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Contents

Clinical Practice Forum

Elliot Marrow

Breaking Cycles of Harm: Lessons From Transgender History for Today's Clinicians • 189

Morgan E. Browning, Elizabeth E. Lloyd-Richardson, Rebecca L. Schneider, Alyssa L. Faro, Jennifer J. Muehlenkamp, Adriana Claudio-Hernández

Obsessive-Compulsive Disorder and Co-Occurring Nonsuicidal Self-Injury: Evidence-Based Treatments and Future Research Directions • 199

Original Research

R. Alexander Blake, Rachel E. Kim, Kelsie H. Okamura

Lexicon Problems in Mental Health Graduate Training: Defining, Understanding, and Implementing Evidence-Based Practice Through Accreditation • 209

News

Emily B. K. Thomas and Rosaura Orengo-Aguayo

ABCT's 2022 Convention Review and Decision Process • 216

At ABCT

Jason Duncan and Beata Krembuszewski

Getting to Know New York: A Constantly Evolving City Where Almost Anything Is Possible • 223

Convention Preview pp. i–xxxvi

ABCT2022



At ABCT

Mary Jane Eimer

From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better • 226

CLINICAL PRACTICE FORUM

Breaking Cycles of Harm: Lessons From Transgender History for Today's Clinicians

Elliot Marrow, University of Massachusetts Boston

ACCESS TO GENDER-AFFIRMING medical care for transgender and gender diverse (TGD) individuals has been historically contentious, both in the popular media and among some researchers. In the present moment, some researchers and clinicians have hypothesized that rising identification with gender diverse identities is the result of social contagion or mental illness (Anderson, 2022; Littman, 2019). Researchers and clinicians have also responded to concerns that youth may erroneously self-identify as transgender (Imbler, 2022; Temple-Newhook et al., 2018; Winters et al., 2018). The fear that a clinician may allow someone who is not “truly trans” access to gender-affirming care has a long history. Though many trans elders are aware of these histories, few clinicians, both cisgender and transgender, are. In this review, I present a brief overview of the history of access to gender-affirming care—and the harm done to TGD individuals—so that today's mental health providers can learn from these histories and break cycles of harm.

The historical data referenced in this review is part of a larger qualitative research project by the author synthesizing archival data from four national and international archives spanning the 1960s–1990s (publications forthcoming; the present paper provides a brief review of a portion of this history and includes modern per-

[continued on p. 191]

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spectives). Citations referencing the “EEF” refer to the Erickson Educational Foundation, an organization that funded much of the early research on gender identity and provided support and referrals to trans individuals; audio reels of symposia and meetings organized by the EEF are referenced. In this paper, “trans” is an umbrella term referring to both modern and historical terms used by gender diverse individuals, such as transgender and transsexual. “Cisgender” refers to individuals who are not transgender.

Therapeutic “Cures”

They are trying to manipulate you ... to support them in their solution and not to be cured ... and you mustn't be had too readily. (EEF, 1969a, pt. 1)

From the 1950s onward, TGD individuals approached providers hoping to gain access to gender-affirming care. These hormonal and surgical options were relatively new; for instance, trans woman Christine Jorgenson began self-administering feminizing hormones in 1949—less than a decade after the first synthetic estrogens were marketed in the U.S. (Jorgenson, 1968; Rudacille, 2006). Although reports of gender-affirming surgeries had existed in Europe since the 1910s, international media coverage in 1953 of a gender-affirming surgery Jorgenson received in Denmark made many aware of these new possibilities (Rudacille, 2006). The numbers of patients requesting medical interventions “utterly overwhelmed” providers, who were disconcerted by patients’ insistence on self-knowledge of their identities and desire to direct their own care (Money, 1978, p. 397). The majority of mental health providers sought to “cure” TGD individuals of gender variance by discovering “the psychological roots of transsexualism” (Lothstein, 1982, p. 423). TGD individuals, however, resisted these cures. They would not or could not change their identities. Instead, they sought “to change the outer world—their anatomy, the people they know, society” (Stoller, 1985, p. 6).

Once it became apparent that TGD adults would not “submit to cure” (EEF, 1969b, pt. 2), some mental health providers with the hypothesis that gender variant behavior was learned in childhood sought to prevent adult TGD identity. These efforts were given consistent financial support by the NIMH for over a decade (Green, 1987, p. ix), and particularly tar-

geted feminine behaviors via behavior modification or talk therapy (Green, 1987).

The repercussions of these efforts to prevent gender diversity in youth spanned decades. In 2003, Kirk Murphy, a former patient in the so-called “sissy boy” study, died of suicide. Family members blamed the study. In an interview with CNN, Murphy’s brother recounted the token system of rewards and punishments used at home with both siblings to reduce Kirk’s feminine behaviors and enforce masculine ones. Red poker chips indicated Kirk had exhibited a feminine behavior and would receive a punishment. “I took some of the red chips and I put them on my side,” Murphy’s brother recalled, in an effort to reduce the physical abuse Kirk was subjected to at home (Bronstein & Joseph, 2011). Many parents resisted the efforts of mental health providers to “cure” their children of gender nonconformity (Green, 1974, pp. 213, 276). In response, psychologists pathologized parents or discussed that such children should be taken from their parents as a “public health” intervention (Money, 1978, p. 415). The efforts to “cure” gender variance in youth and therefore prevent adult trans identity harmed transgender and cisgender youth alike. For instance, the “sissy boy” study targeted feminine behaviors regardless of sexual orientation or gender identity; all researchers involved rationalized their treatment as preventing adult transsexual identity, though some diverged on the prevention of homosexuality as a treatment goal. Sexual orientation and gender identity change efforts are therefore often intertwined. A recent apology statement released by the Association for Behavioral and Cognitive Therapies (ABCT, 2022) and resolutions published by the American Psychological Association (APA, 2021a, 2021b) acknowledge the harms of these change efforts for both sexual and gender minorities.

Comprehensive Assessment

I fear if we set up a clinic for transsexualists, the jolly thing would be used! (EEF, 1969a, pt. 1)

Mental health providers who were willing to support TGD individuals’ access to gender-affirming care often expressed cultural unease and fear of legal liability. This was in part due to the newness of this care and potential of media backlash—candidates for access to care faced a bottleneck of specialty clinics with few resources, and researchers chose candidates they thought

would represent “successful” cases in the media. As one professional at a gender identity symposium stated: “Conformity to the social morays, I think, is an important part of the decision. These individuals should not bring to themselves publicity or notoriety, nor to the surgeons that assist them” (EEF, 1969a, pt. 1).

Gender-Conforming Criteria

The ideal applicant for access to gender-affirming care, researchers discussed in the literature and in symposia, conformed to societal norms and ideals. They were binary (identifying exclusively as a woman or a man) and static in their gender identity, not “ambiguous” with nonbinary or fluid identities (Money, 1986, p. 381). They were heterosexual and financially well-off (EEF, 1971, pt. 6). Researchers rated their patients’ attractiveness (EEF, 1971, pt. 3). Gender identity “experts” stated the ideal candidate for access to care was an “ugly duckling” they could “rehabilitate” who could not otherwise assimilate into society—this, they thought, might “justify” altering sex characteristics as their patients desired (EEF, 1969b, pt. 2). Researchers stated:

It is not enough for the operation to make the patient more comfortable. There should be some medical indication as in the case of abortion, preferably signed by two psychiatrists, to an effect the operation is necessary [to not] mentally deteriorate. (EEF, 1969a, pt. 1)

Proof of Identity

Physicians and surgeons managed their fears of violating social norms and eliciting public backlash by enlisting mental health gatekeepers with whom to “share blame if something goes wrong” (Green, 1987, p. 7) and putting the onus on patients to “prove” gender-affirming care was justified. One provider at a gender identity symposium stated:

Never say “I will offer you surgery.” It is they who come asking for surgery, not wishing to be cured. I say that is your decision. It is up to you to prove, not for me to offer it to you... if they [are targeted by police, lose family ties, or lose their job]... it is their problem, not mine. (EEF, 1969a, pt. 1)

Multidisciplinary, Multistage

Mental health professionals were pivotal in this enforcement of gender-con-

forming criteria to gatekeep access to care. They provided comprehensive assessments of TGD individuals and judged whether a particular individual should be allowed to proceed in a multistage process to access care. For instance, the “bare minimum” process for diagnosing “the self-diagnosed transsexual” at Case Western Reserve listed 21 steps (Denny, 1992, pp. 10–11), a bulleted list of stages with no examples at the Clarke Institute took 10 minutes to read aloud (EEF, 1971, pt. 5), and another clinic’s bulleted list spanned four pages (Money & Primrose, 1969, pp. 133–136). Multidisciplinary teams of professionals (for instance, mental health providers, physicians, surgeons, endocrinologists, neuroendocrinologists, psychiatric sexologists, forensic psychiatrists, and others; EEF, 1971a, pt. 5) voted in consensus on whether patients should be allowed to proceed to the next stage of assessment or be rejected from the clinic—and therefore lose access to care.

Coercion

The process of assessment was often lengthy, humiliating, and coercive for TGD individuals. For instance, a psychiatrist at the Clarke Institute noted the clinic had signed consent to “videotape and photograph patients dressed and undressed”; patients, however, could not proceed to the next stage without completing the requirement (EEF, 1971, pt. 5). Clinics required “hostage money” of several thousands of dollars to be held by the clinic and given back over a period of years at mandated follow-up sessions (EEF, 1971, pts. 2, 5, 7). Trans individuals “consented” to clinic demands—or lost access to care.

Trans individuals wrote about their experiences of assessment in community magazines. One trans woman described a penile plethysmograph “pervert test” where researchers “put electrodes on my dick and showed me pictures of little naked boys being whipped”; this procedure was reportedly not uncommon (Denny, 1992, p. 15; Ghosh, 1979, p. 5). Trans patients reported that clinics forced them to change their names or occupations if clinicians deemed them too masculine or feminine, required lengthy inpatient stays for clinical observation, and gave “unsolicited tranquilizers” to unwilling patients (Denny, 1992, p. 15; Ghosh, 1979, p. 5). Again, there was usually nowhere for trans patients to go outside of the bottleneck of specialty clinics to access gender-affirming care. Despite the humiliating and expensive process of assessment, which often held

little chance of accessing care, trans people continued to fight to access gender affirmation. Reed Erickson of the EEF told researchers his experience of applicants rejected from clinics: “they come running to [the EEF] by sending us letters or tears... it might stop for you but it doesn’t stop for the individual” (EEF, 1971, pt. 7). The experiences of trans individuals were not reported in the academic literature, but trans individuals continued to make their voices heard.

Power and Control

Trans individuals pushed back not only on restrictive and normative criteria, but the power assessors held over their lives and bodies. As one trans person wrote in a community magazine, “They wanted me to be some kind of puppet, to dance on their strings, and I just couldn’t bring myself to do it” (Denny, 1992, p. 15). One trans woman stated she “didn’t need to pay someone to tell me what I already know” and wrote in her letter received by the EEF, “I feel this is my body and my life and why should other people be the judge of whether I should have this operation” (Anonymous, 1984a). Trans people of color and trans individuals who were low income often reported difficulty securing access to care. One gay ally criticized what they described as a researcher’s view that a “successful case ... has to look like a middle-class, white woman from suburbia” (Money, 1978, p. 401). Trans people expressed discomfort with the power of clinicians to decide who is “truly trans”; this gatekeeping disproportionately impacted trans individuals of color, low-income trans individuals, and trans individuals with disabilities, among others.

The Grapevine

Trans individuals often resisted clinicians’ normative criteria and care restrictions. However, trans individuals also feared public backlash and subsequent loss of access to gender-affirming care, and sought to police others in their community. These criticisms often centered multiply marginalized individuals, such as gender nonbinary or low-income trans individuals (Denny, 1993a, 1993b, 1999, p. 22). As one trans person in a community magazine wrote of Leslie Feinberg, who did not identify with a rigid male/female binary, “It’s the ones who change and are sorry, that give us all a bad image” (Anonymous, 1984b, p. 8). Via the community “grapevine,” trans people informed others in the community what criteria researchers

and clinicians sought in their patients. For instance, Miss Major Griffin-Gracy, a trans woman of color and community leader, stated that trans women of color learned to access hormone therapy by reciting expected narratives (such as saying they hated their penises). “We got the treatments. That’s all that counted,” she recalled (Ophelian, 2009).

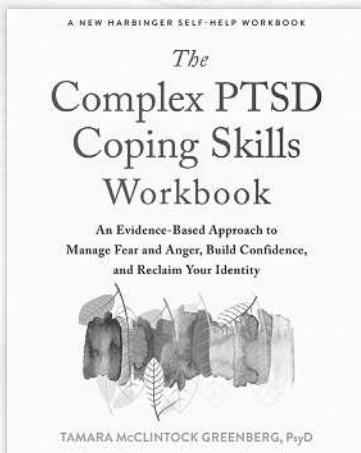
Gender Dysphoria

This community grapevine angered researchers, who pathologized “manipulative” trans individuals who seemed to be aware of their criteria (EEF, 1971, pt. 5). In time, many researchers and clinicians used the umbrella term “gender dysphoric” to describe their patients (Fisk, 1974b). Instead of verbally endorsing particular criteria, which were often subverted due to community knowledge of them, trans individuals would have to prove to clinicians over a period of time they could be “successful” in their desired gender expression before accessing care (the “real-life test”). For instance, one clinic instituted an in-house “charm school” where “successful” trans individuals coached others in appearance and behavior; if patients did not meet a clinician’s standards, access to care was delayed (EEF, 1971, pt. 7). The main proponent of gender dysphoria and the real-life test, Norman Fisk, stated of the shift: “An alternative at that time could have been to re-shape the entire program into a surgery upon demand situation, where only overtly psychotic or borderline individuals were excluded. Fortunately, we were not so disposed” (Fisk, 1974a, p. 8).

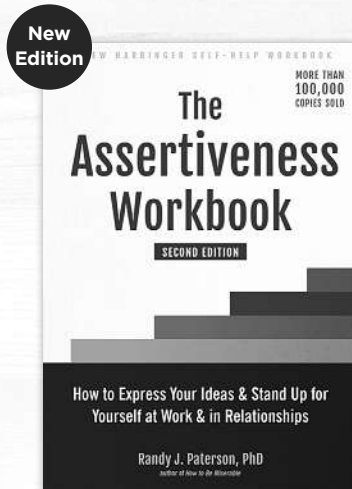
Therapeutic Exploration

In 1974, an academic publication stated that trans surgeries with established informed consent did not appear to be at risk of criminal liability from a legal standpoint (Holloway, 1974). The next year, psychologists concluded that “no surgeon in the United States has faced criminal charges for performing surgery” (Walker & Money, 1975, p. 311). Still, the growing privatization of care, and the potential of increased access to gender affirmation, alarmed researchers and clinicians. In 1978, one psychiatrist warned of a physician whose hormone prescriptions led to “200 self-diagnosed [women] transsexual candidates in the Philadelphia area alone” who received hormones “without ever having seen a psychiatrist... [for] therapeutic intervention or exploration” (Morgan, 1978, p. 276). Therapeutic intervention or exploration continued to serve

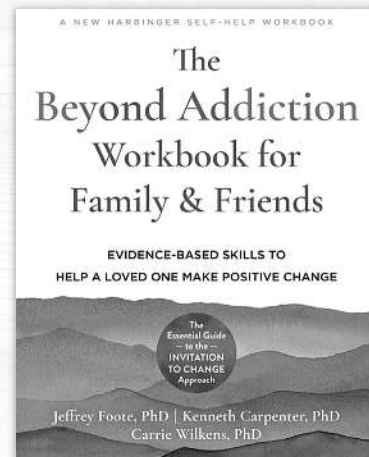
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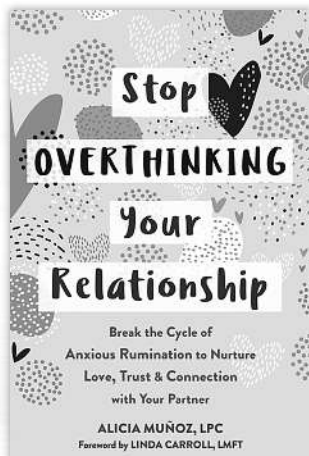
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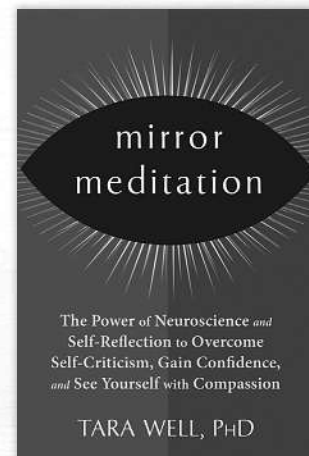
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as a code not for fluid supportive exploration of identity and embodiment, but for discovery of the “root cause” of an individual’s TGD identity—with the hope that some individuals could then be discouraged from transitioning.

Over time, DSM diagnoses and conceptions of gender diversity altered considerably. Decades of research and clinical work culminated in the 1980 DSM-III diagnosis of “transsexualism,” which then became DSM-IV “gender identity disorder,” and finally the modern DSM-5 “gender dysphoria” (Drescher, 2015). The ICD, used for medical coding, has similarly changed over time. The diagnosis label of ICD-10 “transsexualism” changed to the current ICD-11 “gender incongruence,” and the diagnosis moved from the “mental and behavioral disorders” chapter into the “conditions related to sexual health” chapter (WHO, 2020). Although early diagnoses recognized the legitimacy of trans identity and provided a pathway for care, they were also based on restrictive conformist ideals of gender. Overall, diagnostic changes have reflected depathologizing trends.

Criteria for access to care were altered over time in large part by the activism of trans people who were individuals of color, sexual minorities, nonbinary, fluid, and low income. Researcher and clinician conceptualizations of gender entirely neglected the expertise of indigenous gender diverse individuals. For instance, in North America many Native American tribes have specific terms and accepted roles for gender diverse individuals (the modern term *two-spirit* is often used as an umbrella term). Two-spirit peoples in America have been systematically oppressed, including targeted for murder by colonists (see Vasco Núñez de Balboa’s massacre of two-spirit people in the 1510s: Ochoa, 2016) and forced assimilation in Euro-American boarding schools, which have had lasting negative mental health effects (Evans-Campbell et al., 2012). Researchers involved in early gender identity work typically ignored two-spirit peoples, and certainly did not discourage the assimilationist work of boarding schools. Indigenous and cross-cultural knowledge of gender continues to be marginalized in much of the academic work on gender identity.

In sum, researchers and clinicians, mental health providers primary among them, sought to cure, prevent, and normatively assimilate TGD identities. Though researchers and clinicians are not a monolith, many wrote and spoke exhaustively of

the criteria to choose who few “true transsexuals” among many applicants should be allowed access to gender-affirming care. Trans individuals subverted clinicians’ criteria, and, despite humiliation and coercion, sought to claim their own embodiment. Though data continued to show over the span of decades that rates of posttransition regret are very low (Bustos et al., 2021), clinicians and researchers have in many cases not decreased advocacy for the importance of assessment and restrictions on access to gender-affirming care.

Applications for the Present

I’m really being pressed to do the counseling to make others comfortable with my decision ... so it bothers me that this is pitched as being “for my own good.” (Murphy, 2016, p. 1080)

Clinician Uncertainty

Clinicians continue to experience the same uncertainty described by Richard Green in 1987 that they might “green light” a patient and, without prolonged documentation, be blamed if a patient experiences posttransition regret (Green, 1987, p. 7). Trans patients are placed in the position of alleviating clinician uncertainty, which can impair trust and the working alliance between therapist and client (Moye, 2019; Poteat et al., 2013). Although rates of posttransition regret are very low (Bustos et al., 2021), clinicians continue to center the importance of comprehensive assessment, often overestimating the possibility of regret. Alternatives to lengthy and invasive assessment include the provision of care via informed consent, wherein a physician discusses with a patient their history and care goals and ensures they are able to understand the effects of a medical treatment, often by going point by point through a consent form detailing the effects of the desired treatment. This approach does not universally require a mental health gatekeeper, though a provider may request a mental health assessment when needed. Data exist on the use of informed consent for access to gender-affirming care; these data indicate low rates of regret or litigation (Deutsch, 2012). A full review of the informed consent model of care provision is beyond the scope of this paper; for more information, see Cavanaugh et al. (2016). Although the prevention of regret as a form of nonmaleficence maintains dominance in the medical and psychological literatures, trans experiences of harm

from assessment are often discounted. Latham (2017) wrote:

When the involvement of mental health professionals is framed as “psychological support” and inherently of benefit to the patient, this makes many trans people’s experiences of clinical treatment practices invisible. (Latham, 2017, p. 54)

Emotional Harm

The documented emotional costs of assessment for trans individuals include fear and anxiety (Brown et al., 2020; Davy, 2015; Waszkiewicz, 2006), feeling intruded upon, invaded, or vulnerable (Latham, 2013; Waszkiewicz, 2006), feeling patronized, insulted, dehumanized, or demeaned (Ashley, 2019b; Brown et al., 2020; Latham, 2017), and feeling resentment and anger (Budge, 2015; Budge & dickey, 2017; Latham, 2017). For instance, Latham (2017) wrote compulsory assessment for all trans individuals “patronizes trans patients ... by representing them as unable to rationally comprehend surgical possibilities and limits, somehow different from all other (nontrans) patients, who are assumed to be able to understand this information” (p. 52). A trans woman described her anger towards the process of assessment: “I resented need to hide my resentment or run the risk of being rejected as an uncooperative patient. I smiled politely and took the test” (Cummings, 1993, p. 353; Latham, 2017, p. 55).

A qualitative study reported parents of trans youth in the UK found gender clinic sessions “judgmental, intrusive, and inappropriate,” and said clinicians discouraged “listening to and validating their children” (Horton, 2021, p. 1). Parents reported pressure from clinicians to have children identify as cisgender:

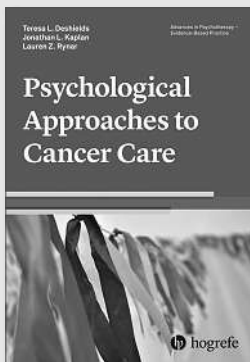
It does feel like, you know, the worst possible outcome would be that your child is trans. And it’s like, well, no, not really, the worst possible outcome is that my child is dead, because you didn’t give them the, the medical care that they needed. That’s the worst possible outcome—there’s nothing wrong with being trans. (Horton, 2021, p. 8)

Budge and dickey (2017) reported that patients are usually compliant with assessment but rarely neutral, and can experience sadness, anger, and shame. Other costs of assessment include financial barriers, which disproportionately impact low-income trans individuals, and experiences of prejudice from clinicians (such as a diag-

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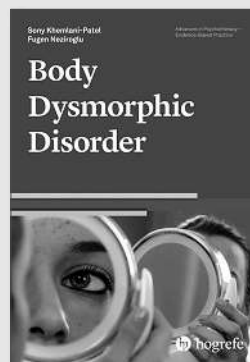


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nosis of psychosis based on a desire for a double mastectomy while identifying as genderqueer rather than male; Budge & dickey, p. 70).

The rapidly shifting legal landscape in the United States includes the imposition of stark barriers to care for TGD youth. As of June 2022, the Freedom for All Americans legislative tracker lists 25 anti-transgender medical care bans filed in the United States (Freedom for All Americans, 2022). Some of these bans include language that criminalizes providing evidence-based care with youth, including a felony charge in Alabama (Chandler, 2022). Efforts to deny, restrict, and delay care for TGD individuals are pervasive and ongoing. To learn more about what gender-affirming care for youth entails, see Salas-Humara et al. (2019) and Rafferty et al. (2018). Guidelines for care with gender diverse youth are published by the Endocrine Society and WPATH.

Questions for Clinicians

Mental health practitioners who view “trans bodies and lives [as] equally morally valuable to cis bodies . . . and lives” (Ashley, 2019b) should seriously consider the reported harms of comprehensive assessment. Why do some clinicians believe comprehensive assessment is universally necessary? Why does increasing identification with gender diversity elicit such alarm? Why do clinicians desire and at times demand “100% certainty” from their trans patients before accessing gender-affirming care (shuster, 2016, p. 325), when they would not do so when patients take on college debt, or have children, or get a tattoo? For clinicians who advocate compulsory exploratory therapy for TGD individuals, why is this? Do these clinicians believe therapy should be continued until a “root cause” is identified (Ashley, 2021)? Does therapy end when the patient identifies as cisgender, and if so, why (Ashley, 2021)? If clinicians believe gender-affirming care must be justified or only allowed as a last resort when all other potential explanations for gender variance have been exhausted, despite the wishes of the patient, why is this? Why do patients have to express a fixed identity before beginning transition when some patients desire identity exploration via experience, including pausing and resuming or stopping social or medical changes at any time (Ashley, 2019a; Turban & Keuroghlian, 2018)?

Supporting Trans Patients

Though trans individuals are not a monolith and their experiences with clinicians vary, harms from interaction with mental health providers in the past and present have been extensively reported. These harms are often underrecognized or discounted as necessary to the prevention of posttransition regret, despite empirical evidence that rates of regret have always been and continue to be low in both assessment and informed consent-based care (Bustos et al., 2021; Deutsch, 2012). As marginalized individuals already carrying the burden of health disparities and minority stress (Delozier et al., 2020; Tan et al., 2019), trans patients should not have to alleviate the anxieties of their clinicians. Instead, clinicians can support their trans patients, including recognizing the expertise of patients’ experience and ability to make informed decisions about their bodies. Clinicians should be aware of how assessment criteria to access gender affirmation often privilege binary and socially conforming identities over nonbinary and fluid ones. Finally, clinicians can support their trans patients by questioning their position of privilege and power to decide who is “trans enough” to be allowed access to care, along with advocating for care access that respects patient autonomy.

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- ...
- This analysis represents a portion of a master’s thesis submitted to the University of Massachusetts Boston. Portions of these findings were presented as a poster at the

2020 American Psychological Association virtual conference. This article draws on a larger archival research project, which has been submitted for publication (cited in the text as “publication forthcoming”). There are some archival quotes from this larger project in the current article, in addition to archival quotes original to the current article. What distinguishes the

current article is its brief historical and modern review format focusing specifically on harms to trans communities, rather than an encompassing 30,000 word purely historical qualitative project. I have no conflicts of interest to disclose.

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CLINICAL PRACTICE FORUM

Obsessive-Compulsive Disorder and Co-Occurring Nonsuicidal Self-Injury: Evidence-Based Treatments and Future Research Directions

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OBSESSIVE-COMPULSIVE DISORDER (OCD) and nonsuicidal self-injury (NSSI) co-occur at a rate 2 to 5 times that of each condition individually (Bentley et al., 2015; Garrison et al., 1993; Patel et al., 2021). Yet, surprisingly little research exists on this topic and few providers feel comfortable treating the complex interaction of co-occurring OCD and NSSI.

Potential Barriers to Treatment Access and Implementation

It is important to consider the context surrounding the high need and lack of resources for patients with this comorbidity. Treatments for OCD and NSSI are both highly specialized, with many providers not comfortable treating either condition. Exposure-based therapy for OCD is underutilized due to lack of education and negative beliefs about exposure (Reid et al., 2018). Similarly, health service providers and mental health professionals lack adequate training and confidence and can experience negative responses in regard to

assessment, case conceptualization, and treatment for NSSI (Andover, 2012; Lloyd-Richardson et al., 2020). Both NSSI and OCD face stigma (Burke et al., 2019; Ponzini & Steinman, 2021). People with OCD face long (approximately 10 years) gaps between symptom onset and accessing proper treatment (Law & Boisseau, 2019), and adolescents with suicidal behavior and NSSI show gaps (1–2 years) between symptom onset and help-seeking as well (Lustig et al., 2021). As a result, there are limited resources available for these two populations. Finding providers who are able to provide evidence-based care for both conditions is difficult given that many focus on either OCD or NSSI. By specializing, providers can more effectively treat these challenging conditions. Nevertheless, OCD providers often refer outpatients with comorbid NSSI, and providers who treat NSSI may only focus on the NSSI and not address the OCD.

In the current paper, we provide a starting point for clinicians and researchers to gain an understanding of this unique

comorbidity. We summarize the existing research, highlight the unique factors present in this population, and illustrate how to address co-occurring OCD and NSSI using a case example. Corresponding parts of the treatment process for the case are embedded in each relevant section. We end with a call for future research on this important and understudied topic.

OCD

OCD affects approximately 1–2% of the population, with a bimodal age of onset in childhood and early adulthood (Anholt et al., 2014; Ruscio et al., 2010). It entails both obsessions (repetitive, unwanted intrusive thoughts that cause distress) and compulsions (repetitive mental or physical behaviors engaged in to reduce anxiety; American Psychiatric Association [APA], 2013). Symptoms tend to align with four themes: unacceptable thoughts, symmetry, responsibility for harm, and contamination (Abramowitz et al., 2010). Both obsessions and compulsions fall under these categories and should be considered dimensionally in terms of time taken up, severity, frequency, and level of impairment (Abramowitz et al., 2010). OCD leads to reduced quality of life across the lifespan, and comorbid conditions exacerbate the experience (Macy et al., 2013; Pozza et al., 2018; Storch et al., 2018). Effective evidence-based treatments exist for OCD for both children and adults, including cognitive behavior therapy (CBT) with exposure with response prevention (ERP). Medication management primarily includes use of serotonin reuptake inhibitors, although not all patients respond or fully remit (Del Casale et al., 2019; Eisen et al., 2013; Öst et al., 2016; Reid et al., 2021; Skapinakis et al., 2016).

NSSI

NSSI is the deliberate, self-inflicted destruction of body tissue (e.g., cutting,

scratching, carving, burning skin) without suicidal intent and for purposes not culturally sanctioned (International Society for the Study of Self-Injury, 2018). Most commonly occurring among adolescents and young adults, as many as 20% of secondary and post-secondary students engage in NSSI (Muehlenkamp et al., 2012; Swannell et al., 2014). A meta-analysis of 56 studies explored the relationship between NSSI and a variety of mood, anxiety, and other emotional disorders and found those engaging in NSSI were significantly more likely to also have an emotional disorder (other than bipolar disorder or social anxiety disorder), although the magnitude of these associations did not differ across disorders (Bentley et al., 2015). NSSI is now included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; APA, 2022) as a disorder for further study. Earlier research by Gratz et al. (2015) found that, among young adults with recent recurring NSSI, 37% met criteria for non-suicidal self-injury disorder (NSSI-D). Those with NSSI-D had greater clinical severity, a greater number of forms and functions of the behavior, and higher rates of emotional dysregulation and psychopathology compared to those without NSSI-D. NSSI is distinguished from suicidal thoughts and behaviors (STBs) on several key dimensions (Hamza et al., 2012): motives (NSSI is engaged in to cope with life's demands, while STBs are driven by a desire to end life); frequency (NSSI is typically engaged in more frequently than suicidal behaviors); and methods (more lethal forms of injury are often used in suicidal behaviors). Nevertheless, NSSI remains the most reliable predictor of STBs (Ribeiro et al., 2016; Whitlock et al., 2013), as those with a history of NSSI are 2–5 times more likely to report later STBs (Kiekens et al., 2018).

OCD, NSSI, and Emotional Disorder Co-occurrence

NSSI is often conceptualized within a broader continuum of self-harm that encapsulates indirect forms of self-damaging behaviors (e.g., disordered eating, repetitive compulsive skin picking/washing, substance use) along with behaviors that result in direct, immediate physical injury. Both sets of behaviors are often engaged in to reduce aversive internal experiences and are maintained by negative reinforcement, thus potentially explaining the high comorbidity between NSSI, anxiety and eating disorders, and

other emotional disorders (Bentley et al., 2015; Muehlenkamp & Tillotson, in press). Despite the potential parallels, NSSI has largely been overlooked in relation to OCD. However, Bentley et al. found a pooled odds ratio of 1.94 for the association between an OCD diagnosis and NSSI. An early study reported that youth with OCD were over five times more likely to engage in NSSI than youth without OCD (Garrison et al., 1993; see also Bolognini et al., 2003), and a study of treatment-seeking adolescents reported that 4% of those with NSSI were diagnosed with OCD (Washburn et al., 2012). Most recently, within a sample of 124 veterans, Patel et al. (2021) found that only two diagnoses predicted clinically severe NSSI: OCD (OR = 3.23) and borderline personality disorder (OR = 7.67). Other studies indicate that even among those with borderline personality disorder (McKay et al., 2000) or eating disorders (Claes et al., 2021), OCD symptoms are significantly elevated and associated with NSSI engagement, suggesting there is an important connection underlying OCD and NSSI.

Within the DSM-5-TR criteria for OCD and NSSI-D (APA, 2022), there appears to be meaningful overlap in the defining features of both disorders. For example, proposed NSSI-D criteria include: (a) that there is planning and preoccupation over the behavior, (b) it causes clinically significant distress, (c) one may engage in the behavior with an expectation to reduce negative feelings, and (d) it does not occur only in the context of intoxication or psychosis. Similarly in OCD, obsessions are recurrent, persistent, intrusive, and distressing. Compulsions are performed with an expectation that distress will be neutralized or reduced. Obsessions and compulsions take up time, cause distress, and occur outside of substance intoxication or psychosis. OCD and NSSI-D symptoms appear to overlap with recurring preoccupation with symptomatic thoughts and expectations that behaviors (compulsions or NSSI) will reduce distress.

Some studies have described repetitive engagement in NSSI as having obsessive (e.g., ruminative cravings, urges that are hard to resist) and compulsive features (e.g., habitual, repetitive, and rigid self-injury routines), further highlighting shared characteristics between NSSI and OCD (Jurska et al., 2019). Similar to OCD, acts of NSSI are often preceded by unwanted, distressing thoughts and emotions that contribute to increasing aversive tension, which is released by engagement

in the self-injurious act, thus temporarily regulating arousal and stress. In addition, some work suggests NSSI and obsessive-compulsive related disorders should be considered along a spectrum of impulsivity and compulsivity due to these shared features (e.g., Jurska et al., 2019; McKay & Andover, 2012). While there is growing evidence that NSSI and OCD frequently occur together and may share similar risk vulnerabilities, as discussed in the next section and in Browning and Muehlenkamp (in press), this specific area of research is novel and understudied, limiting insights and recommendations for treatment.

Transdiagnostic Vulnerabilities

Emotion Dysregulation and the Biosocial Theory of Emotion

Emotion dysregulation is defined as the inability to regulate one's intense emotional arousal (Linehan, 1993). Heightened emotions interfere with an individual's goals, self-control, and ability to reason (Fruzzetti & Worrall, 2010), potentially influencing engagement in avoidant behavior to temporarily escape from distress (Fruzzetti et al., 2005). While everyone can experience emotional dysregulation, for some people it can be chronic, distressing, and influence functioning (Fruzzetti et al., 2008). Linehan uses the biosocial theory to describe the transaction between the biological and environmental components that can develop into emotional dysregulation for some people (Fruzzetti et al., 2005; Fruzzetti & Worrall, 2010). The theory posits both biological components contributing to emotional vulnerabilities that relate to someone's sensitivity and intensity of emotional experience, as well as environmental vulnerabilities resulting from perceptions of people in someone's environment as not validating these strong emotions (Koerner, 2012; Linehan). These biological vulnerabilities can impact responses from others and vice versa (Fruzzetti et al., 2005).

