't have to physically commute and it was…more convenient."
Technology Issues (24%)	● Clients struggled using technology ▪ Problems seen included internet delays, cutting out, screen fatigue, being camera shy, and older/younger clients struggling with technology	"I think that now that we're about a year in, they're losing steam. They're getting tired of being in front of a screen. But I say that's been my biggest challenge."
More distractions (14%)	● Clients had increased interruptions/distractions during therapy session ▪ This included home and computer distractions (e.g., checking email)	"There is…more opportunity for them to be distracted by other things … by like your phone over here or family member calling for you or something like that."
Attrition (12%)	● Increased client attrition following transition to telemental health ● Saw low retention and follow through by clients, potentially due to lack of accountability (e.g., for mandated clients) and removed opportunity for socialization	"I lost two clients who we just decided to terminate because we weren't finding anything really beneficial with telehealth…they thought it was more beneficial for coming to the VA because it gave him a chance to socialize then. And they completely lost out on that."
Confidentiality problems (9.5%)	● Clients reluctant to share sensitive information ▪ Possibly due to clients being in close proximity to family members ● Need to do therapy in odd places (e.g., cars) for privacy	"It can be limiting on how much they're willing to share when their family is around. And they also… have to find weird spots to engage in therapy because [they] might live in a one-bedroom apartment…"
Effectiveness of telemental health is "diagnosis dependent" (9.5%)	● More effective for social anxiety ● Less effective for ADHD and/or autism, possibly due to their difficulty concentrating/understanding telehealth interventions	"…with an eight-year-old with ADHD who's unmedicated… It's incredibly challenging at this point. There are certain cases that really benefit from that in-person work."
Clinician Themes		
Loss of nonverbal communication (29.3%)	● Increased difficulties in nonverbal communication with clients and other clinicians ● Loss of nonverbal cues that provided important context during session (e.g., how clients received information, were coping, and processing)	"… there is no body language even with video because…I can't tell that much by her like right eyeball. And… when I see her in-person, she will talk to me for like an hour and just like keep going. And then, like on telehealth, she'll like, give me one-word answers."
Threatened therapeutic space (18.2%)	● Lack of private space in own home ● Clinicians had to provide services in unique locations (e.g., bathrooms) for confidentiality ● Loss of professionalism due to distractions, interruptions, and not needing to dress professionally	"…finding a space to do [therapy] when you live with somebody else, it is very, very difficult I had to like sit in a bathroom, which was the most confidential place and like adjust my laptop accordingly, so it didn't look like I was sitting in the bathroom."
More convenient/accessible (17.5%)	● Clinicians appreciated not having to commute, saving money on gas/travel, having more flexible schedule, and only having to dress professionally from waist up ● Linked it to increased personal productivity	"I guess there is the nice convenience factor … because you don't have to commute and if you have a break in between clients…you're not sitting at your desk twiddling your thumbs. If someone is a no show, you can go cook dinner."

Table 1 continued

Clinician Themes	Explanations	Quotations
Need to be creative (12%)	● Increased need to be creative to engage clients 　▪ Examples include being creative with experiential ACT exercises and modifying mindfulness techniques to work better virtually	"I did just take some creativity with like asking clients… ahead of time to bring in certain materials and especially working with like worksheets and … making sure to have back-ups for things you can hold up or screen share and stuff like that was a little tricky at first."
Reduced job satisfaction (12%)	● Clinicians reported reduced satisfaction, increased feelings of burnout, lack of enjoyment of therapy 　▪ Linked to screen fatigue, lack of gratification from sessions, and not being able to terminate with certain clients 　▪ Burnout could lead to behaviors of personal and professional blending	"… I was starting to dread my telehealth sessions, and like I never dread sessions. I always enjoyed doing therapy." "I think the risk of burnout is a lot higher, at least for me personally, just because, again, like I don't get the same gratification that I do as if I'm meeting with the person, in-person."
No control over environment (7%)	● Decreased control over therapy environment especially in group therapy ● More chaos and decreased ability to manage certain situations (e.g., not being able to intervene when a client was dysregulated)	"…I also co-lead a DBT group… so that is tricky sort of managing so many faces on the screen and then chatting back and forth with my co-leader if we notice someone has dysregulated during the session and how to manage someone…."
Allowed for observation of natural environment (4%)	● Clinicians discussed benefit of being able to see clients in their own homes 　▪ Offered glimpse of home lives and family interactions ● Improves upon client self-report which tends to be biased	"… it's nice to see how they are like at home or wherever they happen to be and to see … if they're having issues with their kids or if it's a kid who is having issue with their parents, how are they responding, how were they saying…"

[continued from p. 158]

focus group participants. Through the transition to telemental health, many did not have a private space for therapy or had to have sessions around those causing them issues. Burgoyne and Cohn (2020) explain how there is a loss of transition that comes with telemental health. They express the importance of taking time to transition into that therapeutic mindset for both clients and clinicians prior to sessions in order to help them gain the most from their therapy session. Examples include engaging in a joint breathing exercise at the start of a session in order to break the barrier of distance (Maier et al., 2021). Furthermore, it is important to troubleshoot solutions to confidentiality issues with clients prior to starting therapy, such as utilizing whiteboards, chat functions, and recommending headphones or white noise machines to clients (Burgoyne & Cohn). This can help clients gain a larger sense of privacy, and, in turn, become more comfortable engaging deeply in sessions.

Clinicians felt that the effectiveness of telemental health may be "diagnosis-dependent," observing more success for clients with social anxiety, and less with clients with ADHD or autism. Bunnel and colleagues (2021) similarly state that the use of telemental health therapy may not be suitable for patients who are emotionally unstable, impulsive, exhibit poor coping skills, clinically depressed, or experiencing paranoia. It is important for clinicians to carefully assess their patients before deciding if they are suitable for telemental health. Ethically, if a client cannot be appropriately treated via telemental health, clinicians may want to refer them to a different provider. Although telemental health appears that it is here to stay, as the world is opening up, it is no longer the only option. For example, higher levels of care are typically in-person and may be an appropriate referral for higher acuity clients. Maier et al. (2021) also suggest that clinicians monitor client engagement and reception through scaling questions that assess a client's level of comfort with tele-

mental health. This can increase rapport and therapy success.

Last, clinicians identified an increased need to be creative in telemental health, which was seen as a benefit by some and a barrier by others. Increased creativity can help a clinician to feel invested and excited about therapy sessions, but a constant need to be creative can also lead to burnout and reduced job satisfaction. To alleviate the stress associated with creativity, it may be worthwhile to refer to established evidence-based techniques and create similar evidence-based techniques specifically for telemental health (Bunnell et al., 2021). Maier et al. (2021) found that job satisfaction with teletherapy can mirror that of in-person therapy when accommodations for teletherapy are made. These accommodations can include shifting expectations of the therapy to be realistic by forecasting problems with technology or nonverbals that are associated with telemental health. Anticipating problems can lead to a more immersive therapeutic process. This suggests that though telemental health may

require some additional creative work, high job satisfaction is possible.

There are limitations in this study that should be considered. First, the sample size is small and future studies should examine these questions in a larger sample of trainees. Future studies should strive for better representation (the majority of this sample was female) and gather additional data regarding prior training in telemental health and level of support to determine if these factors affect clinician and client response to telemental health. In addition, the current study was based on clinician perspective only, even when questions were asked about clients. Future studies should examine client response to telemental health more directly as clinicians may have misjudged client responses.

Given that telemental health is here to stay, it is important that professional psychology training programs begin incorporating the methods suggested in this article into their training curriculum. The more that trainees practice providing therapy through telemental health, the more in control and satisfied they will feel in their work. Increased training can include role-plays via telemental health to get future clinicians more comfortable with this mode of therapy. Furthermore, discussions about how to assess for nonverbal cues, maintain confidentiality, and create a safe therapeutic space for clients should be incorporated. More work is needed to expand on effective evidence-based approaches specific to telemental health. Through this, we can reduce the creative burnout that currently comes with delivering therapy through telemental health. The more we learn about this therapy method, the more we can better our therapeutic abilities as a profession and improve the mental health in those we serve.

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Clinical Considerations for the Delivery of Virtual Dialectical Behavior Therapy to High-Risk Patients

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THE COVID-19 pandemic presented unprecedented challenges to the delivery of mental health care. In particular, patients with borderline personality disorder (BPD) and other serious mental illnesses (SMI) who exhibit suicidal and self-harming behaviors are at heightened risk for adverse mental health outcomes in times of crisis (Álvaro et al., 2020). Therefore, it has been paramount to continue providing services while adhering to pandemic safety protocols. Dialectical behavior therapy (DBT) is a highly effective treatment for patients with BPD and those who exhibit suicidal and other high-risk behaviors when delivered in person (Cristea et al., 2017). However, implementing DBT using standard platforms for telehealth presents unique challenges due to key symptoms and thought patterns exhibited by patients with BPD, as well as the intensive nature of DBT, which includes one-on-one therapy, skills groups, and phone coaching (O'Hayer, 2021; Zalewski et al., 2021).

BPD is a relatively prevalent psychiatric disorder, present in approximately 1.4 % of the adult population in the United States (Lenzenweger et al., 2007). Key features of BPD include pervasive emotional lability, unstable interpersonal relationships, trauma response symptoms, and self-injurious and suicidal behavior (Black et al., 2004). Individuals with BPD also tend to have greater medical and psychiatric complexity, including comorbid psychiatric and chronic physical conditions, compared to those without a BPD diagnosis (El-Gabalawy et al., 2010; Zimmerman & Mattia, 1999). As a result, direct healthcare costs, including in-patient hospitalization, doctors' visits, and medication costs, incurred by those with BPD are often higher (Bateman & Fonagy, 2003; Bode et al., 2016; Palmer et al., 2006). Effective treatments for BPD can not only improve quality of life and outcomes among individuals receiving treatment, but also reduce associated strain on the healthcare system.

Prior to COVID-19, many mental health providers raised concerns about the delivery of telehealth to high-risk patients due to challenges assessing patient risk, developing therapeutic relationships, and managing highly distressed and suicidal patients remotely (Gilmore & Ward-Ciesielski, 2019; Lopez et al., 2020; Payne et al., 2020). However, social distancing required by the pandemic necessitated providers to reconsider telehealth delivery for high-risk patients in order to meet the need for care. Critically, virtual DBT (vDBT) can provide care to high-need, high-cost patients in times of crisis and to those who are otherwise unable to access DBT due to accessibility barriers (e.g., transportation, physical limitations). Virtual DBT may also improve engagement and retention; the dropout rate in our program (21.5%) is on the lower end relative to in-person, outpatient DBT programs, which report dropout rates between 19% and 58% (Landes et al., 2016; Linehan et al., 2006). Similarly, as the COVID-19 pandemic spurs widespread virtualization of mental health care, organizations have observed significant reductions in cancelled visits (Eyllon et al., 2021; Mishkind et al., 2020) and improvements in DBT skills group attendance (Lopez et al., 2020).

