ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

ISSN 0278-8403
VOLUME 45, NO. 8 • DECEMBER 2022

the Behavior Therapist

Contents

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SCIENCE FORUM

Science on Trial: Policy Disputes Over Sexual Orientation and Gender Identity Change Efforts

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SEXUAL ORIENTATION and gender identity change efforts (SOGICE) are a broad set of practices that seek to change individuals' sexual and gendered desires, identifications, behaviors, and expressions to conform with heterosexual and cisgender norms. These practices encompass "nonaversive" techniques such as counseling, modeling, and rewarding cisgender or heterosexual behavior through operant conditioning methods. They also include aversive behavioral techniques such as pairing sexually arousing imagery or behavior with noxious stimuli, electric shocks, corporal punishment, and chemicals that induce convulsions and nausea (Murphy, 1992; Schroeder & Shidlo, 2002; Smith et al., 2004). Until the late 20th century, SOGICE were sometimes paired with pharmaceutical and surgical interventions such as chemical and physical castration as well as lobotomies (Murphy).

Though fewer U.S. healthcare professionals engage in SOGICE than in previous decades, the number of individuals who receive SOGICE remains unacceptably high. The Williams Institute estimates that almost 700,000 U.S. adults have been subject to SOGICE, with 350,000 of those adults undergoing SOGICE as adoles-

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the Behavior Therapist

Published by the Association for Behavioral and Cognitive Therapies

305 Seventh Avenue - 16th Floor
New York, NY 10001 | www.abct.org
(212) 647-1890 | Fax: (212) 647-1865

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

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cents (Mallory et al., 2019). A 2015 survey conducted in the U.S. found that 3,749 (13.5%) of the 27,716 transgender people sampled underwent attempts to change their gender identity by a mental health professional or religious counselor (Turban et al., 2019). These inhumane practices lead to considerable harm and are associated with vast societal burdens (Forsythe et al., 2022; Ryan et al., 2018; Shidlo & Schroeder, 2002; Turban et al., 2020). In a 2018 U.S. survey of 25,791 LGBTQ+ young people, the 1,088 (4%) who had undergone SOGICE were over twice as likely to have attempted suicide and to have made several suicide attempts compared to LGBTQ+ individuals who had not undergone SOGICE (Green et al., 2020).

Conversely, LGBTQ+ affirming care—supportive and patient-centered health services that help LGBTQ+ persons lead the lives they wish to live and affirm their desires and identities—has been shown to improve mental and physical health outcomes for sexual and gender minorities (McKay et al., 2022; Sorbara et al., 2020; Tordoff et al., 2022). In terms of mental health care, LGBTQ+ affirming services: validate the stress of discrimination; empower patients using a strengths-based approach; and support individuals in building affirming relationships (Austin & Craig, 2015; Pachankis et al., 2015, 2022). For gender diverse individuals in particular, LGBTQ+ affirming mental health practitioners must also provide support for the medical, legal, and social facets of transitioning such as surgical referral letters (Collazo et al., 2013). LGBTQ+ affirming care has been shown to reduce minority stress and improve mental health outcomes (Almazan & Keuroghlian, 2021; Bränström & Pachankis, 2020; Chaudoir et al., 2017; Fontanari et al., 2020; Pachankis et al., 2020).

Given this robust scientific evidence, every major professional medical and mental health association in the U.S. opposes SOGICE (Human Rights Campaign Foundation, n.d.) and supports LGBTQ+ affirming care (American Medical Association, n.d.; American Psychological Association Task Force et al., 2009; Transgender Legal & Education Fund, 2022). These professional associations have issued practice guidelines, outlined curriculum requirements, and expounded antidiscrimination principles in their ethics codes to discourage SOGICE and to promote LGBTQ+ affirming care. Many associations have also partnered with LGBTQ+ advocacy groups to outlaw SOGICE (American Psychological Association, 2021; American Psychological Association et al., 2019; Human Rights Campaign, n.d., 2022b). While legal bans on SOGICE have proliferated in the past decade, these prohibitions are often limited in scope and reach; more recently, these bans have been rolled back entirely by federal judges who have called into question the scientific and professional consensus against SOGICE.