Dysregulated Behaviors

Bresin's (2020) conceptualization of dysregulated behaviors is helpful when considering OCD and NSSI. Dysregulated behaviors are hard to control, are active behaviors engaged in for short-term benefits such as avoiding difficult emotions, and they are associated with long-term distress and impairment in functioning (Bresin; Selby & Joiner, 2009). Dysregulated behaviors are distinct from compulsive behaviors in that most compulsive behaviors are

inherently performed to avoid poor outcomes (Bresin). Thus, both OCD and NSSI are dysfunctional avoidance strategies people engage in for short-term benefits like escaping unpleasant emotions; they have associated long-term distress and impairment; and they can be hard to control. Also, while compulsive behaviors are not inherently harmful, over time they can become harmful, and dysregulated behaviors can be performed compulsively (Bresin).

Rumination and Attention

Rumination is repetitive and frequent thought about oneself in regard to goals or concerns and it can be constructive or not constructive (Watkins, 2008). It can lead to intensifying of negative emotional experiences and then engagement in risky behaviors, and can become a habitual way of processing information in response to lack of goal-directed behavior, which again increases risk (Gillan & Robbins, 2014; Gillan et al., 2016; Selby et al., 2013; Watkins & Roberts, 2020). Challenges with rumination are partly due to heavy atten-

tional focus on relevant stimuli and difficulties switching away from it. This may be due to the powerful initiation of biological processes that can enhance pleasurable feelings immediately following NSSI, thus increasing the salience of NSSI-related stimuli during times of distress (Bresin & Gordon, 2013; Glenn et al., 2017; Halicka-Masłowska et al., 2020). Rumination is relevant in OCD as well, as it leads to increases in OCD symptoms over a 24-hour period (Wahl et al., 2021). Further, with OCD there are associated difficulties in shifting attention away from relevant stimuli and beliefs about attention and lack of confidence in one's senses, memory, and decision making (Ouimet et al., 2019).

Expectancies

Expectancies of situations and behaviors are a core part of both maintenance and treatment of psychopathology, aligning with outcome expectancy theories that people engage in based on the nature of what they expect to happen (Bandura, 1977, 1982). Thus, treatment should facilitate violation of such expectations (Rief et

al., 2015). These ideas align with rule-governed behavior (RGB) in the context of relational frame theory (Hayes et al., 2006), which sets up an "if-then" verbal rule that is learned and internalized and gives context to behavior (Törneke et al., 2008). An example if-then rule for NSSI might be: "If I cut myself while feeling difficult emotions, then I will be able to tolerate them." This verbal rule then can lead to reliance on engaging in NSSI, and subsequent reductions in alternative behaviors to NSSI that involve more flexible responses to challenging emotions (Lynch & Cozza, 2009). A similar rule for engaging in compulsions and ruminating on obsessions may relate to feelings of uncertainty and related distress or feelings of lack of control, which could reinforce and maintain OCD as well as NSSI thoughts and behaviors.

Cognitive Control

Cognitive control encompasses executive function processes of impulsivity (e.g., inhibition of urges), shifting between tasks (e.g., changing mental sets/focus), and monitoring working memory (maintain-

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ing and updating current information; Hofmann et al., 2012). It facilitates engagement in goal-directed behavior and responses to new situations (NIMH, n.d.). Research has demonstrated that all psychiatric disorders (Abramovitch et al., 2021), as well as NSSI (Lockwood et al., 2017), are associated with some level of cognitive control dysfunction. Difficult emotional experiences potentially reduce ability to utilize cognitive control processes and regulate emotions and behaviors (Hofmann et al., 2012).

While NSSI and OCD have been conceptualized on a spectrum of impulsivity to compulsivity (Jurska et al., 2019; McKay & Andover, 2012), perhaps both impulsivity and compulsivity originate from a general sense of behavioral disinhibition, with strong emotions or symptom-relevant beliefs influencing the impulsive or compulsive actions (Fineberg et al., 2010; Hudiburgh et al., 2021; Ouimet et al., 2019). This strong influence of thoughts/beliefs also aligns with the construct of cognitive fusion, or taking thoughts as truths and forming behavioral rules (Hayes et al., 2011). Finally, compulsive and other repeated dysregulated behaviors like NSSI might develop from increased reliance on habits when flexible responding is impacted due to fusion with thoughts (Gillan et al., 2016).

Evidence-Based Treatments

The gold-standard treatment for OCD is ERP (Harvey et al., 2022). ERP involves helping a patient systematically come into contact with their anxiety-provoking stimuli at a tolerable level of distress and doing so without engaging in neutralizing or compulsive thoughts or behaviors. It is a collaborative treatment process, where the therapist and patient work together to develop and execute exposures (Harvey et al.). Both CBT and cognitive therapy (CT) are supported for OCD (Olatunji et al., 2013) but both often include some element of exposure (Harvey et al.).

Importantly, ERP can be tailored to the patient's needs, focusing to a greater extent on comorbid symptoms or family involvement, for example (Harvey et al., 2022). Throughout treatment for OCD, there should be careful assessment for suicidal ideation or self-harm; ERP should continue as it reduces OCD and depressive symptoms, but strategies to regulate emotions may be relevant for use outside of the context of exposures (Harvey et al.).

Specific techniques from dialectical behavioral therapy (DBT) are useful potential adjuncts to ERP to help with regulating emotions. DBT is particularly beneficial for improving emotion dysregulation (Dimeff & Linehan, 2001), and utilizes individual therapy, skills training, telephone coaching and therapist consultation to deliver change-oriented behavioral strategies and acceptance strategies that communicate compassion and validation in order to increase behavioral abilities, enhance motivation for change, and generalize skills in a supportive environment (Dimeff & Linehan; Linehan, 1993; Swenson, 2016). A recent meta-analysis by DeCou et al. (2019) found DBT reduced self-directed violence, including both NSSI and STBs, as well as frequency of psychiatric crisis services.

Harvey et al. (2022) discuss acceptance and commitment therapy (ACT) as another avenue for treatment for OCD, involving mindfulness and acceptance techniques to help a client shift their relationship with their thoughts and act in a valued direction. ACT is an evidence-based therapy that works for a wide variety of conditions, including OCD, although there are few studies for suicidal ideation or NSSI (Bluett et al., 2014; Gloster et al., 2020; Tighe et al., 2018). ACT is a viable addition for further tailoring treatment for OCD and NSSI to support mindfulness and acceptance of urges and valued behavior, perhaps particularly for NSSI given its focus on life-interfering behaviors and unconditional acceptance of internal and external experiences (Browning & Muehlenkamp, in press; Stanley et al., 2014). Importantly, ACT does not include change strategies like DBT, so DBT is still important to support people with extreme emotional experiences; nevertheless, ACT may be a useful adjunct for healing (Lynch & Cozza, 2009).

Currently, there is further movement towards transdiagnostic treatments for emotional disorders. The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP), developed by Barlow et al. (2017), is one such option that targets underlying cognitive and emotional vulnerabilities to promote more adaptive emotion-regulation skills and is effective for many emotional disorders, including NSSI (Bentley, 2017; Cassiello-Robbins et al., 2020) and OCD (Sakiris & Berle, 2019). More broadly, there is a push for process-based therapy, or treatments based on relevant tools and processes derived for an individual patient based on an idiographic function analysis (Hofmann & Hayes,

2019). Many clinicians already operate in this way, as is described in this paper's case example.

Family Involvement in Treatment

• OCD

Family involvement can have positive and negative effects on OCD treatment (see Thompson-Hollands et al., 2014, for a comprehensive review). Family involvement in treatment can occur across the lifespan and may be especially relevant for younger ages given children's lower insight into symptoms, and parents' stronger inclination to reduce distress. For this reason, family use of accommodation must be explored. Accommodation involves adjusting behaviors to reduce distress or time spent experiencing OCD symptoms and can take many forms. While it is natural to want to reduce a family member's distress, in the long run it impacts their ability to learn to manage their distressing internal experiences in treatment. Family-based treatments include psychoeducation and skills training related to accommodation, as well as coaching on how to effectively support a loved one through an exposure.

• NSSI

Families are also an important part of treatment for NSSI, especially for youth as advocates and helpers; parents should be supported to engage in self-care, to manage their own distress, and to support each other, and they should be provided with psychoeducation about NSSI and other coping skills (Arbuthnott & Lewis, 2015). Waals et al. (2018) explain the dynamic between NSSI and family distress in their proposed family distress cascade theory. When a youth engages in NSSI, caregivers often experience confusion about how to react and report feeling guilt, fear, and shame. This cascade of negative feelings and self-appraisals may lead to hypervigilance and increased caregiver efforts to control the youth's behavior. This is often met with resistance on the part of the youth, who may perceive this control as intrusive and an invasion of privacy, which leads to poorer family functioning and increased risk of NSSI. Thus, family involvement in treatment must address this tension often experienced in families trying to find equilibrium between healthy connection and a youth's desire for autonomy and independence, as well as connection and valuable support from loved ones.

See Table 1 for considerations in applying treatments for both conditions.

Case Example Summary

B was a 15-year-old female with previous diagnoses of OCD and major depressive disorder (MDD), who presented to our specialty OCD clinic (AF and RS) for virtual treatment of OCD at a higher level of care following unsuccessful treatment at the outpatient level. She was diagnosed with OCD 1 year prior, despite symptoms being present for approximately 10 years. B described herself as “a bad person” who was deserving of punishment, and stated that, “the universe made a mistake giving me a relatively good life.” Relatedly, she reported fears of not telling the truth and specifically sought certainty that she had an OCD diagnosis, or else she feared she was a terrible person who was malingering. Her parents (divorced) reported that she was “a consummate rule follower” who had appeared anxious since early childhood. She reported passive suicidal ideation, though she also stated that suicide was too frightening to attempt. B also engaged in daily NSSI, which she described as “the best 20 minutes” of her day. She stated that self-harm served multiple functions, including as a way to make her thoughts stop, a punishment for having a life she did not deserve, and a reward at the end of the day. Specifically, she would cut her arms and legs 40 to 50 times using scissors either in the shower or in bed at the end of the day, frequently drawing blood. She also restricted her eating in part due to body

image concerns and in part due to its role in providing punishment; her restricted eating was monitored during treatment and never rose to a level of medical concern.

Assessment and Initial Treatment for B

Upon admission to our clinic, the clinical team completed a thorough assessment with B to better understand her specific behaviors that were influenced by OCD, as well as her attempts at emotion regulation. Her clinical team completed weekly Children’s Yale Brown Obsessive Compulsive Scale (CYBOCS) assessments (Scahill et al., 1997) with her to monitor changes in her OCD symptoms, standard for treatment in the program. In the early stages of treatment, B endorsed more distress from her OCD symptoms and some engagement in NSSI, although the extent of the NSSI was later determined to be greater than initially presented.

The initial plan of care was to address the presenting OCD symptoms while managing the NSSI with DBT skills as an adjunctive component of treatment. Through consultation with a DBT expert (AC), B was introduced to skills for emotion regulation and distress tolerance, utilized behavior chains to increase insight into antecedents of their NSSI, and engaged in self-compassion and behavioral

activation. Diary cards were implemented to track NSSI, with frequent check-ins implemented to review any NSSI behaviors or urges that arose. In the other half of her treatment day, B’s recurring thoughts that she was a terrible person, including the thought that she was fabricating OCD symptoms for attention, were the focus of her work with ERP and ACT. Initial treatment for these thoughts focused on psychoeducation regarding the function of attempting to control thoughts and seek certainty and increasing B’s comfort discussing these thoughts. During this phase, B would report being surprised to learn that some of her presentation could be understood as OCD, (for example, her compulsion to confess). She engaged in cognitive defusion work as an early intervention to distance herself from the cycle of seeking certainty that she was a good person.

There was initial improvement in B’s insight into OCD and her comfort discussing her symptoms, and seemingly the self-harm decreased as well. Further, B was able to reveal and describe more significant fears of causing harm to herself or others. However, as she progressed through her treatment for OCD, there was a sudden increase in NSSI behaviors and reported symptoms of worthlessness, guilt, and hopelessness. On one particularly challenging day, B began self-harming with scissors during a virtual group session. Despite staff

Table 1. Considerations in Treatment Components for OCD and NSSI

OCD Specific	NSSI Specific	Shared Elements
<ul style="list-style-type: none"> Exposures towards feared stimuli in relation to obsessions and compulsions, performed without distraction, relaxation, or avoidance Develop skills for acceptance and tolerance of uncertainty Family involvement as needed to reduce accommodation and reassurance specific to obsessions and compulsions 	<ul style="list-style-type: none"> Develop safety plans and skills to tolerate acute distress and maintain safety Develop skills to neutralize and manage distress and urges directly related to self-harm Develop understanding of NSSI specific expectancies, precipitating situations, and adjusting accordingly 	<ul style="list-style-type: none"> Support family to maintain their own self-care and tolerate distress Support family to understand rationale of treatment and their role in creating a recovery-conducive family environment Facilitate mindful awareness and distance from thoughts to support client agency in their behaviors Increase awareness of values and behavioral activation to facilitate more adaptive behaviors in replacement of symptoms Understand core cognitions, expectancies, or events that may act as antecedents or maintaining factors of both sets of symptoms Support development of self-compassion, spontaneity, curiosity, and flexible responding in everyday life for client

being unaware of what was happening off camera, B noted looking for confirmation that the staff running the group were in agreement with her self-harm when they did not stop her.

A chain analysis revealed that while the thoughts shaped by OCD seized the opportunity to confirm certainty that others thought she was a terrible person, the NSSI itself originated from difficulties with emotion regulation, having felt triggered by hopelessness in the group, and an attempt to boost her mood. At this time, treatment shifted to be more DBT focused rather than the joint approach initiated at the start of treatment. B continued to report increasing depressive symptoms along with increasingly frequent obsessions about being a bad person.

DBT Focus

Partway through treatment, B reported an aborted suicide attempt in which she attempted to cut herself with scissors in order to end her life as a result of feeling overwhelmed by intrusive thoughts and feeling hopeless about treatment. She did not immediately share this information with her parents or therapist but was forthcoming when explicitly asked about recent self-harm. At this point, the decision was made to exclusively focus on DBT skills first to address the NSSI, suicidal urges, and emotion dysregulation. B subsequently spent 6 weeks in an acute residential facility that focused on DBT skills prior to returning to the program. She reported that she found the DBT skills helpful, particularly for refraining from self-harm, but that her OCD worsened while in the DBT program as a result of the reassurance from staff and emphasis on distraction techniques as a coping strategy. The acute residential facility provided excellent care geared toward addressing NSSI; however, without specializing in OCD, the care provided could not successfully walk the line between the two psychiatric concerns. While DBT and ERP can be consistent, a deeper theoretical understanding of the presenting problem must be obtained in order to introduce the combined skills of each treatment to provide a successful marriage of the two. The reassurance provided and focus on decreasing intense emotional states inadvertently fed OCD while addressing the NSSI. Her intrusive thoughts became so strong during the program that at times she had a hard time distinguishing her thoughts from reality.

ERP Focus

Upon returning to the program, B's treatment primarily centered on ERP for OCD. At this point, it had been approximately 6 weeks since her last instance of self-harm. This allowed us to safely address her fear that she could not be trusted around sharp objects because she might lose control and harm others, while also giving her an opportunity to practice using skills to refrain from self-harm in "real-world" scenarios, such as being around a pair of scissors. Exposures included engaging in self-compassion exercises rather than punishing herself to address her fears of being a bad person, being around sharp objects rather than avoiding them, engaging in imaginal exposures to address her harm-related fears, and interacting with content designed to bring up existential fears to address her newer existential OCD concerns. She also practiced "having fun" as an exercise in self-compassion and as behavioral activation.

Special Considerations

Although the DBT skills helped B with emotion regulation, distress tolerance, and refraining from self-harm, she also found herself using the skills to avoid intrusive thoughts and reduce anxiety in a manner inconsistent with ERP. Thus, a core focus during the remainder of treatment was on helping B determine when using a DBT skill was helpful (e.g., listening to music to cope with self-harm urges) vs. an avoidance strategy (e.g., listening to music to drown out intrusive thoughts). Relatedly, she practiced noticing the distinction between engaging in valued activities as a "towards" move vs. a move "away" from distressing, intrusive thoughts.

Special care was also taken when designing ERPs to address B's harm-related fears. We worked to balance maintaining safety (e.g., limiting access to sharp objects while alone) with ERPs targeting harm fears (e.g., holding scissors when around others). B was taught to distinguish helpful avoidance of sharp objects (e.g., in response to self-harm urges) vs. OCD-driven avoidance (e.g., out of fear of harming others) and how to adjust her response as needed.

Family Involvement and B's Treatment

B's family was involved in weekly family therapy to increase family communication and support. As she became more comfortable discussing her OCD, B was able to share more about her obsessive thoughts with her family, which increased mutual

understanding and helped parents make choices that did not inadvertently contribute to worsening OCD. B's parents quickly understood the rationale for reducing reassurance and accommodation and sessions also focused on increasing validation. For instance, B became more comfortable sharing about her self-harm urges, and family sessions incorporated safety planning and how parents could support B when experiencing those urges. Family work also focused on increasing authoritative parenting and utilizing ACT to help parents make values-based decisions and tolerate their own distress when B was experiencing symptoms. Her parents continued to co-parent well and joined together in holding hope for B, praising progress, and fortifying a sense of family in each household. To conclude her family work, B shared about her OCD with her younger sibling, whom she had previously shielded from her experience as a compulsion to protect them.

Conclusion

Conclusion of B's Treatment

As B moved toward the end of treatment, we saw her increasingly using her skills for urges to self-harm, which were significantly less frequent. She was self-directing more through challenging ERPs, creating ERP opportunities, and thinking about the appropriateness of each intervention for the presenting challenge. For example, B would come to her therapist when she noticed she was overusing distraction as a skill for anxiety rather than urges to engage in NSSI. Before discharge, B completed her most challenging ERP, an imaginal exposure incorporating harm and sexual obsessions. She was no longer engaging in NSSI or suicidal thoughts, was able to demonstrate self-compassion, and reported "finally seeing life at the end of the tunnel" and envisioning a future for herself. Her longer-term goals for outpatient care were to be able to choose and maintain healthy relationships with friends, and to practice increasing flexibility, spontaneity, and having fun. She was discharged to outpatient care with a combination of DBT and ERP twice a week.

Future Directions

This paper integrated a case example with a brief but nonexhaustive literature review. OCD and NSSI can each be debilitating conditions (Browning & Muehlenkamp, in press; Patel et al., 2021), so future work exploring the co-occurrence

of OCD and NSSI across contexts (colleges, community samples, residential, etc.) and across the lifespan is critical. Research should explore relevant transdiagnostic constructs spanning experimental to implementation projects to facilitate earlier diagnosis and treatment access. The role of sleep is also worth considering, given various aspects of sleep relate to both OCD and NSSI symptoms, and comorbid symptoms (emotion dysregulation, depression, PTSD) are also relevant in OCD and NSSI's relationships with sleep (Burke et al., 2022; Cox & Olatunji, 2020; Khazaie et al., 2021; Nota et al., 2015).

In therapy, clinically relevant cognitive, emotional, acceptance, and mindfulness evidence-based treatment components should be thoughtfully implemented based on patient needs demonstrated via functional assessment (Kazdin, 2019). A transdiagnostic, client-focused research program maps onto the current movement towards process-based therapy (Hoffman & Hayes, 2019). B's treatment process demonstrates the importance of concurrently targeting both OCD symptoms and co-occurring NSSI. As illustrated with the case example, it is important that the patient is always practicing managing both sets of thoughts and behaviors so that one is not inadvertently reinforced and used as a coping strategy during treatment for the other.

Throughout all this work, it is essential that clinicians adopt an approach anchored in respectful curiosity (Walsh, 2012), and one that conveys a genuine desire to understand and support the patient. Providers must walk alongside patients to investigate together the functions served by their symptoms and to choose skills and tools that will best facilitate the process of a patient engaging with and building a values-driven life.

While specialized training is vital to ensuring fidelity to evidence-based treatments such as ERP and DBT, more collaboration, consultation, and opportunities for education are needed to support clinicians to treat complex comorbidities such as OCD and NSSI. Clinicians should receive a base knowledge and experience utilizing all major evidence-based treatments (e.g., CBT, ACT and DBT) that should include targeting negative beliefs about exposure therapy and evidence-based practice, as well as opportunities for in vivo practice (Reid et al., 2018). Multiple reviews of best practices for training providers in evidence-based interventions have demonstrated the importance of an

active learning component like consultation, the usefulness of online and in-person approaches and train-the-trainer models, the importance of emphasizing behavior change, the importance of good supervision, and the importance of taking a systems-contextual approach to this issue (Beidas & Kendall, 2010; Frank et al., 2020).

With the rise of telehealth and other teleworking communication modalities, more opportunities for consultation could be facilitated like what occurred organically within the hospital where B was treated. OCD specialty providers could have a foundational knowledge of other skills and tools to use to support patients struggling with emotion dysregulation. Then, a second level of support could involve consultation with primary DBT experts who could support them to integrate skills targeting the relevant behaviors. The opposite could occur for someone seeking primary DBT treatment who was also showing OCD symptoms.

Finally, stigma and lack of awareness about symptoms and treatments are barriers to seeking and accessing diagnoses and treatment (Glazier et al., 2015; Pumpa & Martin, 2015). If recommendations are followed and providers receive more knowledge/opportunities for knowledge about treatments for OCD and NSSI, this could help somewhat alleviate stigma and lack of awareness of treatments among providers and those they work with. Psychoeducational programs about both OCD and NSSI should be developed and tested for use within schools or other community settings (Glazier et al.; Pumpa & Martin). Those who come into contact with patients, such as school professionals, primary care physicians, and religious figures, should receive some education on OCD, NSSI, emotions and intrusive thoughts more broadly, and available treatment resources. And finally, those with lived experience who are willing to share their stories can help to increase community awareness and understanding.

It is important that all of these recommendations are carried out thoughtfully and systematically to maintain integrity and fidelity of information and treatments, and safety for all involved. By working to increase education and awareness on OCD and NSSI, training in relevant evidence-based treatments, and spreading the awareness and information to multiple community stakeholders, we can help hasten access to successful treatment and reduce the isolating nature of both conditions.

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Lexicon Problems in Mental Health Graduate Training: Defining, Understanding, and Implementing Evidence-Based Practice Through Accreditation

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"EVIDENCE-BASED" and "empirically supported" have become buzzwords that have origins in the medical community. Evidence-based medicine was a term coined by David Sackett to mean a process of lifelong and self-directed learning in which caring and decision-making for patients is informed by the rapidly growing body of laboratory research specific to the problem area (Sackett & Rosenberg, 1995). Evidence-based medicine is therefore a process—something that a medical provider continually does in their practice. Much like evidence-based medicine, evidence-based practice (EBP) is a process within the mental health field. The American Psychological Association (2005) characterized EBP in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preference" (APA Presidential Task Force on Evidence-Based Practice, 2006; Spring, 2007; see Figure 1). Research evidence, clinical expertise, and patient preferences comprise the EBP three-legged stool to inform clinical decision-making. The APA's EBP definition aligns with other EBP processes developed in social work that describe five steps in clinical decision-making: (a) formulating a practice question that can be answered by searching for research evidence, (b) tracking down the best research to answer the question, (c) critically appraising the evidence, (d) integrating the critical appraisal with practitioner expertise and client attributes to guide your practice decision, and (e) evaluating the outcomes of the practice decision (Rubin & Parrish, 2010).

In contrast, the term empirically supported treatments (ESTs), a noun, refers to psychological treatments shown to be efficacious in controlled research with established evidence criteria (Chambless & Hollon, 1998). Sometimes ESTs are also considered evidence-based treatments, which is a less precise synonym to ESTs due to differing classification systems to determine the strength of the evidence base (Codd III, 2017). A careful critic could argue that ESTs are included within the EBP research evidence domain. However, some clinicians confuse EBP and EST, and terms are often used synonymously, causing a lexicon problem within mental health. For example, Codd III noted that terms such as "evidence-based approach," "evidence-based service," "evidence-based treatment," and "empirically supported treatments" are often used interchangeably and confused to mean a treatment supported by scientific research. The confusion creates an unnecessary division between treatments and decision-making processes. The lexicon issue in this case can also be referred to as a jingle problem, which refers to when researchers use the same word to refer to different constructs (National Academies of Science, 2022). For example, in mental health graduate training, an instructor may use the term "evidence-based practice" to refer to both the EBP and EST. The audible similarity between the two terms leaves a vulnerability to the jingle problem. While the impact of this confusion could be minimal in some cases, it could also mean that a clinician does not have the proper decision-making tools to make informed choices for the

client, which could greatly impact effective treatment for ameliorating the suffering of clients.

Implementation of EBP and EST has been a source of interest for the mental health field for over a decade (McHugh & Barlow, 2010). Commonly understood definitions are fundamental to communication and training in mental health. Carefully defining and measuring EBP and EST knowledge and attitudes has been a priority for implementation science (Lewis, et al., 2015). For example, Okamura et al. (2018) found that when measuring EBP and EST knowledge in community mental health clinicians, the constructs themselves were orthogonal and incrementally impacted EBP attitudes. Furthermore, less experienced clinicians tended to have more positive views regarding EBP than more experienced clinicians (Okamura et al., 2018). This is why timing EBP and EST training is crucial.

Arguably, the most fruitful time to train in EBP and EST would be within graduate training. Becker-Haimes and colleagues (2019) noted that the EBP process, and not just EST, is necessary to teach students how to learn in graduate training. Furthermore, M.S.W. and Psy.D. students generally have cursory EST exposure in graduate training, while Ph.D. programs have the most extensive EST training (Okamura et al., 2012). Ph.D. students tended to have more favorable EBP attitudes than Psy.D. and M.S.W. programs, possibly due to the latter programs requiring more of a breadth of training in various types of therapies (Okamura et al., 2010). Moreover, only 3.7% of students could identify the three legs of the EBP stool and only 27.5% of clinical psychology graduates reported extensive EBP discussions in their curricula (Luebbe et al., 2007). One targeted implementation strategy that would effect change at the mental

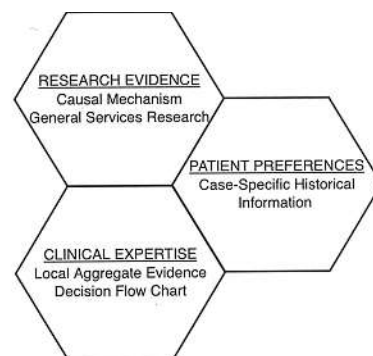


Figure 1. Four evidence bases within the EBP three-legged stool

health field level would be to define constructs at the accreditation level to ensure consistency in training for the implementation of EBP training models. Accreditation standards serve as a way to provide consensus and uniformity in graduate training.

The crucial operationalization of definitions could lead to better instruction of the EBP process at a graduate level, resulting in potentially cost and training time reduction for institutions, removal of confusion across parties, and allow for the best individualized treatments to occur for the clients. Our current study is an initial evaluation of accreditation standards across mental health graduate accrediting bodies. Specifically, we will map accreditation standards to the EBP three-legged stool and find EBP and EST definitions within three major mental health accreditation bodies. The goal of this study is to understand the extent to which standards align with EBP and EST definitions to begin determining if a common definition exists. Regarding EBP, we will specifically examine the extent to which research evidence, clinical expertise, and patient preferences are mentioned and defined in accreditation standards. Given the exploratory nature of our study, we did not have any *a priori* hypotheses.

Method

We used a content analysis approach (Krippendorff, 1980; Stemler, 2000) to examine behavioral health-related accreditation standards for graduate training programs. Three accrediting bodies were selected to demonstrate mapping standards to terms within the mental health field given the large number of trainees the accrediting bodies cover each year (e.g., the American Psychological Association has over 415 accredited doctoral programs). The American Psychological Association Standards of Accreditation and Implementing Regulations (APA; <https://www.accreditation.apa.org/>) and the Psychological Clinical Science Accreditation System Purpose, Organization, Policies, and Procedures (PCSAS; <https://www.pcsas.org/>) were chosen to represent clinical psychology (APA, 2021; PCSAS, 2021). When available, additional supporting documents were also reviewed and coded by the team. For example, PCSAS included exemplars in their review criteria. Exemplars were suggested questions potential applicants and institutions should consider for the purposes of illus-

tration in order for PCSAS to consider them a high-quality program. Additionally, the Council on Social Work Education (CSWE; <https://www.cswe.org/accreditation/>) accreditation standards were chosen to represent master's-level clinicians (CSWE, 2022). Within the standards of CSWE, coders examined competencies and educational policies. Competencies were defined as educational frameworks used to identify and assess what graduates will need to demonstrate in practice. These competencies are used to measure a trainee's ability to demonstrate outlined educational policies. Educational policies are utilized to describe curriculum criteria that the accreditation standards are derived from that specify requirements used to develop and maintain social works programs within the CSWE accreditation.

Two psychologists (in academia and an EBP purveyor organization) and a clinical psychology doctoral student independently read and coded the accreditation standards and supplemental documents (i.e., APA Presidential Task Force on Evidence-Based Practice's Statement, PCSAS Review Criteria) to identify mention of *specific terms and operational definitions* of the following constructs:

- the term *evidence-based practice* and its three parts
 - research evidence,
 - clinical expertise, and
 - patient preferences
- the term *empirically supported treatment*

A definition was determined either through explicit mention of a term and operational definition or through explicit examples that implied a clear definition in the accrediting bodies' conceptualization of the terms. For example, PCSAS exemplar number two aligned with EBP research evidence suggested questions such as "Is research training a core of the program? Are students actively involved in scientific research throughout their graduate education?" While this is not a definition of terms, the exemplar does provide an explicit example of considering research evidence within its evaluation of standards. Coders met to review independent ratings and reached consensus on definition identification. Given the content analytic and thematic approach, coders were not looking for perfect agreement; rather, discrepancies allowed for a discussion on the impact of graduate program level understanding of the constructs. A definition was not determined if a somewhat clear under-

standing of a concept was not understood to some level of congruence between the coders (e.g., "evidence-based approach") however, some of these concepts are noted and addressed in the discussion.

Results

There was no explicit mention found across accrediting bodies' standards for EBP and EST definitions (see Table 1). The APA accreditation standards and implementing regulations did not explicitly mention the APA (2005) EBP definition. However, APA Standards of Accreditation (2021) did note that Doctoral Health Service Psychology programs should contain "integration of empirical evidence and practice: Practice is evidence-based, and evidence is practice-informed" (p. 6). Related, the PCSAS manual (2021) provided an overview of the integration of clinical science and generating new knowledge as a requirement for doctoral training. Definitions specific to research evidence, clinical expertise, and patient preferences were found across APA, PCSAS, and CSWE accreditation standards.

Research evidence was the most robustly identified construct within accreditation standards. Within APA (2021), research evidence consisted of discipline-specific knowledge of research methods (e.g., qualitative methods, quantitative design), statistical analysis (e.g., null-hypothesis testing and its alternatives, power, univariate and multivariate analysis), and psychometrics (e.g., reliability, validity, theory and techniques of psychological measurement) as well as profession-wide competencies on research (e.g., critically evaluate and disseminate research), assessment (e.g., understand behavior within its context, demonstrate knowledge of diagnostic classification, interpret assessment results), intervention (e.g., evaluate intervention effectiveness), and diversity education and training (e.g., knowledge of current theoretical and empirical base as it relates to current client). The PCSAS (2021) accreditation standards emphasized review criteria on the quality of science and application training and provided exemplars on effective training in research, clinical application, and clinical science. The CSWE (2022) accreditation standards focused on both practice-informed research and research-informed practice as well as integrating scientific knowledge on individuals, families, groups, organizations, and communities to inform practice. While the descriptions of research

Table 1. Accreditation Standard Definitions

	APA	PCSAS	CSWE
EBP definition	Policy Statement on Evidence-Based Practice in Psychology (APA, 2005)	Not Found	Not Found
Research evidence	Discipline Specific Knowledge (Section C-7 D) - Research Methods, Statistical Analysis, & Psychometrics (Category 4) Profession-wide competencies (Section C-8 D) - Research (I); Assessment (VI); Intervention (VII) Diversity Education and Training (Section C-9 D)	Quality of the science training (Criteria 3) Quality of the application training (Criteria 4) Curriculum design (Exemplar 2) Research training (Exemplar 2c) Clinical application training (Exemplar 2d) Not Found	Engage in practice-informed research and research-informed practice (Competency 4) Engage with individuals, families, groups, organizations, and communities (Competency 6) Assess individuals, families, groups, organizations, and communities (Competency 7) Intervene with individuals, families, groups, organizations, and communities (Competency 8) <i>Educational Policy 3.1-Generalist practice</i> <i>Educational Policy 3.2-Specialized practice</i>
Clinical expertise	Profession-wide competencies (Section C-8 D) - Professional values and attitudes (IV) & Intervention (VII) Diversity Education and Training (Section C-9 D)		Engage in practice-informed research and research-informed practice (Competency 4) Intervene with individuals, families, groups, organizations, and communities (Competency 8) Evaluate practice with individuals, families, groups, organizations, and communities (Competency 9) <i>Educational Policy 3.1-Generalist practice</i> <i>Educational Policy M3.2.3-Specialized practice</i>
Patient preferences	Profession-wide competencies (Section C-8 D) - Individual and cultural diversity (III) Diversity Education and Training (Section C-9 D)	Not Found	Engage with individuals, families, groups, organizations, and communities (Competency 6) Assess individuals, families, groups, organizations, and communities (Competency 7) Intervene with individuals, families, groups, organizations, and communities (Competency 8) Evaluate practice with individuals, families, groups, organizations, and communities (Competency 9)
EST definition	Not Found	Not Found	Not Found

Note. EBP = evidence-based practice; EST = empirically supported treatment; APA = American Psychological Association, PCSAS = Psychological Clinical Science Accreditation System; CSWE = Council on Social Work Education; underlined items refer to specific sections in accreditation standards.

evidence were informative, they did not operationalize the depth of training needed in any particular domain, exemplar, or educational policy.

Clinical expertise was less defined within accreditation standards. The APA

(2021) accreditation standards noted reflexive thinking around personal and professional functioning to assess students' ability to navigate within the mental health field. The PCSAS (2021) accreditation standards had no mention of clinical

expertise and integration of clinical knowledge. The CSWE (2022) accreditation standards articulated clinical expertise within three competencies including Competency 4: Engage in practice-informed research and research-informed practice (p. 6);

Competency 8: Intervene with individuals, families, groups, organizations, and communities (p. 8); and Competency 9: Evaluate practice with individuals, families, groups, organizations, and communities (p. 8). However, we note here that there was no explicit definition of clinical expertise within any accreditation standards.