Despite the promise of DBT to significantly improve the lives of those with BPD and reduce strain on the healthcare system, a large treatment gap exists. There are relatively few clinicians who are trained in DBT, which significantly limits the ability of patients with BPD to receive effective treatment. Further, individuals with BPD and SMI with similar features often face stigmatization from care providers and some clinicians may refuse to work with these patients (Jobst et al., 2009). Prior to implementing our virtual (vDBT) center, our behavioral health department could not provide appropriate care to these patients who were often placed on waitlists lasting 3 to 6 months to receive care elsewhere in the community. The DBT Center evolved out of the critical need to provide an effective treatment for patients considered high-risk for adverse mental health outcomes, which was determined using several criteria. Patients were referred to the DBT Center for screening if they have capitated insurance plans, their total annual medical expenditure (TME) is greater than $20,000 in the last year or rising significantly, and if mental health problems are a significant part of their need for treatment. On some occasions patients with lower TME are included if there is compelling rationale such as recent decompensation or clinical appropriateness as determined by the lead clinician. The most common reasons for referral are repeated utilization of emergency services for mental health symptoms and behaviors, higher psychiatric care admissions, and medical problems exacerbated by comorbid mental health concerns.

To accommodate these patients, we developed a DBT Center that offers a 1-year, fully virtual program for the delivery of DBT (vDBT) with the goal of caring for high-risk patients who would not otherwise have access to DBT and to reduce steep healthcare costs associated with BPD. This report provides a synthesis of our team's experiences implementing vDBT and identifies practical and clinical considerations for DBT practitioners and healthcare organizations developing virtual models of care delivery.

Clinical and Practical Considerations

Technological Infrastructure and Learning

Implementing the vDBT Center required a suite of HIPAA-compliant tech-

nologies for synchronous therapy and skills group sessions and to facilitate the exchange of information (e.g., diary cards and psychological assessments) between patients and therapists. SecureVideo, a HIPAA-compliant Zoom front-end program, was selected for individual therapy and group sessions. PsychSurveys was selected as a vendor to support diary cards, as there was no cost to patients. PsychSurveys has a desktop dashboard and mobile application, and offers customizable DBT diary cards that therapists can automatically access. PsychSurveys' diary card functionality was easily integrated with SecureVideo using the shared screen feature so patients and clinicians could review the cards together while in session. As part of a larger care organization, we leveraged Epic's MyChart to virtually administer standardized patient assessments including the Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder (GAD-7), and Borderline Symptom List-23 (BSL-23), which enabled therapists to monitor patients' progress while maintaining confidentiality and data security.

There was a steep learning curve for both patients and clinicians using the technology as well as technological glitches, including lagging, freezing, or virtual platform errors that could disrupt the flow of sessions. For example, during an individual therapy session, amidst an intense emotional exchange, the SecureVideo session shut down due to an electricity outage at the therapist's house. While this temporarily intensified the patient's emotion, once the connection was regained, the therapist was able to provide skills coaching and help the patient regulate their emotions in response to the event. Although technological problems could not be avoided in vDBT, they provided a valuable opportunity for patients to practice distress tolerance skills, especially the acceptance skills, to cope with these brief disruptions. As patients and clinicians became more comfortable using the technology, problems that occurred were solved more efficiently. It became clear that therapists needed to have appropriate information technology support structures in place prior to starting virtual delivery as well as contingency plans in place so sessions can be conducted over the phone in the event of internet loss or technology malfunctions to minimize disruptions to the sessions.

Managing Patient High-Risk Behavior

Despite past concerns about mitigating risk-behavior among patients with BPD using telehealth (Lopez et al., 2020), DBT already employs some telehealth methods during potentially high-risk situations. Phone coaching is a critical component of traditional DBT in which a patient can call their therapist in times of crisis for support in applying DBT skills and preventing high-risk behavior. During vDBT sessions, the clinician's response to high-risk behaviors was comparable to responses during phone coaching sessions. Addressing high-risk behaviors virtually can also strengthen skills generalization as the patient can utilize tools in their natural environment instead of using the therapist's resources to employ DBT skills. At the start of each session, the clinician confirms the patient's location in case the patient requires emergency medical or psychiatric intervention. As part of orientation to DBT, the clinician emphasizes the importance of collaboration, especially during times of crisis. The patient is aware that if they end the session abruptly, do not respond to the therapist's outreach, and there is a safety concern (e.g., suicide), then the therapist will be required to determine the intervention independently, which can include emergency services. In the first year and a half of vDBT, safety concerns such as elevated suicidal ideation were managed collaboratively without the use of emergency services and no self-harm incidents occurred during sessions. However, because remote visit platforms are susceptible to interruptions (e.g., loss of internet connectivity), it is important to have contingency plans to reach patients via telephone if necessary.

Accommodating Patients With Disabilities and Chronic Illnesses

Importantly, patients with serious medical problems and physical disabilities can access vDBT, a critical service they might otherwise need to forgo when in person (El-Gabalawy et al., 2010). Several patients in the vDBT Center were undergoing invasive medical treatments like radiation and chemotherapy that would have prevented them from attending in-person DBT but vDBT allowed for accommodations to be made. For example, we permitted one chronic pain patient to recline during sessions in order to participate in DBT. However, these exceptions were only made for patients who required accommodations for medical reasons and others were not permitted to complete sessions lying down. It is essential to consider what provisions will be made for disabilities ahead of time so patients have clear expectations.

Managing Family Disruptions

The closure of schools and childcare centers due to COVID-19 left many clinicians and patients reassessing how to balance work while caring for their children. Virtual DBT enabled parents to attend sessions while also attending to their children's needs rather than having to cancel sessions. At times family disruptions presented challenges, but they also provided valuable opportunities for patients to engage their DBT skills. Family disruptions also created new issues around confidentiality, such as the presence of children within earshot or view of group sessions. Issues that arose were discussed in therapy with patients, among team members in consultation team, or in supervision. Patients and clinicians consistently agreed with the need to attend to young children and did not view it as a violation of confidentiality. While it may be necessary for an infant or young child to be present during the session, the presence of older children and other family members was not deemed appropriate and could constitute a breach of confidentiality during group sessions. For this reason, it was important to make sure patients had a private room with a closed door for sessions. Headphones should also be utilized as needed to protect the other patients from being heard to maintain their confidentiality.

Developing and Maintaining Relationships in Virtual Therapy

Concerns have been raised that it may be more difficult for patients and clinicians to establish and maintain therapeutic relationships using telehealth-based services, since patients previously reported feeling a diminished connection with their therapist (Payne et al., 2020). However, feedback from the vDBT clinicians and patients indicated that a strong therapeutic alliance was still maintained virtually. Furthermore, clinicians in the vDBT Center noted how the virtual modality could provide additional information about patients that could strengthen relationships. Virtual DBT allowed the therapist to use the patient's home environment to learn about the patient and their well-being and self-care. This information replaced some other assessment strategies that were lost in the virtual model (e.g., using patients' physical presentation such as fidgeting below the camera view). Furthermore, because patients were in their homes, activities typically assigned as therapy homework for in-person DBT could occur during sessions. For example, in vDBT, clinicians could

assist patients in developing self-soothe kits during the session, using meaningful items readily available in the patient's home. The sharing of personal items could enhance the therapeutic relationship, giving the patient the opportunity to describe the item's meaning with their therapist and how it would be helpful for self-soothing.

Developing Relationships Among Patients and With Skills Group Co-Leaders

Some evidence suggests that developing relationships among skills group members may be hindered in telehealth (Lopez et al., 2020). Similarly, we found that opportunities for group members to connect and form friendships with their peers more limited in vDBT where patients are not in the same physical space. Developing peer relationships allows patients to practice interpersonal effectiveness skills and so extra efforts should be made by the group co-leaders to foster peer camaraderie in the virtual setting.

Additionally, in vDBT, there were challenges to developing relationships between skills group leaders and co-leaders and patients. To address this, the co-leader privately messaged each patient as they signed into the group. The co-leader asked questions to build a rapport with the patient, determine their coaching needs, and provide reinforcement during the group. For example, the co-leader might message a participant, "I hear congratulations on your new job are in order!" or "I'm so impressed with the examples of distress tolerance that you provided to the group."

Managing Nonverbal Communication in Telehealth

Some critiques suggest that nonverbal communication, also critical to therapeutic relationships, could be compromised during telehealth, particularly when the camera was focused above patients' and clinicians' shoulders (Gilmore & Ward-Ciesielski, 2019; O'Hayer, 2021; Payne et al., 2020). Virtual DBT clinicians did report

that certain nonverbal communication (e.g., hand wringing or leg bouncing, indicating anxious thoughts) could not be observed. Clinicians tried to mitigate this by coaching patients to use "observe and describe," components of mindfulness, to assess and report their bodily changes throughout sessions. This could improve both patients' awareness of their own bodies and emotional expression and improve clinicians' awareness of patients' body language when it was out of sight. While teaching these techniques was beneficial for the participant, clinicians had to rely on patients to communicate their nonverbal behaviors and patients had to be conscious of their own behaviors, meaning some nonverbal cues may have been missed.

Additionally, the self-view feature of SecureVideo was an important tool for clinicians to monitor their own expressions and movements to better communicate with patients. Maintaining self-view allowed for self-correction among clini-

cians who gesticulate often and reminded clinicians to sit further from the camera to reveal more than their face and torso. Since most emotion is conveyed through facial expressions, and individuals with BPD are more sensitive to noting these changes than those without BPD (Lynch et al., 2006), maintaining self-view enabled clinicians to observe their own expressions and address them with patients. Clinicians could also monitor if their verbal praise and facial expressions were in sync and presented with radical genuineness, considered the most effective and influential form of validation in DBT. Also, clinicians could witness if they were inadvertently reinforcing maladaptive behaviors with their facial expressions and movements (e.g., head nodding with a sympathetic smile or an expression of excited interest beyond necessary to appear engaged). Self-view may reduce relationship conflict and misinterpretations, further strengthening the therapeutic relationship.

Skill Generalization in vDBT

Because the patients were in their homes, activities typically assigned as therapy homework for in-person DBT could now occur during sessions. For example, one clinician working with a patient who had an intense fear of going outside on her own had the patient walk outside while they talked over SecureVideo. The therapist asked her to observe and describe her surroundings and physical sensations and coached her to regulate bodily sensations to complete the exposure exercise. Since generalizing skills beyond the clinic environment is often challenging for patients, assisting patients in their natural environment facilitated this process while also giving the clinicians unique insight into the patients' thought processes as they completed the activity. Virtual DBT also provides an opportunity to target body dysmorphia among patients struggling with accepting their physical appearance and for whom looking at themselves on the self-view camera could be emotionally challenging. Although patients could turn off their self-view video, some struggled knowing they were visible to others in the group. To address this, it was critical for individual therapists to coach their patients to cope with the experience of being on camera during 2-hour group sessions prior to starting the group. Therapists used the mindfulness "observe and describe" skills already mentioned. Additional mindfulness skills used included nonjudgment alongside cognitive restructuring, where

the patient restates self-judgments to be more objective, nonjudgmental, and body accepting. Opposite action, which is acting in opposition to the behavior associated with the emotion, was another important skill utilized in vDBT. For example, common emotions associated with body dysmorphia are shame and disgust. To address these emotions, the clinician would have the patient sit up straight, lean in slightly to look at their own image for periods of time, while relaxing their face and body muscles, and regulating their breathing. This would first be implemented during individual therapy and then practiced outside of the session such as when communicating virtually with a group of friends. Practicing in a variety of different contexts helped to generalize this skill and increase effectiveness when in group.