In this piece, we describe recent efforts to enact and undermine SOGICE prohibitions in the U.S. We show how, despite mounting evidence and expert guidelines, conservative judges and legislators have not only opened the door to harmful and antiscientific practices, but they have also called into question the very legitimacy of scientific evidence and professional expertise. We demonstrate how these policy disputes pose a threat to not just LGBTQ+ persons, but to evidence-based care more broadly.

Evidence-Based Policy Successes

In recent years, there has been a push by LGBTQ+ advocacy groups, professional organizations, and former recipients of SOGICE to prohibit these harmful practices (see Appendix A for descriptions of current advocacy efforts). In 2014, the National Center for Lesbian Rights, a LGBTQ+ rights organization, partnered with SOGICE survivors for their "Born Perfect" campaign, a concerted policy and litigation effort to end SOGICE (National Center for Lesbian Rights, 2014). The Trevor Project, one of the largest LGBTQ+ nonprofits, quickly followed suit and in 2020, the organization engaged SOGICE survivors to launch their "Protecting with Pride" campaign to end SOGICE (The Trevor Project, 2020). Professional organizations such as the American Psychological Association and the Association for Behavioral and Cognitive Therapies have increasingly taken stronger stances against SOGICE, from discouraging the practices to considering them violations of their professional codes of conduct (Gamboni et al., 2018; Transgender Legal & Education Fund, 2022). In a landmark executive order signed in June of 2022, President Biden condemned SOGICE and directed the Department of Health and Human Services to pursue efforts to reduce SOGICE by "considering" prohibiting the use of federal funds for SOGICE and to increase the availability of affirming social and health care services for LGBTQ+ youth (Biden, 2022). Biden's executive order also "encouraged" the Federal Trade Commission to consider whether it should issue consumer warnings that SOGICE are deceptive and fraudulent practices.

At the same time, legislative and regulatory efforts to curtail SOGICE have met significant success. SOGICE have been restricted in 27 states, Washington D.C., Puerto Rico, and over 100 municipalities across the U.S. (Movement Advancement Project, 2022b). Most restrictions prohibit licensed mental health professionals from practicing SOGICE with minors given concerns about young people's ability to actively choose and consent to such practices. Some states' restrictions, such as Nevada's, have been particularly forceful, stipulating that SOGICE are never permitted even if underage patients and/or their caregivers willingly consent to such practices (Lapin, 2020). In 2012, when California banned SOGICE for minors, then Governor Jerry Brown celebrated the victory over "quackery," noting that the "bill bans non-scientific 'therapies'…these practices have no basis in science or medicine" (Levs, 2012). While some states, such as Michigan, North Carolina, Minnesota, and Wisconsin, have only been successful in signing executive orders that ban the use of federal or state funds for SOGICE, many more states have passed legislation that categorically prohibits SOGICE with minors (Movement Advancement Project, 2022b).

Until recently, these restrictions have largely been upheld by federal courts. In response to challenges led by conservative legal organizations representing individual SOGICE practitioners, the Ninth U.S. Circuit Court of Appeals ruled in 2013, and again in 2016, that California's SOGICE ban was lawful (*Donald Welch et al., v. Edmund G. Brown Jr et al.*, 2016; P*ickup v. Brown*, 2013). Notably, the judges for the Ninth Circuit cited the evidence-based scientific consensus deeming SOGICE harmful, thereby denying a parent's right to choose an unsanctioned clinical "treatment" (*Pickup v. Brown*, 2013). Similarly, in 2014, the Third U.S. Circuit Court of Appeals upheld New Jersey's SOGICE ban (*King v. Governor of the State of New Jersey*, 2014).