Patient preferences largely fell within diversity and cultural domains within APA (2021) and CSWE (2022) accreditation standards. For example, Section C-8 D. III covering Individual and Cultural Diversity in the APA Implementing Regulations mentions “trainees must demonstrate knowledge, awareness, sensitivity, and skills when working with diverse individuals and communities” (p. 16) and Section C-9 D. covering Diversity, Education, and Training mentions that training should be based on multicultural theoretical and conceptual frameworks and must be integrated into practice but does not expand outside these two sections which largely focused on culture and diversity. The PCSAS (2021) did not mention any standards related to patient preferences. Notably, the CSWE (2022) accreditation standards nested patient preferences within the many contexts (e.g., family, group, organization, community) which an individual interacts. In summary, the clinical expertise and patient preference EBP domains were less developed than the research evidence domain.

Discussion

The mental health field still requires foundational work despite longstanding calls to provide evidence-based practice to people suffering from behavioral health disorders (IOM, 2001). Accreditation standards lack operational definitions of key constructs that would bring the field closer to consensus. Findings from our study elucidate the need to define key constructs across mental health disciplines, with research evidence being the most robustly alluded to in accreditation standards. It may be that the urgency to address the quality chasm and adopt an evidence-based model created more confusion in *what* was needed and *how* the mental health field could do it.

There was no direct mention of an EBP and EST operational definition across accreditation standards reviewed. Research evidence was identified most frequently within standards, although the definitions varied and did not align with EST definitions (Chambless & Hollon, 1998). This

misalignment is problematic for many reasons. First, an argument exists within psychotherapy research regarding the “dodo bird verdict” (Rozenzweig, 1936) that has brought up concerns around research methodology in examining treatment effects (Elliott et al., 2014). More specifically, if the mental health field continues to amass effective treatments through efficacy trials, there may be a (valid) concern regarding the abundance of treatments (Okamura et al., 2020) and how to distinguish treatment appropriateness for a given client (i.e., where do I start as a clinician?). It was interesting that while there have been publications on the EBP process within social work (Rubin & Parrish, 2010), that definition does not appear in accreditation standards. This may be due to the social work discipline taking a more ecological approach with a focus on systems change rather than at the individual level.

Second, clinical expertise and patient preferences were lacking examples and definitions. Indeed, as society changes to address systemic barriers toward quality health care, principles surrounding culture and other social dimensions must be addressed in graduate training. For example, EST generalizability to different cultural contexts is always in question (Cardemil, 2010) and is coupled with misunderstandings between the efficacy and effectiveness of studies (Singal et al., 2014). “Significant findings” in a laboratory setting does not translate to effectiveness in the real world (Shedler, 2018). ESTs are built under the context of nomothetic architecture, usually with randomized samples, yet clinicians are taught to be patient-centered, thus being idiographic in their approach. Lau (2006) argued that there should be a process for adding cultural adaptations to existing ESTs for clients that either do not match samples from a particular EST or if there is a gap in research. The EBP process plays an important role in identifying when an EST is effective and allowing the flexibility to be adaptive, if necessary (Park et al., 2015; Park et al., 2022), but this is only clear if the division of terms is understood and recognized.

As mentioned previously, accreditation standards serve as a way to provide consensus and uniformity in graduate training. Emphasis on explicitly defining the EBP process in graduate training would be beneficial to uniformity in mental health disciplines. There were areas in standards that alluded to use of EBP, such as APA’s Implementation Regulations Section C-8

VII, which states that trainees must demonstrate the ability to “modify and adapt evidence-based approaches when a clear evidence base is lacking” (p. 19). However, this is an example of the lexicon problem. What is meant by “evidence-based approach”? Is this the same as EBP, is it a new type of EST, or perhaps its own unique concept? This could easily be susceptible to the jingle problem discussed earlier. This starts with having clear definitions that are understood by faculty. Unfortunately, it may be that the pervasive lexicon problem has contributed to faculty’s unawareness of the subtle differences in definitions that hinder EBP learning (Bertram et al., 2015). Students may have modest to no exposure to the EBP process without faculty awareness. This underprepares students for real-world practice through insufficient first-hand experiences to solidify learning (Lushin et al., 2019). The amount of experiential exposure to these concepts in graduate training also contributes to favorable EBP attitudes (Okamura et al., 2010).

The integration of EBP and EST definitions into accreditation standards via graduate training models would be beneficial to ensure exposure, habit formation, and increased favorability. As a first step, it is crucial to define “evidence-based,” especially given that the APA implementing regulations noted “evidence-based” 25 times without explicit definition. Due to familiarity, the authors propose the Evidence-Based Services System model as a training model created by Hawai’i State Department of Child and Adolescent Mental Health Division (Daleiden & Chorpita, 2005). The model was developed with an emphasis on four complimentary evidence sources: (a) causal mechanism (i.e. clinical and psychopathology theory), (b) general services research (i.e., ESTs and EST intervention techniques), (c) local aggregate (e.g., findings across multiple clients in a local area), and (d) case-specific historical information (i.e., facts about client history, past treatments, and individual characteristics). Using the four evidence bases, a treatment team establishes goals, settings, practices to be utilized, and ensures treatment integrity and progress is being made through continued monitoring. To integrate all forms of evidence, clinicians use a decision flow chart to inform which EST is appropriate and clinical data to inform whether new practices should be employed. The four evidence bases and decision flowchart satisfy all three EBP stool legs (see Figure 1). The authors recog-

nize that this is only one model example of many (e.g., Coalition for the Advancement and Application of Psychological Science, 2018) that can be used.

While accrediting bodies have emphasized research evidence, the same emphasis must be made in identifying effective teaching and learning strategies. If graduate training programs are tasked with trainee learning, then there must be consensus on *what* it is and *how* we are training. To emphasize EBP as a process, there are principles that need to be integrated into graduate training, including: (a) making decisions based on research, (b) encouraging critical thinking, (c) thinking about learning beyond continuing education credits, and (d) increased emphasis on process training (Beck et al., 2014). Within the clinical psychology discipline, there have been criticisms over APA accreditation standards being more concerned with competencies and knowledge in specific areas and less on the integration of clinical

science (Levenson, 2017). This criticism may have spurred the PCSAS formation and APA's refocused efforts toward clinical science (e.g., Science Spotlight newsletter introduced in 2021).

Additionally, broad constructs without operational definitions leave much interpretation to individual programs and faculty. Discussions regarding academic freedom and pedagogy are beyond the scope of this paper, however, graduate training programs would benefit from shared value in behavioral principles in skill acquisition. Didactic learning (e.g., workshops) alone does not lead to EBP adoption and sustainability. The addition of active learning strategies, with an emphasis on interactive components (e.g., role-plays) and reflections (e.g., reviewing therapy sessions) along with didactics, ultimately leads to behavioral change and actual EBP adoption (Beidas & Kendall, 2010; Frank et al., 2020). Furthermore, there is emerging evidence to suggest that clinicians that engage

in deliberate practice of treatment strategies to identify and evaluate practice errors may be more effective over time (Chow et al., 2015). Importance needs to be placed in graduate training on how to learn about new ESTs as new evidence presents itself to inform the EBP process, not simply on each current EST with no updates or consideration of context.

An additional benefit to including EBP operational definitions allowing for standardized EBP training models within graduate programs is the possible mitigation of training burden within the existing behavioral health workforce. Many EBP and EST training initiatives focus on continuing education of clinicians employed by mental health agencies (i.e., completed their graduate programs). These endeavors can be costly and burdensome to an already overwhelmed workforce. Time in training activities may result in a loss of direct service hours, and subsequently revenue, if agencies choose to offset productivity



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requirements when clinicians engage in EST training and consultation (Lang & Connell, 2017; Okamura et al., 2018). Additionally, the time clinicians spend to review and prepare creates indirect costs for lost productivity (Lang & Connell) or may add to clinicians' already overwhelmed workloads. Another challenge to continuing education training is the high level of clinician turnover in community mental health settings (Adams et al., 2019). Some agencies may be reluctant to invest in training when many clinicians leave the agency shortly after. By emphasizing precise definitions and EBP training at the graduate level, clinicians are entering the workforce with more robust clinical decision-making tools, which may reduce how much agencies must invest in training while also supporting more effective services.

In light of findings, some limitations should be noted. First, our study was a preliminary attempt to examine accreditation standards for evidence-based practice constructs. We strategically chose two differing doctoral accrediting organizations (i.e., APA and PCSAS) while also having representation from a master's accrediting organization (i.e., CSWE). Future studies may examine additional accreditation bodies in the field of mental health (e.g., Council for Accreditation of Counseling and Related Educational Programs, Masters in Psychology and Counseling Accreditation Council) that build off the framework and method proposed in the current study. Additionally, this study used a content analysis approach to examine evidence-based practice language within accreditation standards. The authors note the method by which these standards are implemented in training programs varies widely. Future research examining the extent to which these standards are translated into course syllabi, experiential training activities, and other related educational activities (e.g., comprehensive exams) is warranted. Finally, how two disciplines define competencies as outlined in accreditation standards was not addressed by the current study. Indeed, there may be pedagogical and operational differences in competency definitions.

An EBP definition explicitly embedded into accreditation standards and graduate training models implemented to clearly understand these definitions could be controversial. It would require faculty and programs to undergo potentially significant and time-consuming shifts in the focus of current training principles, faculty recruit-

ment, and student admissions. However, with current accrediting standards focused on research evidence without clear direction on how to use research evidence, definitional additions with the intention of improved EBP training would move students from technicians to clinicians by providing clinical decision-making tools to adapt as clinical science evolves. Perhaps the overemphasis on research evidence is a byproduct of the need for psychological services to align with medical models. That is why the field is ripe for understanding the extent to which varying forms of evidence can impact the quality and effectiveness of patient care. By integrating research evidence into clinical expertise and patient preferences, graduate training programs have the potential to shift the mental health field.

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ABCT's 2022 Convention Review and Decision Process

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DURING Dr. Laura Seligman's presidency, she has prioritized *transparency* to promote greater access and equity within ABCT and bring forward the highest quality science (Seligman, 2022). As we (Program Chairs) prepared for the abstract submission, peer review, and decision process for ABCT's 56th Annual Convention in New York City, we created a plan for each step with this core value in mind. Below we will summarize the process for peer review, program decisions, and resulting outcomes to make the process public and to inform future conversations around the process of continual improvement. Moreover, this publication will serve as an archive of this year's convention process with the hope that other program chairs will follow suit to demonstrate continued evolution of the peer review and decision processes that determine whose work is represented at the Annual Convention. We wish to acknowledge the efforts of Stephen Crane (ABCT Convention Manager), who was instrumental in helping us make these changes in the platform utilized for convention submissions and review (Cadmium), helped with organizing and exporting data, and swiftly adapted to many process changes. We also wish to thank Dr. Laura Seligman and the ABCT Board for encouraging and supporting us along the way, and to all the ABCT members and SIGs (in particular, the Sexual and Gender Minority [SGM] SIG), as well as ABCT's Dissemination, Implementation, and Stakeholder Engagement Committee (DISEC) that contributed helpful feedback and suggestions this year (more details below).

On January 26, 2022, we (Program Chairs), in conjunction with Dr. Laura Seligman, ABCT President, and Dr. Christina (Tina) Boisseau (Workshops Committee Chair & Interim Coordinator of Convention and Education Issues), hosted a virtual Town Hall, inviting all ABCT members. Existing convention submission and decision procedures were summarized, and feedback was elicited

from attendees about concerns and areas for improvement. A video recording of this first Town Hall meeting can be accessed here: <https://www.youtube.com/watch?v=wjIGSXGgt4U>. These suggestions were then turned into action items for this year's convention and presented to membership in a second virtual Town Hall meeting on February 17, 2022. A video recording of this second Town Hall meeting can be accessed here: <https://www.youtube.com/watch?v=-2j0DLyJH3E>. These videos were disseminated to ABCT membership via email communications and ABCT social media platforms.

For reference, there are six types of General Session convention submissions: Symposia, Panel, Clinical Round Table, Spotlight Research, Poster, and Clinical Grand Rounds. Below is a summary of the actions taken related to the Town Hall discussions and feedback from membership.

1. The peer review process for General Sessions was entirely masked for the first time in ABCT history (i.e., no author names or demographic information were available to reviewers or to the program chairs who analyzed peer review data). Upon completion of the masked reviews and decisions, program chairs analyzed these data to determine if there were any demographic differences in terms of who submitted and who was accepted (results reported below).
2. The peer review criteria for General Sessions were revised to better align with National Institutes of Health (NIH) and to clarify the scale ratings. The core seven items included: significance, approach, innovation, inclusion of diverse populations, appropriateness to convention theme, relevance to ABCT's mission and goals, and contributing team. Each item was rated on a 5-point Likert scale (0 = *poor*, 1 = *limited*, 2 = *adequate*, 3 = *good*, 4 = *excellent*). For the spotlight research presentations, there was an additional item regarding appropriateness for this presen-

tation type. Following the second Town Hall, the peer review criteria were posted publicly on the ABCT website (<https://www.abct.org/convention-ce/preparing-to-submit-an-abstract/>) so that submitters could review and craft submissions accordingly.

3. During the submission process, authors were asked to provide information about the contributing team in a masked fashion, describing qualifications and experience of the contributing team. The intention of using a masked process, along with this item, was to ensure that name recognition did not guide reviewer decisions, while also accounting for the qualifications and diversity of the contributing teams.

4. Town Hall discussions frequently focused on increasing representation of diverse populations, women, and a range of career stages among the presenters at ABCT. To address this concern, we felt it was first important to obtain baseline demographic and career stage data for this year's conference. When submitting this year, presenter authors were asked individually and *voluntarily* to report diversity demographic and career stage information, which will be reported herein. Based on feedback from membership, we quickly reworked the convention programming software so that these data were not visible to co-authors (thank you to those who noticed this issue and notified us so that we could swiftly correct this issue).

5. Several attendees expressed confusion as to how SIG-sponsorship is weighed in decision-making after peer review. As such, we established an a priori plan to formalize the process; any SIG-sponsored submission that scored above the median within the submission category would be automatically accepted. For those that did not score above the median, the item rating averages were reviewed by the program chairs, and scores below *adequate* were closely reviewed.

6. Attendees requested training for reviewers to improve the standardization of the peer review process. A video training was recorded by the program chairs and distributed to all reviewers in March of 2022. A video recording of this training can be found here: <https://www.youtube.com/watch?v=UjGHp55b2ys>.

7. Several questions were asked about the *Approach* item and the requirement of sufficient empirical evidence to support a presentation. Clarification was included in the ratings for peer review to indicate that

Table 1. Summary Statistics by Submission Type

	<i>n</i>	25th %ile	Median	75th %ile	Skewness	Kurtosis
Symposia	206	21.34	23.33	24.67	-0.82	0.84
Panels	70	21.0	23.17	25.67	-0.48	-0.56
Clinical Round Tables	42	18.01	19.67	21.42	0.15	-1.02
Spotlight Research	12	23.08	26.83	28.34	-1.40	1.81
Posters	1,306	18.0	20.0	22.50	-0.31	0.06

Note. Median is reported because the summary statistics provided were across reviewer averages of the total score.

Table 2. Item Rating Averages by Submission Type

	Significance	Approach	Innovation	Inclusion of Diverse Populations	Appropriateness to Convention Theme	Relevance to ABCT's Mission and Goals	Contributing Team	Spotlight Research
Symposia	3.67	3.33	3.33	2.67	3.0	3.67	3.67	-
Panels	3.67	3.0	3.33	3.0	3.33	3.67	3.67	-
CRT	3.67	3.0	3.33	2.67	3.33	3.67	3.67	-
Spotlight	3.67	3.17	3.33	2.50	3.17	3.84	3.84	2.84
Posters	3.0	3.0	3.0	2.0	3.0	3.0	3.0	-

Note. CRT = Clinical Round Tables. Medians are reported because summary statistics provided were across reviewer averages of the item ratings. Spotlight Research rating item only applies to Spotlight submission type.

authors need not be the researchers who established empirical evidence for a particular approach but can instead cite evidence to indicate empirical support. Clarification was also provided to consider qualitative and mixed methods research (not just RCT data).

Peer Review

After the submission deadline (which was extended to March 15, 2022, due to the significant world events and ongoing stressors), all submissions were allocated for peer review. The reviewers needed to meet two criteria: (a) be members of ABCT and (b) have a conferred terminal degree. Students could be invited to participate in the review process under the direction of their mentors. The final review committee was comprised of (a) past year reviewers who met these criteria and agreed to review again and (b) reviewers who had been nominated by ABCT Special Interest Groups (SIGs) via a survey in advance of the submission deadline. Reviewers specified their area of research and/or specialty to align reviews accordingly. There were

200 peer reviewers who participated in the peer review process for the 2022 convention. Each oral presentation submission was assigned to three independent peer reviewers, and poster presentations were assigned two peer reviewers. As a reminder, this year *all submissions were masked* (completely deidentified).

Decision Process

Once the program chairs received the deidentified peer review data, the data were organized by submission type. Across all categories, 1,638 abstracts were submitted, and of those, 1,189 were accepted (73% acceptance rate). Of note, ABCT Convention Manager Stephen Crane informs Program Chairs of the number of presentations by type (e.g., symposia, posters) that can be accepted based on that year's venue capacity. This resulted in different numbers of each presentation type that could be feasibly included given space limitations. Below is a summary of the descriptive characteristics of the submissions by type. The information is included in aggregate only to protect author identities. Notably, specific review criteria were not created for

Clinical Grand Rounds submissions, so the Clinical Round Table criteria were used for these ratings during peer review. As such, no summary statistics are provided for these submissions ($n = 2$). Summary statistics provided to the Program Chairs included total score averages across reviewers, as well as item rating averages across reviewers.

Overall summary statistics are detailed in Table 1. Percentile scores are reported within each submission type to convey the central tendency of the average total score across reviewers. Given that data can be nonnormally distributed, skewness and kurtosis values are also reported. Moreover, the individual item scores are reported by submission type; again, these are averages across reviewers, so median scores are reported (see Table 2).

Symposia

With a maximum total score of 28, the median total score was 23.33. When examining specific items, it was clear that submissions were on average rated well above adequate (2) in all domains, with the lowest ratings in Inclusion of Diverse Populations. All submissions that scored at or above the

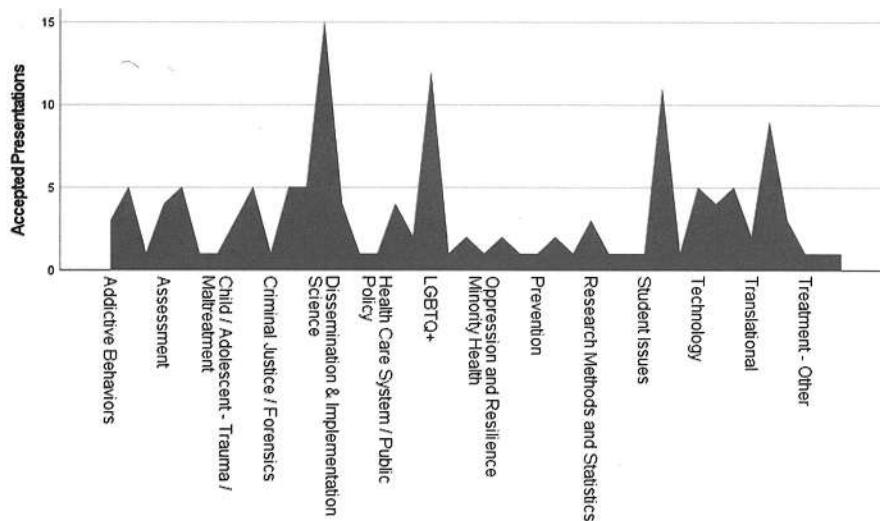


Figure 1. Frequency of author-identified topics among accepted symposia submissions. *Note.* Given the many topic areas available for submission, this figure intends to convey that there was a wide range of topic areas across accepted submissions. For interpretation, the x-axis represents some of the topic areas, but due to space constraints, not all could be included in the figure. The y-axis represents the frequency of accepted submissions.

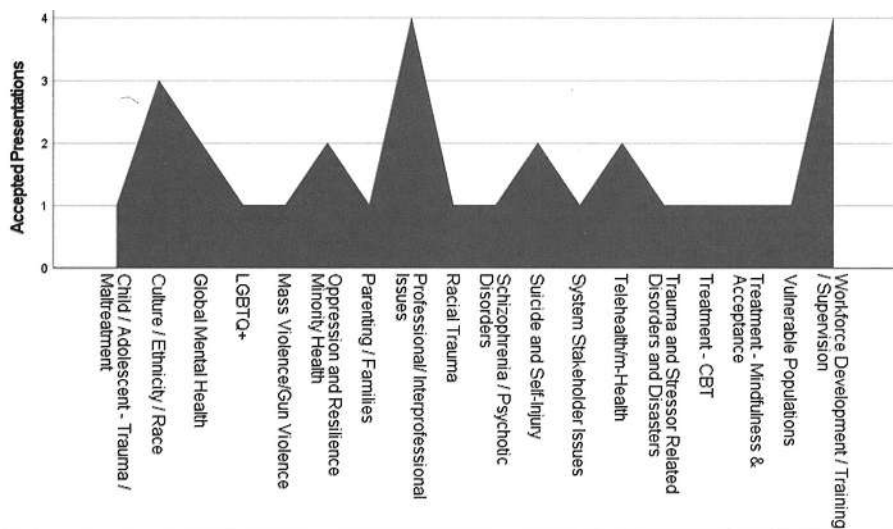


Figure 2. Frequency of author-identified topics among accepted panel submissions. *Note.* Given the many topic areas available for submission, this figure intends to convey that there was a wide range of topic areas across accepted submissions. For interpretation, the x-axis represents some of the topic areas, but due to space constraints, not all could be included in the figure. The y-axis represents the frequency of accepted submissions.

median were accepted ($n = 106$). SIG-sponsored presentations whose total scores were not scored above the median were examined in terms of item ratings. For those that had items rated on average below adequate (2), the submission was rejected; for those with all ratings above adequate, the submission was accepted. Subsequently, the remaining submissions were reviewed by item rating averages, and

those that had 5 or more item rating averages of ≥ 3 were accepted. Of the 206 submissions, 138 were accepted (67%) that ranged across author-identified topics (see Figure 1).

Panels

With a maximum score of 28, the median average total score was 23.17. Examination of item rating averages indi-

cated that ratings were all above *good* (3), with the lowest item median being Inclusion of Diverse Populations (Median = 3.0). Of the 70 submissions, 31 were accepted (44%). All submissions at or above the 75th percentile were accepted ($n = 18$). Moreover, the SIG-sponsored submissions that were above the median were also accepted. Presentations that were rated above the median and had seven average item ratings of ≥ 3 were accepted. Accepted panel submissions ranged across topic areas (see Figure 2).

Clinical Round Tables

With a maximum total score of 28, the median of the averaged total score was 19.67. Averaged item ratings indicated that lowest median scores were in ratings of Inclusion of Diverse Populations (2.67) and Approach (3.0). Of the 42 submissions, the 10 presentations in the top quartile were accepted, and notably, all were from different topic areas. Two of the SIG-sponsored presentations were accepted after review of item averages. Remaining decisions were made using item ratings ≥ 3 , as well as average total score ratings above the median. A total of 15 submissions were accepted (of 42 submitted; 36% acceptance rate), and 13 topic areas were represented (see Figure 3).

Two clinical grand rounds submissions were received, and the program chairs did not develop criteria for this presentation type. As such, the clinical round table criteria were used for peer review, as well as the median (19.67) for clinical round tables.

Spotlight Research

Spotlight research presentations are a unique presentation format, and the acceptances are traditionally limited at ABCT to those presentations that are especially innovative and warrant a 45-minute oral presentation with 15 minutes for questions. Twelve submissions were reviewed. With a maximum score of 32, including the spotlight-specific item, the median total score was 26.83. Notably, the skewness and kurtosis values were higher than the other categories, but this may be expected with a limited sample ($n = 12$). Regarding averaged item ratings, lowest scores were observed on Inclusion of Diverse Populations (2.5) and Fit with the Spotlight Presentation Format (2.84). No spotlight submissions were SIG-sponsored. The submissions in the top quartile ($n = 3$) were accepted, and one additional presentation was accepted based on high total score and high item ratings (33% acceptance rate).

The four accepted presentations spanned four topic areas: LGBTQ+, Multicultural Psychology, Program/Treatment Design, and Treatment – CBT.

Poster Presentations

Two reviewers provided ratings for each poster presentation submission. In total, 1,307 abstracts were submitted. To avoid any one review biasing the outcome, descriptive statistics were calculated for the average score, as well as for reviewer 1 and 2. Fortunately, the medians were identical. Nevertheless, additional precautions were taken. If a poster was rated above the median on average *or* by either reviewer, the presentation was accepted. This included all SIG-sponsored presentations that were rated above the median. In addition, item ratings were reviewed with attention to submissions that received average item ratings of ≥ 3 . SIG-sponsored posters that received ratings below *adequate* (2) were rejected. In total, 1,002 submissions were accepted (77% acceptance rate). Notably, the accepted submissions spanned across topic areas. See Figure 4 for visual depiction of topics of the accepted submissions.

Author Characteristics

As detailed above, one of the concerns at the first Town Hall was that certain groups or individuals were more likely to have submissions accepted or were more likely to have certain types of submissions (e.g., oral presentations) accepted. To address this concern, author data were collected regarding demographic characteristics and career stage to evaluate whether this bias occurred in the 2022 review process. Author diversity demographic questions were developed in consultation with the ABCT Sexual and Gender Minority (SGM) SIG. Note that author data were collected *voluntarily*; that is, authors could indicate that they preferred not to answer for each question. Reviewers were not given access to these data to preserve anonymity of review. Given the concerns about bias expressed at the Town Hall, the analyses reported herein examine directly whether bias was observed in the acceptance rates across identities and career stage, and poster and oral presentations were examined separately.

Within poster presentations, no significant differences in acceptance rates were observed based on identifying as a sexual minority (i.e., lesbian/gay/bisexual/queer/asexual/ or another sexual minority iden-

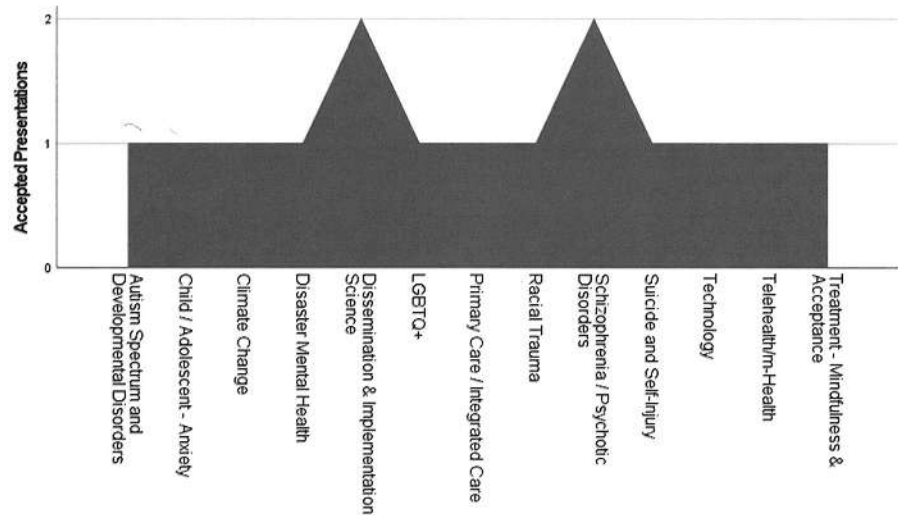


Figure 3. Frequency of author-identified topics among accepted clinical round table submissions. *Note.* Given the many topic areas available for submission, this figure intends to convey that there was a wide range of topic areas across accepted submissions. For interpretation, the x-axis represents some of the topic areas, but due to space constraints, not all could be included in the figure. The y-axis represents the frequency of accepted submissions.

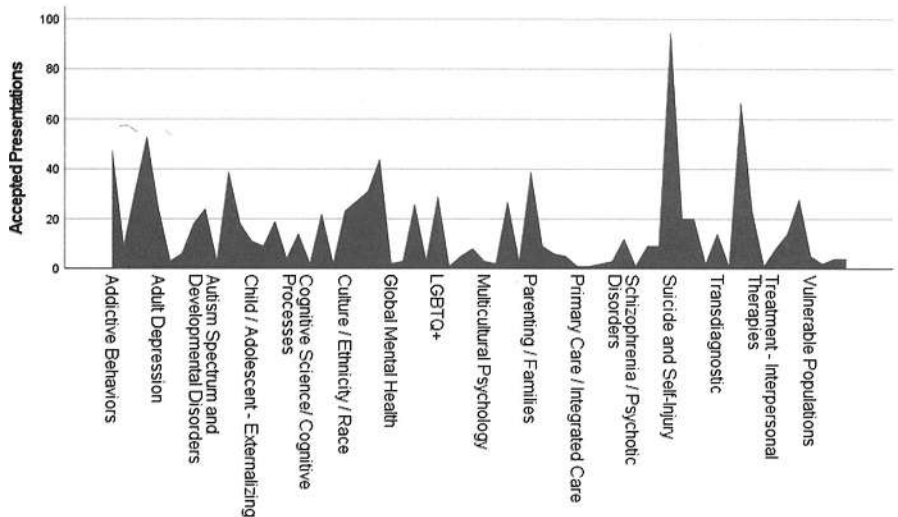


Figure 4. Frequency of author-identified topics among accepted poster presentation submissions. *Note.* Given the many topic areas available for submission, this figure intends to convey that there was a wide range of topic areas across accepted submissions. For interpretation, the x-axis represents some of the topic areas, but due to space constraints, not all could be included in the figure. The y-axis represents the frequency of accepted submissions.

tify), gender minority (i.e., trans woman/trans man/nonbinary/gender queer/or another gender minority identity), person with a disability, woman/female, religious minority, or international presenter. However, higher acceptance rates were

observed among those who identified as a racial or ethnic minority in country of residence (84.5%) than those who did not (78.1%), $C^2(1) = 16.8$, $p < .001$. Additionally, significantly higher acceptance rates were observed among those who identified

Table 3. Percentage of Accepted Presentations by Self-Reported Author Identities

	Identified	Not Identified	C ²
Poster Presentations			
Sexual minority (e.g., lesbian, gay, bisexual, pansexual, queer, or another sexual minority identity)	79.1%	78.9%	0.01
Gender minority (e.g., trans woman, trans man, nonbinary, genderqueer, or another gender minority identity)	74.2%	79.0%	1.28
Person with a disability	85%	78.8%	2.97
Racial or ethnic minority in country of residence	84.5%	78.1%	16.8***
Immigrant to current country of residence	84.7%	78.7%	4.50*
English as a second language	85.2%	78.6%	6.57**
Identify as a woman/female	79.8%	78.5%	1.42
Religious minority	81.5%	78.8%	1.16
International presenter	100%	78.9%	1.34 ^a
Oral Presentations			
Sexual minority (e.g., lesbian, gay, bisexual, pansexual, queer, or another sexual minority identity)	72.1%	56.4%	22.40***
Gender minority (e.g., trans woman, trans man, nonbinary, genderqueer, or another gender minority identity)	81.8%	58.2%	7.44**
Person with a disability	55.6%	58.8%	0.30
Racial or ethnic minority in country of residence	67.9%	56.4%	15.65***
Immigrant to current country of residence	62.4%	58.4%	0.84
English as a second language	67.4%	58%	4.52*
Identify as a woman/female	61.4%	55.6%	6.25*
Religious minority	55.3%	59%	0.78
International presenter	60.3%	58.6%	0.08

Note. * $p < .05$. ** $p < .01$. *** $p < .001$. ^aFor poster presentations, the number of presenters who identified as an international presenter was small ($n = 5$), so this comparison should be interpreted with caution.

as an immigrant to current country of residence (84.7%) as compared to those who did not (78.7%), $C^2(1) = 4.50$, $p < .05$. Finally, significantly higher acceptance rates were observed between those who identified English as a second language (85.2%) as compared to those who did not (78.6%), $C^2(1) = 6.57$, $p < .01$. See Table 3 for complete reporting of the rates and group comparisons.

For oral presentations, including symposia, panels, clinical round tables, clinical grand rounds, and spotlight research presentations, comparisons were conducted to examine differences in acceptance rates. No significant differences in acceptance rates were observed based on identifying as a person with a disability, immigrant to current country of residence, religious minority, or international presenter. Significantly higher acceptance rates were observed among presenters who identified as a sexual minority (72.1%) compared to those who did not (56.4%), $C^2(1) = 22.4$, $p < .001$. Acceptance rates were significantly

higher among individuals who identified as a gender minority (81.8%) compared to those who did not (58.2%), $C^2(1) = 7.44$, $p < .01$. Significantly higher acceptance rates were also observed among individuals who identified as a racial or ethnic minority in country of residence (67.9%) as compared to those who did not (56.4%), $C^2(1) = 15.65$, $p < .001$. Additionally, significantly higher acceptance rates were also observed among individuals who identified English as a second language (67.4%) as compared to those who did not (58%), $C^2(1) = 4.52$, $p < .05$. Finally, higher acceptance rates were observed among individuals who identified as a woman or female (61.4%) than those who did not (55.6%), $C^2(1) = 6.25$, $p < .05$. See Table 3 for complete report of the rates and group comparisons.

When examining career stage, significant differences in acceptance rates were observed across career stage in both poster and oral presentations. Within poster presentations, undergraduate student authors were least likely to have their submission

accepted (74.6%), whereas mid-career authors were most likely to have their submission accepted (82.5%). Within oral presentations, early career authors were most likely to have their submission accepted (63%), whereas late career authors were least likely to have their submission accepted (43.5%). Importantly, because limited undergraduate student authors submitted an oral presentation for peer review ($n = 1$), undergraduate student could not be examined reliably as a category for oral presentations and was thus excluded. See Table 4 for complete rates and comparisons.

Program Organization

A final topic of discussion at the first Town Hall was the specific day on which certain presentations are scheduled, with particular attention to diversity, equity, and inclusion topics being observed as disproportionately occurring on Sunday, the final day of the convention. As such, this is

Table 4. Rates of Accepted Submissions Across Self-Identified Career Level

	Undergraduate Student	Graduate Student	Early Career	Mid-Career	Late Career	C ²
Poster Presentations	74.6%	77.8%	78.4%	82.5%	78.2%	9.74*
Oral Presentations	-	61.3%	63%	53.7%	43.5%	19.25***

reported herein. For poster sessions, all diversity, equity, and inclusion topics were included on Thursday–Saturday based on author-identified topics at submission. In addition, oral presentation distributions are as follows: Friday – 23, Saturday – 27, and Sunday – 16. Furthermore, Sunday’s convention programming will continue through 1:30 p.m. Eastern Time, and we hope that all attendees will consider staying for the duration of the program, if possible, to maximize attendance throughout the duration of the convention.