Addressing Distractions and Problematic Behaviors

Virtual DBT may create more opportunities for patients to engage in inappropriate behavior and to be distracted by their home environment compared to in-person therapy. For example, some patients attempted to participate while underdressed, and others had the TV on or smoked during sessions. During vDBT, clinicians had to decide how and when to address these behaviors. These issues were discussed during the consultation team meeting or individual supervision when clinicians had difficulty determining how to address them. Additionally, patients could leave group more easily in vDBT by simply pushing the "leave meeting" button, which was problematic when patients relied on this during times of intense emotion. As a result, patients may miss more skills training material and therapy sessions than in-person where providers have the opportunity to coach patients back to the session.

Disruptive and inappropriate behavior was especially problematic in group therapy as it distracted other group members trying to learn; however, virtual platforms allow skills coaching to occur in a more discrete manner. In our program, virtual coaching during skills training took place using the private chat feature within the SecureVideo platform. When verbal coaching was required, the patient and co-leader could mute their audio and turn off the camera to talk by phone. Furthermore, if there were visual disruptions (e.g., patient moving around, self-harming), the co-leader could turn off the patient's camera and address the concerns by private chat or

phone. This was less intrusive and distracting for the rest of the group in comparison to in-person skills groups in which the leader often would have to pause teaching to address a patient's escalating behavior, interfering with the group's learning, or the co-leader would have to accompany the patient out of the room for more extensive skills coaching.

Team Building Among Clinicians

Team building and interpersonal connections were also impaired among clinicians. Impromptu casual conversations among colleagues, considered vital to worker well-being, are often limited when clinicians work remotely (Kniffin et al., 2021). Furthermore, due to COVID-19, more natural team-building activities like potlucks at team meetings could no longer occur. Another critique of working remotely was that asynchronous communication such as email often replaced synchronous communication (Yang et al., 2021). Since asynchronous communication often lacks the richness and nuance of synchronous communication, it could lead to more conflicts among clinicians and make it difficult to readily resolve problems and interpersonal disconnects (Kniffin et al.). One way this was addressed was by adding team check-ins to consultation team meetings where clinicians briefly exchanged updates on their work and personal life (Sayrs & Linehan, 2019). As a result, clinicians got to know one another better and even developed relationships outside of work. With time, clinicians began seeking out each other for impromptu meetings, which mimicked content that would occur in person between meetings.

Conclusion

The COVID-19 pandemic has required rapid recalibration of behavioral health services, which has been challenging across all sectors of healthcare, but particularly so for high-risk patients for whom the use of telehealth has raised concerns. We found that the telehealth model for DBT can be successfully implemented, but requires careful planning to mitigate potential risks and the use of particular strategies to facilitate relationship building and communication. Furthermore, vDBT requires a specific technological infrastructure, as well as unique policies to govern patient behavior in the presence of increased distractions found in the home environment. Our dropout rates were on the lower end for

comprehensive DBT programs, suggesting that the virtual modality may improve convenience for patients (e.g., fewer transportation and scheduling barriers), thus improving retention. We did not have an in-person program with which to compare vDBT dropout rates, and more work is needed to understand the impact of vDBT on patient engagement.

Although vDBT presents some unique challenges, we were able to overcome many of these challenges by using them as opportunities for patients to practice DBT skills, emphasizing the dialectical perspective that challenging experiences and opportunities can co-exist. Given the medical and psychiatric complexity of patients with BPD and serious mental illnesses, there is a critical need to improve the accessibility of DBT for patients. vDBT provides a promising model for improving access to appropriate, high-quality care while simultaneously reducing healthcare costs. However, our understanding of vDBT is still in its infancy and work is needed to optimize clinical processes for the virtual delivery of DBT as well as evaluate clinical outcomes among patients receiving vDBT, and determine the impact of vDBT on medical expenditure associated with comorbid chronic conditions.

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Apps
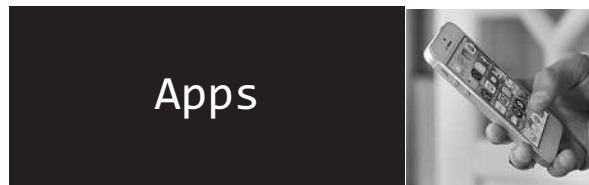
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SCIENCE FORUM

Strategies for Inclusivity of American Indian and Alaska Native Peoples in Behavior Therapy Research: Within-Group Diversity, Data, and Ethical Recommendations

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THE DOMINANT narrative and depictions of American Indian and Alaska Native (AI/AN) communities are situated in the past, within fictionalized media representations, and posit that AI/AN peoples no longer exist. The reality is that AI/AN communities have and still do inhabit their traditional homelands, and tribal communities can be traced across the U.S. A constant is that most, if not all, tribal names reflect an interconnectivity and a recognition of humanity; these names hold variations that translate to "people," the "real people," or "human beings." Identity reflects geography, history, ancestry, and an understanding of what it means to be alive and in communion with all that is alive. Likewise, the authors of this piece come to you humbly as academics, teachers, and learners, but also as the real people of the tribal lands of Turtle Island (i.e., the U.S.). The goal of this commentary is to (1) convey the richness, diversity, and inherent strengths of AI/AN peoples, which cannot and have not been extinguished by any force of humankind; (2) lay charge to the persistent and unrelenting impacts of historical trauma and oppression upheld by sociopolitical systems and institutions of settler-colonial dominance and evident in racism; (3) posit that behavioral therapy research, data, conclusions and applications therein are rarely specific to nor examined among AI/AN communities; and (4) hold that addressing issues with sampling, methodology, measurement, and data management are key to increasing appropriate research and data analyses specific to the AI/AN population, and thus, pertinent to research reconciliation and sovereignty. Moreover, we assert that the twofold process of decolonization and indigenization is crucial. Smith (2021) defines decolonization as "once viewed as the formal process of handing over the instruments of government, is now recognized as a long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power" (p. 112). Whereas indigenization refers to the inclusion of Indigenous peoples, epistemologies, knowledge systems, worldviews in science, research, and policy to predominantly Western spaces and systems (Gaudry & Lorenz, 2018).

Tribal Diversity Across Turtle Island

AI/AN peoples are often viewed as a large, homogenized group, leading to the prevalent belief in a monolithic culture. However, this misconception cannot be further from reality. Across the U.S., there are currently 574 federally recognized tribes that represent distinct cultures, geographic locales, and 175 unique languages. Though there are similarities among AI/AN groups, the 574 federally recognized tribes reflect a great diversity of culture and self-governance of tribal citizens that exist among and across these communities (National Congress of American Indians [NCAI], 2020). The cultural distinctions span from the most remote village or reservation to the most populated cities, where the needs and behaviors of the people can differ greatly (Herron et al., 2021). In fact, while only 3% of the AI/AN population lives on reservations, it is estimated that over 70% live in urban areas,

which indicates an outward migration from rural communities and/or reservations towards higher resourced centers (e.g., transportation, medical care, employment). Alarmingly, only 3% of AI/AN research is based within these urban centers. There could be many reasons for this, such as access and availability, proximity to Indian Health Services, real or perceived need, or limited knowledge of population distribution and what it means to identify as AI/AN. However, to unravel the discrepancies and disparities within AI/AN research, it is important to understand the historical context.

Historical Trauma and Postcolonial Distress

A discussion of historical trauma is pertinent to the psychosocial, ethical, and methodological issues pertaining to AI/AN communities and research. Historical trauma is defined as culturally based traumas intentionally inflicted on a cultural group systematically and systemically (e.g., genocide, forced relocation, residential boarding schools; Graziosi et al., 2021). However, historical trauma is not situated in history alone—it represents an ongoing process that has not been stopped or ceded (Kirmayer et al., 2014). Rather, postcolonial distress is characterized as (a) the initial colonial wounding perpetrated against AI/AN peoples through extermination, relocation, decimation, segregation, and assimilation; (b) the traumas that halted the natural course of change and stole critical components of culture (e.g., language, medicine people) while simultaneously enforcing settler-colonial ideals; (c) the colonization is continuous in sociopolitical systems, institutions, and policies, while also being cumulative and exacerbated by present stressors (e.g., racism, violence); and (d) the intergenerational transmission of these traumas and effects continues through physiology, environment, and/or social interaction until the cycle is broken.

Postcolonial distress is exacerbated by racism in all its forms: oppressive policies, stealing of tribal lands, inadequate resources, and limited access to healthcare, education, housing, employment, and healthy foods (Kirmayer et al., 2014; Whitesell et al., 2012). Further, the symptoms and sequelae include health disparities and disproportionate rates of homelessness, violence, suicide, and substance use disorders (SUDs; BigFoot & Schmidt, 2010; Lopez et al., 2021; Whitesell et al.). In fact, AI/AN peoples are two times more likely to experience posttraumatic stress disorder (PTSD) and have a higher 12-month and lifetime prevalence of PTSD in contrast to all other U.S. ethnoracial groups (Gameon & Skewes, 2020; Goldstein et al., 2016). In addition, AI/AN populations experience disproportionately high rates of SUDs; namely, AI/AN communities experience the highest rates of alcohol use dis-

order (AUD), binge drinking, alcohol-related consequences, and severity for life-time prevalence and alcohol-related mor-bidity and mortality (Grant et al., 2015; Lopez et al., 2021; Whitesell et al., 2012). Moreover, while there are variations in rates by tribe and region, more research is needed to understand these rates to work with communities to improve, increase, and culturally tailor mental health treat-ments.