The Limited Efficacy and Scope of SOGICE Regulations

Despite these successes, SOGICE restrictions have not been a panacea in rooting out these harmful and antiscientific

practices. Even when SOGICE laws are on the books, SOGICE are not criminalized; therefore, penalties for licensed mental health providers that practice SOGICE generally involve small fines and require patients to file their complaints with an external reviewer. This creates significant barriers for minors who are often brought into SOGICE "counseling" by their caregivers and therefore may be unaware that such practices are illegal if the authorities in their lives are sanctioning these practices (Taglienti, 2021). In one survey, 53% of LGBTQ+ young adults reported that their caregivers tried to change their sexual orientation, and 34% reported being taken to a therapist or counselor by their caregiver to change their sexual orientation (Ryan et al., 2018). Though some legal scholars and healthcare providers have argued that SOGICE and denials of gender-affirming care constitute child maltreatment, SOGICE are not considered abusive or neglectful by child welfare agencies (DePanfilis, 2018; Dubin et al., 2020; Haldeman, 2002; Hughes et al., 2021; Lee, 2022). This stands in contrast to the uptick in states that have sought to criminalize gender-affirming care (provided by caregivers, school staff, and clinicians alike) and deem it child abuse (Freedom for All Americans, 2022; Paxton, 2022).

While SOGICE restrictions apply to licensed professionals who practice SOGICE with minors, as we will describe further, their scope is limited for three main reasons. First, current SOGICE regulations that apply to licensed providers working with minors do not apply to unlicensed practitioners such as religious counselors. This is a significant limitation given that religious counselors provide the majority of change efforts for minors (Higbee et al., 2022). Second, even licensed mental health providers can use legal loopholes to skirt SOGICE regulations through religious "conscience protections"—legal protections that allow healthcare providers to claim religious or ethical objections to providing certain kinds of care (Cardoza, 2019). These conscience protections have allowed some licensed mental healthcare providers to deny services to LGBTQ+ persons and promote SOGICE. Third, existing SOGICE regulations do not apply to anyone engaged in SOGICE with adults (licensed or unlicensed). A recent meta-analysis, which included 190,695 LGBTQ+ individuals, found that the mean age of initiation of SOGICE was 25 years old (Forsythe et al., 2022). Thus, existing SOGICE restrictions as well as some popularly proposed alternatives are markedly limited in their scope, undermining the reach of scientific and expert consensus.

Religious Counselors and the Limited Scope of SOGICE Regulations

A large share of SOGICE practitioners are religious counselors, spiritual advisors, or ministers. A recent survey of LGBTQ+ adults living in 14 southern states found that 60% of those who had experienced SOGICE in their youth had received SOGICE from a faith leader or clergy member (Higbee et al., 2022). The number of licensed mental health professionals practicing SOGICE is already quite small and dwindling, suggesting that religious leaders who practice SOGICE are a larger threat to the safety of LGBTQ+ persons (George, 2016). Recent estimates from the Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy at UCLA suggest that anywhere between 37,000 to 94,000 adolescents (ages 13–17) are at risk of receiving SOGICE from a faith leader—about 3.5 times as many as those who are at risk of receiving SOGICE from a licensed health care provider (Mallory et al., 2019).

Moreover, although SOGICE restrictions vary in their stipulations, most laws are relatively permissive of a range of behaviors that are coercive and harmful to LGTBQ+ persons. While some states such as Massachusetts forbid licensed health care providers from advertising or engaging in SOGICE, most states grant professionals far more latitude (An Act Related to Abusive Practices to Change Sexual Orientation and Gender Identity in Minors, 2019). For example, many SOGICE restrictions do not forbid mental health professionals from "expressing their views to patients; recommending SOCE [SOGICE] to patients... or referring minors to unlicensed counselors, such as religious leaders" (*Otto v. City of Boca Raton, Florida*, 2020). Other regulations explicitly affirm providers' rights to offer religious change effort counseling so long as the providers are working in their capacities as "members of the clergy or as religious counselors" (SB 201, 2017). These regulations rarely define what practicing in one's capacity as a religious counselor might mean, creating the possibility that this term could be understood quite expansively. In states without explicit prohibitions, SOGICE practicing licensed health care providers who are members of a house of worship could claim that they are working in their capacity as faith leaders.