Conclusions

The submission process for the 2022 convention was full of well-rated presentations across presentation types and topic areas. The review criteria revisions appeared to result in ratings that were normally distributed and rated on average as good or excellent across the items. Moreover, the submissions aligned with ABCT’s mission and goals, as well as this year’s convention theme. As program chairs, we were thrilled to see that the masked review process, with the addition of the contributing team description in the submission process, was feasible. Importantly, the contributing team item was generally rated highly (≥ 3) by reviewers across presentation type (see Table 2), suggesting that in order to peer review, reviewers do not need names or affiliations, which aligns with many journals’ review processes. However, we can still establish qualifications and experience using the contributing team item.

Moreover, the author data provided interesting insights. Across both poster and oral presentations, when examining whether acceptance rates differed across author identities, we observed significant differences in some categories (e.g., racial or ethnic minority in country of residence) that reflected *higher* acceptance rates among those identifying with the underrepresented and minoritized identity. Most important, reviewers and program chairs *did not* have access to author information, including names, affiliations, or these data,

when reviewing the submissions. As these data have not been collected ever before in ABCT convention history, no causal attributions can be made as to whether the lack of bias observed was due to the masked peer review and decision-making process. Nevertheless, these results are outstanding and positive. As an organization that seeks to value equity and inclusion, this is a huge stride in this direction. Masked peer review may well be an important method that ABCT should continue for future conventions. Masked peer review mirrors journal procedures and, in this case, went a step further—whereas editors have access to author information and reviewers do not, neither program chairs nor reviewers had access to identifying information. Again, this was only possible with the data management and organizational procedures put in place with the assistance of Stephen Crane and the Cadmium team. Interestingly, in examining acceptance rates across career levels, findings indicated significant differences. At the first Town Hall, concerns were raised regarding early career acceptance rates for oral presentations, and with the masked review, it appears that early career authors had the *highest* rates of acceptance (63%) for oral presentations, and graduate student acceptance rates were not far behind (61.3%). In the future, similar data might be collected regarding our program committee so that membership have information about the peer reviewers who are reviewing the submissions.

As a scientific organization, we would be remiss to interpret the data without drawing attention to future directions and areas for further improvement. Across all submission types, there were consistently lower ratings on inclusion of diverse populations. As a field, this is an area where we must significantly improve. Beyond abstract submissions for ABCT, we must work to improve our efforts to be inclusive in research, clinical service, supervision, and teaching. As we write grants, design studies, implement programs, and work with individuals and groups, we must consider how our assessments and treatments were developed and evaluated. Moreover,

even if we are conducting pilot work, we must consider the implications for diverse populations and be intentional in noting the importance of future work. As a community, emphasizing the applicability of our work across contexts, with individuals of all backgrounds and around the world, is an essential step to improving global mental health. Furthermore, as mentioned previously, we acknowledge that this approach requires further revision based on lessons learned and feedback from membership. For instance, further areas of growth based on postdecision member feedback (via emails and social media) is to: (1) disseminate the review criteria with ample time before submission deadlines; (2) improve the ABCT website so that information is easier to find; (3) offer more opportunities for membership to receive information about the submission process (especially any changes made, as they increase submission burden and time); (4) consider revising the weight (if any) that convention theme should have in the decision-making process (some members have proposed to eliminate this criteria altogether); (5) greater a priori transparency about convention spacing limitations (which impacts the number of submissions within categories that can be accepted each year); (6) offering workshops, technical assistance, and abstract writing mentoring and feedback options to students, trainees, and new conference attendees; (7) continue engaging the SIGs in the submission and review process and incorporate feedback (something we especially focused on this year); and (8) mirror these general session processes in the ticketed session submission process. The submission and peer review processes asked contributors to provide additional information, including individual and contributing team information, which also increased the material that reviewers considered. Important to consider in future years is how to collect author and contributing team data in the most efficient manner to minimize burden and maximize equity, inclusion, and quality. Finally, nearly half of the authors who submitted an abstract to this year’s convention

were not involved with a SIG and thus did not get to participate in nominating reviewers to serve on the Program Committee. Moreover, SIG-sponsored presentations were weighted in the review process. We encourage members to explore whether SIG involvement is of importance to increase involvement in the selection of the Program Committee, make connections with colleagues, receive feedback on submissions, and potentially have a SIG-sponsored submission. In addition, no spotlight research presentations were SIG-sponsored; this is a presentation type that SIGs should consider in future convention submissions.

Change is hard, yet necessary for growth. We are grateful to the ABCT community for your support as we engaged in committed action toward our values of transparency and data-driven programming decisions for the 2022 ABCT Annual Convention. We welcome ABCT membership comment and feedback (<https://services.abct.org/i4a/forms/index.cfm?id=34>), which will help inform future convention

programming. We are particularly interested in your feedback regarding what additional data would be helpful to collect in future convention processes (and what can be omitted to alleviate burden), what information would be useful as submissions are prepared, and what training or assistance would be most beneficial to authors and reviewers. As we wrote this article and navigated the months of preparation for the 2022 convention, we often noticed discomfort as we identified new methods of review, analyzed our review data, and worked to examine the many areas of improvement. We believe this discomfort is representative of our acknowledgment that this is a mere first step toward transparency and a data-driven peer review process, but we are nowhere near the finish line. Please know that we acknowledge the many steps that must come next and the areas for additional improvement, and we hope that you can view our report through this lens. With humility and much gratitude, thank you for your participation in this year's convention, and we look forward

ward to seeing you in November in New York!

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Webinar

SEPTEMBER 22 | 2:00 P.M. EDT

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Moral Injury: An Overview of Conceptual, Definitional, Assessment, and Treatment Issues

— Brett Litz, Ph.D.

The idea that people can be lastingly harmed by their own transgressive behavior and can suffer because of others' moral failures is as old as humanity, yet these age-old concepts have only recently been considered as clinically relevant social, biological, spiritual, and psychological problems. Moral injury (MI) is the multidimensional outcome from exposure to transgressive harms that undermine foundational beliefs about the goodness and trustworthiness of oneself, others, or the world. Although moral injury has gained widespread acceptance, we have only just recently defined the syndrome and generated a method to measure the syndrome that can be used clinically. I will define the boundary conditions for MI and distinguish MI as a clinical problem in contrast to moral frustration and moral stress, describe the domains impacted by exposure to morally injurious events, provide an assessment tool that can be used clinically and in research, provide case conceptualization heuristics and treatment approaches that can be used when MI is the principal target (e.g., when a traumatic event is a MI) or when another presenting problem is colored by MI, and discuss process issues that arise when clinicians are confronted with the existential realities of grave transgressive behaviors or high stakes systemic failures.

<https://elearning.abct.org/>

Getting to Know New York: A Constantly Evolving City Where Almost Anything Is Possible

Jason Duncan and Beata Krembuszewski, *Local Arrangements Committee*

THE LOCAL ARRANGEMENTS Committee for ABCT is very pleased to welcome you to New York City for the 56th Annual Convention in November. New York City is an expansive place, and the city's offerings are among the most culturally diverse in the world. There is, quite literally, something for everyone in New York City. The Committee is particularly excited to share information about POC-owned businesses (<https://trippin.world/guide/black-owned-businesses-in-new-york>) so our attendees can support these communities.

Although the majority of your time may be spent attending sessions at the convention, we hope you will also make some time to experience some extra slices of "The Big Apple." The City itself is composed of five, larger neighborhoods called "boroughs," and they include Manhattan, Brooklyn, Queens, the Bronx, and Staten Island. The convention itself takes place in Manhattan, and while the majority of our suggestions will be for this borough, we will also make some suggestions for larger attractions in the other boroughs, provided below.

Let's get more familiar with Manhattan. This borough is broadly separated into four areas: Uptown, Downtown, Midtown, and Harlem/The Heights. For clarity, "going Uptown" refers to heading north, while "going Downtown" means heading south. The area south of 14th Street is known as Downtown, then Midtown refers to the area between 14th and 60th Street, extending to the southernmost part of Central Park. Uptown refers to the area between 60th and 116th Street, and everything north of 116th Street is Harlem. Downtown, Midtown, Uptown and Harlem are further divided into smaller neighborhood areas.

Although New York City is filled with so many different opportunities, we understand that many of these experiences are costly. Therefore, we also recommend following these various Instagram accounts to get the latest scoop on free, or low-cost,

attractions and events closer to the time of the convention: "@nyc_forfree" "@explorenycfree" and "@thefreeatery." For students, we recommend visiting <https://www.cityguideny.com/article/where-students-can-get-discounts-in-nyc-to-find-attractions-with-student-discounts>. If you are planning on bringing your kiddos to ABCT this year, check out this website <https://www.timeout.com/new-york-kids/things-to-do/101-things-to-do-with-kids-in-nyc> for 101 things to do with kids in NYC!

If you do plan on bringing your children to the convention, ABCT is proud to offer childcare at the New York Marriott Marquis hotel through the company Kid-dieCorp. Childcare is available for children ages 6 months to 12 years. Childcare is available on Friday, November 18, and Saturday, November 19, from 8:00 a.m. to 10:00 p.m. There is a 2-hour minimum. The hourly rate is as follows: one child (\$12), two children (\$20), and three children (\$25), which can be paid via credit card or check, or cash day-of, space permitting. Be sure to reserve childcare at the following link <https://form.jotform.com/KiddieCorp/abctkids> by October 21, 2022. Please note, there will be an added fee of \$5 for every 5 minutes you are late picking up the kids.

Hotel and Immediate Surroundings

The 56th ABCT Annual Convention will be held at the New York Marriott Marquis Hotel, located in the heart of Times Square: 1535 Broadway, New York, NY 10036.

The hotel is newly renovated and situated near multiple attractions, including Times Square, Rockefeller Center, Theater District (to catch a show on Broadway), and Radio City Music Hall. The hotel itself features a 24-hour fitness center, in-room dining, and a 5,000 square foot M Club. We recommend checking out "The View Restaurant and Lounge" located on the

48th floor of the hotel. This unique American bar and grill offers 360-degree views of the city and, what's more, the dining room itself revolves so you can sightsee while enjoying your meal. However, this is not the only unique dining experience the city has to offer, and some of the best dining spots in the world can be accessed from a brief 10- to 15-minute walk outside the hotel.

Restaurants

When you are dining in NYC, the options for cuisine are endless. The committee is pleased to offer you some guidance in making a selection as we have prepared a restaurant guide that can be accessed here: <https://www.abct.org/2022-convention/restaurants/>. The guide lists both casual and formal dining located within a 10- to 15-minute walk of the hotel, formal dining located elsewhere in the city, POC-owned restaurants, and various dining options for those with dietary restrictions (Kosher, Halal, Vegetarian, Vegan, Gluten-Free). If you are looking for a taste of everything, we recommend visiting Restaurant Row (<https://www.timessquarenyc.org/locations/dining/restaurant-row>), which is conveniently located near Times Square.

Attractions

For a complete list of attractions constructed by the committee, visit <https://www.abct.org/2022-convention/local-attractions/> for a listing of attractions in various boroughs, parks, observation decks, museums, shows, and includes low-cost or free options. As discussed above, the hotel is within walking distance of multiple NYC sites, including:

Times Square: 42nd St. to 47th St. at the junction of Broadway and 7th Ave.

Radio City Music Hall: 1260 6th Avenue, New York, NY 10020

Rockefeller Center (including Observation Deck "Top of the Rock"): 45 Rockefeller Plaza, New York, NY 10111

Theater District: 47th Street and 7th Avenues, New York, NY 10036

If you have the time and want to see a show on Broadway, please visit TKTS Times Square for discounted same-day tickets at <https://www.tdf.org/nyc/7/> TKTS-ticket-booths located at Broadway

and West 47th Street, in Times Square. Regular priced advanced purchase can be done at <https://www.broadway.com>

If you are looking to see as much as possible during the convention, we recommend booking a walking tour <https://free-toursbyfoot.com/new-york-tours/>, which allows you to pay-what-you-wish.

We included some of the must-see attractions from our list below and we separated them by borough [Note: we did not include attractions in Staten Island as these would only be accessible via ferry].

Manhattan

- Be sure to check out the Empire State Building, and if you have time, head on up to the observation check for breathtaking city views.
- To see the Statue of Liberty, you can book a complete tour of Ellis Island, or you can view it in passing for free by taking the Staten Island Ferry.
- For a unique architectural experience, be sure to check out Hudson Yards and the Vessel, which is free to view from the outside, but you can purchase tickets for the full experience.
- Immerse yourself in priceless pieces of art and history at some of NYC's most famous museums, including the Metropolitan Museum of Art ("The MET"), the Museum of Modern Art ("MoMA"), the American Museum of Natural History, the Morgan Library and Museum, or the Guggenheim.
- Make sure to check out Wall Street and "The Charging Bull" statue which sits directly in front of the NYC Stock Exchange in the financial district.
- Visit the World Trade Center Memorial and the National September 11 Memorial Museum. During your visit to this location, you can also check out "One World Observatory" located in the One World Trade Center building, the tallest building in NYC.
- Depending on the dates of their opening, you may also want to check out some of NYC's famous holiday markets, such as the Bank of America Winter Village and Union Square Holiday Market, or go ice-skating at The Rink at Rockefeller Plaza.

Brooklyn

- Be sure to check out the Brooklyn Bridge, a famous piece of architecture and iconic NYC attraction, which can be accessed via Manhattan or the Brooklyn Promenade.

• Brooklyn is also home to the Brooklyn Academy of Music, the Brooklyn Museum, and the Brooklyn Transit Museum.

- If you are looking to do a little shopping without breaking the bank, check out the expansive Brooklyn Flea Market.

The Bronx

- Hop on a brief subway headed north to check out authentic Italian restaurants on Arthur Avenue, widely regarded as the "Real Little Italy."
- Fans of horror and history should also take the time to check out Edgar Allen Poe's cottage and museum, with low-cost entry and discounts for students.
- Even if you do not support them as your team, sports lovers may want to check out the historic Yankee Stadium.
- The Bronx Zoo is also a great option, and it is family friendly for those with kiddos!

Queens

- So you're not a Yankees fan, and if you cannot bring yourself to visit Yankee Stadium but are still a sports lover, check out Citi Field, home of the Mets!
- Queens is also home to MoMA PS1, a cheaper alternative to the original museum. You can also check out the famous Socrates Sculpture Park.
- Interested in movies and TV shows? Check out SilverCup Studios located conveniently in Queens!

For Outdoors Folks

Even though we are expecting some cold weather come November, NYC has numerous expansive parks that offer brief reprieves from the bustling city, starting with one of the most famous parks in the world, Central Park, which offers a labyrinth of biking and jogging trails. Be sure to also check out the Central Park Zoo, especially if you have the kids with you at the convention. For other, unique park options, be sure to check out the High Line Park—a truly unique NYC experience—which is free to enter and features beautiful sculptures. Little Island, located on the Hudson River, also offers a vastly different experience from traditional parks as this space is a floating oasis with incredible views of the city.

Getting to and From the Hotel to JFK or LaGuardia Airport

JFK Airport is located approximately 15 miles away from the New York Marriott Hotel. However, please be mindful the drive to and from the airport via taxi or rideshare (Uber/Lyft) could take 30 minutes to an hour due to traffic and may be a costly option (\$60-\$100+) for those traveling alone. Taking the subway is a low-cost option to get to or from the airport and involves taking the AirTrain JFK Red along with the "E" line. If you are going to opt for the subway option, we recommend using Google Maps to assist you, as this service will specify which lines you may need, and which stops to exit on.

LaGuardia Airport is located approximately 9 miles from the hotel. Although this airport is significantly closer, once again, please be mindful of the traffic as it could take upwards of 45+ minutes to commute to or from the airport. Taxi or rideshare would be a convenient option but may cost around \$60-\$100+. Public transportation may be an attractive low-cost option; however, it requires the use of both a bus and subway and may be confusing for those who are not accustomed to making transfers between these two services. Again, if you opt for public transportation, we recommend utilizing Google Maps to assist you in determining which buses and subway trains you will need to take.

Newark Liberty International Airport is located approximately 17 miles from the hotel. Travel time ranges from approximately 30 minutes during off-peak traffic times, up to an hour via taxi or rideshare, and could cost about \$60-\$100+. If you are going to opt to take public transportation, we recommend using the AirTrain. This train is quick and provides connections with PATH, NJ TRANSIT, and Amtrak through the gateway "Newark Liberty International Airport Station." The Newark Airport Express, which is a shuttle bus that conveniently has a stop that is less than half a mile away from the hotel, is another option, but this again would involve traffic. A one-way bus ticket for the Newark Airport Express is \$18 (round trip is \$30). Other options for public transportation include taking more than one local bus, which can be complicated and is not recommended for first-time transit riders.



Emergency & Disaster Preparedness and Response

ABCT 2022

November 17–20 | New York City

Welcome From the Program Chairs	—	ii
About the Itinerary Planner	—	iv
CE Credits	—	iv
Clinical Intervention Trainings	—	v
Presidential Address	—	v
Institutes	—	vi
AMASS	—	vi
Master Clinician Seminars	—	viii
Workshops	—	vii
Invited Panels	—	vii
Lifetime Achievement Address	—	ix
Invited Talks	—	x
General Sessions	—	xiv
<i>Panel Discussions</i>	—	xiv
<i>Symposia</i>	—	xviii
<i>Clinical Round Tables</i>	—	xxix
<i>Spotlight Research</i>	—	xxxi
<i>Mini Workshops</i>	—	xxxii
<i>Research and Professional Development</i>	—	xxxiii
Special Interest Group Meetings		xxxiv
Hotel & Registration		xxxv

Note Program details such as educational objectives, session level, fees, presenter credentials, and number of CE credits that can be earned may be found in the program book on ABCT's website. Program subject to change.

Welcome From the Program Chairs



Rosaura Orengo-Aguayo, Ph.D. (she/her/ella), *Program Chair*, National Crime Victims Research & Treatment Center and Medical University of South Carolina

Emily B.K. Thomas, Ph.D. (she/her), *Associate Program Chair*, The University of Iowa

It is with great enthusiasm that we, your ABCT 2022 Program Chairs, welcome you to ABCT's 56th Annual Convention in New York City! As we write this message in July 2022, we are hopeful that we can once again gather in person safely for our Annual Convention. The past two years have been incredibly challenging for many. Some of us will carry both the joy of gathering with esteemed colleagues and friends and the sadness of those we have lost. For many students, this will be the first time attending a professional conference in person. And for others, it will not be possible to attend due to the continuation of this pandemic and concerns about health and safety. ABCT's priority is to hold a safe event based on CDC guidance, federal, state, and local regulations applicable at the time of the event, as well as what ABCT deems necessary to manage the risk for its event attendees. Some of the most salient measures being taken are the requirement of proof of full vaccination against COVID-19 and required mask wearing. We encourage attendees to read and adhere to ABCT's full COVID-19 protocol on the convention webpage, while being mindful that engaging in these behaviors will protect our community. May we embrace the cutting-edge science and wonderful presentations in this year's program, while creating a safe space for all who attend.

ABCT's 56th convention theme is "Emergency & Disaster Preparedness and Response: Using Cognitive and Behavioral Science to Make an Impact." The COVID-19 pandemic revealed incredible strengths and formidable weaknesses in our preparedness and response to a global health emergency. Concurrently, additional emergencies, epidemics, and syndemics were revealed, some of which were caused or exacerbated by COVID-19, and others were longstanding but became more apparent (e.g., mass shootings, hate-based crimes, increase in suicide, substance use, mental health disorders, rise in disasters due to climate change). This year's convention will spotlight research that helps us answer the question of where we are in developing the robust theory and sound science to be able to respond to health emergencies, epidemics, and syndemics that we face. Do we know enough about the mechanisms of action and essential ingredients of our interventions so that we can quickly develop, adapt, and deploy cognitive and behavioral interventions to prepare and respond? Do we have the public health systems and ev-

idence-based policies in place to recognize mental/public health emergencies and respond to them effectively? Do we have evidence-based ways to communicate the evidence for cognitive and behavioral interventions to the public and policymakers to effect change? Are we equipping current and future professionals with the necessary tools to respond to disasters? Finally, do we have the contingencies in our field to encourage this kind of science?

Our invited addresses and panels will feature some of the world's leading experts in these topics, some of whom will be bringing new voices and perspectives to ABCT. Melissa Brymer, Ph.D., Psy.D., Director of the Terrorism and Disaster Program at the UCLA/Duke University National Center for Child Traumatic Stress, will contextualize the youth mental health crisis within an era of mass violence and disasters. Cheryl L. Holder, M.D., Associate Dean for Diversity, Equity, Inclusivity and Community Initiatives at Florida International University, will bring light to the impact of climate change on health disparities. Carmen D. Zorrilla, M.D., Professor of Obstetrics and Gynecology at the University of Puerto Rico School of Medicine, will present on the COVID-19 Public Health Response in Puerto Rico, resulting in the highest vaccination rate in the U.S. Enola Proctor, Ph.D., Professor Emeritus, Washington University in St. Louis, will highlight the crucial role of implementation science in emergency and disaster response moving forward. ABCT 2021 Lifetime Achievement Award winner, Dr. Patricia Resick, will speak to us about Cognitive Processing Therapy for PTSD, its history and its future.

In addition to our impressive keynote speakers, this year we will have three invited panels with multidisciplinary experts from our field and beyond: (1) "Psychological Science's Role in Addressing Mental, Physical and Social Health Epidemics: A Call to Action"; (2) "Open Science: The Future of Psychology"; and (3) "(Non-Traditional) Funding Mechanisms for Behavioral Science Research," which will bring together NIH and PCORI program officers and division directors. Be sure to check out more in-depth descriptions on the ABCT 2022 convention page.

We will also have a rich program including 138 symposia, 31 panels, 15 clinical round tables, 4 spotlight research, and 1,002 poster presentations encompassing diverse topics of interest for all ABCT members: suicide and self-injury; disaster mental health; addictive behaviors; racial trauma; LGBTQ+; tele-

health/mHealth; dissemination & implementation science; psychotic disorders; autism spectrum and developmental disorders; trauma and stressor-related disorders; culture, race, and ethnicity; oppression and resilience minority health; and child maltreatment, anxiety, depression, and ADHD. Importantly, this is in no way an exhaustive list and represents some of our more frequently selected submission topics for the convention.

Of note, in accordance with President Seligman's core theme of transparency this year, we held a series of town halls to elicit feedback from membership on convention submissions and decisions, incorporated this feedback into actionable steps, and used a data-driven approach to make program decisions. Of the 1,638 submissions, 1,189 were accepted. Decisions were difficult due to space constraints at the convention hotel and the many excellent submissions that were received this year. Please be on the lookout for a detailed report in this issue of *the Behavior Therapist*, for more information on the peer review and decision-making process. In particular, we conducted analyses to answer questions from membership about whether authors who identify as part of an underrepresented or minoritized identity are less likely to have their submissions accepted. We extend our sincere gratitude to all ABCT members and SIG leaders who attended these town halls and/or reached out individually to us to share their concerns and constructive feedback. We hope this will serve as a foundation for future ABCT program chairs to continue to improve upon.

It has been an honor to serve as ABCT's 56th Annual Convention Program Chairs this year. ABCT has been one of our main professional homes since we both began graduate school and it has helped us grow as scientists and clinicians, promoted fruitful collaborations, and inspired new projects and ideas. Most important, serving in this role has allowed us to meet and collaborate with amazing colleagues across the nation with whom we would not have otherwise connected. It has been a lot of work, and it has helped us move toward our values of transparency, collaboration, and service.

We wish to thank President Dr. Laura Seligman for her incredible support, vision, and encouragement and Mrs. Susan Kroska for offering excellent technical assistance and support. We are grateful to the ABCT Board of Directors for supporting our new ideas and proposals and the ABCT Central Office staff, Mary Jane Eimer (Executive Director), Stephen Crane (Convention Manager), and Dakota McPherson (Membership and Marketing Manager) for providing much needed technical assistance and guidance. We also are grateful to the past Program Chairs (Dr. Gregory S. Chasson and Dr. Elizabeth C. Katz) for their helpful guidance and consultation. This program would not be possible without the vision and hard work of the chairs and volunteers of the Convention and Education Issues Committee: Dr. Katharina Kircanski (Convention and Education Issues Coordinator) and Dr. Christina (Tina) Boisseau (Workshops Committee Chair & Interim Coordinator of Convention and Education Issues), Dr. Samantha Farris (Institutes Chair), Dr. Tejal Jakatdar (Master Clinician Seminar Chair), Dr. Amanda Raines (Research and Professional Development Chair), Dr. Patrick McGrath (Sponsorship Chair), Dr. Miryam Yusuf (Advanced Methodology and Statistics Seminar Chair), Dr. Jason Duncan (Local Arrangements Chair), and Dr. Katherine (Katie) Baucom (Board Liaison to Convention and Education Issues). We additionally extend our deepest gratitude to the 200 Program Committee members who served as scientific peer reviewers for the convention, with an extra thanks to those who served as super reviewers. We would also like to acknowledge Dr. Jennifer Sumner and Dr. Sierra Carter, Program Chairs for the 2022 International Society of Traumatic Stress Studies, who graciously shared materials and exchanged ideas with us to help improve our process. Finally, a big shout-out to our incoming ABCT 57th Annual Convention Program Chairs, Dr. Emily Bilek and Dr. Krystal Lewis, who will taking the baton and leading us to Seattle in 2023!

Wishing everyone a safe and enriching ABCT Convention!



There will be screening of the documentary **CONVERSION**, directed by Gregory Caruso, at the Annual Convention on **Saturday, November 19**, from 10:15 a.m. - 11:45 a.m.

A psychologist practicing conversion therapy has a chance encounter with a young gay activist, resulting in his own epiphany concerning the very practice he was conducting.

Itinerary Planner

* Available in August *

> Browse by day, time, or session type

> Search by author or keyword

The pages that follow provide an overview of the ticketed sessions and general sessions that will be part of the 2022 convention. In order to learn more details about the sessions, including full descriptions and times, skill levels, and learning goals, please utilize the Itinerary Planner. Feel free to access the Itinerary Planner at <https://www.abct.org/2022-convention/>. To view the entire convention program—including SIG meetings, poster sessions, invited addresses—you can search by session type, date, time, presenter, title, category, or keyword, or you can view the entire schedule at a glance. After reviewing this special Convention 2022 insert, we hope you will turn to the online Itinerary Planner and begin to build your ultimate ABCT convention experience!

www.abct.org/convention-ce/

Continuing Education Credits

At the ABCT Annual Convention, there are ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and general sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. Below is a list of organizations that have approved ABCT as a CE sponsor. Note that we do not currently offer CMEs.



Psychology

ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content.



Counseling

The Association for Behavioral and Cognitive Therapies has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 5797. Programs that do not qualify for NBCC credit are clearly identified. The Association for Behavioral and Cognitive Therapies is solely responsible for all aspects of the programs.



Marriage and Family Therapy:

The Association for Behavioral and Cognitive Therapies is recognized by the California Board of Behavioral Sciences for Marriage and Family Therapist (MFT) to offer continuing education as Provider #4600.

New York State Psychologists

Association for Behavioral and Cognitive Therapies (ABCT), is recognized by the New York State Education Department's State Board for Psychology as an approved provider of continuing education for licensed psychologists #PSY-0124

New York State Social Workers:

Association for Behavioral and Cognitive Therapies (ABCT), is recognized by the New York State Education Department's State Board for Social Workers as an approved provider of continuing education for licensed social workers #SW-0657.

For full information about our CE program, visit:

<https://www.abct.org/Conventions/index.cfm?m=mConvention&fa=ceOpportunities>

Clinical Intervention Trainings

TICKETED SESSIONS

Thursday, November 17 | 8:30 AM – 5:00 PM

CIT 1 | **CBT Made Simple: The Unified Protocol for the Transdiagnostic Treatment of Co-occurring Anxiety, Depressive, and Related Disorders**

♦ *Participants earn 7 continuing education credits*

Shannon Sauer-Zavala, Ph.D., *Associate Professor, University of Kentucky*

A quick Amazon search turns up hundreds of workbooks for anxiety and depression. How do you select an evidence-based approach for your patients from all of the available options? Indeed, the explosion of specific treatment manuals for each DSM disorder has created unintended barriers for implementation and dissemination of evidence-based psychological treatments. It is costly to receive training in each protocol and it may not be feasible for busy clinicians to prep different interventions for the myriad problems faced by patients on their caseloads. The Unified Protocol for the Treatment of Emotional Disorders was developed to address these barriers. The UP is a transdiagnostic, emotion-focused cognitive-behavioral treatment (CBT) that targets core deficits occurring across the neurotic spectrum (e.g., anxiety, depressive, and related disorders [e.g., eating disorders, borderline personality disorder]). This workshop will first briefly review evidence supporting the development of such transdiagnostic interventions. This will be followed by a description and demonstration of how to apply core UP treatment modules, along with the similarities and differences between the UP and traditional CBT. Audio and videotaped illustrations of core treatment interventions (e.g., mindful awareness, emotion exposures) will be presented, along with detailed case examples involving complex comorbidity. Attendees will be invited to participate in exercises as part of these demonstrations.

Thursday, November 17 | 8:30 AM – 5:00 PM

CIT 2 | **Transdiagnostic Contextual Behavioral Approaches to Respond to Sexual and Gender Minority Stress**

♦ *Participants earn 7 continuing education credits*

Matthew D. Skinta, Ph.D., ABPP, *Roosevelt University*

Sexual and gender minority stress appear to contribute to a variety of transdiagnostic concerns among sexual orientation and gender diverse people. This CIT will teach process-based behavioral techniques that take advantage of research on minority stress and processes that foster resilience and well-being. The session will incorporate both theoretical and experiential work. Moving through life as a sexual or gender minoritized person often entails some period of secrecy, guardedness, shame, and familial ruptures. We will explore the therapeutic techniques that tackle these concerns in the therapy hour and within the therapeutic relationship. This training will also aid clinicians in cultivating their own compassion and values toward meeting the challenges of moving through life as a SGM person, particularly through targeting the therapist's own history of cultural messages about gender and sexuality. Through the use of awareness, courage, therapeutic love, compassion, perspective-taking, and acceptance, participants will grow in their ability to relate as from the perspective of self-awareness of their own sexual orientation and gender. Clinicians will leave with a greater understanding of how concepts such as minority stress, rejection sensitivity, and shame can be better responded to in session.

Presidential Address



Saturday, November 19 | 6:15 PM – 7:30 PM

CBT for the Public Good: Why We Need to Be More Comfortable Using Someone Else's Toothbrush

♦ *Participants earn 1 continuing education credit*

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

The alleviation of human suffering or, put differently, the enhancement of health and well-being, is at the core of ABCT's mission. As we gather for the first time in 3 years due to a pandemic and a response that could be described as a very public and dramatic failed behavior change effort, we must ask ourselves how are we doing as a field. ABCT has its roots in a treatment that purported to offer optimism not evidenced in the prevailing methods of the time; optimism borne out of the promise to help people change behavior through the reliance on experimental psychology. I would argue that given these foundations, the work of cognitive behaviorists has the potential for broad and meaningful impact—impact that has not been fully realized. I will discuss the factors that I believe must be addressed for us to realize this potential, factors that include aligning the contingencies in our field with those that best serve the public good, a renewed focus on theory, and a reorientation toward collaboration and an iterative process over proprietary branding and novelty. Most importantly, however, we need to reacquaint ourselves with transparency and scientific debate with those who can challenge us so that we move steadily towards truth and ensure that the impact we do have will be a positive one.

Institutes

TICKETED SESSIONS

Designed for clinical practitioners, discussions and display of specific intervention techniques.

Institute 1 | Thursday, November 17: 8:30 AM – 5:00 PM
♦ Participants earn 7 continuing education credits.

CBT for Depression in the Second Half of Life: Personalized Treatment Approaches

Ann M. Steffen, ABPP, Ph.D., *Professor of Psychological Sciences, University of Missouri, St. Louis*

Institute 2 | Thursday, November 17: 8:30 AM – 5:00 PM
♦ Participants earn 7 continuing education credits.

ACT for Life: Using Acceptance and Commitment Therapy to Prevent Suicide and Build Meaningful Lives

Sean M. Barnes, Ph.D., *Clinical Research Psychologist, VA Rocky Mountain MIRECC*
Lauren M. Borges, Ph.D., *Clinical Research Psychologist, VA Rocky Mountain MIRECC*
Robyn D. Walser, Ph.D., *Clinical Psychologist, National Center for PTSD*

Institute 4 | Thursday, November 17: 1:30 PM – 6:30 PM
♦ Participants earn 5 continuing education credits.

A Step-by-Step Consensus Protocol for Cognitive Behavioral Therapy for Nightmares

Kristi Pruiksma, Ph.D., *Associate Professor-Research, University of Texas Health Science Center at San Antonio*
Hannah C. Tyler, ABPP, Ph.D., *Assistant Professor-Research, University of Texas Health Science Center San Antonio*

Institute 5 | Thursday, November 17: 8:00 AM – 1:00 PM
♦ Participants earn 5 continuing education credits.

Trauma-Informed Mindfulness: Integrating Mindfulness-Based Practices into Psychotherapy With Traumatized Clients

Terri L. Messman, Ph.D., *University Distinguished Scholar & Professor of Psychology, Miami University*
Noga Zerubavel, Ph.D., *Assistant Consulting Professor, DUMC; Co-Founder, Arise Psychological Wellness & Consulting, Duke University Medical*

Institute 6 | Thursday, November 17: 8:00 AM – 1:00 PM
♦ Participants earn 5 continuing education credits.

Evidence-Based Assessment and Treatment Augmentation for Depression and Bipolar Disorders in Youth and Early Adulthood

Eric A. Youngstrom, Ph.D., *Professor; Executive Director, University of North Carolina at Chapel Hill; Helping Give Away Psychological Science*

Institute 7 | Thursday, November 17: 1:30 PM – 6:30 PM
♦ Participants earn 5 continuing education credits.

Healing the Soul: Using ACT-CI to Promote Personal Growth in Times of Personal Crisis

Kirk D. Strosahl, Ph.D., *President, HeartMatters Consulting*
Patricia Robinson, Ph.D., *President, Mountainview Consulting Group*

Advanced Methodology and Statistics Seminars

A special series of offerings for applied researchers, presented by nationally renowned research scientists. TICKETED SESSIONS

AMASS 1 | Thursday, November 17 | 8:30 AM - 12:30 PM
♦ Participants earn 4 continuing education credits.

An Introduction to Qualitative Research

Anna C. Revette, Ph.D., *Senior Research Scientist, Survey and Qualitative Methods Core, Division of Population Sciences, Dana-Farber Cancer Institute, Instructor, Harvard T.H. Chan School of Public Health*

AMASS 2 | Thursday, November 17 | 1:00 PM – 5:00 PM
♦ Participants earn 4 continuing education credits.

Application of Geographic Information Systems to Quantify Exposure to Socio-Environmental Factors

Kevin M. Mwenda, Ph.D., *Assistant Professor of Population Studies, Brown University*

Master Clinician Seminars

TICKETED SESSIONS

These seminars involve the presentation of case material, session videotapes, and discussion to enable participants to further understand the application of cognitive and behavioral techniques.