Culturally Congruent Behavior Therapies

Behavioral interventions have largely been normed and, thus, adapted for the general, predominantly White U.S. popu-lation (Novins et al., 2016). Even interven-tion studies that consider broader ethnora-cial categories focus mainly on White, Black, and Latinx population, whereas the AI/AN sample is frequently lumped into the "other" category that often includes Asian, Native Hawaiian, Pacific Islander, and/or multiracial participants (Gartner et al., 2021; Novins et al., 2016). Cultural derived and adapted evidence-based treat-ments (EBTs) have been found to be effica-cious and are well received among AI/AN communities, which is critical given the disparities experienced and the resultant treatment needs (Coser et al., 2021; Gameon & Skewes, 2020; Graziosi et al., 2021). In other words, EBTs have demon-strated cultural congruency, acceptability, and efficacy among AI/AN populations when they are based on cultural values and practices (e.g., sweat lodge, ceremony, tra-ditional teachings; Rowan et al., 2014) and when they are culturally adapted (Venner et al., 2016). For example, incorporating cultural practices into dialectical behavior therapy (DBT) among AI/AN youth diag-nosed with a SUD demonstrated that 96% had improved or recovered at discharge, as measured by internalizing and externaliz-ing on the Youth Outcome Questionnaire–Self Report and evidenced by significance and large treatment effects (Beckstead et al., 2015). As another illustration, a clinical trial of a cognitive processing therapy (CPT) adaptation to treat PTSD, illicit drug and alcohol use, and high-risk sexual behavior among AI/AN adults, it was observed that the treatment group had large reductions in symptoms across all treatment targets (Pearson et al., 2019). Furthermore, evidence-based interven-tions that are culturally derived/adapted (i.e., based in and developed from cultural practices and worldviews within the target

community) have demonstrated efficacy for the treatment of PTSD, AUD, SUDs, and other mental health diagnoses (Big-Foot & Schmidt, 2010; Dickerson et al., 2018; Johnson et al., 2021). However, while behavioral EBTs for mental health and SUDs have demonstrated efficacy for AI/AN peoples, barriers related to under-utilization of data, and lack of cultural interventions that increase access, efficacy, and retention, persist.

Identity Politics and Sampling

An array of factors that contribute to how and why AI/AN peoples do or do not self-identify has been found in U.S. Census data (Wood & Hays, 2014). In 2010, 5.6 million AI/AN peoples reported identify-ing as multiracial, and 2.9 million reported identifying solely as AI/AN (Connolly et al., 2019). AI/AN peoples are the only racialized group in the U.S. who must prove their identity through blood quan-tum and tribal enrollment, which has long been a tool of conquest and acquisition of tribal lands through systematic dilution of identity (Gartner et al., 2021). However, with the insurgence of ancestry testing (e.g., DNA) and long-lost Indigenous ancestry being in vogue, there has been an increase in people reporting mixed AI/AN heritage on census data, but not a compa-rable increase in tribal enrollment (Con-nolly et al.). Nonetheless, it is likely that those who have a matching between AI/AN identity and culture are more likely to be utilizing relevant services and resources pertinent to AI/AN specific mental health treatment and research. While the use of data for AI/AN alone might be appropriate for policy or program research that could impact funding and be specific to federally recognized tribal enti-ties, AI/AN alone or in conjunction with another race could be more appropriate when considering more general cultural categories and identities related to behav-ioral intervention research (Connolly et al., 2019)—namely, those who are tribal mem-bers of tribes not federally recognized or decedents of enrolled members who have been raised in the culture and context of their tribal ancestry. Consideration of AI/AN heritage in conjunction with another ethnoracial category is an impor-tant means of understanding and validat-ing the lived realities of the critically under-represented Indigenous Black and mixed Indigenous American and Latinx popula-tions. Moreover, while beyond the scope of this commentary, Native Hawaiian,

Chamorro, and American Samoan com-munities are also considered Native Amer-ican, albeit not federally recognized but as trust territories, and have experienced sim-ilar histories of colonization, historical trauma, and postcolonial distress (Leavitt et al., 2015; NCAI, 2020).

There are copious reasons as to why deindividuation of AI/AN identity occurs, such as invisibility and erasure; internaliza-tion of homogenized and pejorative repre-sentations (e.g., "savagery," mascots); and the very real dangers of identifying as AI/AN (e.g., racism, oppression, violence), to name a few (Leavitt et al., 2015; Wood & Hays, 2014). However, government and medical officials tend to underreport AI/AN identity even when the person is tribally enrolled. This is due to multiple factors embedded in racist views of how an AI/AN person is expected to speak, look, and present (Wood & Hays). In some instances, tribal enrollment relative to birth is contrary to race on death certificates. In other words, a person is born AI/AN but dies non-Native. In the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) and the related National Longitudinal Mortality Study survey, 78% of those of AI/AN ancestry were placed into a different racial category, which was 57–77 percentage points higher than all other racial categories' misclassifi-cation (Clegg et al., 2007). Administrative misclassification has been demonstrated in comparisons of survey data and clerical data within the Veterans Affairs (VA), prison system, and healthcare settings (Leavitt et al., 2015). Posited reasons for misclassification incongruous with self-report include unfamiliarity with tribal diversity, assumptions made about last names (e.g., Hernandez, Smith), and racist or biased views of phenotypes and what it means to be AI/AN (Leavitt et al., 2015; Wood & Hays).

Importantly, inclusion of AI/AN peo-ples in clinical research is critical to cultur-ally congruent, tailored, and accessible mental health treatment for this under-served population. Notably, Hays and Iwa-masa (2019) state that "the omission of ethnic and other cultural information is the rule rather than the exception in clinical and counseling research" (p. 5). Part of integrating AI/AN, multicultural, and diverse perspective into clinical theory and practice starts with the inclusion of those knowledge systems and very peoples at the data gathering, analytic, and reporting levels. In other words, sampling and cul-tural identity—and thus, cultural practices,

knowledge, and worldview—are crucial to the fit of clinical interventions (Bernal & Domenech Rodriguez, 2012). While some strictly adhere to the fidelity of an EBT protocol in resistance to adaptations, research (BigFoot & Schmidt, 2010; Coser et al., 2021; Pearson et al., 2019; Venner et al., 2016) has observed that culturally derived and adapted treatments are efficacious, relevant, and reflect culturally responsive research and practice. Furthermore, meta-analyses have demonstrated that culturally adapted treatments are equally if not more effective that nonadapted treatments (Benish et al., 2011; Rathod et al., 2018; Smith et al., 2011).

Appropriate Methodology and Measurement

Methodology and measurement within AI/AN EBT research have the potential to be decolonizing and have been defined by an iterative process representative of the pan-Indigenous medicine wheel (Walls et al., 2019). Occurring across three levels of specificity, methodology is tailored for (a) the general and broad AI/AN community, (b) a population, region, or locale (e.g., rural, urban); or (c) a specific tribal group or community. A priori AI/AN conceptualizations and operationalization for the research specific to the level of tribal specificity are posited to increase validity (Lopez, 2020; Walls et al., 2019). Collaborative and participatory research is most analogous to Indigenous research approaches and recognizes tribal and data sovereignty and knowledge ownership. These partnerships also greatly impact the results and the ways in which the results are understood and shared.

Correspondingly, measurement equivalence is integral to making comparisons and obtaining appropriate data, just as cultural adaptation is essential for salient behavior therapies. For example, Motivational Interviewing (MI) has previously been critiqued for its usage with AI/AN peoples based on its development and norming with predominantly White U.S. populations (Venner at al., 2008; Venner et al., 2016); however, after cultural adaptations and equivocal norming, it has been found to be efficacious with AI/AN populations (Dickerson et al., 2018; Novins et al., 2016). Where larger, epidemiological datasets are considered, data weighting has been accepted as another way to contextualize data for typically small samples like AI/AN subsamples in contrast to other groups. However, to mitigate error and

Table 1. Recommendations for Clinical Research and Datasets

Recommendation	Strategies
1. Consult with tribal communities and understand the data sovereignty protocols, guidelines, and practices in the community or region the research is being/was conducted.	Ideal for engaging the community for ethical research, initial introduction to recruitment, and/or increasing participation.
2. Be clear when communicating racial and ethnic identification selection procedures to ensure accurate reporting. It is recommended that participants be encouraged to select AI/AN alone and careful considerations be made about selecting multiple ethnoracial categories.	Selection can affect what is reported regardless of sample size and can impact future sampling procedures, techniques, and strategies.
3. Under no circumstances should participants be categorized without their knowledge, as this is impacted by implicit biases; AI/AN categorization should be by self-selection.	Never assume identity; always let participant/client self-identify to obtain the most accurate and contextual information.
4. Include culturally relevant variables to enhance understanding of the data and to make the data culturally salient, consistent, and of good quality. For example, collect data about tribal affiliation.	Regardless of target sample size, ask about tribe, tribal affiliation, reservation/village involvement, etc. Unless targeting a non-AI/AN sample, do not assume none will be AI/AN.
5. Conduct mixed methods research to obtain both quantitative and qualitative data that represents the lived realities of the AI/AN sample.	Both are valuable methods and are strengthened together, particularly when sample sizes are small (e.g., qualitative data can contextualize the sample).
6. Use culturally derived/culturally adapted measures for construct equivalence in the AI/AN sample (i.e., AI/AN measures, measures adapted for AI/AN peoples).	Using measures not otherwise used with the AI/AN sample can be limiting, not measuring the same construct, and be culturally inappropriate.
7. Count AI/AN peoples alone and in conjunction with other ethnoracial groups. Inclusion is the antidote to othering. Thus, resist grouping AI/AN into the multiracial or the other category.	Do not lump data into an "other" category; rather, report the subsample and what is known, even if subsample analyses cannot be done.
8. Use weighted sampling procedures if indicated and applicable for proportional comparisons and contextualization of the sample.	Use ranking, matching, propensity weighting, or a combination, as deemed appropriate for small, medium, or large sample sizes.
9. Share what is there. Small sample size and inability to achieve statistical significance is not a barrier for AI/AN communities who want to know and understand their data.	Sharing the sample data is critical to representation, current and future data usage, including metanalytic procedures, data pooling, and transparency of AI/AN data.
10. Disseminate based on the recommendations of tribal communities, advisor(s), and/or the tribal institutional review board(s).	Always consult with tribal review boards, community members, and/or advisor(s) to determine who owns the data, ow confidentiality is protected, and to guide all aspects of the research.

inaccuracies, it is suggested to only weight the data when appropriate (e.g., larger sample size, more than 100) and usage of fewer variables is indicated (Becker et al., 2021; Gartner et al., 2021; Urban Indian Health Institute [UIHI], 2020). Furthermore, a careful consideration by researchers of best practices in designing research, measurement strategies, and use and analyses of AI/AN data has the potential to effect larger changes across research and presents real-world impacts for AI/AN communities that have been historically under- and misrepresented.

The othering of AI/AN in datasets can be misleading, represent a systematic erasure of Indigenous communities, diminish the urgency to serve these populations, and act as an injustice to unique mental health and treatment needs of AI/AN peoples (Gone & Kirmayer, 2020). Furthermore, the lack of emphasis or outright exclusion of these populations in datasets directly erases the AI/AN participant community and thereby limits the resources that are developed and made available. The diversity that prevails in AI/AN populations is negated by the secular or ignored reporting in ethnicity-based reports. For datasets to best identify ways to serve Indigenous communities' quality of health, the ethnicity-based data collected must be segregated by location so that tribal-specific data can identify the unique needs of different tribes. This cannot be achieved without first including the AI/AN data on all reports that concern ethnicity or race. The NCAI (2020) refers to AI/AN peoples in research as "the asterisk nation," meaning that the population is not represented in the data or as a data point but rather is demarcated by an asterisk in reports. This is particularly poignant for AI/AN peoples, as national datasets are used to make policy decisions and allocate large funds to tribal communities for crucial resources.