The Rise of Conscience Protections: Providers' Rights to Deny Evidence-Based LGBTQ+ Care and to Recommend SOGICE

Though most professional associations' ethical codes prohibit discrimination against sexual and gender minorities, new state laws and court decisions afford mental health professionals a religious justification for such discrimination (American Medical Association, 2017; American Mental Health Counselors Association, 2020; American Psychological Association, 2017; National Association of Social Workers, 2021). Conscience protections grant healthcare providers the right to deny patients care and to promote SOGICE on moral, ethical, or religious grounds. As of June 2022, seven states have passed laws permitting providers to refuse to serve LGBTQ+ persons on the basis of their religious beliefs (Movement Advancement Project, 2022a).

These laws have become gradually more expansive in whom they protect. For example, Arizona's 2011 law prohibits social work, counseling, or psychology programs from disciplining or "discriminating against" students who refuse to see patients whose treatment goals conflict with the students' religious beliefs (HB 2565, 2011). In 2016, Tennessee allowed not just students but all mental health providers to deny care that conflicts with their "sincerely held principles" (Conscientious Objections to Provision of Counseling or Therapy Services, 2016). Even more expansive, Ohio's 2021 law allows any health care provider, health care institution, or health care payer to deny or refuse to pay for care that violates their moral, ethical, or religious beliefs (Freedom to Decline for Conscience-Based Objections, 2021).

In courts, judges have split on whether the U.S. Constitution protects providers who wish to discriminate against sexual and gender minorities. In 2011, the Eleventh Circuit Court of Appeals issued a decision in a case respecting the American Counseling Association's Code of Ethics against a student who suggested that her religious objections compelled her to deny services to LGBTQ+ patients and to refer them to SOGICE (Keeton v. Anderson-Wiley, 2011). The court determined that the student's university did not violate her First Amendment free religious exercise and free speech rights by putting the student on a remediation plan that would prompt her to read more peer-reviewed scientific articles on how to offer evidence-

based care to LGBTQ+ persons. A year later, however, in a similar case, the Sixth Circuit was more favorable to a student who had been expelled from Eastern Michigan University's counseling program for refusing to treat someone in a same-gender relationship. The court directed the student's university to settle with her for violating her religious free exercise rights (Ward v. Polite, 2012).

Given the current conservative tilt of the U.S. Supreme Court, it is possible that religious objectors may soon be afforded a constitutional right to deny all kinds of LGBTQ+ affirming care. Indeed, since 2014 the Court has privileged religious free exercise rights over the Affordable Care Act's (ACA) mandate that health insurance plans cover basic forms of reproductive healthcare (*Burwell v. Hobby Lobby Stores, Inc.*, 2014; *Little Sisters of the Poor v Pennsylvania*, 2020). Ongoing federal litigation against the ACA would also allow religious businesses to refuse coverage for evidence-based preventative care regimens such as pre-exposure prophylaxis (PrEP) medications that protect against HIV transmission, which some healthcare payers contend might "encourage or facilitate homosexual behavior" (*Braidwood Management Inc. v. Becerra*, 2022). Moreover, religiously affiliated hospitals and Christian medical professional associations have argued against the constitutionality of ACA antidiscrimination requirements to provide evidence-based gender-affirming medical procedures such as hysterectomies for trans men and nonbinary persons (Jost & Keith, 2020). Given these developments, a Supreme Court ruling respecting the religious rights of licensed mental healthcare providers could override existing state SOGICE restrictions.

Failed Efforts to Protect Adults From SOGICE

LGBTQ+ advocacy groups have attempted to expand the scope of SOGICE restrictions to apply to adults by contending that private groups who practice SOGICE are engaged in fraudulent, deceptive, and harmful practices in violation of consumer protections (*Ferguson v. Jonah*, 2015; Therapeutic Fraud Prevention Act, 2021). In a landmark New Jersey state court case, a jury ruled that the group Jews Offering New Alternatives to Healing (formerly known as Jews Offering New Alternatives to Homosexuality), or JONAH, had engaged in consumer fraud for selling services that claimed they could "convert" people from gay to straight (*Ferguson v. Jonah*, 2015).