MCS 1 | Friday, November 18: 8:30 AM – 10:30 AM

♦ Participants earn 2 continuing education credits

Addressing Treatment-Interfering Behavior: An Integrative Cognitive Behavioral Approach

Alec Pollard, Ph.D., *Professor Emeritus, Saint Louis University*

MCS 2 | Friday, November 18: 8:30 AM – 10:30 AM

♦ Participants earn 2 continuing education credits

Can Head Knowledge Become Heart Knowledge? The Use of Behavioral Experiments in the Treatment of Insomnia and Other Sleep/Circadian Problems

Allison G. Harvey, Ph.D., *Professor & Clinical Psychologist, University of California Berkeley*

MCS 3 | Friday, November 18: 11:00 AM - 1:00 PM

♦ Participants earn 2 continuing education credits

Developing a Case Formulation and Using It to Guide CBT

Jacqueline Persons, Ph.D., *Director, Bay Area Trauma Recovery Clinical Services*

MCS 4 | Friday, November 18: 1:30 PM – 3:30 PM

♦ Participants earn 2 continuing education credits

Positive Affect Treatment for Depression and Anxiety

Michelle G. Craske, Ph.D., *Distinguished Professor, University of California Los Angeles*

Alicia E. Meuret, Ph.D., *Professor of Psychology, Southern Methodist University*

MCS 5 | Saturday, November 19: 8:30 AM – 10:30 AM

♦ Participants earn 2 continuing education credits

Shaping Bravery: A Clinical Demonstration of Shared Processes Across ACT and CBT That Target Youth Anxiety and Avoidance

Jill Ehrenreich-May, Ph.D., *Professor, University of Miami*
Lisa W. Coyne, Ph.D., *Assistant Professor, Harvard Medical School*

MCS 6 | Saturday, November 19: 11:00 AM – 1:00 PM

♦ Participants earn 2 continuing education credits

Using Virtual Reality to Treat Anxiety Disorders

Elizabeth McMahon, Ph.D., *Independent Practice*

MCS 7 | Saturday, November 19: 1:30 PM – 3:30 PM

♦ Participants earn 2 continuing education credits

Cognitive Behavior Therapy for Regret

Robert L. Leahy, Ph.D., *Director, American Institute for Cognitive Therapy*

Workshops

TICKETED SESSIONS

Workshops provide up-to-date integration of theoretical, empirical, and clinical knowledge about specific issues or themes

Workshop 1 | Friday, November 18, 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

Parent Child Interaction Therapy for Selective Mutism

Rachel Merson, Psy.D., *Research Assistant Professor, Boston University Center for Anxiety and Related Disorders*
Rachel Busman, Psy.D., *Senior Director, Child and Adolescent Anxiety & Related Disorders Programs, Cognitive and Behavioral Consultants*

Jami M. Furr, Ph.D., *Senior Psychologist, Florida International University*

Workshop 2 | Friday, November 18, 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

Trauma Management Therapy for PTSD

Amie R. Newins, Ph.D., *Associate Professor, University of Central Florida*
Deborah C. Beidel, ABPP, Ph.D., *Professor of Psychology, University of Central Florida*

Workshop 3 | Friday, November 18, 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

Transdiagnostic Brief Behavior Therapy for Youth Anxiety and Depression

V. Robin Weersing, Ph.D., *Professor, SDSU-UC San Diego JDP in Clinical Psychology*

Michelle Rozenman, Ph.D., *Assistant Professor, University of Denver*

Araceli Gonzalez, Ph.D., *Associate Professor, California State University Long Beach*

Workshop 4 | Friday, November 18: 12:00 PM – 3:00 PM

♦ Participants earn 3 continuing education credits

The New School Refusal—Logged on or Logged Off, but Still Checked Out: Managing Chronic School Disengagement During COVID-19

Brian C. Chu, Ph.D., *Professor, Rutgers University*

Laura Skriner, Ph.D., *Founding Member, Co-Director, The Center for Stress, Anxiety, and Mood*

Workshop 5 | Friday, November 18: 12:00 PM – 3:00 PM

♦ Participants earn 3 continuing education credits

Socratic Questioning 2.0: Dialectical and Contextual Strategies for Lasting Change

Scott H. Waltman, ABPP, Psy.D., *Center for Dialectical and Cognitive Behavior Therapies*

Lynn M. McFarr, Ph.D., *Founder/Executive Director, CBT CALIFORNIA*

Dennis Tirch, Ph.D., *Founding Director, The Center for CFT*

Robyn D. Walser, Ph.D., *National Center for PTSD*

Workshop 6 | Friday, November 18: 12:00 PM – 3:00 PM

♦ Participants earn 3 continuing education credits

Pain Reprocessing Therapy: A Framework for Resolving Chronic Pain

Yoni Ashar, Ph.D., *Weill Cornell Medical College*

Daniella Deutsch, MSW, *Co-Founder, Pain Reprocessing Therapy Center*

Workshop 7 | Saturday, November 19: 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

Making CBT Pop (Culture): Supercharging Youth Therapy with Songs, Superheroes, Sports, and More

Sandra Pimentel, Ph.D., *Chief, Child and Adolescent Psychology, Montefiore Medical Center- AECOM*

Ryan C. DeLapp, Ph.D., *Attending Psychologist, Montefiore Medical Center*

Workshop 8 | Saturday, November 19: 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

Lessons from Pandemic Parenting: Clinical Approaches and Tools to Help Parents and Caregivers Face Growing Youth Mental Health Concerns

Andrea B. Temkin, Psy.D., *Assistant Professor of Psychology in Psychiatry, Weill Cornell Medicine*

Lisa Coyne, Ph.D., *Founder & Executive Director,*

New England Center for OCD and Anxiety

Samuel Fasulo, Ph.D., *Clinical Assistant Professor, NYU Langone Child Study Center*

Anthony Puliafico, Ph.D., *Associate Professor of Medical Psychology (in Psychiatry), Columbia University Medical Center*

Workshop 9 | Saturday, November 19: 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

Improving Delivery of Cognitive Processing Therapy for PTSD: Targeting Therapist Factors That Impact Outcome

Stefanie T. LoSavio, ABPP, Ph.D., *Clinical Associate, Duke University Medical Center*

Patricia A. Resick, ABPP, Ph.D., *Professor of Psychiatry and Behavioral Sciences, Duke Health*

Workshop 10 | Saturday, November 19: 8:30 AM – 11:30 AM

♦ Participants earn 3 continuing education credits

GRIEF Approach: A Comprehensive Treatment Model for Traumatic Loss

Alyssa A. Rheingold, Ph.D., *Professor, Medical University of South Carolina*

Joah Williams, Ph.D., *Assistant Professor, University of Missouri-Kansas City*

Workshop 11 | Saturday, November 19: 12:00 PM – 3:00 PM

♦ Participants earn 3 continuing education credits

Cognitive-Behavioral Therapies for Social Anxiety Disorder: An Integrative Strategy

Larry I. Cohen, LICSW, *Cochair and cofounder, National Social Anxiety Center*

Workshop 13 | Saturday, November 19: 12:00 PM – 3:00 PM

♦ Participants earn 3 continuing education credits

Acceptance and Commitment Therapy for Managing Cravings and Addictive Behaviors

Maria Karekla, Ph.D., *University of Cyprus*

Megan M. Kelly, Ph.D., *VA Bedford Healthcare System*

Invited Panels

Friday, November 18 | 12:30 PM – 2:00 PM

#1: **Psychological Science's Role in Addressing Mental, Physical and Social Health Epidemics: A Call to Action**

Saturday, November 19 | 12:00 PM – 1:30 PM

#2: **Open Science: The Future of Psychology**

Saturday, November 19 | 3:30 PM – 5:00 PM

#3: **Funding Mechanisms for Behavioral Science Research**

Lifetime Achievement Award Address



Cognitive Processing Therapy for PTSD: Where We Have Come and What Is Next

Patricia A. Resick, Ph.D., ABPP, *Professor of Psychiatry and Behavioral Sciences, Duke Health*

Friday, November 18 | 11:00 AM - 12:00 PM

♦ Participants earn 1 continuing education credit

Patricia A. Resick, Ph.D., ABPP, is Professor of Psychiatry and Behavioral Sciences at Duke Health and Adjunct Professor, Medical University of South Carolina. After graduating with her Ph.D. in Psychology from the University of Georgia, Dr. Resick served as an Assistant and Associate Professor at the University of South Dakota. She also served as Associate to Full Professor at the University of Missouri-St. Louis and was awarded an endowed professorship, Curator's Professor in 2000. During that period, she also founded and was the first Director of the Center for Trauma Recovery. In 2003, Dr. Resick became the Director of the Women's Health Sciences Division of the National Center for PTSD, VA Boston Healthcare System and Professor of Psychiatry at Boston University. In 2013, she moved to Duke University. Dr. Resick's specialty is in understanding and treating the effects of traumatic events, particularly PTSD. In 1988, she developed Cognitive Processing Therapy (CPT) for PTSD, a brief evidence-based treatment and has overseen multiple clinical trials. The treatment manual for CPT has been translated into 12 languages and has been formally disseminated throughout the Department of Veterans Affairs in the U.S., Canada, and Australia, and now the Democratic Republic of Congo. CPT is considered a first line-therapy for PTSD. Dr. Resick's research has been continuously funded for 40 years; she has published over 350 articles and chapters and 11 books on PTSD. She has served as the President of both the International Society for Traumatic Stress and the Association for Behavioral and Cognitive Therapies. She has won research and mentoring awards, as well as Lifetime Achievement Awards from the Trauma Division (56) of the American Psychological Association, the International Society for Traumatic Stress Studies and the Association for Behavioral and Cognitive Therapies.

Cognitive Processing Therapy (CPT) was first developed 34 years ago, focusing on victims of rape. Since clinical testing and a first study, CPT has been the subject or comparison group for dozens of randomized controlled trials, development studies, program evaluation studies, and many case studies with a range of traumas and populations across many countries. Because CPT has been disseminated throughout the Department of Veterans Affairs since 2007, many studies of predictors of dropout, improvement, and completion have been conducted as well as newer studies on therapist factors on outcomes. As I look ahead to my next retirement, I will look back at the evolution of CPT, in its various iterations and formats and then will anticipate the next stages of development with both the therapy protocol itself, as well as issues in implementation. The greatest challenge ahead is shared by other therapies as well, the regular adoption and use of evidence-based treatments in practice. The next frontier is not the development of more therapies for PTSD but getting treatments that work into the hands of patients who need them and helping practitioners and agencies to adopt them as usual practice.

Invited Address 1

Friday, November 18 | 9:00 AM – 10:00 AM

♦ Participants earn 1 continuing education credit

Addressing the Mental Health Crisis Facing Youth: We Need to Respond Now to Promote the Growth of Our Youth!



Melissa Brymer, Ph.D, Psy.D., *Director of the Terrorism and Disaster Program, University of California, Los Angeles, and Duke University National Center for Child Traumatic Stress, National Child Traumatic Stress Network*

Melissa Brymer, Ph.D, Psy.D. is Director of the Terrorism and Disaster Program of the UCLA/Duke University National Center for Child Traumatic Stress and its National Child Traumatic Stress Network. In this capacity, Dr. Brymer been involved with the development of acute interventions, assessment, and educational materials in the area of terrorism, disasters, public health emergencies, and school crises. She is one of the primary authors of NCTSN/NCPTSD Psychological First Aid and Skills for Psychological Recovery and has served as a consultant for many federal, state, and local agencies across the country and internationally after disasters, terrorism, school shootings, and other mass emergencies. Dr. Brymer was the lead advisor to the Newtown Public Schools Recovery Program and has led the NCTSN's response to COVID-19. Dr. Brymer is also a Researcher at the UCLA David Geffen School of Medicine. Her research interests have been in the area of examining the effectiveness of acute disaster behavioral health interventions, examining the short and long-term impact of mass violence on children and families, and enhancing community practices after disasters.

At the end of 2021, the U.S. Surgeon General's Office released an advisory report regarding the urgent mental health crisis facing youth, exacerbated by the COVID-19 pandemic. In March of this year, the CDC also released new data shining additional light on the mental health consequences of the pandemic on youth disproportionately. Specifically, more than 140,000 U.S. youth have lost a primary or secondary caregiver due to the pandemic and there has been a significant rise in emergency room visits for suspected suicide attempts, especially for adolescent girls. Youth and their families have also experienced additional adversities, including abuse; financial, home, and food insecurities; missed milestones/rites of passage; other community traumas (disasters, violence, hate), and lost time with peers in school, extracurricular activities, and cultural/religious activities. Additionally, the pandemic has shone a spotlight on discrimination, racism, and health disparities in the U.S. These reports recognize that mental health is an essential part of a youth's overall health and that we need to act now to positively shape our youth's development. This presentation will review key resources that educate and empower families to support their children and how we need to enhance youth's connectedness at school. A public behavioral health approach will be discussed on how to identify and treat youth based on their current need for service using a DEI lens. The presentation will review different trauma and grief informed evidence-based interventions that can be used for different developmental levels and for different child serving systems. Finally, this presentation will also address the toll the pandemic has had on our workforce and ways to enhance provider wellness and mitigate secondary traumatic stress.

Invited Address 2

Saturday, November 19 | 9:00 AM – 10:00 AM

◆ Participants earn 1 continuing education credit

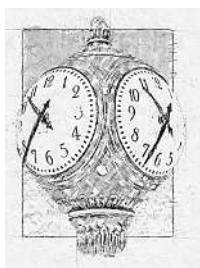
Climate Change, Health and Equity



Cheryl L. Holder, Ph.D., Associate Dean of Diversity, Equity, Inclusivity and Community Initiatives, Herbert Wertheim College of Medicine, Florida International University

Dr. Cheryl L. Holder, Fellow of the American College of Physicians, has dedicated her medical career to caring for low-wealth populations. She has served as a National Health Service Corp Scholar, as Medical Director of Jackson Memorial Hospital's north Dade Health, and as a participant on NIH and CDC health advisory and programmatic review panels. In 2009, she joined the faculty of Herbert Wertheim College of Medicine at Florida International University and currently serves as Associate Dean of Diversity, Equity, Inclusivity and Community Initiatives. She focuses on teaching the impact of social determinants of health, addressing diversity in health professions, increasing awareness of HIV prevention and health impact of climate change. Most recently, her TED Talk "The Link Between Climate Change, Health and Poverty" has had over 300K views.

Scientists have concluded that climate change and shifts in temperatures and weather patterns over time can occur through the natural variations in the solar cycle. However, since the 1800s, human activities—primarily burning fossil fuels like coal, oil, and gas to power the industrial revolution—have contributed to climate warming to life-threatening levels. This talk will review the science of climate change, the health impacts of the climate change, the populations that are impacted now, the role of clinicians, and possible solutions for limiting planetary warming.



Visit www.abct.org/2022-convention/ for **INFORMATION**

- > **City Map**
- > **Travel Guide**
- > **Hotel Information**
- > **Local Attractions**
- > **Restaurants**
- > **Delta Airlines Discount**
- > **Child Care**
- > **Code of Conduct**
- > **Health & Safety Protocols**

Invited Address 3

Saturday, November 19 | 2:00 PM - 3:00 PM

◆ Participants earn 1 continuing education credit

The Role of the UPR Medical Sciences Campus in the COVID-19 Public Health Response in Puerto Rico



Carmen D. Zorrilla, M.D., *Professor Obstetrics and Gynecology, University of Puerto Rico School of Medicine*

Dr. Carmen D. Zorrilla is a professor of obstetrics and gynecology at the UPR School of Medicine, certified by the American Board of Obstetrics and Gynecology and the American Academy of HIV Medicine. In 1987, she established the first longitudinal clinic for women living with HIV in Puerto Rico. She participated in the PACTG 076 as one of the first 10 pilot sites and was instrumental in making AZT available to pregnant women living with HIV in Puerto Rico. Her clinic, in which more than 600 infants have been born to HIV-positive women, has had a nearly zero transmission rate during the past 17 years. Dr. Zorrilla implemented a program for group prenatal care at the University Hospital, the first in Puerto Rico. This new model of care evidenced a reduction in preterm births. She is one of leaders who spearheaded the research response to the emerging Zika epidemic among pregnant women in Puerto Rico and established a multidisciplinary clinic for pregnant women with Zika. During the COVID-19 pandemic she spearheaded the development of a Molecular testing program at the RCM, a Phase III vaccine trial and a COVID Vaccine Center with a 97% vaccination rate of the faculty, students, and staff at the UPR-MS. She is a member of the Scientific Coalition named by PR Governor Hon. Pedro Pierluisi to advise on issues related to the COVID pandemic response and to further incorporate the input of Science into public policy. .

By June 8, 2022, Puerto Rico has administered 7,107,447 vaccine doses in a population of 3,076,212. The coverage of 95% people with at least 1 dose is greater than many States. Since protection wanes after 6 months, 1.3M people need a booster. The success of the public health response was in large part due to planning and inclusion of most health care sectors in the response. In addition, PR has traditionally reported good vaccination rates among school-aged children. The UPR Medical Sciences Campus response to the COVID-19 pandemic and its sustained work includes several strategies. With 6 schools: Medicine, Dental Medicine, Nursing, Pharmacy, Health Professions and Public Health, a community of about 5,000 individuals (students, faculty, residents, and staff), we are educators, health care providers (HCP) and research leaders. Specifically, we will address research, molecular testing, and vaccination efforts. With a need for testing and diagnosis, as a step for research and management of cases, we established a molecular testing center in 2020. It allowed our investigators to offer participation in diverse research activities and access to testing for our students and staff. We were part of clinical trials for vaccines (Novavax) and new treatments (ACTIV-network). Once the testing program was ongoing and vaccines were available by December 2020, we established a Vaccine Center with active participation of the Deans and faculty of 5 schools. Fair distribution of vaccines required assessment of exposure risks among students and faculty per school and program, planning for appointments according to capacity, dissemination of the plan with its specific rationale and monitoring to assure compliance of the plan. Our model decentralized the establishment of risk category of staff, faculty and students, and the appointment lists at the Deanship of each school. We determined the vaccination slots per day and assigned numbers to the Deanships which in turn provided a list by school per each vaccine day. All schools had a portion of the daily appointments to foster coverage. In 4 months, we reached more than 98% coverage of our community. One unique strategy was the use of therapy dogs for the vaccination efforts for children.

Invited Address 4

Sunday, November 20 | 10:00 AM- 11:00 AM

♦ *Participants earn 1 continuing education credit*

Evidence for Emergency and Disaster Response: We Need a Faster Lane for Science



Enola Proctor, Ph.D., *Professor Emeritus, Washington University in St. Louis*

Dr. Proctor is Shanti K. Khinduka Distinguished Professor Emeritus. The National Institute of Mental Health has supported her research and training grants for 29 consecutive years. She has pioneered the field of dissemination and implementation science, leading teams to distinguish, clearly define, develop taxonomies, and advance the conceptual, linguistic, and methodological clarity in the field. She directs the Implementation Research Institute, a training program in implementation science funded by the National Institute for Mental Health. Proctor was a member of the inaugural class of fellows in the American Academy of Social Work and Social Welfare. Her awards include Washington University's Arthur Compton Holly Distinguished Faculty Award, the Society for Social Work and Research's Distinguished Research Award, the National Association of Social Workers' President's Award for Excellence in Social Work Research, and the American Public Health Association Stephen M. Banks Award for Outstanding Mentoring in Mental Health Services. She has advised the National Institutes of Health and the World Health Organization on several implementation science projects in low and middle income countries, including current work on COVID vaccine implementation.

Health emergencies and disasters require rapid response. Front-line providers, policymakers, and health system administrators need solid evidence of how to prepare and react, and they need that evidence in short order. Yet many emergencies are novel, as with the COVID-19 pandemic. How can we know what to do in situations never faced before? How can translational researchers more effectively move evidence from the lab into the real world even as evidence evolves? And how can cognitive and behavioral scientists tackle the fact that evidence-based recommendations are often met with indifference, resistance, and rage? This presentation addresses the challenge of how to accrue new, and how to act on existing, evidence more rapidly. The magnitude of this challenge is demonstrated in the fact that, even in the best of times, Americans receive about 55% of clinical interventions known to benefit health.

Implementation science informs the use of evidence-based interventions in real-world settings. However, along with intervention development, implementation science has not met the challenge of equipping providers and systems for rapid response. Therefore, the presentation will address the importance of faster implementation, urging attention to capturing speed metrics in implementation studies and to identifying factors associated with faster or slower implementation. How fast can we implement? How fast should we implement? Finally, the presentation will identify research priorities for building a repository of ready-to-implement change techniques, especially those that tackle the mechanisms of attitude and behavior change in times of health emergency and disaster.

General Sessions

NO TICKET REQUIRED

Panel Discussions, Symposia, Clinical Round Tables, Mini Workshops are part of the general convention program: no tickets are required. Visit abct.org for a complete listing of general sessions.

■ PANEL DISCUSSIONS

FRIDAY, November 18

◆ *Participants earn 1.5 continuing education credits*

PD1: Ethical Considerations for Anti-Racism Training and Consultation

Moderators: Amber Calloway, Ph.D., Research Associate, The Penn Collaborative for CBT and Implementation Science, Perelman School of Medicine, University of Pennsylvania
Kimberly E. Dean, Ph.D., Clinical Research Fellow, Massachusetts General Hospital/Harvard Medical School

Panelists: Jessica G. Graham-LoPresti, Ph.D., Assistant Professor, Suffolk University
Lauren Wadsworth, Ph.D., Founder & Director, Genesee Valley Psychology
Juliette McClendon-Iacovino, Ph.D., Assistant Professor of Psychiatry & Clinical Research Psychologist, Boston University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

PD2: Practice What You Preach: How Psychology and Systems Can Support Its Working Parents in Times of Emergency

Moderators: Christine J. Cho, Psy.D., Post-Doctoral Fellow, Kurtz Psychology Consulting PC
Andrea B. Temkin, Psy.D., Assistant Professor of Psychology in Psychiatry, Weill Cornell Medicine

Panelists: Christine J. Cho, Psy.D., Post-Doctoral Fellow, Kurtz Psychology Consulting PC
Andrea B. Temkin, Psy.D., Assistant Professor of Psychology in Psychiatry, Weill Cornell Medicine
Laura D. Seligman, ABPP, Ph.D., Professor, University of Texas Rio Grande Valley
Simon A. Rego, ABPP, Psy.D., Chief of Psychology, Montefiore Medical Center
Brian C. Chu, Ph.D., Professor, Rutgers University
Linda Oshin, Ph.D., Assistant Professor, Rutgers University
Sophie A. Palitz Buinewicz, Ph.D., Postdoctoral Fellow, Center for the Treatment and Study of Anxiety, Perelman School of Medicine

◆ *Participants earn 1.5 continuing education credits*

PD3: The Impact of COVID-19 on Rural Clinical Training: Adapting Telehealth Services and Supervisee Experiences Across Multiple Training Settings

Moderator: Karen Kelley, M.S., Clinical Psychology Doctoral Student, Mississippi State University
Panelists: Nathan Barclay, M.S., Clinical Psychology Doctoral Student, Mississippi State University
Acacia R. Lopez, M.S., Clinical Psychology Doctoral Student, Mississippi State University
Emily S.H. Stafford, Ph.D., Psychology Training Clinic Director and Assistant Clinical Professor, Mississippi State University

Ty Stafford, Ph.D., Psychology Internship Program Director, Mississippi State University
Michael R. Nadorff, Ph.D., Clinical Psychology PhD Program Director and Associate Professor, Mississippi State University

◆ *Participants earn 1.5 continuing education credits*

PD4: Past, Present and Future: Presidential Perspectives on ABCT, CBT, and the Field of Psychotherapy!

Moderator: Simon A. Rego, ABPP, Psy.D., Chief of Psychology, Montefiore Medical Center

Panelists: Anne Marie Albano, ABPP, Ph.D., Professor of Medical Psychology in Psychiatry, Columbia University College of Physicians and Surgeons
David H. Barlow, ABPP, Ph.D., Founder & Professor Emeritus, Center for Anxiety and Related Disorders, Boston University
Michelle G. Craske, Ph.D., Distinguished Professor, University of California Los Angeles
Linda C. Sobell, ABPP, Ph.D., President's Distinguished Professor, Nova Southeastern University
Terence Wilson, Ph.D., Professor, Rutgers University

◆ *Participants earn 1.5 continuing education credits*

PD5: How Do We Know When Treatment for Suicidal Individuals "works"? Reconsidering Outcomes in Intervention Trials with Suicidal Populations

Moderators: Shireen L. Rizvi, ABPP, Ph.D., Associate Professor, Rutgers University

Evan M. Kleiman, Ph.D., Assistant Professor, Rutgers, The State University of New Jersey
Panelists: David A. Jobes, Ph.D., Professor of Psychology, Director of the Suicide Prevention Laboratory, The Catholic University of America
Regina Miranda, Ph.D., Professor of Psychology, Hunter College and The Graduate Center, City University of New York
Lauren Weinstock, Ph.D., Professor, Brown University

◆ *Participants earn 1.5 continuing education credits*

PD6: Using Media as a Tool for Social Good: Disseminating Cognitive Behavioral Science and Practice Online with a Social Justice Lens

Moderator: Ilana Seager van Dyk, Ph.D., Senior Lecturer, Massey University

Panelists: Kevin Chapman, Ph.D., Licensed Psychologist/Director, The Kentucky Center for Anxiety and Related Disorders
Juliette McClendon-Iacovino, Ph.D., Assistant Professor of Psychiatry & Clinical Research Psychologist, Boston University School of Medicine & National Center for PTSD
Jeffrey M. Cohen, Psy.D., Assistant Professor of Medical Psychology (In Psychiatry), Columbia University
Jessica L. Schleider, Ph.D., Assistant Professor, Stony Brook University

Participants earn 1.5 continuing education credits

PD7: Living Through a Global Pandemic: How Transgender and Gender Diverse Communities Found Strength in Compounded Adversity

Moderators: Sage A. Volk, Doctoral Student, University of Nebraska-Lincoln

Niko Vehabovic, M.A., Graduate Student, University of Nebraska-Lincoln

Panelists: Nathan A. Woodruff, Leader, Local Community Board, University of Nebraska-Lincoln

Ariel Botta, Ph.D., LICSW, MSW, Coordinator of Group Psychotherapy, Boston's Children's Hospital

Shelley L. Craig, Ph.D., LCSW, Canada Research Chair in Sexual and Gender Minority Youth, University of Toronto

Norik Kirakosian, B.S., Doctoral Student, University of Miami

Aaron S. Breslow, Assistant Professor, Albert Einstein College of Medicine

SATURDAY, November 19

◆ *Participants earn 1.5 continuing education credits*

PD8: Ethical Considerations Related to Managing Risk When Conducting Youth Treatment Research in Low-and Middle-income Countries

Moderator: Natalie Johnson, M.P.H., Research Manager, Shamiri Institute

Panelists: Daniel Coppersmith, M.A., Ph.D. Candidate, Harvard University

Katherine E. Venturo-Conerly, Ph.D. Candidate, Harvard University

Christine Wasanga, M.A., Ph.D., Senior Lecturer, Counseling Psychologist, Kenyatta University

Eve S. Puffer, Ph.D., Assistant Professor, Clinical Psychologist, Duke University

Tom Osborn, Ph.D., Co-Founder and CEO, Shamiri Institute

David Ndeti, Ph.D., Professor, Psychiatry, University of Nairobi

◆ *Participants earn 1.5 continuing education credits*

PD9: Being Bold in Our Conversations: potential Therapeutic Power in Providing a Platform for Open Discussions Around Systemic Racism in Academic Medicine

Moderator: Patrice K. Malone, M.D., Ph.D., Assistant Professor, Columbia University Medical Center

Panelists: Claude A. Mellins, Ph.D., Professor of Medical Psychology, Columbia University Medical Center

Robert Fullilove, M.S., Associate Dean for Community and Minority Affairs, Columbia University Medical Center

Tonya M. Richards, M.S., Chief Diversity, Equity, and Inclusion Officer, Columbia University Medical Center

Monica Lypson, M.D., Vice Dean of Education, Columbia University Medical Center

Warren Ng, M.D., Medical Director Outpatient Behavioral Health, Columbia University Medical Center

◆ *Participants earn 1.5 continuing education credits*

PD10: Engaging in Community-based Participatory Research to Inform Suicide Prevention

Moderator: Alexandra Bettis, Ph.D., Assistant Professor, Vanderbilt University Medical Center

Panelists: Ellen-ge Denton, Psy.D., Associate Professor, CUNY

College of Staten Island

Lauren A. White, M.P.H., MSW, Doctoral Student, University of Michigan

Kirsty A. Clark, Ph.D., Assistant Professor, Vanderbilt University

Kathryn R. Fox, Ph.D., Assistant Professor, University of Denver

Carolina Vélez-Grau, D.Phil., LCSW, Postdoctoral Fellow/ Assistant Professor, New York University

◆ *Participants earn 1.5 continuing education credits*

PD11: Building Diversity, Equity, and Inclusion: Perspectives and Concerns of ABCT's Minority Special Interest Groups

Moderator: Janie J. Hong, Ph.D., Clinical Associate Professor, Stanford University School of Medicine and Redwood Center for CBT and Research

Panelists: Ashleigh Coser, Ph.D., Health Service Psychologist, Cherokee Nation of Oklahoma

Jamilah R. George, M.S., Ph.D. Candidate, University of Connecticut

Ilana Seager van Dyk, Ph.D., Senior Lecturer, Massey University

Alexandria N. Miller, M.S., Doctoral Student, Suffolk University

Juventino Hernandez Rodriguez, Ph.D., Assistant Professor, The University of Texas Rio Grande Valley

◆ *Participants earn 1.5 continuing education credits*

PD12: Responding to Covid-related Challenges in Intervention Development Research for Persons with or at Risk for HIV in Sub-saharan Africa

Moderator: Amelia Stanton, Ph.D., Fellow, Harvard Medical School/Massachusetts General Hospital

Panelists: Conall O'Cleirigh, Ph.D., Director, Behavioral Medicine, Harvard Medical School/ Massachusetts General Hospital,

Jasper S. Lee, M.S., Predoctoral Fellow, Harvard Medical School / Massachusetts General Hospital

Lena S. Andersen, Ph.D., Assistant Professor, University of Copenhagen

Melanie A. Broadhead, M.D., Ph.D., Professor of Global Mental Health, King's College London

Concilia T. Bere, M.S., Clinical Psychologist and Lecturer, University of Zimbabwe

Fortunate N. Mosery, B.S., Programme Director, University of the Witwatersrand

◆ *Participants earn 1.5 continuing education credits*

PD13: Let's Talk: Managing Microaggressions at Work, in Our Work, and in Our Lives

Moderators: Simon A. Rego, ABPP, Psy.D., Chief of Psychology, Montefiore Medical Center

Jessica Floyd Alexander, Psy.D., Senior Psychologist, N/A

Panelists: Anne Marie Albano, ABPP, Ph.D., Professor of Medical Psychology in Psychiatry, Columbia University College of Physicians and Surgeons

Yash Bhambhani, Ph.D., Attending Psychologist, Montefiore Medical Center

Ryan C. DeLapp, Ph.D., Attending Psychologist, Montefiore Medical Center

Patricia A. Resick, Ph.D., ABPP, Ph.D., Professor of Psychiatry and Behavioral Sciences, Duke Health

◆ *Participants earn 1.5 continuing education credits*

PD14: Making Fidelity Assessment Attainable in the Pandemic Era and Beyond

Moderators: Sarah L. Kopelovich, Ph.D., Associate Professor and Professor of Cognitive Behavioral Therapy for Psychosis, University of Washington School of Medicine
Torrey A. Creed, Ph.D., Assistant Professor, Perelman School of Medicine at the University of Pennsylvania

Panelists: Maria Monroe-DeVita, Ph.D., Associate Professor, University of Washington School of Medicine
Shannon Wiltsey Stirman, Ph.D., Associate Professor/Acting Deputy Director, Stanford University
Shannon Dorsey, Ph.D., Professor and Associate Chair of Graduate Studies, Psychology, University of Washington, Seattle

◆ *Participants earn 1.5 continuing education credits*

PD15: Goal -setting Beyond Barriers for People with SMI: Bringing Together DEIB and Psychosocial Rehabilitation and Recovery Perspectives for People with Significant Barriers and Limited Resources

Moderators: Charlie A. Davidson, Ph.D., Licensed Psychologist and Adjunct Professor, Atlanta Center for Cognitive Therapy
Kim Mueser, Ph.D., Boston University

Panelists: Brittney Jones, Psy.D., Psychologist, Stanford University
Nadine A. Chang, Ph.D., Clinical Psychologist, Gracie Square Hospital
Marianne D. Farkas, Director, Training, Dissemination, TA; Co-PI, Rehabilitation Research & Training Center, Boston University
Jamilah R. George, M.S., Ph.D. Candidate, University of Connecticut
Susan R. McGurk, Ph.D., Professor of Occupational Therapy, Boston University

◆ *Participants earn 1.5 continuing education credits*

PD16: Mentorship Match: Challenges, Learnings, and Tips for Developing and Implementing Mentorship Programs for Mental Health Professionals with Minoritized Identities

Moderator: Monica Shah, Psy.D., Psychologist, Behavioral Wellness of NYC, St. John's University

Panelists: Monica Shah, Psy.D., Psychologist, Behavioral Wellness of NYC, St. John's University
Janie J. Hong, Ph.D., Clinical Associate Professor, Stanford University School of Medicine and Redwood Center for CBT and Research
Michelle E. Roley-Roberts, Ph.D., Assistant Professor, Creighton University
Juventino Hernandez Rodriguez, Ph.D., Assistant Professor, The University of Texas Rio Grande Valley
Natalie R. Holt, Ph.D., Clinical Psychology Fellow, VA Tennessee Valley Healthcare System
Shirley B. Wang, M.A., Ph.D. Candidate, Harvard University
Ashleigh Coser, Ph.D., Health Service Psychologist, Cherokee Nation of Oklahoma

◆ *Participants earn 1.5 continuing education credits*

PD17: Considerations of Diversity, Equity, and Inclusion in the Design and Use of Digital Mental Health Interventions with Individuals from Marginalized Identities

Moderator: Giovanni Ramos, M.A., University of California Los Angeles

Panelists: Adrian Aguilera, Ph.D., Associate Professor, University of California, Berkeley
Jeffrey M. Cohen, Psy.D., Assistant Professor of Medical Psychology (In Psychiatry), Columbia University
Torrey A. Creed, Ph.D., Assistant Professor, Perelman School of Medicine at the University of Pennsylvania
Emily G. Lattie, Ph.D., Assistant Professor, Northwestern University Feinberg School of Medicine
Stephen M. Schueller, Ph.D., Associate Professor of Psychological Science, University of California, Irvine
Colleen Stiles-Shields, Ph.D., Assistant Professor, Rush University Medical Center

◆ *Participants earn 1.5 continuing education credits*

PD18: Taking the Career Path Less Traveled: Alternative Careers Applying Clinical Science and Practice