Data disaggregation has been identified as a strategy for inclusion and increased participant numbers and, thus, increased power for analyses among the AI/AN subgroup (Becker et al., 2021; Lopez, 2020). By definition, "data disaggregation refers to the separation of compiled information into smaller units to elucidate underlying trends and patterns" (Pan American Health Organization [PAHO], 2021). For AI/AN peoples this would mean disaggregating race by tribal affiliation (e.g., Navajo Nation, Aztec, Nome Eskimo Community). According to the Fundamental Principles of Official Statistics, at a minimum, efforts should also be made to disaggregate by demographics, such as age, gender, sex, education, and geography/region. For example, data that disaggregates AI/AN people as a distinct ethnoracial group (as opposed to the typical categorization of "multiracial" or "other") is more representative of the population and yields more contextualized data. Moreover, the disaggregation of the AI/AN category into specific tribal/regional groups helps further contextualize the nuance of tribal diversity by identifying the position and constraints defined by sociopolitical systems (e.g., sexual orientation, location, socioeconomic status) as it pertains to tribal/regional differences.

Undoing Past Hurts of Research

There are long and painful histories of unethical research in AI/AN communities that have all but eroded trust between researchers and participants, healthcare systems and patients, and governments and constituents (Griffiths et al., 2021; Herron et al., 2021; Pacheco et al., 2013). However, ethical, inclusive, indigenized, and decolonial research practices in these communities have the power to build relationships, strengthen partnerships, instill trust, and, ultimately, begin to undo the history of the hurts of the past. Managing and stewarding the data in ways that are inclusive of tribal communities is a best-practice framework for conducting research and engaging with AI/AN data. Several recommendations related to research and analyses of AI/AN datasets are in Table 1 and based on existing literature (Becker et al., 2021; Gartner et al., 2021; Lopez, 2020; UIHI, 2020). This table lists recommendation and related strategies to consider whether sampling is large (e.g., epidemiological), medium (e.g., most clinical research), small (e.g., unable to achieve significance but able to report

Table 2. Recommended Reading and Resources for Ethical Research Practices With AI/AN Peoples

Readings	Websites	Videos
Best Practices for American Indian and Alaska Native Data Collection (Urban Indian Health Institute, 2020)	National Congress of American Indians https://www.ncai.org/policy-research-center/research-data/introduction-to-research	"Decolonizing Data: Strengthening Community Voices to Take Action for Our Missing Relatives" https://www.uihi.org/resources/decolonizing-data-strengthening-community-voices-to-take-action-for-our-missing-relatives/
Culturally Responsive Cognitive Behavior Therapy, Second Edition: Practice and Supervision (Hays & Iwamasa, 2019; Book)	National Council of Urban Indian Health https://ncuih.org/	"Ethical Frameworks for Research Collaboration with Indigenous Communities" https://elsihub.org/video/ethical-frameworks-research-collaboration-indigenous-communities
Indigenous Data, Indigenous Methodologies and Indigenous Data Sovereignty (Walter & Suina, 2019; Article)	Substance Abuse and Mental Health Service Administration https://www.samhsa.gov/tribal-affairs	"Supporting Ethical Research Involving American Indian/Alaska Native (AI/AN) Populations" https://videocast.nih.gov/watch=42314

effect sizes), and if one is considering engaging the AI/AN community. Additionally, the table can be used generally to consider ways to enhance and improve research and/or clinical work among the AI/AN population. Last, for further readings and materials, please see Table 2.

Conclusion

Othering is not only an extension of historical trauma and violence, but a function of sociopolitical structures of racism and oppression that has no place in behavioral treatment or research. Future directions include concerted efforts to include the AI/AN populations in behavioral research; inclusive statistical strategies for analyses of small group data; intervention norming and cultural adaptations; and inclusion of AI/AN participation and voice in behavioral research for collective group visibility, belonging, and empowerment. The insufficient data-collecting and reporting of AI/AN communities is a pertinent example of how systems that carry historically harmful intended actions continue to jeopardize Indigenous peoples. The product of the faulty data–collecting and reporting of AI/AN communities is perpetual invisibility that fails to recognize the support that could otherwise be provided for the Indigenous people of Turtle Island. The disaggregation of data and inclusion of AI/AN subsamples would provide invaluable information about the efficacy of culturally derived and adapted EBTs. Expectantly, this increase in data clarity and availability could increase AI/AN focused and funded research. Furthermore, an indigenized, decolonial process could undo past hurts, promote reconciliation, and support tribal sovereignty.

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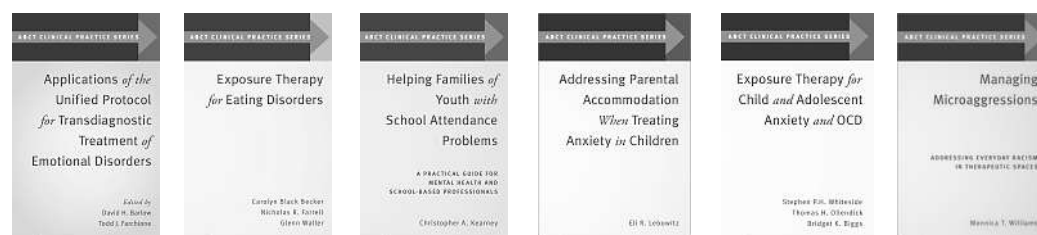
The Preliminary Development of the North Dakota Sexual Violence Intervention Acceptability Measure

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SEXUAL VICTIMIZATION, the experience of nonconsensual sexual activity of any type, affects at least one in four American women and many more proportionally when specific groups, such as LGBTQ+ individuals, are considered (Black et al., 2011). Given the frequent incidence of sexual victimization and the high conditional probability of PTSD (40–50%; Breslau et al., 1998; Dworkin et al., 2021), alongside increased risk of a plethora of other health problems (Dworkin et al., 2017; Koss, 1993), sexual victimization is a leading cause of health impairment. In this article we focus on interventions designed to reduce the incidence of sexual victimization, in other words, reducing the likelihood that a new episode of sexual assault would occur. Because sexual victimization is by definition perpetrated by a second person, sexual victimization interventions are efforts to reduce risk among those targeted (e.g., possible victim/survivors). In contrast, prevention interventions would target perpetration behavior, a separate, complicated, yet extremely worthy approach to that investigated here. It is important to note that risk reduction interventions should not be needed. Rather, perpetration prevention would ideally circumvent the need for any further intervention with potential victims. However, this is not currently feasible. As of this writing, there is no empirically supported intervention to reduce perpetration in adults.

Recent years have witnessed burgeoning new and effective interventions for decreasing the risk of experiencing sexual victimization such as feminist self-defense and bystander interventions (Orchowski et al., 2018; Senn et al., 2015). As new interventions are developed, more interventions become available, and research moves from efficacy testing to effectiveness, understanding the acceptability of various interventions becomes crucial. However, to our knowledge there is no measure for the acceptability of sexual victimization risk reduction interventions. Rather, most investigators create ad-hoc or bespoke measures as part of the intervention development process. This is likely adequate for this narrow, specific purpose. However, for better understanding of differential acceptability and preferences for interventions at the user (e.g., consumer) level—in other words, understanding why a person prefers one intervention over another—a standard measure would be useful. Thus, the goal of this study was to develop a standardized measure for assessing sexual victimization risk reduction intervention acceptability utilizing a theoretical framework to enhance applicability across intervention types (group, individual, community level), foci (self-defense, bystander, other), and clinical utility. We do not evaluate the psychometric properties of the measure in this article; rather, we present pilot data to evaluate whether further development would be fruitful.

Why Focus on Acceptability?

An intervention could be perfectly efficacious, but its practical impact will be nil if it is unacceptable. Thus, considering acceptability, that is, the perceived cognitive and emotional responses to interventions, is important to consider in the development, implementation, and dissemination of interventions. This is a somewhat new concept in intervention research generally and particularly in thinking about preventative interventions like sexual victimization risk reduction. Until now, the goal has largely been to develop *something* efficacious. Luckily, research has progressed to the point that there are now multiple efficacious programs. Given this outstanding, historic progress, the goals of research can shift to the latter components Gordon Paul articulated: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" (Paul, 1967, p. 111). Acceptability is a critical component for elaborating the answer to this question.

We also argue that acceptability is particularly important for conducting a clinical psychological science that is inclusive and equitable. Because many populations have been historically left out of research, marginalized populations may feel that existing interventions simply do not speak to their needs. In the case of sexual victimization risk reduction, many underrepresented and marginalized groups may feel that because these interventions were developed with higher income, White, heterosexual, college women, they are neither applicable nor appealing.

Sekhon's Acceptability Framework

Most prior studies of the acceptability of sexual violence interventions have created an ad-hoc, unique questionnaire for the given study, an expected outcome when no or few standard questionnaires exist. This appears common among the field more broadly (Lewis et al., 2015). Thus, the development of a theoretically grounded questionnaire that can be used in a more standardized fashion across intervention approaches and types is necessary for improving sexual violence interventions and their implementation. Further, grounding this questionnaire in a theoretical framework should increase the utility of responses. We chose Sekhon and colleagues' (2017) framework of acceptability, which comprises seven components: affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy. This framework was developed from conducting a systematic review of the literature and applying inductive and deductive methods to the research identified to develop an operational definition and theoretical framework. Thus, this framework appeared to be the most empirically grounded among available approaches to defining acceptability. Thus, we attempted to create a questionnaire with at least one item for each theoretical component of acceptability for a minimum seven-item measure.

This approach is complementary to one of the few standardized questionnaires we were able to locate, the Acceptability of Intervention Measure (AIM). The AIM is three items long and designed to be applicable to any intervention (Weiner et al., 2017). This measure was developed via expert ratings and systematic review within an implementation science framework (Weiner et al., 2017). This questionnaire is concise and efficient, yet may not capture all seven components of acceptability.