In the wake of this small victory, civil rights groups began to pursue the consumer fraud strategy; however, they have thus far failed to make headway. For instance, the Human Rights Campaign, the National Center for Lesbian Rights, and the Southern Poverty Law Center filed a complaint with the U.S. Federal Trade Commission against the private group "People Can Change, Inc.," asserting that it engaged in fraudulent, deceptive, and harmful business practices by promoting SOGICE (*Human Rights Campaign et al v People Can Change Inc.,* 2016). During President Donald Trump's administration, the Federal Trade Commission did not take action against People for Change Inc. and may have even worked with the group both to change their name to "Brothers on a Road Less Traveled" and to assist it in strategically tempering its claims about its ability to change sexual attraction (Chibarro Jr., 2018).

Legislative attempts to pursue consumer protections have been similarly unsuccessful at all levels of government. Although LGBTQ+ rights groups have pushed Congress to pass the Therapeutic Fraud Prevention Act, which would explicitly consider SOGICE consumer fraud under the purview of the Federal Trade Commission, the bill has not been deliberated despite being introduced four times (Human Rights Campaign, 2022c). At the state level, California Senator Evan Low introduced bill AB 2943: "Unlawful Business Practices: Sexual Orientation Change Efforts" in 2018, which would have added SOGICE to the state's Consumer Legal Remedies Act. The bill quickly triggered opposition from social conservative and religious liberty groups, prompting Low to abandon the bill despite winning the necessary votes to ensure its passage (Wuest, 2023). For a brief moment from 2017 to 2019, New York City passed an ordinance banning any person from engaging in SOGICE on consumer protection grounds; however, the city council repealed its ordinance after a lawsuit threatened to escalate the matter up to the U.S. Supreme Court, which had become more conservative during Donald Trump's presidency (Mays, 2019).

Given the Supreme Court's recent decisions significantly narrowing the power of federal agencies, it is likely that the Court's conservative supermajority would consider a national consumer protection law unconstitutional (King v. Burwell, 2015; Empire Health Foundation v. Becerra, 2021; American Hospital Association v. Becerra, 2022; *West Virginia v. EPA*, 2022). Even if Congress did pass a version of the Therapeutic Fraud Prevention Act and the Supreme Court upheld it as a lawful exercise of the Federal Trade Commission's authority, such a law would likely place the burdens (and therefore resource demands) of demonstrating fraudulent and deceptive practices on complainants. Altogether, these factors make consumer protection regulations a relatively inadequate strategy to combat SOGICE.

Legal Efforts to Eliminate SOGICE Restrictions for Minors

Since the first SOGICE restriction was passed into law, opponents have waged legal campaigns to eliminate them (Wuest, 2021). Conservative Christian legal organizations representing licensed mental health providers have asked the federal courts to rule as unlawful all existing SOGICE restrictions. To do so, the interest groups, attorneys, and judges engaged in rollback efforts have called into question the scientific and medical basis of the anti-SOGICE consensus.

First, opponents of SOGICE regulations have argued that the scientific consensus position against SOGICE has been overstated. In the landmark decision *Otto v. Boca Raton* (2020), the Eleventh Circuit Court of Appeals ruled as unconstitutional a Boca Raton, Florida, ordinance and a Palm Beach County, Florida ordinance banning SOGICE for minors, thereby nullifying all such existing local and state laws in Florida, Georgia,, and Alabama. The case involved two licensed therapists who offered SOGICE for minors experiencing so-called "unwanted same-sex attraction or unwanted gender identity issues" (*Otto v. City of Boca Raton, Florida*, 2020, p. 861). The Liberty Counsel, a conservative Christian legal organization founded in 2000 and described by the Southern Poverty Law Center as a designated hate group, successfully argued on the therapists' behalf against reigning standards of evidence-based care (Southern Poverty Law Center, n.d.). Noting the American Psychiatric Association's 1987 decision to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* entirely (in 1973, the American Psychiatric Association depathologized homosexuality while maintaining that subjective experiences of distress with one's sexual orientation could be deemed a disorder), the court

explained that such "about-face" changes demonstrate that judges and policymakers cannot be certain that medical opinion will not suddenly change once again. In the court's words, "the change itself shows why we cannot rely on professional organizations' judgments—it would have been horribly wrong to allow the old professional consensus against homosexuality to justify a ban on counseling that affirmed it" (*Otto v. City of Boca Raton, Florida*, 2020, pp. 869–870). Here, the court leveraged a change in scientific opinion to undermine the notion that scientific expertise can ever be trusted as a source for lawmaking.