Moderator: Alayna Park, Ph.D., University of Oregon

Panelists: Lynn F. Bufka, Ph.D., Associate Chief, Practice Transformation, American Psychological Association
Allison R. Love, Ph.D., Training Manager, PracticeWise LLC
Rachel E. Kim, Ph.D., Director of Implementation, Judge Baker Children's Center
Kelsie H. Okamura, Ph.D., Judge Baker Children's Center
Resham Gellatly, Ph.D., Director of Child and Adolescent Services, Center for Anxiety, Boston
Katherine Tsai, M.P.H., Ph.D., Director of Research and Clinical Training, Five Acres

◆ *Participants earn 1.5 continuing education credits*

PD19: Challenges and Future Directions of Addressing Racial Trauma Among Black Communities Within Research and Clinical Practice

Moderator: Donte Bernard, Ph.D., Assistant Professor, University of Missouri-Columbia

Panelists: Ryan C. DeLapp, Ph.D., Attending Psychologist, Montefiore Medical Center
Shawn Jones, Ph.D., Assistant Professor, Virginia Commonwealth University
Isha W. Metzger, Ph.D., Assistant Professor, Georgia State University
Farzana Saleem, Ph.D., Assistant Professor, Stanford University
Monnica T. Williams, ABPP, Ph.D., Associate Professor, University of Ottawa

SUNDAY, November 20

◆ *Participants earn 1.5 continuing education credits*

PD20: Expanding Treatment Delivery Options During Challenging Times: Increasing Access for Underserved Patients, Building Team Cohesion, and Improving Outcomes Through Virtual Intensive PTSD Programs

Moderator: Cynthia Yamokoski, Ph.D., PTSD Mentoring Program, Associate Director, National Center for PTSD

Panelists: Allison C. Aosved, ABPP, Ph.D., Program Manager,

Intensive Virtual EBP Team, US Department of Veteran Affairs, Phoenix
Heather Flores, Psy.D., Program Manager, VA Northeast Ohio Healthcare System
Jeremy A. Fowler, Psy.D., Clinical Lead of the Accelerated PTSD Treatment (APT) Program, US Department

◆ *Participants earn 1.5 continuing education credits*

PD21: At a Crossroads: Making APA's Apology Actionable Through CBT-based Mentoring Practices

Moderators: Jonah D. McManus, M.A., Kean University
Nnamdi Uzoaru, M.A., 3rd Year PsyD Student, Kean University
Panelists: Barbara A. Prempeh, Psy.D., Psychology Supervisor, Children's Specialized Hospital
Paola Ricardo, Psy.D., Professor, Kean University
Jessica G. Graham-LoPresti, Ph.D., Assistant Professor, Suffolk University
Uchenna Baker, Ph.D., VP for Student Affairs and Dean of Students, Fairleigh Dickinson University
Donald R. Marks, Psy.D., Associate Professor, Kean University

◆ *Participants earn 1.5 continuing education credits*

PD22: Accommodations and Lessons Learned During the COVID-19 Pandemic Working with Underserved Populations with and at Risk for HIV And/or Substance Use Disorder

Moderators: Mary B. Kleinman, M.P.H., M.S., Doctoral Candidate, Clinical Psychology, University of Maryland, College Park
Jessica F. Magidson, Ph.D., Assistant Professor, University of Maryland
Panelists: Trevor A. Hart, Ph.D., Professor and Director, HIV Prevention Lab, Ryerson University
Abigail W. Batchelder, M.P.H., Ph.D., Assistant Professor, MGH/Harvard Medical School
Sannisha Dale, Ph.D., Associate Professor of Psychology, University of Miami
Valerie Bradley, Research Coordinator, University of Maryland- College Park
Tiffany R. Glynn, Ph.D., Post-doctoral Fellow, Massachusetts General Hospital/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

PD23: Evidence-based Approaches to address Behavioral Health Needs After Mass Violence - Readiness, Response and Recovery

Moderator: Daniel W. Smith, Ph.D., Professor, Medical University of South Carolina
Panelists: Rochelle F. Hanson, Ph.D., Professor, Medical University of South Carolina
Melissa Brymer, Ph.D., Psy.D., Program Director, Terrorism Disaster Program at NCCTS, UCLA School of Medicine
Elizabeth Cronin, B.A., Director, NYS Office of Victim Services
Dean G. Kilpatrick, Ph.D., Distinguished University Professor, Medical University of South Carolina
Angela Moreland, Ph.D., Associate Professor, Medical University of South Carolina
Alyssa A. Rheingold, Ph.D., Professor, Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

PD24: Stress and Trauma in Youth of Color: Treatment, Advocacy, and Best Practices

Moderator: Erika Roach, M.A., Ph.D. Student, University of California at Berkeley
Panelist: Ryan C. DeLapp, Ph.D., Attending Psychologist, Montefiore Medical Center
Ryan Matlow, Ph.D., Clinical Associate Professor & Director of Community Programs, Stanford Early Life Stress and Resilience, Stanford School of Medicine, Ravenswood Family Health Center
Candace Mootoo, M.A., Ph.D., Postdoctoral Psychology Fellow, Mount Sinai Morningside
Wei-Chin Hwang, Ph.D., Professor, Claremont McKenna College

◆ *Participants earn 1.5 continuing education credits*

PD25: Opportunities and Challenges of Engaging With Industry Partners and Community Stakeholders During and After the COVID-19 Pandemic

Moderators: Rachel R. Ouellette, Ph.D., Psychology Fellow, Yale University School of Medicine
Xin Zhao, M.S., Psychology Resident, University of Washington School of Medicine
Panelists: Evan Auguste, Ph.D., Incoming Assistant Professor, University of Massachusetts Boston
Margaret T. Anton, Ph.D., Senior Clinical Research Scientist, AbleTo, Inc.
Brad Nakamura, Ph.D., Professor, University of Hawaii at Manoa
Margaret H. Sibley, Ph.D., Associate Professor of Psychiatry & Behavioral Sciences, University of Washington School of Medicine

◆ *Participants earn 1.5 continuing education credits*

PD26: Mindfulness-based Interventions for Diverse Populations: Acceptance, Change, and Values-driven Behavior in the Context of Marginalization

Moderator: Giovanni Ramos, M.A., University of California Los Angeles
Panelists: Shadi Beshai, Ph.D., Associate Professor, University of Regina
Jeffrey M. Cohen, Psy.D., Assistant Professor of Medical Psychology (In Psychiatry), Columbia University
Oswaldo Moreno, Ph.D., Assistant Professor of Psychology, Virginia Commonwealth University
Laurie Gallo, Ph.D., Lead Psychologist AOPD, Director, THRIVE, Assistant Professor of Psychiatry and Behavioral Sciences, Montefiore Medical Center
Amanda J. Shallcross, M.P.H., M.D., Associate Professor, NYU School of Medicine
Natalie N. Watson-Singleton, Ph.D., Assistant Professor, Spelman College

◆ *Participants earn 1.5 continuing education credits*

PD27: Transforming Roles of Clinical Scientists in a Post-covid World: Exploring New Career Opportunities in Industry, Entrepreneurship, and Academia

Moderator: Paul J. Geiger, Ph.D., Clinical Research Psychologist, RTI International
Panelists: Jeff Glenn, Ph.D., Analytics Manager, Deloitte
Elsa Friis, Ph.D., Director of Clinical Research, Little Otter

Alice Thornewill, Ph.D., Co-Founder and Director, Center for Cognitive Behavioral Therapy & Mindfulness
Alexandra Werntz, Ph.D., Postdoctoral Research Fellow, University of Massachusetts Boston
Kathryn (Ryn) P. Linthicum, M.S., Graduate Student, Florida State University

◆ *Participants earn 1.5 continuing education credits*

PD28: Trauma Informed and Evidence Based Approaches to Parenting During COVID-19

Moderators: Tian Saltzman, Ph.D., Rutgers University
Angela W. Wang, M.S., Ph.D. Candidate in Clinical Psychology, Rutgers University

Panelists: Liane Nelson, Ph.D. – Chief Psychologist and Director, Trager Lemp Center for Trauma and Resilience, Westchester Jewish Community Services (WJCS)
Sandra Pimentel, Ph.D., Chief, Child and Adolescent Psychology, Montefiore Medical Center- AECOM
Marc S. Atkins, Ph.D., Professor of Psychiatry and Psychology, University of Illinois at Chicago
Lindsay Anderson, Psy.D., Supervising Psychologist, Caring Cove; RDTc at Newark Beth Israel Medical Center
Heather Agazzi, ABPP, M.S., Ph.D., Professor of Pediatrics and Psychiatry, Chief of Child Development, Psychology Internship Director

◆ *Participants earn 1.5 continuing education credits*

PD29: Modifying CBT to “save” CBT: Incorporating Context, Culture, Comorbidity, and Companionable Theories

Moderators: Elizabeth R. Halliday, M.S., Clinical Psychology Graduate Student, University of Miami

Jill Ehrenreich-May, Ph.D., Professor, University of Miami

Panelists: Marvin R. Goldfried, Ph.D., Distinguished Professor, Clinical Psychology, Stony Brook University

Stefan G. Hofmann, Ph.D., Professor, Boston University

Monnica T. Williams, ABPP, Ph.D., Associate Professor, University of Ottawa

Allison G. Harvey, Ph.D., Professor & Clinical Psychologist, University of California Berkeley

Aaron J. Fisher, Ph.D., Associate Professor, University of California, Berkeley

◆ *Participants earn 1.5 continuing education credits*

PD30: Addressing the Needs of Masters-level CBT Clinicians Across Multiple Disciplines: Education, Professional Training and User-centered Design of Intervention Materials

Moderator: Sean A. Lauderdale, Ph.D., Associate Professor, Texas A&M University-Commerce

Panelists: Adam P. McGuire, Ph.D., Assistant Professor, University of Texas at Tyler

Lisa Pote, MSW, Executive Director, Beck Institute

Joseph Keifer, Psy.D., RN, Staff Psychologist and Registered Nurse, Beck Institute

Ann M. Steffen, ABPP, Ph.D., Professor of Psychological Sciences, University of Missouri-St. Louis

Georganna R. Sedlar, Ph.D., Assistant Professor, University of Washington, Seattle

◆ *Participants earn 1.5 continuing education credits*

PD31: Preparing the Next Generation of Frontline Mental Health Providers: Assessment and Teaching of Scientific Competence for Master’s-Level Health Service Psychology Students

Moderator: Yevgeny Botanov, Ph.D., Assistant Professor, Pennsylvania State University York

Panelists: Andrew Bertagnolli, Ph.D., Assistant Professor, San Francisco Campus, Alliant International University

Lee Cooper, Ph.D., Clinical Professor, Virginia Polytechnic Institute and State University

Tammy McClain, Psy.D., Psychology Professor, Clinical Psychologist, West Liberty University

Jason J. Washburn, ABPP, Ph.D., Professor, Northwestern University Feinberg School of Medicine

■ SYMPOSIA

FRIDAY, November 18

◆ *Participants earn 1.5 continuing education credits*

Symposium 1: Emergency & Disaster Response: Using Telehealth Treatments to Continue to Make an Impact in Adult and Pediatric Mental Health

Chair: Martin E. Franklin, Ph.D., Rogers Behavioral Health

Discussant: Jonathan Comer, Ph.D., Professor of Psychology and Psychiatry, Florida International University

◆ *Participants earn 1 continuing education credit*

Symposium 2: The Role That Emotions Play in OCD: It’s Not Just an Anxiety Disorder

Chair: Melissa M. Norberg, Ph.D., Principal Investigator, Macquarie University

Discussant: Bunmi O. Olatunji, Ph.D., Gertrude Conaway Vanderbilt Professor of Psychology, Vanderbilt University

◆ *Participants earn 1.5 continuing education credits*

Symposium 3: Prospective Risk for Self-injurious Thoughts and Behaviors Among Vulnerable Populations Across the Lifespan

Co-Chairs: Roberto Lopez, Jr., M.A., Doctoral Candidate, George Mason University

Christianne Esposito-Smythers, Ph.D., Professor, George Mason University

Discussant: Matthew Nock, Ph.D., Professor, Harvard University

◆ *Participants earn 1.5 continuing education credits*

Symposium 4: Mechanisms of Change in Exposure Therapy for Eating Disorders

Chair: Julia K. Nicholas, B.S., Ph.D. Student, University of Louisville

Discussant: Cheri Levinson, Ph.D., Associate Professor, University of Louisville

◆ *Participants earn 1.5 continuing education credits*

Symposium 5: Brief Innovative Approaches to Preventing Prescription Stimulant Misuse and Diversion

Chair: Laura J. Holt, Ph.D., Trinity College

Discussant: Amelia Arria, Ph.D., Professor and the Director of the Center on Young Adult Health and Development, University of Maryland

◆ *Participants earn 1.5 continuing education credits*

Symposium 6: Suicidal Thoughts and Behaviors During the COVID-19 Pandemic

Chair: Rebecca G Fortgang, Ph.D., Postdoctoral Fellow, Harvard University

Discussant: Christine Y. Moutier, M.D., American Foundation for Suicide Prevention

◆ *Participants earn 1.5 continuing education credits*

Symposium 7: Understanding the Impact of COVID-19 on Family Functioning, Risk, and Decision-Making: Overview and Treatment Considerations

Chair: Lauren Quetsch, Ph.D., Assistant Professor, University of Arkansas

Discussant: Angela Moreland, Ph.D., Associate Professor, Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

Symposium 8: There Is No Such Thing as a Single-Issue Struggle: Exposure and Effects of Intersectional Stress in LGBTQ+ POC Communities

Co-Chairs: Shelby B. Scott, Ph.D., University of Texas at San Antonio

Kevin Narine, Ph.D., Clinical Psychology Doctoral Student, William James College

Discussant: Skyler D. Jackson, Ph.D., Associate Research Scientist, Yale School of Public Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 9: Amplifying Stakeholder Voices: Using Qualitative and Mixed Methods to Reduce Treatment Barriers for Anxiety and Obsessive-Compulsive Disorders

Co-Chairs: Gabriella T. Ponzini, M.S., Ph.D. Candidate, West Virginia University

Shari A. Steinman, Ph.D., Assistant Professor, West Virginia University

Discussant: Sara J Becker, Ph.D., Associate Professor, Brown University School of Public Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 10: Examining Intra-daily Fluctuations in Psychological Processes Among Suicidal Individuals

Co-Chairs: Ki Eun (Kay) Shin, Ph.D., Assistant Professor, Long Island University - Post

Christine B. Cha, Ph.D., Assistant Professor, Teachers College, Columbia University

Discussant: Matthew Nock, Ph.D., Professor, Harvard University

◆ *Participants earn 1.5 continuing education credits*

Symposium 11: Advancing Equitable and Inclusive Cultures in Higher Education

Chair: Christin A. Mujica, M.A., University of Arkansas

Discussant: Ana J. Bridges, Ph.D., Professor, University of Arkansas

◆ *Participants earn 1.5 continuing education credits*

Symposium 12: Mindfulness- and Acceptance-Based Treatments for Eating Disorders

Co-Chairs: Margaret Sala, Ph.D., Assistant Professor, Ferkauf Graduate School of Psychology

Corey R. Roos, Ph.D., Assistant Professor, Yale University School of Medicine

Discussant: Hedy Kober, Ph.D., Associate Professor, Yale University

◆ *Participants earn 1.5 continuing education credits*

Symposium 13: Interpersonal Risk Factors Across the Psychotic Spectrum Disorder Illness Trajectory

Chair: Daisy Lopez, M.S., Graduate Student, University of Miami

Discussant: Carrie E. Bearden, Ph.D., UCLA School of Medicine

◆ *Participants earn 1 continuing education credit*

Symposium 14: Developments in Child Maltreatment Services and Future Directions to Support Community Providers

Chair: Elizabeth A. McGuier, Ph.D., Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Discussant: Rochelle F. Hanson, Ph.D., Professor, Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

Symposium 15: Innovations in Evidence-Based Assessments: Novel Strategies for Supporting Public Health, Policy, Research, and Practice

Chair: Tristan Maesaka, M.A., University of Hawai'i at Manoa

Discussant: Michael A. Southam-Gerow, Ph.D., Faculty, Virginia Commonwealth University

◆ *Participants earn 1.5 continuing education credits*

Symposium 16: A Queer Eye on Psychotherapy: A Look at Evidence-based Treatments for Sexual and Gender Minority Clients

Co-Chairs: Eve Rosenfeld, Ph.D., Clinical Psychologist (Fellow), VA Palo Alto Health Care System/Stanford

Donovan Edward, B.S., VA Palo Alto Health Care System/Stanford

Discussant: Debra Hope, Ph.D., University of Nebraska-Lincoln

◆ *Participants earn 1.5 continuing education credits*

Symposium 17: Dealing with Uncertainty: New Research Findings on Intolerance of Uncertainty and Psychopathology

Chair: Hannah C. Broos, M.S., University of Miami

Discussant: Norman Schmidt, Ph.D., Professor, Florida State University

◆ *Participants earn 1.5 continuing education credits*

Symposium 18: Responses to Reward and Risk for Suicide Across Age, Context, and Levels of Analysis

Co-Chairs: Courtney Forbes, M.A., M.Ed., Clinical Psychology Intern, Emory University School of Medicine
Gabriela K. Khazanov, Ph.D., Corporal Michael J Crescenzo VA Medical Center

Discussant: Michelle G. Craske, Ph.D., Professor of Psychology, Psychiatry and Biobehavioral Sciences, University of California Los Angeles

◆ *Participants earn 1 continuing education credit*

Symposium 19: Combatting Anti-Asian Racism and Supporting AAPI Community

Co-Chairs: Xin Zhao, M.S., Psychology Resident, University of Washington School of Medicine

Lu Dong, Ph.D., Associate Behavioral and Social Scientist, RAND Corporation

Discussant: Janie J. Hong, Ph.D., Clinical Associate Professor, Stanford University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 20: Addressing the Mental Health Crisis on University Campuses: Innovations and Challenges in Adapting Evidence-based Interventions

Co-Chairs: Emily E. Bernstein, Ph.D., Postdoctoral Fellow, Massachusetts General Hospital

Nicole LeBlanc, Ph.D., Postdoctoral Scholar, Massachusetts General Hospital

Discussant: Stephanie L. Pinder-Amaker, Ph.D., Chief Diversity Equity & Inclusion Officer & Director College Mental Health Program, McLean Hospital

◆ *Participants earn 1.5 continuing education credits*

Symposium 21: Evaluating the Role of Substance Use Stigma in Treatment Delivery, Access, and Outcomes for Diverse Populations

Co-Chairs: Kristen S. Regenauer, M.S., Doctoral Student, University of Maryland

Jessica F. Magidson, Ph.D., Assistant Professor, University of Maryland

Discussant: Abigail W. Batchelder, M.P.H., Ph.D., Assistant Professor, MGH/Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

Symposium 22: Sleep and Circadian Functioning: Unpacking Clinician Training and Treatment Delivery in Routine Care Settings

Co-Chairs: Nicole B. Gumport, Ph.D., Postdoctoral Fellow, Stanford University

Catherine Callaway, Ph.D., Doctoral Student, University of California at Berkeley

Discussant: Shannon Wiltsey Stirman, Ph.D., Associate Professor/Acting Deputy Director, Stanford University

◆ *Participants earn 1.5 continuing education credits*

Symposium 23: Promoting Strong African American Families (ProSAAF): Building Resilience to External Stressors by Strengthening Family Relationships

Chair: Olutosin Adesogan, B.S., University of Georgia

Discussant: Steven Beach, Ph.D., Professor, University of Georgia

◆ *Participants earn 1.5 continuing education credits*

Symposium 24: LGBTQ-affirmative CBT: From Theory to Trial to Community Dissemination and Implementation

Co-Chairs: Mark Hatzenbuehler, Ph.D., John L Loeb Associate Professor of the Social Sciences, Harvard University

John E. Pachankis, Ph.D., Susan Dwight Bliss Professor of Public Health (Social and Behavioral Sciences), Yale School of Public Health

Discussant: Joanne Davila, Ph.D., Professor, Stony Brook University

◆ *Participants earn 1 continuing education credit*

Symposium 25: Couple Functioning in the Face of Internal and External Relationship Threats

Co-Chairs: Mollie E. Shin, Ph.D., University of Colorado Denver

Corey Petit, M.A., University of Virginia

Discussant: Hannah Williamson, Ph.D., The University of Texas at Austin

◆ *Participants earn 1.5 continuing education credits*

Symposium 26: Barriers to Treatment Access Among High Mortality and Underserved Mental Health Populations in the United States

Co-Chairs: Samantha P. Spoor, B.S., Graduate Student, University of Wyoming

Julia K. Nicholas, B.S., Ph.D. Student, University of Louisville

Discussant: Jessica L. Schleider, Ph.D., Assistant Professor, Stony Brook University

◆ *Participants earn 1.5 continuing education credits*

Symposium 27: Impact of the COVID-19 Pandemic on Provider Training, Supervision, Clinical Practice, and Youth Outcomes

Chair: Rochelle F. Hanson, Ph.D., Professor, Medical University of South Carolina

Discussant: Amanda Jensen-Doss, Ph.D., Professor, University of Miami

◆ *Participants earn 1.5 continuing education credits*

Symposium 28: Mental Health and Resilience During a Global Stressor: Examination of Mechanistic Affective Cognitive Processes During COVID-19 Pandemic and Efficacy of Online Training Procedures

Chair: Malvika Godara, Ph.D., Max Planck Society

Discussant: Bethany Teachman, Ph.D., Professor, University of Virginia

◆ *Participants earn 1.5 continuing education credits*

Symposium 29: The Intersection of Identity Factors and Traumatic Stress: Examining the Roles of Gender, Sexuality, Race, Ethnicity, and Occupation

Chair: Carter E. Bedford, Ph.D., Florida State University

Discussant: Tracy K. Witte, Ph.D., Auburn University

◆ *Participants earn 1.5 continuing education credits*

Symposium 30: Social Safety Net for Children: Building Preparedness for Mental Health Supports in Routine Community Settings

Chair: Erum Nadeem, Ph.D., Rutgers University

Discussant: Kimberly Hoagwood, Ph.D., New York University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 31: Exploring Distress Due to the COVID-19 Pandemic Across the Developmental Spectrum

Co-Chairs: Nicholas P. Allan, Ph.D., Assistant Professor, Ohio University

Ashley A. Knapp, M.A., Ph.D., Northwestern University Feinberg School of Medicine

Discussant: Norman Schmidt, Ph.D., Professor, Florida State University

◆ *Participants earn 1.5 continuing education credits*

Symposium 32: Embedding Evidence-Based Practices into Youth's Daily Lives: From Children's Books to Paraprofessionals

Chair: Alexandra Werntz, Ph.D., Postdoctoral Research Fellow, University of Massachusetts Boston

Discussant: Miya Barnett, Ph.D., Assistant Professor, University of California Santa Barbara

◆ *Participants earn 1.5 continuing education credits*

Symposium 33: Sleepless Night: Examining the Role of Sleep in Suicidal Ideation Among Diverse Populations

Chair: Jiyoung Song, Ph.D. Student, University of California, Berkeley

Discussant: Allison G. Harvey, Ph.D., Professor & Clinical Psychologist, University of California Berkeley

◆ *Participants earn 1.5 continuing education credits*

Symposium 34: Helping the Helpers: Introducing Resiliency and Coping Interventions for Healthcare and Frontline Workers

Chair: Alexandra K. Gold, M.A., Graduate Student, Massachusetts General Hospital

Discussant: Simon A. Rego, ABPP, Psy.D., Chief of Psychology, Montefiore Medical Center

◆ *Participants earn 1.5 continuing education credits*

Symposium 35: Psychosocial and Structural Influences on Mental Health and Health Behaviors Among Sexual and Gender Minority Older Adults

Chair: Brian Feinstein, Ph.D., Associate Professor, Rosalind Franklin University of Medicine and Science

Discussant: Mark Brennan-Ing, Ph.D., Director of Research and Evaluation, Brookdale Center for Healthy Aging, Hunter College, CUNY

◆ *Participants earn 1 continuing education credits*

Symposium 36: Novel Adaptations to Dyadic Clinical Research for High-risk and Underserved Populations During the COVID-19 Pandemic

Co-Chairs: McKenzie K. Roddy, Ph.D., VA Tennessee Valley Healthcare System

Karen Rothman, Ph.D., Graduate Student, Together CBT

Discussant: Christina Balderrama-Durbin, Ph.D., Assistant Professor, Binghamton University

◆ *Participants earn 1 continuing education credit*

Symposium 37: A Free, Open-Access, Internet-Based CBT Training Platform for Clinicians Working with Children on the Autism Spectrum: Development and Initial Evaluation

Chair: Jeffrey J. Wood, Ph.D., Professor, UCLA

Discussant: Aaron Hogue, Ph.D., Vice President, Partnership to End Addiction

◆ *Participants earn 1.5 continuing education credits*

Symposium 38: Diversity in Digital Mental Health Interventions

Co-Chairs: Alison Darcy, Ph.D., Founder & President, Woebot Health

Athena Robinson, Ph.D., Chief Clinical Officer, Woebot Health

Discussant: Carolyn J. Greene, Ph.D., University of Arkansas for Medical Sciences

Participants earn 1.5 continuing education credits

Symposium 39: Examining the Effects of Syndemic Problems on STI/STD Treatment and Prevention Around the World

Chair: Jasper S. Lee, M.S., Predoctoral Fellow, Harvard Medical School / Massachusetts General Hospital

Discussant: Brooke G. Rogers, M.P.H., Ph.D., Assistant Professor, Alpert Medical School of Brown University

◆ *Participants earn 1.5 continuing education credits*

Symposium 40: All in the Family: New Approaches to Understanding Family-level Impacts of Military-related PTSD Symptoms

Chair: Steffany J. Fredman, Ph.D., The Pennsylvania State University

Discussant: Keith D. Renshaw, Ph.D., Department Chair and Professor of Psychology, George Mason University

◆ *Participants earn 1.5 continuing education credits*

Symposium 41: Combining Basic Psychological Science and Innovative Technologies to Develop and Deliver Effective and Efficient Interventions to Address Crisis, Adversity and Emergencies

Chair: Cristina Botella, Ph.D., Professor, Universitat Jaume I

Discussant: Stefan G. Hofmann, Ph.D., Professor, Boston University

◆ *Participants earn 1.5 continuing education credits*

Symposium 42: Patient and Therapist Memory for Treatment: A Transdiagnostic Mechanism of Change

Chair: Catherine Callaway, Ph.D., Doctoral Student, University of California at Berkeley

Discussant: Allison G. Harvey, Ph.D., Professor & Clinical Psychologist, University of California Berkeley

◆ *Participants earn 1 continuing education credit*

Symposium 43: Addressing the Firearm Suicide Epidemic in the U.S.: Opportunities for Behavioral Science to Make an Impact

Co-Chairs: Kelly L. Zuromski, Ph.D., Postdoctoral Fellow, Harvard University

Catherine L. Dempsey, M.P.H., Ph.D., Research Assistant Professor, Uniformed Services University of the Health Sciences

Discussant: Craig J. Bryan, ABPP, Psy.D., Director, Division of Recovery and Resilience, The Ohio State University Wexner Medical Center

◆ *Participants earn 1.5 continuing education credits*

Symposium 44: Evidence of Both Risk and Resilience During the COVID-19 Pandemic: Experiences of Stress and Well-being Among Minoritized Individuals

Chair: Amanda Venta, Ph.D., Associate Professor, University of Houston

Discussant: German A. Cadenas, Ph.D., Lehigh University

◆ *Participants earn 1.5 continuing education credits*

Symposium 45: Towards Exercise Prescriptions: Identifying and Targeting Mechanistic Factors That Optimize Exercise Engagement and Promote Clinical Outcome Across Disorders

Chair: Kristin L. Szuhany, Ph.D., NYU School of Medicine

Discussant: Jasper Smits, Ph.D., Professor, The University of Texas at Austin

◆ *Participants earn 1.5 continuing education credits*

Symposium 46: Engaging Stakeholders to Improve Implementation of Evidence-based Mental Health Services for Youth

Co-Chairs: Rafaella Sale, Ph.D., Virginia Commonwealth University

Gwendolyn Lawson, Ph.D., Assistant Professor, The Children's Hospital of Philadelphia

Discussant: Rachel Haine-Schlagel, Ph.D., San Diego State University

◆ *Participants earn 1 continuing education credit*

Symposium 47: Exploring Risk Factors for Intimate Partner Violence in Sexual and Gender Minority Individuals

Co-Chairs: Ishita Munshi, Ph.D., M.A. Student, Cleveland State University

Evan J. Basting, M.A., Doctoral Student, University of Tennessee, Knoxville

Discussant: Sarah Whitton, Ph.D., Professor, University of Cincinnati

◆ *Participants earn 1 continuing education credit*

Symposium 48: Top Problems During Precedented and Unprecedented Times: Highlighting the Benefits of Measuring Idiographic, Consumer-nominated Problems to Personalize Assessment

Chair: Lauren J. Hoffman, Psy.D., Columbia University Medical Center

Discussant: Brian C. Chu, Ph.D., Professor, Rutgers University

◆ *Participants earn 1 continuing education credit*

Symposium 49: Understanding the Role of Stigma on Utilization of Medical Aid in Dying: An Examination of Current Literature, Public View, Patients' Engagement, and Clinicians' View on Prescribing

Chair: Jonathan Singer, Ph.D., Visiting Assistant Professor, Texas Tech University

Discussant: Elizabeth Loggers, M.D., Ph.D., University of Washington School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 50: Stress, Resilience, and Syndemic Response Among LGBTQ+ Communities

Co-Chairs: Francesca Kassing, Ph.D., University of Nevada, Reno

Natalie R. Holt, Ph.D., Clinical Psychology Fellow, VA Tennessee Valley Healthcare System

Discussant: Debra Hope, Ph.D., University of Nebraska-Lincoln

◆ *Participants earn 1.5 continuing education credits*

Symposium 51: Strengthening Resilience in Sexual Minority Couples: Lowering Barriers to Inclusive, Affirmative, Relationship Healthcare

Chair: Tatiana D. Gray, Ph.D., Assistant Professor, Springfield College

Discussant: Shelby B. Scott, Ph.D., University of Texas at San Antonio

◆ *Participants earn 1.5 continuing education credits*

Symposium 52: Leveraging Stakeholder Perspectives to Optimize Intervention Effectiveness and Facilitate Implementation Within the Autistic Community

Chair: Alexis Brewe, M.A., The University of Alabama

Discussant: Lauren Brookman-Frazee, Ph.D., Professor, University of California, San Diego

SATURDAY, November 19

◆ *Participants earn 1 continuing education credit*

Symposium 53: Telehealth ROCKS: Using Telehealth Technology to Increase Care Access and Provider Training to Make an Impact on Youth in Rural Communities During the Pandemic

Chair: Leni Swails, Ph.D., Assistant Professor, Pediatrics

Discussant: Erin Hambrick, Ph.D., Assistant Professor, University of Missouri, Kansas City

◆ *Participants earn 1.5 continuing education credits*

Symposium 54: Generating and Implementing Insights from Emergency Situations: Using Novel Network Methodologies to Advance Preparedness

Co-Chairs: Tessa Blanken, Ph.D., University of Amsterdam
Julian Burger, M.S., Graduate student, University of Groningen, University Medical Center Groningen

Discussant: Laura Bringmann, Ph.D., University of Groningen

◆ *Participants earn 1 continuing education credit*

Symposium 55: Help-Seeking for Suicide-related Concerns: An Overview of Experimental Investigations and Recommendations for Improved Methodologies

Chair: Raymond P. Tucker, Ph.D., Assistant Professor, Louisiana State University

Discussant: Brooke A. Ammerman, Ph.D., University of Notre Dame

◆ *Participants earn 1.5 continuing education credits*

Symposium 56: From the Structural to the Individual: Assessing the Multilevel Impacts of Stigma on Mental Health and Mental Health Disparities in Marginalized Groups

Chair: Stephanie H. Yu, M.A., University of California, Los Angeles

Discussant: Omar G. Gudiño, ABPP, Ph.D., Clinical Child Psychology Program, University of Kansas

◆ *Participants earn 1.5 continuing education credits*

Symposium 57: The Youth Behavioral Health Crisis in the Juvenile Justice System: Innovations in Treating Behavioral Health Concerns

Co-Chairs: Kaitlin Sheerin, Ph.D., Postdoctoral Research Fellow, Alpert Medical School of Brown University
Sarah Helseth, Ph.D., Brown University School of Public Health

Discussant: Kathleen Kemp, Ph.D., Assistant Professor (Research), Brown University Medical School

◆ *Participants earn 1.5 continuing education credits*

Symposium 58: Frontiers in Transdiagnostic Perspectives: Exploring Immune and Endocrine Markers as Potential Missing Links in Common Mental Disorders

Co-Chairs: Nur Hani Zainal, M.S., Graduate Student, Massachusetts General Hospital

Michelle G. G. Newman, Ph.D., Professor, Penn State University

Discussant: Lauren B. Alloy, Ph.D., Temple University

◆ *Participants earn 1.5 continuing education credits*

Symposium 59: Building Misophonia Knowledge Through the Examination of Phenotypes, Mechanisms, Treatment Strategies, Stakeholder Perceptions, and Public Awareness

Co-Chairs: Laura J. Dixon, Ph.D., Assistant Professor, University of Mississippi

Mary Schadegg, M.A., University of Mississippi

Discussant: Dean McKay, ABPP, Ph.D., Professor, Fordham University

◆ *Participants earn 1.5 continuing education credits*

Symposium 60: Unpacking the Complexity of Minority Stress in Sexual and Gender Minority Romantic Relationships

Co-Chairs: Nicholas Perry, Ph.D., Research Assistant Professor, University of Denver

Shelby B. Scott, Ph.D., University of Texas at San Antonio

Discussant: Sarah Whitton, Ph.D., Professor, University of Cincinnati

◆ *Participants earn 1.5 continuing education credits*

Symposium 61: Digital Mental Health Interventions: Investigations of the Use of Coaching, Text Messaging, and Patterns of Engagement

Chair: Meaghan McCallum, Ph.D., Noom, Inc.