Table 1. Tested Sexual Violence Intervention Acceptability Measure Items

	Acceptability Component	Item	Response Format
1	Affective attitude	How positively or negatively do you feel about the *self-defense class name* class?	7-point Likert scale *extremely negative* to *extremely positive*
2	Burden	How easy or difficult was it for you to participate in *self-defense class name*?	7-point Likert scale *extremely difficult* to *extremely easy*
3	Ethicality	How much do you agree with this statement: The class *self-defense class name* aligns well with my personal value system.	7-point Likert Scale *strongly disagree* to *strongly agree*
4	Intervention Coherence	How clear is your understanding of the class *self-defense class name*?	6-point Likert scale *not at all clear* to *very clear*
5	Intervention Coherence	How much do you agree with this statement: I understand how *self-defense class name* works.	7-point Likert scale *strongly disagree* to *strongly agree*
6	Opportunity Costs	In order to attend *self-defense class name*, would you pay $30 (or pay a babysitter $30)?	5-point Likert scale *definitely yes* to *definitely not*
7	Opportunity costs	In order to attend *self-defense class name*, would you miss class or work?	5-point Likert scale *definitely yes* to *definitely not*
8	Opportunity Costs	In order to attend *self-defense class name*, would you reschedule a date or outing?	5-point Likert scale *definitely yes* to *definitely not*
		Tell us more about what might STOP you from signing up to participate in *self-defense class name*:	Text response
		Tell us more about what would make you MORE LIKELY to participate in *self-defense class name*:	Text response
9	Perceived effectiveness	How effective do you think *self-defense class name* will be in helping you to prevent sexual assault or rape?	5-point Likert scale *very effective* to *not at all effective*
10	Self-efficacy	How confident are you that you did successfully engage in and complete *self-defense class name*?	5-point Likert scale *very confident* to *not at all confident*
		Would you recommend *self-defense class name* to a friend?	*Yes, no, maybe/unsure (tell us more)*

Note. The full, current version of this questionnaire is also available at https://commons.und.edu/psych-stu/3/.

However, the brevity is consistent with the hierarchical structural model of construct validity—that an item for each component of the structure is unnecessary and can inflate variance (Clark & Watson, 2019). Ultimately, it may be prudent to rely on such a brief measure; however, we consider that an empirical question to be tested in future research.

Self-Defense as Sexual Victimization Risk Reduction

Feminist self-defense interventions to reduce the risk of rape have a long history and are well-studied (Gidycz & Dardis, 2014). Feminist self-defense is a cognitive-behavioral intervention that includes: psychoeducation around sexuality, challenging cognitions that are barriers to effective self-defense, and the behavioral practice of self-defense. One of the most well-studied examples is the Enhanced Assess, Acknowledge, Act Sexual Assault Resistance program, aka the Flip the Script program, which takes 16 hours to complete and is delivered by highly trained peers (Senn et al., 2015). For individual women who wish to reduce their risk of rape, self-defense is one of the, if not the only, empirically supported options designed to target individual change (in contrast to bystander interventions that target community-level change; Orchowski et al., 2018). Self-defense is efficacious; Flip the Script reduces the risk of rape by nearly 50%—in other words, reducing the risk of rape from 9.8% to 5.2% (Senn et al.). Only recently have non-self-defense interventions become available, and none yet meet the criteria for an empirically supported intervention as yet. However, as intervention options proliferate, it is important to understand why individuals may prefer and respond differentially to various interventions.

Current Study

This study aimed to develop a theoretically based questionnaire of acceptability for evaluating sexual violence interventions. Acceptability is a key tool for improving the reach and inclusivity of interventions. We sought to develop a questionnaire that could be applied to the wide variety of forms and foci of sexual victimization risk reduction interventions. This article presents a description of the development and pilot testing of these items to determine whether further testing would be appropriate, *not* intervention acceptability data. We utilized the instrument model described by Clark and Watson (2019) in considering the development process to be iterative and ongoing throughout the lifespan of the measure with the initial stages focusing on the conceptualization of the construct. Given this iterative model, we are writing this article to (a) model this iterative practice including at the peer-review stage, (b) invite feedback from peer reviewers and general readers, and (c) demonstrate how even simple pilot data raises important questions about measure development. Finally, we hope that the data presented here identifies future areas for refinement and psychometric testing for our team and others.

Thus, at this stage we focused on developing the item pool, and pilot-testing for readability and logical consistency. We pilot tested items with college and community women who had completed self-defense. We focused on self-defense because it is the longest-standing risk reduction intervention and the only one offered in our local community. We recruited a sample of community women to diversify our analysis beyond college women, and to recruit a group who had not taken self-defense as recently and may therefore have different insights regarding acceptability. In our analysis of items, we focus on whether items were understandable to participants and whether the reported data was logically consistent. We did not examine the reported data for acceptability itself, given the small samples recruited and high statistical floor of acceptability given that all participants had opted to complete a self-defense course.

Method and Item Development Findings

Development of the Item Pool

We first developed items anchored to Sekhon's (2017) framework. Items were drafted by the second author based on Sekhon's framework and examination of relevant comparison literature (e.g., Newins & White, 2018; Tarrier et al., 2006). Some components of the framework are represented by one item while others are associated with multiple or multi-part items for clarity (see Table 1). This is consistent with Clark and Watson's (2019) suggestion to err on the side of multiple items, which can be reduced quantitatively in later testing rather than underrepresent dimensional content. We also included two open-ended items that asked participants to report reasons why they might or might not participate in a sexual assault program. This data was reviewed to evaluate whether the items developed may have missed relevant barriers or facilitators.

Expert Review of Items

An expert review of the initial items was conducted by the second author's thesis committee, which included four members who ranged in gender (men, woman, agender), age (30s–60s), and sexual orientation (heterosexual, bisexual), although all were White. Each item was evaluated for clarity, grammar, face validity, and redundancy. The expert review process resulted in changes that clarified language in the open-ended questions regarding what would make participants more likely/unlikely to register for and/or participate in an intervention.

Peer Review of Items

Peer review of items was done within the supervising investigator's research lab (first author). Because college students are frequently the targets and deliverers of sexual assault risk reduction interventions, we reasoned it was appropriate to seek their input for item revision. This group of 17 people included mostly White heterosexual women, but also three Indigenous women, one Hispanic woman, one Indigenous man, one Asian American woman, one Black man, and bisexual and gay individuals, whose ages ranged from 18–47. Peer review suggested we change the term "intervention" to "program" to make the items more salient for laypeople. Items were also added asking participants if they would recommend the intervention (a) to a friend, or (b) to a friend who had experienced sexual violence.

Pilot Testing of Items

The items tested are presented in Table 1. We pilot tested two versions of these items. In one test we recruited participants from a specific self-defense class and therefore included that name in the items, consistent with the approach of similar measures including the AIM. In the second pilot test we recruited any adult who had taken a self-defense or similar class and thus revised items to "the Self-Defense class." In this round of pilot testing, we focused on self-defense because that is the only type of sexual assault risk-reduction program historically offered in the community of testing. At this stage, we wanted to restrict the variance in the programs about which participants were responding to ensure that any variance in results could be attributable to the questionnaire or the population and not the nature of the intervention.

Participants were provided with the 12-item acceptability questionnaire and two items assessing whether the questionnaire was understandable (e.g., readability): (1) "How easy or difficult to understand were the questions on this survey?" and (2) "Tell us more about why you thought the questions on this survey were easy or difficult to understand." Participant demographics were also collected. To assess social desirability or response sets, one item was administered: "How honest were you in answering these survey questions? Your response is confidential and will not impact your chance to win the raffle."

Sample 1

Participants were college women ($n = 19$) and nonbinary or gender-nonconforming individuals ($n = 1$) enrolled in a Midwestern university's Rape Aggression and Defense (R.A.D.) course, $n = 20$ total participants. Participant ages ranged from 18–21 ($M = 19$, $SD = 1.00$). Participants could select multiple sexual, racial, and ethnic identities. The majority sexual identity was heterosexual ($n = 15$, 75%), with others identifying as sexual minorities, including bisexual ($n = 3$), asexual or demisexual ($n = 2$), lesbian ($n = 1$), and queer ($n = 1$). The sample was primarily White ($n = 18$, 81.82%), with some participants identifying as Asian ($n = 1$) and as Indigenous ($n = 1$). Two waves of data were collected, one in fall 2020 and one in winter 2022.

Sample 2

Participants were five community women. They participated in three different types of self-defense training, one via the military, one via a college class, and one via independent jiu jitsu courses. The time since taking the class ranged from a few (2019) to many years (1997). Participant

ages ranged from 33–56 and all identified as heterosexual White women with one also identifying as Two-Spirit. Regarding their sexuality, four participants identified as heterosexual and one as mostly heterosexual. Data were collected in winter 2022. Because Sample 2 women described different barriers and facilitators and had taken self-defense classes longer ago, we analyzed their data separately to examine whether the questionnaire generalized.

Results

Readability of the Questionnaire

Participants in both samples overwhelmingly reported that the questionnaire was easy to understand (Figure 1) with the lowest rating for this item being "neither easy nor difficult." All participants reported being moderately or extremely honest. We also examined responses to an open-ended item, "Tell us more about why you thought the questions on this survey were easy or difficult to understand," designed to assess the readability of the questionnaire. All but three participants reported the measure was understandable, saying things like, "clearly stated" and "straight forward questions." Thus, the questionnaire appears to be sufficiently readable and we consider the following pilot data below to be interpretable.

Feedback on the Questionnaire

Two participants from Sample 1 (college students) noted that some of the response options were too long. One participant noted having capital letters in the items helped with quick comprehension, for example, "Tell us more about what might STOP you from signing up to participate in this program." All study items are listed in Table 1. Sample 2 (community women) had much more feedback on the items themselves. One noted that that effectiveness item was confusing and another raised questions regarding intervention coherence, seeming to suggest it was tautological: "'I understand how self-defense works' seems nebulous—the definition is the defense of yourself."

Logical Consistency in Participant Responses

Means and standard deviations for each item are presented in Table 2 by sample. Inspection of the data in Table 2 suggests that the questionnaire functions as intended. Responses were in the intended direction given that all participants enrolled in self-defense on an elective basis (and therefore positive perceptions would be inflated) and are face valid. Most participants reported a positive affective attitude, low burden, high ethicality, high coherence, good effectiveness, and high self-efficacy for self-defense classes. This is logically consistent with a group who opted to take a semester-long course and would

therefore naturally be more committed to and positive regarding self-defense.

Our focus on practical opportunity cost items showed greater variability in responding with most participants having positive but not uniformly positive responses. For example, the average response to "would you miss a class or work to attend the program?" was met with "might or might not." Although perhaps not promising for this particular intervention, we consider the variability in responses highly promising for the questionnaire—participants did not appear to be engaging in an overly positive response set.

Between Sample Differences

There were many small differences between the samples, with community women's acceptability ratings being slightly attenuated in comparison to the college sample. This is perhaps most notable for the item regarding recommending the class to a friend who experienced sexual assault, with only one community woman answering yes in comparison to all 11 college women. Community women had very nuanced views, many mentioning it would depend on the specifics. Sample differences in four of the seven theoretical domains suggest promise for the questionnaire in that we would expect the positive valence of responses to somewhat attenuate over time.