Discussant: Sabine Wilhelm, Ph.D., Professor, Chief of Psychology, Harvard Medical School

◆ *Participants earn 1 continuing education credit*

Symposium 62: Helping the Frontline: Addressing First Responder Needs and Behavioral Health Outcomes

Co-Chairs: Antoine Lebeaut, M.A., University of Houston

Maya Zegel, M.A., Doctoral Candidate, University of Houston

Discussant: Suzy B. Gulliver, Ph.D., Director, Texas A&M College of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 63: Firearm Injury, Prevention, and Suicidal Behavior: Developing Insights Using Public Health Data

Chair: Aleksandrs T. Karnick, M.P.H., M.A., Graduate Student, University of Southern Mississippi

Discussant: Mike Anestis, Ph.D., Executive Director, New Jersey Gun Violence Research Center

◆ *Participants earn 1.5 continuing education credits*

Symposium 64: Understanding the Experiences, Fear, and Effects of Discrimination Among Asian Americans During COVID-19

Chair: Quyen A. Do, M.Ed., Project Director, Graduate Research Assistant, Ph.D. Student, University of Texas San Antonio

Discussant: Joyce P. Yang, Ph.D., Assistant Professor, University of San Francisco

◆ *Participants earn 1.5 continuing education credits*

Symposium 65: Eating Pathology in Sexual and Gender Minority Individuals: Prevalence, Related Sociocultural Factors, and Treatment

Chair: Taryn A. Myers, Ph.D., Virginia Wesleyan University

Discussant: Kimberly Claudat, Ph.D., University of California, San Diego

◆ *Participants earn 1.5 continuing education credits*

Symposium 66: Innovative Methods for Building and Disseminating Brief Mental Health Interventions

Chair: Katherine Cohen, M.A., Graduate Student, Stony Brook University

Discussant: Emily M. Becker-Haimes, Ph.D., Assistant Professor, University of Pennsylvania

◆ *Participants earn 1 continuing education credit*

Symposium 67: Identifying the Impacts of COVID-19 on Participants Enrolled in US-based HIV-Related Research: Implications for Developing Robust and Sustainable Cognitive Behavioral Interventions

Chair: Amelia Stanton, Ph.D., Fellow, Harvard Medical School/Massachusetts General Hospital

Discussant: Conall O'Cleirigh, Ph.D., Director, Behavioral Medicine, Harvard Medical School/ Massachusetts General Hospital

◆ *Participants earn 1.5 continuing education credits*

Symposium 68: Expanding Your Analytic Toolkit: Applying Innovative Statistical Methods to Clinical Science

Co-Chairs: Ki Eun (Kay) Shin, Ph.D., Assistant Professor, Long Island University - Post

Gemma T. Wallace, M.S., Graduate Student, Colorado State University

Discussant: Craig Henderson, Ph.D., Professor, Sam Houston State University

◆ *Participants earn 1.5 continuing education credits*

Symposium 69: Implementation Strategies to Support Lay Health Worker-delivered Interventions to Reduce Disparities

Chair: Erika Luis Sanchez, M.A., University of California, Santa Barbara

Discussant: Miya Barnett, Ph.D., Assistant Professor, University of California Santa Barbara

◆ *Participants earn 1.5 continuing education credits*

Symposium 70: Trauma and Cognition: Cognitive Processes in PTSD Risk and Treatment

Chair: Blair E. Wisco, Ph.D., University of North Carolina at Greensboro

Discussant: J Gayle Beck, Ph.D., University of Memphis

Participants earn 1.5 continuing education credits

Symposium 71: Examining the Real-time Mental Health Impact of Minority Stress Among Sexual and Gender Minority Individuals

Chair: John (Kai) Kellerman, M.S., Rutgers University

Discussant: Brian Feinstein, Ph.D., Associate Professor, Rosalind Franklin University of Medicine and Science

◆ *Participants earn 1.5 continuing education credits*

Symposium 72: Development and Evaluation of Scalable Web-based Interventions Targeting Malleable Transdiagnostic Risk Factors

Chair: Danielle M. Morabito, M.S., Clinical Psychology Graduate Student, Florida State University

Discussant: Norman Schmidt, Ph.D., Professor, Florida State University

◆ *Participants earn 1.5 continuing education credits*

Symposium 73: Co-occurrence of ADHD and Borderline Personality Disorder in Youth: Predictors, Impairments, and Treatment Targets

Chair: Julia D. McQuade, Ph.D., Amherst College

Discussant: Katherine Dixon-Gordon, Ph.D., Assistant Professor, University of Massachusetts Amherst

◆ *Participants earn 1.5 continuing education credits*

Symposium 74: Understanding and Addressing Race-Related Stress and Trauma in Youth of Color

Chair: Erika Roach, M.A., Ph.D. Student, University of California at Berkeley

Discussant: Monnica T. Williams, ABPP, Ph.D., Associate Professor, University of Ottawa

◆ *Participants earn 1 continuing education credit*

Symposium 75: Developmental Considerations When Evaluating the Relationship Between Social Media Use and Positive and Negative Affect in Teens

Chair: Simone I. Boyd, M.A., Rutgers University

Discussant: Jessica L. Hamilton, Ph.D., Assistant Professor, Rutgers

◆ *Participants earn 1.5 continuing education credits*

Symposium 76: Creating Prepared, Resilient, and Equitable Services and Systems: Multilevel Approaches to Preparing for and Responding to Disasters

Co-Chairs: Alex R. Dopp, Ph.D., Behavioral/Social Scientist, RAND Corporation

Vivian Byeon, M.A., University of California, Los Angeles

Discussant: Stanley J. Huey, Ph.D., Associate Professor, University of Southern California

◆ *Participants earn 1.5 continuing education credits*

Symposium 77: Implementing Digital Mental Health Interventions in Real-World Settings

Chair: Alexandra L. Silverman, M.A., Doctoral Student, University of Virginia

Discussant: Stephen M. Schueller, Ph.D., Associate Professor of Psychological Science, University of California, Irvine

◆ *Participants earn 1.5 continuing education credits*

Symposium 78: Novel Approaches to Increase Access to and Engagement in PTSD Treatment

Chair: Anna E. Jaffe, Ph.D., Assistant Professor, University of Nebraska-Lincoln

Discussant: John C. Fortney, Ph.D., University of Washington School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 79: Novel Daily Methodologies to Understand the Syndemics of Suicide and Nonsuicidal Self-harm Among High-risk and Marginalized Populations

Co-Chairs: Alexa M. Raudales, M.A., University of Rhode Island

Nicole Weiss, Ph.D., Professor, University of Rhode Island

Discussant: Heather Schatten, Ph.D., Professor, Brown University & Butler Hospital

◆ *Participants earn 1.5 continuing education credits*

Symposium 80: Picky Eating, Not Just for Kids: Presentation and Treatment of Avoidant/restrictive Food Intake in Transition Age Youth and Young Adults

Chair: Jessie Menzel, Ph.D., Equip Health

Discussant: Jennifer J. Thomas, Ph.D., Psychologist, Massachusetts General Hospital

◆ *Participants earn 1.5 continuing education credits*

Symposium 81: When “gold Standard” Fails the Patient: Understanding How to Better Meet Our Patients’ Needs in Treatment

Chair: Jennie M. Kuckertz, Ph.D., Instructor, McLean Hospital/Harvard Medical School

Discussant: Stefan G. Hofmann, Ph.D., Professor, Boston University

◆ *Participants earn 1 continuing education credit*

Symposium 82: Neurocognitive Predictors of Behavioral Parent Training for ADHD: Bridging Etiological Science and Treatment Research to Identify Potentially Novel Intervention Targets

Chair: Lauren M. Friedman, Ph.D., Assistant Professor, Arizona State University

Discussant: Mary V. Solanto, Ph.D., Northwell Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 83: Help-Seeking and Therapeutic Relationships Among Minoritized Individuals

Chair: Rebecca Browne, M.S., Suffolk University

Discussant: Jessica G. Graham-LoPresti, Ph.D., Assistant Professor, Suffolk University

◆ *Participants earn 1.5 continuing education credits*

Symposium 84: Dealing with Distress: Transdiagnostic Presentation and Treatment of Dysregulated Emotion and Coping Processes

Chair: Natasha H. Bailen, M.A., Ph.D., Boston University Center for Anxiety and Related Disorders

Discussant: Todd J. Farchione, Ph.D., Research Associate Professor, Boston University

◆ *Participants earn 1.5 continuing education credits*

Symposium 85: Using Technology to Support Couples During Times of Crisis

Chair: Kayla Knopp, Ph.D., Post-Doctoral Fellow, VA San Diego Health Care System

Discussant: Samantha Connolly, Ph.D., Clinician Investigator, Harvard Medical School

◆ *Participants earn 1.5 continuing education credits*

Symposium 86: Evaluating Strategies to Disseminate Information About Evidence-based Practices to Stakeholders

Chair: Margaret E. Crane, M.A., Temple University

Discussant: Sara J Becker, Ph.D., Associate Professor, Brown University School of Public Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 87: Frontiers in Perinatal Mental Health: Assessing and Intervening on Psychological Distress During a Critical Vulnerability Window

Chair: Samantha N. Hellberg, M.A., Graduate Student, University of North Carolina at Chapel Hill

Discussant: Cynthia L. Battle, Ph.D., Alpert Medical School of Brown University

◆ *Participants earn 1.5 continuing education credits*

Symposium 88: Examining Psychotherapy Dose for Post-traumatic Stress Disorder and Clinical Outcomes

Chair: Jenna M. Bagley, B.S., B.A., Case Western Reserve University

Discussant: Tara Galovski, Ph.D., VA National Center for PTSD, Boston University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 89: Understanding Individuals' Preferences for and Experiences in PTSD Treatment and Delivery Modalities

Chair: Stephanie Y. Wells, Ph.D., Research Psychologist, Durham VA Health Care System/VISN 6 Mid-Atlantic MIRECC

Discussant: Leslie Morland, Psy.D. Professor, University of California-San Diego/San Diego VA

◆ *Participants earn 1.5 continuing education credits*

Symposium 90: The Collateral Consequences of COVID-19: Psychological and Behavioral Sequelae Among Psychiatrically Acute Adolescents

Chair: Jennifer A. Poon, Ph.D., Postdoctoral Fellow, Alpert Medical School of Brown University

Discussant: Jarrod M. Leffler, ABPP, Ph.D., Virginia Commonwealth University

◆ *Participants earn 1.5 continuing education credits*

Symposium 91: The Role of Eating Disorder Symptoms Across Underrepresented Groups in Eating Disorder Research: What Non-Eating Disorder Professionals and Researchers Need to Know

Chair: Caroline Christian, M.S., Doctoral Student, University of Louisville

Discussant: Carolyn B. Becker, Ph.D., Professor, Trinity University

◆ *Participants earn 1.5 continuing education credits*

Symposium 92: Complicated Grief: Investigating Bereavement Experiences, End-of-life Caregiving, and Suicide Exposure Among Sexual and Gender Minority Adults

Chair: Kirsty A. Clark, Ph.D., Assistant Professor, Vanderbilt University

Discussant: Skyler D. Jackson, Ph.D., Associate Research Scientist, Yale School of Public Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 93: Mechanisms of Treatment in Action: Using Innovative Methods to Examine Symptom Change Across Cognitive-behavioral Interventions

Chair: Alexander R. Daros, Ph.D., Centre for Addiction and Mental Health

Discussant: Elizabeth H. Eustis, Ph.D., Boston University Center for Anxiety and Related Disorders

◆ *Participants earn 1 continuing education credit*

Symposium 94: Optimizing Interventions for ADHD Using Technology: Designs to Improve Treatment Engagement and Implementation

Co-Chairs: Melissa R. Dvorsky, Ph.D., Assistant Professor, Children's National Health System

Lauren M. Haack, Ph.D., Associate Professor, University of California San Francisco

Discussant: Michael C. Meinzer, Ph.D., Assistant Professor, University of Illinois at Chicago

◆ *Participants earn 1.5 continuing education credits*

Symposium 95: Stigma, Sexual Assault, and Harassment: Mental and Behavioral Health Considerations of Female Servicemembers

Co-Chairs: Shannon L. Exley, Ph.D., Uniformed Services University of the Health Sciences

Amanda Murray, M.A., M.S., Doctoral Candidate, Uniformed Services University of the Health Sciences

Discussant: Natasha Schvey, Ph.D., Assistant Professor, Uniformed Services University of the Health Sciences

◆ *Participants earn 1 continuing education credit*

Symposium 96: Evidence-based Cognitive-behavioral Treatments for Autistic Individuals: Adapting Approaches and Predicting Response

Chair: Kelsey S. Dickson, Ph.D., Assistant Professor, San Diego State University

Discussant: Jan Blacher, Ph.D., Distinguished Professor, University of California, Los Angeles

◆ *Participants earn 1.5 continuing education credits*

Symposium 97: Novel Approaches for the Study of Repetitive Negative Thinking

Chair: Sarah C. Dolan, M.A., Graduate Student, Hofstra University

Discussant: Greg J. Siegle, Ph.D., University of Pittsburgh School of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 98: Transdiagnostic Behavioral Economic Mechanisms of Substance Use and Comorbid Psychiatric Symptoms

Co-Chairs: Samuel F. Acuff, B.S., M.S., The University of Memphis

Lauren E. Oddo, M.S., Doctoral Candidate, University of Maryland, College Park

Discussant: Chris Correia, Ph.D., Auburn University

◆ *Participants earn 1.5 continuing education credits*

Symposium 99: The Impact of COVID-19 on Students from Elementary School Through College

Co-Chairs: Jill Stadterman, M.A., Fordham University

Amy Roy, Ph.D., Professor of Psychology, Fordham University

Discussant: Stephen P. Becker, Ph.D., Associate Professor, University of Cincinnati College of Medicine

◆ *Participants earn 1.5 continuing education credits*

Symposium 100: Disaster Resilience Across the Disaster Management Cycle

Chair: Marcela C. Weber, Ph.D., Postdoctoral Fellow, University of Arkansas for Medical Sciences

Discussant: Alyssa Wood, M.S., University of Mississippi

Discussant: Stefan E. Schulenberg, Ph.D., Professor of Psychology, University of Mississippi

◆ *Participants earn 1 continuing education credit*

Symposium 101: Exposure Therapy for Youth: Novel Insights from Efficacy to Implementation

Chair: Emily M. Becker-Haimes, Ph.D., Assistant Professor, University of Pennsylvania

Discussant: Anne Marie Albano, ABPP, Ph.D., Professor of Medical Psychology in Psychiatry, Columbia University College of Physicians and Surgeons

SUNDAY, November 20

◆ *Participants earn 1.5 continuing education credits*

Symposium 102: Selecting Suicide During Crisis: Clarifying Mechanisms of Suicide Risk Using Decision Science Approaches

Co-Chairs: Adam Jaroszewski, Ph.D., Postdoctoral Fellow, Massachusetts General Hospital

Peter J. Franz, Ph.D., Montefiore Medical Center

Discussant: Alexander Milner, Ph.D., Research Associate, Franciscan Children's Hospital

◆ *Participants earn 1.5 continuing education credits*

Symposium 103: Making Sense of the LGBTQA+ Youth Mental Health Crisis: The Role of CBT

Chair: Natalie Rodriguez-Quintana, M.P.H., Ph.D., University of Michigan Medical School

Discussant: Claire A. Coyne, Ph.D., Northwestern University Feinberg School of Medicine

◆ *Participants earn 1 continuing education credit*

Symposium 104: Advances in the Measurement of Pediatric Irritability

Co-Chairs: Emily Hirsch, M.A., Fordham University

Amy Roy, Ph.D., Professor of Psychology, Fordham University

Discussant: Melissa A. Brotman, Ph.D., Principal Investigator, National Institute of Mental Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 105: Attentional Processing of Affective Stimuli and Psychopathology: Infancy to Adulthood

Chair: Mary E. McNamara, M.A., The University of Texas at Austin

Discussant: Jutta Joormann, Ph.D., Yale University

◆ *Participants earn 1.5 continuing education credits*

Symposium 106: Encouraging Responsiveness in the Clinical Context: The Value of Person-centered Practices Within Child and Adolescent Mental Healthcare

Chair: Christopher Georgiadis, M.S., Florida International University

Discussant: Brian C. Chu, Ph.D., Professor, Rutgers University

◆ *Participants earn 1 continuing education credit*

Symposium 107: Considering the Roles of Parental Stress and Child Behavior Problems in the Prevention and Treatment of Child Physical Abuse

Co-Chairs: Lindsay R. Druskin, M.S., West Virginia University

Cheryl B. McNeil, Ph.D., Professor, West Virginia University

Discussant: Rochelle F. Hanson, Ph.D., Professor, Medical University of South Carolina

◆ *Participants earn 1 continuing education credit*

Symposium 108: Strategies to Monitor and Support Fidelity to Cognitive Behavioral Therapy and Cognitive Processing Therapy

Chair: Shannon Wiltsey Stirman, Ph.D., Associate

Professor/Acting Deputy Director, Stanford University

Discussant: Debra Kaysen, ABPP, Ph.D., Professor, Stanford University

◆ *Participants earn 1.5 continuing education credits*

Symposium 109: Who Helps the Helpers? Investigating the Experiences of Non-healthcare Frontline Workers During the COVID-19 Pandemic

Chair: Melanie D. Hetzel-Riggin, Ph.D., Professor of Psychology, Penn State Behrend

Discussant: Tonya Hansel, Ph.D., MSW, Tulane University

◆ *Participants earn 1.5 continuing education credits*

Symposium 110: New Approaches to Parenting of Disruptive Behaviors

Co-Chairs: Annabeth Groenman, Ph.D., Assistant Professor, University of Amsterdam

Tycho J. Dekkers, Ph.D., Assistant Professor, University of Amsterdam

Discussant: Tycho J. Dekkers, Ph.D., Assistant Professor, University of Amsterdam

Participants earn 1.5 continuing education credits

Symposium 111: Realizing the Full Potential of Measurement-based Care (MBC) to Support Clinical and Organizational Decision-making: Lessons Learned from a Series of Mixed-methods MBC Implementation Studies

Chair: Amanda Jensen-Doss, Ph.D., Professor, University of Miami

Discussant: Kelsie H. Okamura, Ph.D., Judge Baker Children's Center

◆ *Participants earn 1.5 continuing education credits*

Symposium 112: Rapid Mental Health Responses During the COVID-19 Pandemic

Chair: Andrew G. Guzick, Ph.D., Assistant Professor, Baylor College of Medicine

Discussant: Jonathan Comer, Ph.D., Professor of Psychology and Psychiatry, Florida International University

◆ *Participants earn 1.5 continuing education credits*

Symposium 113: Hidden and Structural Barriers to Evidence-based Mental Health Treatment Access and Engagement for Youth

Chair: Briana S. Last, M.A., Doctoral Candidate, University of Pennsylvania

Discussant: Jessica L. Schleider, Ph.D., Assistant Professor, Stony Brook University

◆ *Participants earn 1.5 continuing education credits*

Symposium 114: The Impact of the COVID-19 Pandemic on Neural and Behavioral Markers of Mental Health Across Child and Adolescent Development

Co-Chairs: Aaron Heller, Ph.D., Associate Professor, University of Miami

Dylan Gee, Ph.D., Assistant Professor, Yale University

Discussant: Daniel Pine, M.D., Senior Investigator, National Institute of Mental Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 115: Disaggregating the Monolith: Identity Nuances Among Sexual and Gender Minoritized Individuals in the Study and Treatment of Self-injurious Thoughts and Behaviors

Chair: Adam J. Mann, M.S., University of Toledo

Discussant: John E. Pachankis, Ph.D., Susan Dwight Bliss Professor of Public Health (Social and Behavioral Sciences), Yale School of Public Health

◆ *Participants earn 1 continuing education credit*

Symposium 116: Telehealth Facilitated Programs to Promote Trauma Resilience and Recovery

Chair: Zachary Adams, Ph.D., Assistant Professor of Psychiatry and Clinical Psychology, Indiana University

Discussant: Kimberly Canter, Ph.D., Nemours Children's Health

◆ *Participants earn 1.5 continuing education credits*

Symposium 117: Factors Contributing to Depression and Suicide Among Youth in India: Importance of Contextually Grounded, Innovative Approaches to Prevention and Intervention

Co-Chairs: Pankhuri Aggarwal, M.A., Graduate Student, Miami University

Vaishali V. Raval, Ph.D., Professor, Miami University

Discussant: Tracy K. Witte, Ph.D., Auburn University

◆ *Participants earn 1.5 continuing education credits*

Symposium 118: Innovative Approaches to Studying Unequal Mental, Behavioral, and Physical Health Burdens on Diverse Sexual and Gender Minority Populations

Chair: Alison Cerezo, Ph.D., University of California, Santa Barbara

Discussant: Jillian R. Scheer, Ph.D., Syracuse University

◆ *Participants earn 1.5 continuing education credits*

Symposium 119: Recent Developments in Assessment, Diagnosis, and Classification of OCD and Related Disorders

Chair: Amitai Abramovitch, Ph.D., Texas State University

Discussant: David Tolin, ABPP, Ph.D., Director, Anxiety Disorders Center, The Institute of Living

◆ *Participants earn 1.5 continuing education credits*

Symposium 120: Harnessing Real World Behavior Data to Optimize Treatment Delivery

Co-Chairs: Jonah Meyerhoff, Ph.D., Research Assistant Professor, Northwestern University

Caitlin A. Stamatidis, Ph.D., Clinical Intern, Northwestern University Feinberg School of Medicine

Discussant: Bethany Teachman, Ph.D., Professor, University of Virginia

◆ *Participants earn 1.5 continuing education credits*

Symposium 121: Exploring Relationships Between Various Cognitive Mechanisms and COVID-19 Emotional Distress

Co-Chairs: Hayley E. Fitzgerald, M.A., Boston University

M. Alexandra Kredlow, Ph.D., Tufts University

Discussant: Michael Otto, Ph.D., Professor, Boston University

◆ *Participants earn 1.5 continuing education credits*

Symposium 122: Recent Advances in Person-Centered, Context-aware, and Complex Systems Research

Chair: Samantha N. Hellberg, M.A., Graduate Student, University of North Carolina at Chapel Hill

Discussant: Donald Robinaugh, Ph.D., Assistant Professor, Northeastern University

◆ *Participants earn 1.5 continuing education credits*

Symposium 123: The International Impact of COVID-19 on the Educational, Social, and Mental Health Functioning of Children and Adolescents with ADHD and Related Behavioral Disorders

Chair: Kellina Lupas, Ph.D., Assistant Professor, Florida International University

Chair: Jennifer Piscitello, Ph.D., Florida International University

Discussant: Jonathan Comer, Ph.D., Professor of Psychology and Psychiatry, Florida International University

◆ *Participants earn 1.5 continuing education credits*

Symposium 124: On the Front Lines of the Muslim Mental Health Crisis: Risk of Psychosis, High Suicide, Low Help-seeking, and the Vulnerability of Converts to Islam

Chair: Merranda M. McLaughlin, M.S., Graduate Student, University of Miami

Chair: Salman S. Ahmad, M.S., Graduate Student, University of Miami

Discussant: Amy G. Weisman de Mamani, Ph.D., Professor, University of Miami

◆ *Participants earn 1.5 continuing education credits*

Symposium 125: The Integration of Evidence-Based Practice and Practice-based Evidence in the Context of Measurement-based Care and Shifts to Telehealth

Chair: James F. Boswell, Ph.D., Associate Professor, University at Albany, SUNY

Discussant: Shannon Sauer-Zavala, Ph.D., Assistant Professor, University of Kentucky

◆ *Participants earn 1.5 continuing education credits*

Symposium 126: Impact of COVID-19 and Lockdown on Autistic Individual and Their Families in Latin America and the Caribbean. Multi-informant Perspectives

Chair: Maria Cecilia Montenegro, M.Ed., The University of Texas Rio Grande Valley

Discussant: Cecilia M. Montiel-Nava, Ph.D., University of Texas Rio Grande Valley

◆ *Participants earn 1.5 continuing education credits*

Symposium 127: Development of Novel Mhealth Interventions to Address COVID-19 Related Mental Health Impacts: Opportunities to Leverage Technology to Increase Access to Care

Chair: Debra Kaysen, ABPP, Ph.D., Professor, Stanford University

Chair: Katherine A. van Stolk Cooke, Ph.D., Stanford University

Discussant: Candice M. Monson, Ph.D., Professor, Ryerson University

◆ *Participants earn 1.5 continuing education credits*

Symposium 128: Innovative Digital Interventions Can Transform Health Care Delivery and Alleviate Suffering

Chair: Maria Karekla, Ph.D., University of Cyprus

◆ *Participants earn 1.5 continuing education credits*

Symposium 129: Harnessing Technology to Increase Impact: Digital Mental Health Interventions for Anxiety and Depression

Chair: Elizabeth H. Eustis, Ph.D., Boston University Center for Anxiety and Related Disorders

Discussant: Stephen M. Schueller, Ph.D., Associate Professor of Psychological Science, University of California, Irvine

◆ *Participants earn 1.5 continuing education credits*

Symposium 130: The Role of Artificial Intelligence in Evaluating, Refining, and Supervising Evidence-based Mental Health Practices

Chair: Torrey A. Creed, Ph.D., Assistant Professor, Perelman School of Medicine at the University of Pennsylvania

Discussant: David Atkins, Ph.D., Research Professor, Lyssn.io Inc.

◆ *Participants earn 1 continuing education credit*

Symposium 131: Exploration of Treatment Mechanisms of Change and Neural Activation in Borderline Personality Disorder and General Personality Pathology

Chair: Amanda A. Uliaszek, Ph.D., Associate Professor, University of Toronto

Discussant: Alexander Chapman, Ph.D., Professor, Simon Fraser University

◆ *Participants earn 1.5 continuing education credits*

Symposium 132: Opening the Door to Open Science: Identifying Barriers to Uptake and Generating Creative Solutions to Move Cognitive Behavioral Science Forward

Chair: Erin E. Reilly, Ph.D., Assistant Professor, University of California San Francisco

Discussant: Natasha L. Burke, Ph.D., Assistant Professor, Fordham University

◆ *Participants earn 1.5 continuing education credits*

Symposium 133: Preparing and Supporting Diverse Workforces in Varied Contexts to Effectively Respond to Crises: Applying an Implementation Science Lens to Consider Needs, Strengths, and Contextual Variables

Chair: Katherine Pickard, Ph.D., Assistant Professor, Emory University School of Medicine

Chair: Davielle Lakind, Ph.D., Mercer University

Discussant: Amanda Jensen-Doss, Ph.D., Professor, University of Miami

◆ *Participants earn 1.5 continuing education credits*

Symposium 134: Pouring from an Empty Cup: Cognitive-emotional Processes Impacting Caregiver and Child Adjustment During the COVID-19 Pandemic

Chair: Olivia J. Derella, Ph.D., Montefiore Medical Center/Albert Einstein College of Medicine

Discussant: Jeffrey D. D. Burke, Ph.D., Associate Professor, University of Connecticut

◆ *Participants earn 1.5 continuing education credits*

Symposium 135: Exploring Transdiagnostic Mechanism-based Intervention Development

Chair: Hayley E. Fitzgerald, M.A., Boston University

Chair: Alexandra K. Gold, M.A., Graduate Student, Massachusetts General Hospital
Discussant: Michael Otto, Ph.D., Professor, Boston University

◆ *Participants earn 1.5 continuing education credits*

Symposium 136: Recent Research on Parent Training in Autism Spectrum Disorder: optimizing the Reach

Chair: CYNthia Anderson, Ph.D., Senior Vice President, May Institute
Chair: Cynthia R. Johnson, Ph.D., Cleveland Clinic & Case Western Reserve University
Discussant: Eric M. Butter, Ph.D., Chief of Psychology; Director of Behavioral Health; Associate Professor, Pediatrics, Nationwide Childrens Hospital

◆ *Participants earn 1.5 continuing education credits*

Symposium 137: Qualitative and Mixed-method Approaches to Understand and Address Mental Health Inequities

Chair: Noah S. Triplett, M.S., University of Washington, Seattle
Chair: Giovanni Ramos, M.A., UCLA
Discussant: Anna S. Lau, Ph.D., Professor, UCLA

◆ *Participants earn 1.5 continuing education credits*

Symposium 138: Novel Strategies to Increase Treatment Engagement in Mental Health Services: The Role of Patients Culture, Stakeholder Perspectives, and Delivery Models

Chair: Wendy Chu, Ph.D., Graduate Student, University of South Carolina
Discussant: Kimberly Becker, Ph.D., Associate Professor, University of South Carolina

■ CLINICAL ROUND TABLES

FRIDAY, November 18

◆ *Participants earn 1.5 continuing education credits*

CRT1: The impact of COVID-19 on CBT in Inpatient Psychiatric Care: Responses and Adjustments From Early Pandemic to Omicron Surge

Moderator: Nadine A. Chang, Ph.D., Clinical Psychologist, Gracie Square Hospital
Presenters: Victoria M. Wilkins, Ph.D., Assistant Professor, Weill Cornell Medicine/New York-Presbyterian Hospital
Dora Kanellopoulos, Ph.D., Associate Professor, Weill Cornell Medicine

◆ *Participants earn 1.5 continuing education credits*

CRT2: Training the Next Generation of Tele-Behavioral Health Providers: Looking Beyond COVID-19

Moderator: Mariah Stickley, Ph.D., Assistant Professor, Texas A & M University
Presenters: Kaylee Jackson, M.A., Doctoral Student, Texas A & M University
Katie Console, Doctoral Student, Texas A & M University
Grace Anderson, B.S., Doctoral Student, Texas A & M University
Kelly Sopchak, Ph.D., Licensed Psychologist, Texas A & M University

Meredith Williamson, ABPP, Ph.D., Assistant Professor, Texas A & M University
Carly McCord, Ph.D., Director of Tele-Behavioral Health, Texas A & M University

◆ *Participants earn 1.5 continuing education credits*

CRT3: The Mental Health Crisis in Pediatric Medical Settings: Applying Evidence-Based Approaches to Support Physicians

Moderators: Abigail Zisk, Ph.D., Postdoctoral Psychology Fellow, NewYork-Presbyterian Hospital/Weill Cornell Medicine
Eliana Butler, M.A., Psychology Intern, Geisinger Health Systems
Presenters: Corinne Catarozoli, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry and Pediatrics, Weill Cornell Medicine
Alexandra Huttie, M.D., Pediatric Chief Resident, New York-Presbyterian Hospital/Weill Cornell Medicine
Stephanie N. Rohrig, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry, Weill Cornell Medicine
Becky H. Lois, Ph.D., Clinical Associate Professor, Hassenfeld Children's Hospital at NYU Langone
Christina Moore, Ph.D., Postdoctoral Psychology Fellow, Dartmouth-Hitchcock Medical Center

◆ *Participants earn 1.5 continuing education credits*

CRT4: Meeting the Mental Health Needs of the Climate Crisis: Considerations in the Application of Cognitive-Behavioral Theory and Approaches

Moderators: Kelsey Hudson, Ph.D., Research Scientist, Boston University, Center for Anxiety and Related Disorders
Katherine Crowe, Ph.D., Clinical Psychologist, Home for Anxiety, Repetitive Behaviors, OCD, and Related Disorders
Presenters: Anthony Puliafico, Ph.D., Associate Professor of Medical Psychology (in Psychiatry), Columbia University Medical Center
Eric Lewandowski, Ph.D., NYU Langone Medical Center
Sandra Pimentel, Ph.D., Chief, Child and Adolescent Psychology, Montefiore Medical Center- AECOM
Kyle Hill, M.P.H., Ph.D., Assistant Professor, University of North Dakota

◆ *Participants earn 1.5 continuing education credits*

CRT5: Facilitating Trauma Recovery and Managing Risk Behaviors in the Context of Global Crises

Moderator: Samantha N. Hellberg, M.A., Graduate Student, University of North Carolina at Chapel Hill
Presenters: Tiffany Hopkins, Ph.D., Psychologist, University of North Carolina at Chapel Hill
Melanie Harned, ABPP, Ph.D., Associate Professor and Psychologist, VA Puget Sound Health Care System & University of Washington
Juliette C. McClendon, Ph.D., Director of Medical Affairs, Big Health
Carolina P. Clancy, ABPP, Ph.D., Staff Psychologist, Evidence Based Psychotherapy Coordinator, CPT Trainer and Consultant, US Department of Veterans Affairs
Lorie A. Ritschel, Ph.D., Associate Professor, Clinic Director, UNC School of Medicine; Triangle Area Psychology Clinic
Jennifer Y. Yi, Ph.D., Staff Psychologist, Durham Veterans Affairs Healthcare System

SATURDAY, November 19

◆ *Participants earn 1.5 continuing education credits*

CRT6: Moving Forward During the Challenges of the Double Pandemic: What We Learned Transitioning in a Time of Crisis While Managing Our Vicarious Traumatization

Moderators: Mudita A. Bahadur, Ph.D., Psychologist, Private Practice

Lizbeth Gaona, Ph.D., LCSW, MSW, Assistant Professor, California Baptist University

Presenters: Janee Steele, Ph.D., LPC, Core Faculty, Walden University

Lisa S. Bolden, Psy.D., Assistant Clinical Professor, UCLA School of Medicine

Carmella Tress, Psy.D., Licensed Clinical Psychologist, Coatesville VA Medical Center

Jamie Schumpf, Psy.D., Director of Clinical Training, Yeshiva University - Ferkauf Graduate School of Psychology

Hollie Granato, Ph.D., Clinical Professor, UCLA

◆ *Participants earn 1.5 continuing education credits*

CRT7: The Roles and Responsibilities of Mental Health Providers Working with Transgender and Gender Diverse Youth and Families

Moderator: Claire A. Coyne, Ph.D., Pediatric Clinical Psychologist, Northwestern University Feinberg School of Medicine

Presenters: Jessica M. Bernacki, Ph.D., Clinical Psychologist, UCLA School of Medicine

Diane Chen, Ph.D., Associate Professor/Director of Behavioral Health in Adolescent & Young Adult Medicine, Ann & Robert H. Lurie Children's Hospital of Chicago/Northwestern

Feinberg School of Medicine

Christy L. Oleski, Ph.D., Associate Professor, Yale University School of Medicine

Jonathan Poquiz, Ph.D., Pediatric Psychologist, Johns Hopkins All Children's Hospital

◆ *Participants earn 1.5 continuing education credits*

CRT8: Virtual Reality Interventions to Address Psychological Distress: Leveraging an Innovative Technology to Enhance Mental Health Care During a Global Mental Health Crisis

Moderator: Rachel Waldman, Ph.D., Postdoctoral Fellow, Weill Cornell Medicine

Presenters: Michelle Pelcovitz, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry, Weill Cornell Medicine

Stephanie Cherestal, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry, Weill Cornell Medicine

Dora Kanellopoulos, Ph.D., Associate Professor, Weill Cornell Medicine

Abhishek Jaywant, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry, Weill Cornell Medicine

William Lamson, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry, Weill Cornell Medicine

Shira Ritholtz, Ph.D., Assistant Professor of Psychology in Clinical Psychiatry, Weill Cornell Medicine

◆ *Participants earn 1.5 continuing education credits*

CRT9: Maybe It's Not Simply Rigidity: A Trauma-Informed Lens for Utilizing CBT to Treat Autistic Adolescents

Moderator: Rebecca Sachs, ABPP, Ph.D., Founder, CBT Spectrum

Presenters: Dena Gassner, MSW, Adjunct Professor, Towson University/Ph.D. Candidate, Adelphi University, MSW Matthew D. Lerner, Ph.D., Associate Professor, Stony Brook University

Lauren Moskowitz, Ph.D., Associate Professor, St. John's University

Tamara Rosen, Ph.D., Psychologist, St Christopher's Hospital for Children (Drexel University/Tower Health)

Briana S. Last, M.A., Doctoral Candidate, University of Pennsylvania

Hilary E. Kratz, Ph.D., Assistant Professor, La Salle University

◆ *Participants earn 1.5 continuing education credits*

CRT10: What to Do When Worries Ring True: How CBT Clinicians Can Address Realistic Worries Among Youth With Anxiety During Our Challenging Times

Moderators: Alyssa M. Farley, Ph.D., Research Scientist, Boston University Center for Anxiety and Related Disorders Rachel Merson, Psy.D., Research Assistant Professor, Boston University Center for Anxiety and Related Disorders

Presenters: Annie W. Dantowitz, LICSW, Group Director of the Child and Adolescent Program, Boston University Center for Anxiety and Related Disorders

Donna B. Pincus, Ph.D., Professor, Boston University

Kelsey Hudson, Ph.D., Research Scientist, Boston University, Center for Anxiety and Related Disorders

Amanda Sanchez, Ph.D., Assistant Professor, George Mason University

Alicia R. Fenley, M.A., Boston University

◆ *Participants earn 1.5 continuing education credits*

CRT11: Effectively Treating Diverse Presentations in Early Psychosis: Overcoming Crisis and Other "Complicating Factors"

Moderator: Daniel I. Shapiro, Ph.D., Assistant Professor, University of California, Davis

Presenters: Khalima A. Bolden, Ph.D., Health Sciences Assistant Clinical Professor, University of California Davis Early Psychosis Clinic

Katherine Eisen, Ph.D., Clinical Assistant Professor, Stanford University School of Medicine

Sabrina Ereshefsky, Ph.D., Postdoctoral Scholar, University of California, Davis

Johanna B. Folk, Ph.D., Assistant Professor, University of California, San Francisco

Victoria Galvez, Psy.D., Clinician, UCD Psychiatry

Karina Muro, Ph.D., Assistant Professor, University of California Davis

SUNDAY, November 20

◆ *Participants earn 1.5 continuing education credits*

CRT12: Telehealth for Suicide Ideation With Marginalized Populations

Moderator: Linda Oshin, Ph.D., Assistant Professor, Rutgers University

Presenters: Kenji Takeda, Psy.D., Clinical Psychologist, Rutgers University
Jeffrey M. Cohen, Psy.D., Assistant Professor of Medical Psychology (In Psychiatry), Columbia University
Christy L. Oleski, Ph.D., Associate Professor, Yale University School of Medicine

♦ *Participants earn 1.5 continuing education credits*

CRT13: Compassion-Focused Psychotherapies: Emerging Interventions for Troubled Times

Moderator: Keryn Kleiman, M.A., Doctoral Student Clinician/Researcher, Kean University
Presenters: Benjamin Foote, M.A., Doctoral Student Clinician/Researcher, Kean University
Dennis Tirsch, Ph.D., Founding Director, The Center for CFT
Laura Silberstein-Tirsch, Psy.D., Director & Clinical Psychologist, The Center for Compassion Focused Therapy
Emory Marino, Psy.D., Psychologist, Corporal Michael J Crescenzo VA Medical Center
C. Virginia O'Hayer, Ph.D., Clinical Associate Professor, Thomas Jefferson University Hospital
Maureen Sessa, M.A., M.S., Doctoral Student, Kean University

♦ *Participants earn 1.5 continuing education credits*

CRT14: Task Sharing to Bridge the Mental Health Treatment Gap: Strategies, Challenges, and Opportunities for Training Nonspecialists to Participate in Care

Moderators: Eve S. Puffer, Ph.D., Assistant Professor, Duke University
Jessica F. Magidson, Ph.D., Assistant Professor, University of Maryland
Presenters: Miya Barnett, Ph.D., Assistant Professor, University of California Santa Barbara
Katherine E. Venturo-Conerly, Ph.D. Candidate, Harvard University
Ali Giusto, Ph.D., NIH T32 Postdoctoral Fellow, Columbia University/New York State Psychiatric Institute
Gabriela A. Nagy, Ph.D., Assistant Professor, Duke University
Dwayne Dean, Peer Recovery Specialist, Project HEAL, University of Maryland

♦ *Participants earn 1.5 continuing education credits*

CRT15: Implementing LGBTQ-Affirmative CBT: Increasing Uptake Across Strategic Settings Nationwide

Moderators: Zachary A. Souliard, Ph.D., Postdoctoral Associate, Yale School of Public Health
John E. Pachankis, Ph.D., Susan Dwight Bliss Professor of Public Health (Social and Behavioral Sciences), Yale School of Public Health
Presenters: Amy Green, Ph.D., Vice President of Research, The Trevor Project
Antonio Ruberto, Jr., M.S., Senior Director of Behavioral Health, The Lesbian, Gay, Bisexual and Transgender Community Center
Joel T. Sherrill, Ph.D., Deputy Director, Division of Services & Intervention Research, NIMH, National Institute of Mental Health
Sarah M. Wilson, Ph.D., Assistant Professor, Duke University School of Medicine

■ SPOTLIGHT RESEARCH

FRIDAY, November 18

SR1: Outcomes from a Mindfulness-Based Interdisciplinary Pain Management Clinical Trial for Pain and Comorbid Opioid Use

Chair: Donald McGeary, ABPP, Ph.D., Associate Professor, University of Texas Health Science Center San Antonio
Panelist: Cindy A. McGeary, ABPP, Ph.D., Associate Professor, University of Texas Health Science Center at San Antonio

SATURDAY, November 19

SR2: Cognitive Behavioral Therapy to Explicate Biological Mechanisms of Intersectional Minority Stress: A Randomized Controlled Trial of the AWARENESS Intervention

Chair: David W. Pantalone, Ph.D., Professor of Psychology, University of Massachusetts Boston
Panelist: Annesa Flentje, Ph.D., Associate Professor, University of California San Francisco

SR3: Predictors and Determinants of Coping with COVID-19: Cross-cultural Perspectives

Chair: William H. O'Brien, Ph.D., Professor, Bowling Green State University
Panelists: Kullaya Pisitsungkagarn, Ph.D., Associate Professor, Chulalongkorn University
Panita Suavansri, Ph.D., Lecturer, Chulalongkorn University
Jennifer Chavanovanich, Ph.D., Director of East West Psychological Science and Research Center, Chulalongkorn University
Shan Wang, Ph.D., Assistant Professor, Duke Kunshan University

SUNDAY, November 20

SR4: Outcomes of a Randomized Clinical Trial of a Novel CBT Intervention for Posttraumatic Headache and Comorbid PTSD

Chair: Donald McGeary, ABPP, Ph.D., Associate Professor, University of Texas Health Science Center San Antonio
Panelist: Cindy A. McGeary, ABPP, Ph.D., Associate Professor, University of Texas Health Science Center at San Antonio

■ MINI WORKSHOPS

FRIDAY, November 18

♦ *Participants earn 1.5 continuing education credits*

MWK1: Use of Motivational Interviewing for Individuals with PTSD: Ways to Increase Treatment Engagement, Retention, and Readiness to Change

Debra Kaysen, ABPP, Ph.D., Professor, Stanford University
Denise Walker, Ph.D., Research Professor, University of Washington, Seattle

◆ *Participants earn 1.5 continuing education credits*

MWK2: The Hope Institute - A Model for Next-Day Care for Suicide Risk Using CAMS and DBT

Amy M. Brausch, Ph.D., Western Kentucky University
Derek Lee, LPCC, Chief Executive Officer, Perrysburg Counseling Services, LLC

◆ *Participants earn 1.5 continuing education credits*

MWK3: Sexual and Gender Minority Stress: Pride and Prejudice in the Era of Covid and Increased Discrimination

Joel L. Becker, Ph.D., Clinical Professor, UCLA
Greg Stanford, Psy.D., Clinical Instructor, UCLA
Trevor A. Hart, Ph.D., Professor and Director, HIV Prevention Lab, Ryerson University
Jae A. Puckett, Ph.D., Assistant Professor, Michigan State University

◆ *Participants earn 1.5 continuing education credits*

MWK4: When the Pandemic Isn't the Worst Thing That's Happened: Practical Tools for Complex PTSD Survivors in Our Troubled Times

Tamar Gordon, Ph.D., Clinical Director, Gordon Therapy Group
Susan Paula, Ph.D., Senior Staff Psychologist, American Institute for Cognitive Therapy

◆ *Participants earn 1.5 continuing education credits*

MWK5: Introduction to the Coping Long-term with Active Suicide Program (CLASP)

Ivan W. Miller, Ph.D., Professor, Brown University & Butler Hospital
Brandon A. Gaudiano, Ph.D., Professor, Brown University & Butler Hospital
Lauren Weinstock, Ph.D., Professor, Brown University

◆ *Participants earn 1.5 continuing education credits*

MWK6: How Can I Possibly Validate Everyone: A Live, Annotated Demonstration of Family Therapy in DBT-A

Alison M. Yaeger, Psy.D., Program Director, Associate Director of Training, Instructor of Psychology, McLean Hospital/Harvard Medical School
Ashley Maliken, Ph.D., Psychologist, University of California San Francisco
Maggie Gorraiz, Ph.D., Program Director, School Consultation Service, McLean Hospital, Harvard Medical School
Esme A. Shaller, Ph.D., Clinical Director, Child & Adolescent Outpatient Services Clinical Director, Wavefront Dialectical B, UCSF
Aditi Vijay, Ph.D., Assistant Professor, Private Practice/Georgetown University

◆ *Participants earn 1.5 continuing education credits*

MWK7: Doing Cognitive Behavior Therapy with LGBTQ Youth and Their Families: A Live Demonstration

Jeffrey M. Cohen, Psy.D., Assistant Professor of Medical Psychology (In Psychiatry), Columbia University
Ilana Seager van Dyk, Ph.D., Senior Lecturer, Massey University

◆ *Participants earn 1.5 continuing education credits*

MWK8: Cultural Competence to Cultural Intelligence: Understanding the Intersection of Discrimination, Microaggressions and Shame in the Treatment of Eating Disorders in BIPOC and LGBTQ+ Communities

Norman Kim, Ph.D., Founder, Institute for Antiracism and Equity

◆ *Participants earn 1.5 continuing education credits*

MWK16: Early Intervention for Distress Following Disaster: Skills for Life Adjustment and Resilience (SOLAR)

Scott M. Pickett, Ph.D., Associate Professor, Center for Translational Behavioral Science, Department of Behavioral Sciences and Social Medicine, Florida State University College of Medicine
Meaghan O'Donnell, Ph.D., Professor, Head of Research, Centre for Posttraumatic Mental Health, University of Melbourne

SATURDAY, November 19

◆ *Participants earn 1.5 continuing education credits*

MWK9: Making Every Minute Count: The Nuts and Bolts of Evidence-based Trauma Assessment for Youth

Cameo F. Stanick, Ph.D., Vice President of Training and Implementation Practice, Sycamores
Ceth Ashen, Ph.D., C. Ashen Psychological Consulting

◆ *Participants earn 1.5 continuing education credits*

MWK10: A Postvention Process for Supporting Clinicians Navigating the Death of a Client

Jennifer C. Veilleux, Ph.D., Associate Professor, University of Arkansas
Sarah A. Bilsky, Ph.D., Assistant Professor, University of Mississippi

◆ *Participants earn 1.5 continuing education credits*

MWK11: Improving Access to Evidence-based ACT for Social Anxiety: In-person and Virtual Group Approaches (and Self-help)

Nancy L. Kocovski, Ph.D., Professor, Wilfrid Laurier University
Jan E. Fleming, M.D., Clinical Associate, The Mindfulness Clinic

◆ *Participants earn 1.5 continuing education credits*

MWK12: Preparing Your Community for Response and Recovery to Mass Violence Incidents

Alyssa A. Rheingold, Ph.D., Professor, Medical University of South Carolina

◆ *Participants earn 1.5 continuing education credits*

MWK13: Taking Exposure and Response Prevention from the Treatment Manual to Your Patients: A Guide to Application for All Mental Health Disciplines

Patrick B. McGrath, Ph.D., Chief Clinical Officer, NOCD

◆ *Participants earn 1.5 continuing education credits*

MWK14: The Empowering, Vigorous and Compassionate Approach of Rational Emotive Behavior Therapy

Dr. Debbie Joffe Ellis, Adjunct Professor, Columbia University
TC

◆ *Participants earn 1.5 continuing education credits*

MWK15: A Safety Aid Reduction Treatment for Anxiety and Related Disorders

Amanda M. Raines, Ph.D., Clinical Investigator, Southeast Louisiana Veterans Health Care System
Joseph Boffa, Ph.D., Assistant Professor, Tulane University

SUNDAY, November 20

◆ *Participants earn 1.5 continuing education credits*

MWK17: Enhancing Engagement in Digital Mental Health: Coaching 101

Courtney Beard, Ph.D., Psychologist, McLean Hospital
Jacqueline R. Bullis, Ph.D., McLean Hospital/Harvard Medical School
Harris E. Bajwa, Ph.D., Research Assistant and CBT Coach, Massachusetts General Hospital
Sara Mei, B.S., Research Assistant, McLean Hospital

◆ *Participants earn 1.5 continuing education credits*

MWK18: Inner Resources for Stress: Essential Skills for Using Mindfulness and Meditation for Stress and Trauma

Lynn C. Waelde, Ph.D., Adjunct Clinical Professor, Stanford University School of Medicine

◆ *Participants earn 1.5 continuing education credits*

MWK19: Using Digital Technologies to Make an Impact

Presenter: Page L. Anderson, ABPP, Ph.D., Associate Professor, Georgia State University

◆ *Participants earn 1.5 continuing education credits*

MWK20: Serving the Underserved: Providing Specialized Treatment for Rural Eating Disorders

Jennifer Copeland, Psy.D., Licensed Psychologist, Ozark Center
Carolyn B. Becker, Ph.D., Professor, Trinity University
Jacob Hefner, Ed.S., LPC, Director of Adult Outpatient Services, Ozark Center

RESEARCH AND PROFESSIONAL DEVELOPMENT

FRIDAY, November 18

◆ *This session does not offer continuing education credits*

RPD 1: Women Supporting Women: Building Female Mentoring Networks in Academic Medicine

Victoria E. Cosgrove, Ph.D., Clinical Associate Professor, Stanford University School of Medicine
Amy E. West, Ph.D., Professor of Clinical Pediatrics, Psychology and Psychiatry, Children's Hospital Los Angeles/University of Southern California School of Medicine
Louisa G. Sylvia, Ph.D., Psychologist, Massachusetts General Hospital
Caryn Rodgers, Ph.D., Associate Professor, Albert Einstein College of Medicine

◆ *This session does not offer continuing education credits*

RPD 2: Growing Your Mental Health System: How to Build an IOP/PHP Level of Care

Micaela Thordarson, Ph.D., Program Supervisor, Children's Health Orange County

SATURDAY, November 19

◆ *Participants earn 1 continuing education credit*

RPD 3: CBT Careers Beyond the Ivory Tower: Industry Based Roles That Promote the Transfer of Evidence-based Principles Into the Real World

Margaret T. Anton, Ph.D., Senior Clinical Research Scientist, AbleTo, Inc.
Nicholas R. Forand, ABPP, Ph.D., Director of Clinical Program Development, AbleTo, Inc.
Alyssa Dietz, Ph.D., Director, Precision Innovation, Strategy & Operations, Happify health
Amy M. Schreiner, Ph.D., Clinical Therapy Design Specialist, Mahana Therapeutics

◆ *This session does not offer continuing education credits*

RPD 4: Overcoming Impediments to Conducting Research in Your Private Practice

Travis L. Osborne, Ph.D., Clinical Director; Co-Director of Research and Outcomes Monitoring, Evidence Based Treatment Centers of Seattle
Mary K. Alvord, Ph.D., Psychologist/Director, Alvord, Baker & Associates, LLC
J. Ryan Fuller, Ph.D., Co-founder, My Best Practice: Evidence-based EHR
Andrew White, ABPP, Ph.D., Associate Director, Portland DBT Institute
Jacqueline Persons, Ph.D., Director, Bay Area Trauma Recovery Clinical Services

◆ *This session does not offer continuing education credits*

RPD 5: Are You Ok? Wellness and Resilience Workshop for Clinicians and Researchers

Andrada D. Neacsiu, Ph.D., Assistant Professor, Duke University Medical Center

SUNDAY, November 20

◆ *This session does not offer continuing education credits*

RPD 6: The ABCs of Educating the Public via the Media

Richard J. McNally, Ph.D., Professor, Harvard University

◆ *This session does not offer continuing education credits*

RPD 7: Careers in Clinical Psychology: Which Path Makes Sense for Me?

Jedidiah Siev, Ph.D., Associate Professor, Swarthmore College
Sabine Wilhelm, Ph.D., Professor, Chief of Psychology, Harvard Medical School
Matthew Nock, Ph.D., Professor, Harvard University
Jonathan B. Grayson, Ph.D., Director, University of Southern California
Barbara W. Kamholz, ABPP, Ph.D., Associate Director, Outpatient MH/Associate Professor of Psychiatry, VA Boston HCS/Boston University School of Medicine

NETWORKING Special Interest Group Meetings

Attendance at an ABCT Special Interest Group meeting is a wonderful networking opportunity. The SIGs focus on a diverse range of topics, including treatment approaches, specific disorders or unique populations. SIGs are open to ABCT members only, so be sure to join or renew your membership. The SIG Poster Exposition, Friday, 6:30 PM - 8:30 PM, is a fabulous chance to get an overview of ABCT's SIG Program.

SIG Leaders Meeting – November 19, 8:00 AM – 9:00 AM
Addictive Behaviors – November 19, 9:30 AM-11:00 AM
Aging Behavior and Cognitive Therapy – November 18, 1:30 PM – 2:30 PM
Anxiety Disorders – November 20, 12:00 PM – 1:00 PM
Asian American Issues in Behavior Therapy and Research – November 18, 10:00 AM – 11:30 AM
Attention-Deficit/Hyperactivity Disorder (ADHD) – November 18, 12:00 PM- 1:30 PM
Autism Spectrum and Developmental Disabilities (AS/DD) – November 19, 10:00 AM – 11:30 AM
Behavioral Medicine and Integrated Primary Care – November 19, 2:00 PM – 3:30 PM
Behavioral Sleep Medicine - November 19, 10:00 AM – 11:30 AM
Black Americans in Research and Behavioral Therapy – November 20, 12:00 PM – 1:30 PM
Child and Adolescent Anxiety – November 19, 12:00 PM – 1:30 PM
Child and Adolescent Depression – November 19, 3:30 PM – 4:30 PM
Child Maltreatment and Interpersonal Violence – November 20, 10:00 AM- 11:30 AM
Clinical Psychological Science – November 20, 12:00 PM – 1:00 PM
Clinical Psychology at Liberal Arts Colleges - November 19, 4:00 PM – 5:30 PM
Clinical Research Methods and Statistics - November 19, 8:30 AM – 9:30 AM
Cognitive Therapy SIG – November 20, 12:00 PM – 1:00 PM
Couples Research and Treatment - November 19, 8:30 AM – 9:30 AM
Dissemination and Implementation Science – November 19, 4:00 PM – 5:30 PM
Eating Disorders and Eating Behaviors (EDEB) – November 18, 4:00 PM – 5:30 PM
Latinx – November 18, 10:00 AM – 11:30 AM
Mindfulness and Acceptance - November 18, 12:00 PM – 1:00 PM
Native American Issues in Behavior Therapy and Research – November 18, 8:00 AM – 9:30 AM
Oppression and Resilience: Minoritized Mental Health - November 18, 4:00 PM – 5:30 PM
Master's Level Clinical Training, Education and Practice – November 20, 8:00 AM – 9:30 AM
Neurocognitive Therapies and Translational Research – November 20, 12:00 PM- 1:00 PM
Parenting and Families – November 18, 2:00 PM – 3:30 PM
Personality Disorders – November 20, 8:00 AM – 9:00 AM
Psychosis and Schizophrenia Spectrum – November 19, 10:00 AM – 11:30 AM
Research in Clinical Practice – November 19, 12:00 PM – 1:00 PM
Sexual and Gender Minority – November 18, 2:00 PM – 3:30 PM
Spiritual and Religious Issues in Behavior Change – November 20, 12:00 PM – 1:00 PM
Suicide and Self-Injury – November 18, 11:30 AM – 1:00 PM
Student – November 20, 12:00 PM – 1:00 PM
Technology and Behavior Change – November 18, 8:30 AM – 9:30 AM
TIC and Obsessive-Compulsive Related Disorders – November 19, 1:30 PM – 3:00 PM
Women's Issues in Behavioral Therapy – November 20, 10:00 AM – 11:30 AM



The special ABCT Convention rates will be offered, based on mutual agreement with the Hotel, 3 days before and 3 days after the official Convention dates of November 17 – 20, 2022. The block is limited and available on a first-come basis until the block is depleted. If you are interested in upgrading your hotel accommodations, there are limited options available, at an increased rate. Contact the hotel directly.

All ABCT Convention scientific sessions, special interest group meetings, committee meetings, poster sessions, exhibits, and special events will take place at the New York Marriott Marquis Hotel. General registration includes panel discussions, clinical round tables, symposia, mini-workshops, and poster sessions. Remember to check out the limited-attendance CE events – both on Thursday and throughout the Convention on Friday and Saturday. The Welcoming Reception/SIG Exposition will take place on Friday night from 6:30 p.m. to 8:30 p.m.

Stay at the Marriott Marquis to meet your friends and colleagues on the elevator, in the coffee shop, as well as in the meeting rooms. Your support of the convention hotels also helps to keep the overall expenses to a minimum. Rooms and rates are subject to rate and room availability. Please be sure to book your reservation early!

Sleeping Room Rate: \$239 (up to 4 people in a room)

Booking Link: <https://book.passkey.com/e/50319584>

Or call:

Reservations Toll Free: 1-877-303-0104

Reservations Local Phone: 1-212-398-1900

Reservation Cut-off Date: Friday, October 12, 2022

New York Marriott Marquis is an iconic fixture of Times Square and brilliantly captures the vibrant energy and spirit of Manhattan. Located on West 46th Street and Broadway, the hotel places guests near some of NYC's most exciting attractions including Rockefeller Center, Radio City Music Hall and the Theater District. Experience incredible restaurants including New York's only revolving dining room with 360-degree views of Manhattan. Set the stage for a relaxing stay with a 24-hour fitness center, in-room dining, and 5,000 square foot M Club. After an eventful day of sightseeing, relax and recharge in spacious hotel accommodations with views of Broadway, Times Square, and Manhattan.

Registration

Preregister on-line at www.abct.org. To pay by check, complete the registration form available in PDF format on the ABCT website. Participants are strongly urged to register by the preregistration deadline of October 14. Beginning October 15 all registrations will be processed at the on-site rates. Please note: Convention Program Books will NOT be distributed. A flipbook of the program book will be available and posted to the ABCT convention page. Please download the convention app to view and create your own personalized schedule.

► **To receive the member-discounted convention registration rate, members must renew for 2023 before completing the registration process or they must join as a new member of ABCT.**

Preconvention ticketed sessions and registration for preconvention sessions will be held on Thursday, November 17 at the New York Marriott Marquis Hotel. All preconvention sessions are designed to be intensive learning experiences. Preregister to ensure participation. Registration for all PRE-convention sessions (AMASS, Clinical Intervention Seminars, Institutes) will take place in the New York Marriott Marquis Hotel at the ABCT onsite registration area in the fifth floor:

Thursday, November 17: 7:30 a.m. - 6:30 p.m.

General Registration Upon arrival at the New York Marriott Marquis Hotel, you can pick up the program addendum, additional convention information, and ribbons at the Pre-Registration Desk on the fifth floor.

PLEASE REMEMBER TO BRING CONFIRMATION LETTER WITH YOU TO THE MEETING.

Onsite Registration AND Preregistration pickup will be open:

- Thursday, November 17: 7:30 a.m. - 6:30 p.m.
- Friday, November 18: 7:30 a.m. - 6:30 p.m.
- Saturday, November 19: 7:30 a.m. - 6:30 p.m.
- Sunday, November 20: 7:30 a.m. - 1:00 p.m.

The general registration fee entitles the registrant to attend all events on November 17 - November 20 except for ticketed sessions. Your canceled check is your receipt. Email confirmation notices will be generated automatically for on-line registrations and will be sent via email the same day you register. Email confirmations will be sent within 1 week for faxed and mailed registrations. If you do not receive an email confirmation in the time specified, please call the ABCT central office, (212) 647-1890, or email Tonya Childers at tchilders@abct.org.

You must wear your badge at all times to be admitted to all official ABCT sessions, events, and the exhibits. If you lose your badge there will be a \$15 charge for the replacement.

All presenters (except for the first two presenters of ticketed CE sessions) must pay the general registration fee. Leaders of ticketed session will receive information regarding their registration procedure from the ABCT Central Office. Admission to all ticketed sessions is by ticket only. Preregistration is strongly advised as ticketed sessions are sold on a first-come, first-served basis.

Please note: **NO PURCHASE ORDERS WILL BE ACCEPTED.**

To register, please choose one format:

Registering On-Line

The quickest method is to register on-line (go to [abct.org](https://www.abct.org) and click on the convention banner on the home page or go to <https://www.abct.org/2022-convention/>). Use this method for immediate feedback on which ticketed sessions you will be attending. To receive members' discounted rates, your ABCT dues must be up to date. If your membership has lapsed, use this opportunity to renew.

To get member rates at this conference, your ABCT dues must be paid through October 31, 2023. The ABCT membership year is November 1, 2022 - October 31, 2023. To renew, go to [abct.org](https://www.abct.org) or the on-site membership booth.

Registering by Fax

You may fax your completed registration form, along with credit card information and your signature, to (212) 647-1865. If you choose this method, please DO NOT send a follow-up hard copy. This will cause double payment. For preregistration rates, please register BEFORE the deadline date of October 14.

Registering by Mail

All preregistrations that are paid by check must be mailed to ABCT, 305 Seventh Avenue, 16th Floor, New York, NY, 10001. For preregistration rates, forms must be postmarked by the deadline date of Friday, October 14.

Forms postmarked beginning Saturday, October 15 will be processed at on-site rates. There will be no exceptions. Refund Policy Cancellation refund requests must be in writing. Refunds will be made until the October 14 deadline, and a \$50 handling fee will be deducted. Because of the many costs involved in organizing and producing the Convention, no refunds will be given after October 14.

Payment Policy

All fees must be paid in U.S. currency on a U.S. bank. Any bank fees charged to the Association will be passed along to the attendee. Please make checks payable to ABCT.

Exhibits, ABCT Information Booth Hours

- Friday & Saturday: 8:00 a.m. - 5:30 p.m.
- Sunday, 8:00 a.m. - 11:00 a.m.

REGISTER NOW! <https://www.abct.org/2022-convention/>

Getting Around NYC

While there are a multitude of options for dining and attractions within walking distance of the convention hotel, if you choose to explore additional parts of Manhattan or the surrounding boroughs, utilizing taxi services, which can be quickly accessed almost anywhere in the city, rideshare options (i.e., Uber/Lyft), or public transportation, may be necessary. Although using rideshare options allows for prior scheduling of transportation, this also incurs additional fees, and it may be most efficient and cost-effective to utilize taxi services. If you are interested in utilizing only low-cost transportation, please visit the Metropolitan Transit Authority (MTA) website (<https://new.mta.info/agency/new-york-city-transit>) for information and updates about subways and buses, and utilize Google Maps when routing to your destination. The closest MTA subway station to the hotel is located at 49th Street and 7th Avenue with connections to the N, R, and W subway lines and is around a 5-minute walk. The Times Square Station on 42nd Street and 7th Avenue has the most subway connections (N, Q, R, S, W, 1, 2, 3 and 7). The S train runs between Times Square and Grand Central Station. 42nd Street/Port Authority Bus Terminal subway station located at 41st Street and 8th Avenue is home to the A, C, and E subway lines. There is also a bus stop on 44th Street and 7th Avenue.

Weather

In November, the average high temperature is 55 degrees Fahrenheit, and the low temperature is 42 degrees Fahrenheit. Make sure you have a nice warm jacket and other outdoor clothing (such as mittens, hat, and scarf) if you plan on walking outside. Also, be prepared to see some potential snow flurries!

We Are Excited to See You in November!

If you are in need of any assistance or clarification during the ABCT Convention, please do not hesitate to stop by the Local Arrangements table! We are also available to be contacted via email jason@drjasonduncan.com. We are happy to provide additional information or tips and tricks for exploring New York City.

Continue checking the ABCT website for additional updates. We cannot wait for the convention and to assist you in any way possible on your trip to The Big Apple! ■

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:

Robert D. Friedberg, Ph.D., ABPP
Laura Payne, Ph.D.

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 co-morbid 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 as 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

► **Manuscript submission portal:** <https://www.editorialmanager.com/candbp>

► **Deadline for Submissions:** February 2023

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

Mary Jane Eimer, *Executive Director*



It is with much pleasure that I inform you that ABCT has hired BARE Mental Health and Wellness as the firm to work with leadership and staff for expanding inclusion, equity, and access in ABCT. We used a competitive bidding process and had several competent firms to choose from and all agreed BARE Mental Health

Wellness had the vision and skill sets best suited for our needs.

Shortly you will be asked to complete a survey or invited to participate in a focus group, some of which will be held during our November convention. Rather than summarize specifics, below please see BARE's Statement for Scope of Work and Introduction.

Drs. Jessica Graham-LoPresti and Tahirah Abdullah-Swain co-founded BARE Mental Health & Wellness. For full description of their work: www.BAREMHW.com



Dr. Graham-LoPresti has focused her career on promoting the resilience, health, and well-being of people and communities of color and has published extensively on the multi-level impact of racism on mental health as well as barriers to quality and effective mental health-care for underserved and underrepresented communities.



Dr. Abdullah-Swain's research focuses on the impact of racism and discrimination on mental health, barriers to help-seeking for mental health problems, mental illness and mental health treatment stigma, and understanding Black Americans' therapy experiences. Both Drs. Graham-LoPresti and Abdullah-Swain are actively engaged in academics.

Statement for Scope of Work and Introduction

Dear ABCT community,

Our company, BARE Mental Health and Wellness, was selected as the contractor in response to ABCT's April 2022 RFP for Expanding Inclusion, Diversity, Equity, and Access in ABCT. As we embark on our work with ABCT, we wanted to share more about ourselves and the work we are planning with ABCT.

After years of conversations about our experiences as Black women professors and psychologists, and the need for systemic level change in our institutions and field, we founded Black Advocacy, Resistance, and Empowerment for Mental Health and Wellness (BAREMHW) in March 2020 with a primary mission of addressing disparities in access to health, wellness, education, and employment for Black Americans. Our approach to this work is multi-pronged, addresses intersecting forms of oppression and includes direct outreach to minoritized and marginalized communities as well as consultation and training services to healthcare and education institutions, law firms, businesses, and nonprofit organizations looking to develop and maintain equitable, just, inclusive, and diverse environments for members, employees, and clients.

(continued on next page)

We were hired by ABCT to consult on long-term, organizational needs and changes related to inclusion, diversity, equity, and access (IDEA). Our work builds on ABCT's 2019-2020 Task Force for Equity, Inclusion, and Access (EIA) Report to the Board of Directors. Specifically, as stated in the RFP, the primary scope of our work includes: determining whether ABCT needs an IDEA staff member and/or an ongoing relationship with a consultant, or other staffing arrangement, writing job description(s) and assisting with finding candidates for the position(s), defining the role of an IDEA committee and writing role descriptions for committee members.

In order to effectively determine the role, scope of work, values and goals for IDEA staff and an IDEA committee, we first need to better understand ABCT and the experiences of the organization's members as it relates to IDEA to guide that work. We have outlined the phases of our consultation and planned timeline below. We invite the entire ABCT community to give voice to your experiences with ABCT as part of the process, and we will share a more detailed invitation soon.

- Phase 1 - Needs Assessment (July - November 2022):
 - (1) A systematic review of ABCT's written policies and practices, strategic plan, and public facing material (e.g. website, social media platforms) with a focus on the integration of IDEA.
 - (2) A survey that can be accessed by current and past members, as well as potential members that will allow these participants to contribute their perspectives on organizational, systemic, and interpersonal barriers IDEA in the context of ABCT
 - (3) Focus groups and individual interviews with current and past members, as well as potential members that will allow these participants to contribute their perspectives on organizational, systemic, and interpersonal barriers to IDEA in the context of ABCT.
- Phase 2 - Data Analysis and Consultation Report (December 2022 - January 2023):
 - (1) Analyze data gathered through the needs assessment
 - (2) Produce a written consultation report that includes an executive summary, de-identified summary of collected data, and a strategic plan which will include concrete recommendations to address the needs outlined in the needs assessment.
 - (3) Provide job descriptions for all proposed IDEA staff and committee position(s) as well as a roadmap for equitable recruitment and hiring processes for the IDEA staff and committee position(s).
- Phase 3 - Implementation of Strategies to Address IDEA Needs of ABCT (TBD): Support ABCT in the implementation of strategies to address the recommendations. Timeline and specifics to be determined based on the outcome of the previous phases.
- Phase 4 - Accountability and Follow-up (TBD): One-year follow-up to formally assess the progress of ABCT based on the implementation of strategies to address recommendations that arose from the needs assessment. The purpose of this follow-up is to ensure the organization's accountability as it relates to the IDEA strategic plan and to support the organization in navigating any barriers to success in addressing IDEA needs.

the Behavior Therapist

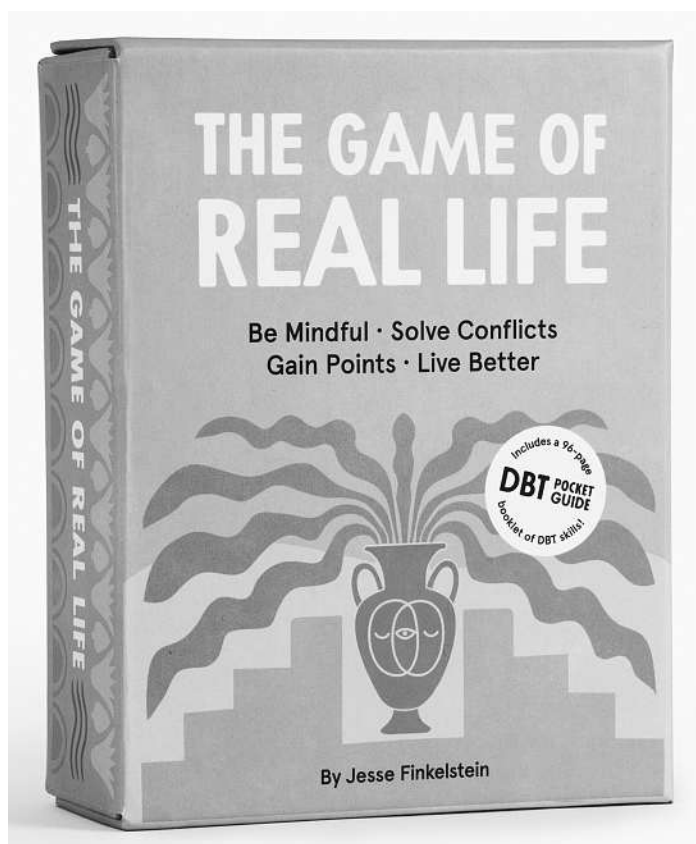
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