Differences Between Sexual Minority and Majority Participants in Sample 1

Comparing the interpretive range (rather than statistical values), there were four domains in which sexual minority participants reported less acceptability than heterosexual participants (see Table 3). For affective attitude, ethicality, coherence (item B), and opportunity costs ($) sexual minority participants reported one level difference in the interpretive range of the average response. For example, regarding affective attitude, heterosexual participants' average ratings were in the "extremely positive" range whereas sexual minority participants were in the "positive" range. These minor differences may be due to restricted sample size but are also logically consistent with prior research that suggests marginalized groups feel that interventions developed for majority culture needs may not apply to them (Seaver et al., 2008; Wells et al., 2013).
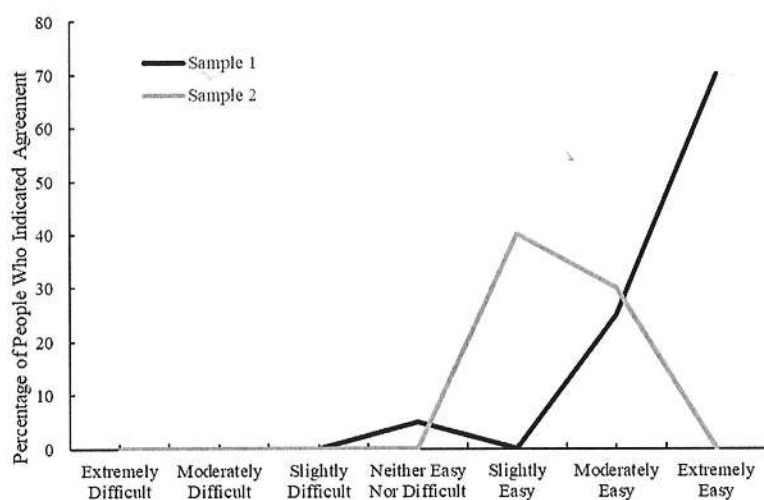

Figure 1. Understandability of SVIAM
Note. Participants were asked to rate the difficulty of understanding the items on the ND SVIAM on a 7-point Likert scale from 1 (*extremely difficult*) to 7 (*extremely easy*).

Table 2. Mean Item Ratings for Each Item Across Samples

Acceptability Item/ Likert Range	Sample 1 Mean Rating (SD), *n* = 20	Sample 1 interpretive range	Sample 2 Mean Ratings (SD), *n* = 5	Sample 2 interpretive range
1. Affective attitude / 7	6.55 (.50)	Extremely positive*	6.00 (.63)	Positive*
2. Burden / 7	6.70 (.46)	Extremely easy*	6.20 (.40)	Easy*
3. Ethicality / 7	6.50 (.50)	Strongly agree*	5.80 (.98)	Agree
4. Coherence A "clarity" / 5	5.00 (0)	Very clear*	4.40 (.49)	Somewhat Clear*
5. Coherence B "how it works" / 7	6.55 (.59)	Strongly agree*	6.00 (.63)	Agree
6. Effectiveness / 5	4.30 (.46)	Somewhat effective	3.80 (.40)	Somewhat Effective
7. Self-efficacy / 5	4.95 (.46)	Very confident	4.60 (.49)	Very confident
8. Opportunity costs, pay $30 /5	3.85 (1.06)	Probably yes*	3.40 (1.62)	Might or might not*
9. Opportunity costs: miss class or work / 5	2.95 (0.97)	Might or might not*	2.60 (.80)	Probably not*
10. Reschedule a date /5	4.2 (.68)	Probably yes*	2.80 (.40)	Probably not*
11. Barriers to participation (open-ended)	Lack of time, performance anxiety, want friends to come with, timing		Timing, money, misogynist instructor	
12. Facilitators (open-ended)	See a woman do it, being able to defend myself, peer approval, timing, low-cost		Being a workout, free, good instructor, regular schedule	
13. Recommend to a friend	Yes (20)	—	Yes (4), maybe (1)	—
14. Recommend to a survivor	Yes (19), maybe (1)	—	Yes (1), maybe (4)	—
Mean, SD, median, mode, range of items 1-9 in Sample 1: 51.3(3.23), 51.0, 47, range: 47-56, possible range: 10-59.			—	—

Note. * indicates a difference between samples in the interpretive ranges.

Open-Ended Responses Regarding Barriers

Responses to barriers indicated the expected general barriers such as lack of time. Indeed, 75% of Sample 1 specifically mentioned time and scheduling as a barrier, with one participant noting "work or class commitments kept me from taking it the last two years," suggesting that they had been trying to enroll for years. Some barriers appeared unique to self-defense, such as performance anxiety, with one participant noting "anxiety to participate in front of [classmates]." Finally, one barrier may be unique to violence and sexual assault programs: wanting to attend with a friend. No additional barriers were described in open-ended responses by the college sample. Barriers were generally very similar across Sample 1 and Sample 2 in that timing was a primary barrier; time was also mentioned by 3/5 community women. Community women also mentioned concerns about the structure of the class (e.g., "Does it only focus on the physical part of self-defense?") Another community participant noted concerns about the instructor, citing a prior bad experience with a misogynistic male instructor.

Open-Ended Responses Regarding Facilitators

As with barriers, the cross-cutting general barrier of time and money was reported, seven college participants specifically mentioned timing- and location-related issues and three mentioned needing low- or no-fee classes. Five mentioned physical self-defense, with comments such as, "want to be able to protect myself." Further, potentially unique facilitators, including peer approval, "knowing people taking the class," and gender of the instructor, were reported by more than one participant in Sample 1. Community women were also concerned with time and location (two), cost and intellectual stimulation, saying, "keeping my interested from week to week."

Discussion

The goal of this study was to take the first step in developing a theoretically grounded measure of acceptability for sexual violence interventions, particularly one to be valuable for many different types of interventions and foci. Our initial data suggest promise for future clinical utility, psychometric testing, and areas for further refinement of the measure. Consistent with an iterative model of instrument development, we expect that this measure would be continually refined and tested as it is used rather than relying on data from only initial testing. Thus, we hope this article stimulates discussion and feedback; the questionnaire is available open-access at this address, https://commons.und.edu/psych-stu/3/, and in Table 1.

Readability and Logical Consistency Findings

Readability ratings were high for all items, though multiple participants did provide specific feedback to incorporate in future versions of this questionnaire. Both samples reported generally positive experiences with the various types of self-defense classes they took. Although the community women generally reported slightly lower ratings than the college women, the overall pattern of responding was the same, with the exception of recommendations for a

sexual assault survivor. Community women had very nuanced opinions about recommending to a survivor. Participants generally had strong and positive affective attitude, ethicality, and coherence ratings, and low burdensomeness ratings, but lower ratings of self-efficacy, effectiveness, and opportunity costs. Similar to the differences between the college and community sample, ratings from sexual minority participants (those who identify as bisexual, lesbian, and queer) were attenuated compared to heterosexual participants among the college sample. Thus, our questionnaire appeared to capture all seven components of acceptability, show appropriate variance with respect to population, and provide practical, actionable data for intervention development and planning.

Clinical Implications

Affective attitude, burden, and ethicality were the highest rated items in both samples. Considering how to "sell" an intervention to future participants, these components may be the most effective in predicting attendance. This is consistent with prior research on completing psychotherapy—a more positive attitude towards treatment is associated with treatment completion (Valenstein-Mah et al., 2019). This is also consistent with research on resistance to self-defense (Hollander, 2009)—negative, inaccurate attitudes impair initiation and provision of self-defense. In the open-ended responses, college participants brought up being able to attend with a friend; this is consistent with prior research (Hollander, 2010) and suggests that incorporating a social aspect to self-defense could be effective. This is similar to some treatment models for psychological disorders that incorporate peer, partner, or family support. However, much like the dominance of individual psychotherapy, the incorporation of peers or supportive others has been understudied in sexual victimization risk reduction. Interestingly, and perhaps in contrast to psychotherapy, the comments of many participants indicated they felt the intervention should be free. Thus, even though self-defense is a cognitive-behavioral intervention encompassing 12–16 hours of training, perhaps because of the history of intervention being free and the external nature of the risk, participants felt the intervention should be free of charge. Cost is always an important barrier to consider and may be even more salient for those seeking sexual victimization risk reduction.

We were surprised at the relative low ratings for the opportunity costs items, particularly considering that all of these participants had, in fact, borne some opportunity cost already by completing self-defense. Thus, perhaps participants were considering future costs, and since they had already taken self-defense, had lower ratings for this item. It will be important to compare this data point to future research where participants complete the questionnaire before choosing or completing an intervention. This is especially important considering a simple "intent to attend" item is predicting of intervention completion for PTSD, a disorder that tends to have high dropout rates for intervention (Shulman et al., 2019). Although it has never been studied, considering that PTSD is a mediator of risk for repeated victimization (Risser et al., 2006), it is entirely possible that psychotherapy can function as a sexual victimization risk-reduction intervention. Thus, this questionnaire could be used to measure the acceptability of trauma-focused therapy for PTSD when it is administered with the purpose of risk reduction. However, given the dominance of self-defense-type interventions in popular imagination, it may be a "hard sell" to convince participants to try other psychological interventions to reduce the risk of sexual violence.

Areas for Future Refinement

This analysis highlighted several areas for refinement of the measure. For example, revision of the self-efficacy and effectiveness items is recommended. Given the tautological nature of the self-efficacy item, a better item might use a behavioral definition of self-defense. However, this could reduce the applicability of the questionnaire across sexual violence interventions. We also wonder how to improve the effectiveness item. As behavioral scientists and members of the Association for Behavioral and Cognitive Therapies, we maintain that it is likely beyond the capability of the participant to evaluate effectiveness without data and, for some, even with data. Thus, perhaps a revised version of the item should anchor responses to whether the participant was provided with any type of information or data on effectiveness during the intervention. This is likely true for other acceptability questionnaires targeting psychological interventions—public understanding of science, much less behavioral science, is limited. We chose to use very practical items to assess opportunity cost, which may have been too narrow to

fully capture participants' complex decision-making process to decide how to spend their time. We will definitely seek uniformity regarding the Likert scale range of response options used in the future. Similarly, our readability item was double-barreled, as was the affective attitude item. Finally, we wonder whether future research should specifically mention the lack of availability of perpetration prevention interventions in setting the context for acceptability of risk reduction interventions. Some participants may feel risk reduction interventions are inappropriate and victim-blaming without this fuller context.

Limitations

All data presented in this article are preliminary and collected with mostly women, who were mostly White, mostly heterosexual, and located in one region of the United States. We hope that this article's critical feedback and reactions help us improve the North Dakota Sexual Violence Intervention Acceptability Measure (SVIAM) questionnaire for future research and clinical work. Future research should compare the incremental validity of this measure to a more general measure like the AIM. Testing other dimensions of the psychometric properties is important, such as validity, reliability, and internal consistency (via inter-item correlations) across groups. Finally, although our team's ultimate goal of testing acceptability is inclusion, our sample was not very inclusive, a common feature of unfunded research. Future research testing the psychometric properties of the ND SVIAM must be more inclusive to meet this goal.

Conclusion

The development and pilot testing phase of the SVIAM demonstrates the difficulties inherent in developing an inclusive, psychometrically supported, yet clinically useful questionnaire. It is of note that this phase of research, though prepsychometric, is valuable in establishing a need for future research at all, given the intensive resources that large-scale, inclusive psychometric validation requires. The pilot data here suggest the SVIAM has promise for differentiating acceptability between groups and interventions. Future research should continue to refine and test the items, particularly the intervention coherence and effectiveness items with larger, more inclusive groups.

Table 3. Mean Item Ratings Comparing Heterosexual and Sexual Minority College Participants

Acceptability Item	Heterosexual Mean Rating (SD), *n* = 15	Heterosexual interpretive range	Sexual Minority Mean Ratings (SD), *n* = 5	Sexual Minority interpretive range
1. Affective attitude	6.60 (.51)	Extremely positive*	6.40 (.55)	Positive*
2. Burden	6.73 (.46)	Extremely easy	6.60 (.55)	Extremely easy
3. Ethicality	6.60 (.51)	Strongly agree*	6.20 (.48)	Agree*
4. Coherence A	5.00 (0)	Very clear	5.00 (0)	Very clear
5. Coherence B	6.67 (.49)	Strongly agree*	6.20 (.84)	Agree*
6. Effectiveness	4.27 (.46)	Somewhat effective	4.40 (.55)	Somewhat effective
7. Self-efficacy	4.67 (.49)	Very confident	4.80 (.45)	Very confident
8. Opportunity costs, $	4.13 (.83)	Probably yes*	3.00 (1.41)	Might or might not*
9. Opportunity costs: miss work	2.87 (1.06)	Might or might not	3.20 (.84)	Might or might not
10. Reschedule a date	4.13 (.74)	Probably yes	4.40 (.55)	Probably yes
13. Recommend to a friend	Yes (15)	—	Yes (5)	—
14. Recommend to a survivor	Yes (14), maybe (1)	—	Yes (5)	—

Note. *indicates a difference between samples in the interpretive ranges. There were no differences in reported barriers/facilitators (items 11, 12).

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Fostering Transparency Around ABCT's Election Process

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

FOR SO MANY of us, ABCT is a professional home, one that is distinctive for its vibrant climate, compelling vision, and edifying connections. Indeed, one of the purposes of ABCT is to "facilitate professional development, interaction, and networking" among our members as we collectively strive to achieve a collective vision: to promote wellness through the application of science to human problems.

Because we pride ourselves as an organization that fosters human connections, we must go beyond naturally occurring networks to build social capital that helps all members to understand our governance systems. Indeed, ABCT's current President, Laura Seligman, has publicly stated that transparency is a theme of her presidency. To that end, here are some attempts to demystify our annual nomination and election process:

MYTH: I just don't have the time to nominate.

REALITY: Completing a nomination itself is a very easy process. Any full or new professional members of the organization can nominate a 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. All you need to do is to share your name and the name of the person you want to nominate on the brief form provided in this issue or on the website (https://services.abct.org/i4a/forms/index.cfm?id=31). Then (e)mail it along. The whole process takes just a few minutes.

MYTH: There are some ABCT colleagues whom I admire and would like to see lead the organization but I feel like it would be an imposition to nominate someone unless I was sure that they wanted to become a candidate.

REALITY: Nominating someone does not obligate them to run. For a period of time, ABCT collects self and peer nominations. At the end of nomination season, the two candidates with the most nominations for each position are contacted by the chair of Leadership and Elections and asked to confirm that they are willing to stand for election. If so, they are placed on the ballot. If they decline, we move onto the next person on the list until we have the ballot for each position filled. Nominees who declined to run in recent years often remark that they are honored by their peer nomination(s). Some of these nominees report that hearing about others' confidence in their qualifications made them entertain a bid for election. When you nominate a peer, it is most likely to be taken as a compliment, not an imposition.

MYTH: I am interested in self-nominating but I am not [fill in the blank: senior, well-known, accomplished] enough to stand for election.

REALITY: We seek a wide range of members who can bring their energy, commitment, and good ideas to the organization. Feel like ABCT's historic leadership profiles do not fully align with what you have to offer? This is even more reason to consider your candidacy. The diversity of our membership is what brings such vibrancy to ABCT. We are constantly seeking candidates who can expand the organization's leadership to match the diverse needs and perspectives of our membership. There are many individuals in recent years who have landed on the ballot who started from a tentative place but who have thrived in the leadership of the organization over the years. Why not you?

For the upcoming 2023 election, the Leadership and Elections Committee seeks nominations for ABCT's next President-Elect (2023-24; President, 2024-2025; Immediate Past President, 2025-2026) and for a Representative-at-Large (RAL; 2023-2026). Each RAL serves as a liaison to one of the governing branches of the association and the representative position open for 2023 will connect and coordinate with the Membership Issues Coordinator and committees.

Remember that there are many ways to invest in ABCT's future. We'll share three. The first is to nominate yourself or a colleague. Another is to remember to take a few minutes to vote in our annual election

this November. It is easier than ever, with an email reminder delivered right to your inbox. Finally, know that there are other ways to get involved in ABCT governance beyond running for office. Look for announcements of appointed committee openings through our online member forum. For example, what about joining the committee on Leadership and Elections? Each year we shepherd annual elections and consider how to expand the leadership pool for the future. Membership is approved by ABCT's Board of Directors and includes a chair and two members. Our Chair is Patricia DiBartolo (pdibarto@smith.edu), from Smith College, who has served on the committee since 2016. Simon Rego at the Albert Einstein College of Medicine (dr.rego@gmail.com) is a continuing member (kpl9716@u.washington.edu) and we are recently joined by Angela Fang (angfang@uw.edu) at the University of Washington. If you are interested in joining our committee or are curious about other ways to get involved in the organization, please contact any one of us or ABCT's Executive Director, Mary Jane Eimer (mjeimer@abct.org).

For so many of us, ABCT is a professional home. Claim the privileges of ABCT membership—nominate, vote, and serve—so that together, we can realize the organization's loftiest goal to promote human health and wellness. Please be in touch any time, in the voting booth and outside of ■

I nominate

the following individuals for ABCT office

▶ **PRESIDENT-ELECT** (2023–2024)

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_____

▶ **REPRESENTATIVE-AT-LARGE** (2023–2026)
Liaison to Membership Issues

_____

_____

▶ **NAME**

_____

Send your form to Patricia DiBartolo, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001

Or email form to membership@abct.org (Subject line: Nominations)

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 1, 2022, will be counted.**

◆ **DEADLINE: Monday, September 1, 2022**

ABCT's Champions of Evidence-Based Interventions

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

▶ Potential Candidates

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

▶ Recognition

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

▶ How to Nominate

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

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

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

Call for Applications | # FELLOWS

ABCT Fellow Status for 2022

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

Multiple Routes to ABCT Fellow Status

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

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

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

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

ABCT Fellows Committee

Linda C. Sobell, Ph.D., Chair
J. Gayle Beck, Ph.D.
Brian Chu, Ph.D.
Debra Hope, Ph.D.
Christopher Martell, Ph.D.
Simon Rego, Ph.D.
Maureen Whittal, Ph.D.
Antonette Zeiss, Ph.D., Vice Chair

APPLICATION DEADLINE:
July 1, 2022

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

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

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

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

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

Call for Papers | *Cognitive and Behavioral Practice*
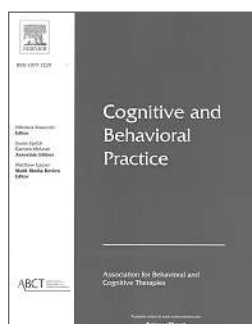
Special Section: "Applications of Cognitive Behavioral Therapy to Psychological Disorders and Comorbid Medical Conditions in Pediatric Patients"

GUEST EDITORS:

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Pediatric medical settings often represent the front door for behavioral health concerns. Moreover, integrated pediatric behavioral health care is an emerging frontier and CBT is poised to play a significant role in patient services. This development is especially fortuitous since these clinical sites are experiencing major surges in cases requiring psychosocial intervention. However, there is a relative lack of research directing the application of CBT for psychological conditions in comorbid medical disorders as well as a dearth of resources detailing the application of CBT in these pediatric cases. Accordingly, providing more clinically relevant research and practitioner-friendly guides for working with these patient populations is the precise focus of this special issue.

Our goal is to represent the perspectives of research-focused, education-focused, and practice-focused readers of the journal. C&BP is a practitioner-oriented journal. Consistent with the aims, scope, and mission set by Dr. Nikolaos Kazantzis' editorial team, we are interested in data-based manuscripts as long as these are presented in the context of rich clinical descriptions (e.g., case vignettes, video demonstrations, and therapist guidelines). We also encourage review articles and commentaries with focus on clinical practice implementation that complement empirical submissions.

Authors or author groups with questions about potential submissions are invited to contact the Guest Editor team identified above. Those manuscripts selected for further consideration will be peer reviewed according to the journal's usual editorial policies and procedures. Authors will be expected to revise manuscripts promptly. Accepted articles will be posted online within a short time frame of acceptance.

Topics may include but are not limited to:
- Treating traditionally underserved and marginalized pediatric patient populations diagnosed with comorbid psychological and medical conditions with CBT spectrum approaches
- Training clinicians to deliver CBT to pediatric patients with comorbid psychological and medical conditions
- Assessment and adjunctive treatment of female-specific health conditions, including premenstrual exacerbation of psychiatric symptoms, endometriosis, etc.
- CBT for psychological disorders comorbid with pediatric medical conditions such asthma, pain (menstrual pain, endometriosis, headache, G-I, etc.), diabetes, sickle cell disease, cystic fibrosis, inflammatory bowel disease, etc.
- CBT for anxiety and or depression presenting in primary care settings
- CBT for pediatric sleep problems
- CBT approaches to medical nonadherence in pediatric patients
- CBT for children with fears about medical procedures

Author guide:
https://www.elsevier.com/journals/cognitive-and-behavioral-practice/1077-7229/guide-for-authors

Manuscript submission portal:
https://www.editorialmanager.com/candbp

Deadline for Submissions:
February 2023

ABCT Research Facilitation Committee

— Call for Committee Members —

The Research Facilitation Committee (RFC) is looking for 1 to 2 new committee members to serve as a liaison between ABCT and agencies that set the agenda and provide funding for activities relevant to our ABCT's core mission and values. The new member(s) would attend these meetings (e.g., Consortium of Social Sciences Associations [COSSA], Mental Health Liaison Group (MHLG), sessions sponsored by NIH, and other opportunities that we are made aware) as the representative of ABCT, take meeting minutes, and report back to ABCT leadership. Lessons learned from these meetings will be shared with the broader ABCT membership as applicable. Applicants should be Full Members of ABCT.

If you are interested in applying, please send a CV and cover letter detailing your interest in this position to Dr. Ryan Jacoby (rjjacoby@mgh.harvard.edu) by Friday, July 15, 2022.

For more information about the RFC, see our Research Resources page:
https://www.abct.org/for-professionals/research-resources/