Furthermore, the two therapists in *Otto v. Boca Raton* distorted evidence-based guidelines by drawing a distinction between aversive techniques that involve "reprimand, punishment, or shame to turn a person away from certain thoughts or behaviors" and their self-described "nonaversive" talk therapy techniques (*Otto v. City of Boca Raton, Florida*, 2020, p. 870). The therapists, who only offered the latter, contended that there was no scientific evidence that their "nonaversive" techniques were deleterious to minors' health.

Despite evaluating expert reports and peer-reviewed studies demonstrating the harm associated with a wide variety of SOGICE, including "non-aversive" SOGICE, two judges appointed by former President Donald Trump sided with the SOGICE practitioners. They disingenuously cited a decade-old task force report by the American Psychological Association (APA) that recognized that "nonaversive" techniques have not been "rigorously evaluated" (American Psychological Association Task Force et al., 2009, p. 43). However, in that same report the APA also concluded that there was some evidence to suggest "nonaversive" techniques are associated with harm and that rigorous evaluations of any SOGICE would be unethical to conduct. Additionally, scientific associations have since more strongly opposed all varieties of SOGICE (American Academy of PAs et al., 2022; Human Rights Campaign, 2022a, 2022b). Nevertheless, the judges wrote that Boca Raton and Palm Beach County had "offer[ed] assertions rather than evidence" regarding the harms of "nonaversive" techniques (*Otto v. City of Boca Raton, Florida*, 2020, p. 868).

Last, while all licensed therapy is typically regulated by public health departments as a form of medical practice, the therapists in Boca Raton advanced a novel argument that such "talk" therapy is actually constitutionally protected free speech. Again, by drawing a distinction between aversive and so-called "nonaversive" care, the therapists alleged that the First Amendment protected the purely verbal nature of their SOGICE practices. In justifying its decision in favor of the providers, the Eleventh Circuit cited a 2018 Supreme Court opinion that ruled as unconstitutional a California regulation mandating that pro-life crisis pregnancy centers advertise the availability of state-funded reproductive healthcare (*National Institute of Family and Life Advocates v. Becerra*, 2018). In *National Institute of Family and Life Advocates (NIFLA) v. Becerra*, Justice Clarence Thomas stressed "the danger" of free speech "regulations in the fields of medicine and public health" while suggesting that SOGICE restrictions might also violate such First Amendment speech protections (National Institute of Family and Life Advocates v. Becerra, 2018, pp. 7–9). Now that the Eleventh Circuit has disagreed with the Ninth and Third Circuit on the constitutionality of SOGICE bans, the issue is ripe for the Supreme Court to decide whether all of the country's bans are lawful.

Beyond Boca Raton, conservative legal organizations have attempted to use the NIFLA and Boca Raton decisions to undermine professional licensure requirements more broadly. In 2021, the libertarian legal organization the Institute For Justice sued Florida on behalf of an unlicensed dietician and nutritionist, asserting that Florida's Dietetics and Nutrition Practice Act had violated her First Amendment speech rights per Boca Raton and NIFLA (*Del Castillo v. Secretary, Florida Department of Health*, 2022). Although the Eleventh Circuit ruled against this claim, the litigation exemplifies the long-term strategy of many SOGICE ban opponents. The Institute for Justice, the Liberty Counsel, and other litigation organizations like it are funded by conservative leaders like Charles Koch and coordinate with the American Legislative Exchange Council (ALEC), a coalition of business leaders who write and disseminate deregulatory legislation for state legislators (Lafer, 2017; Rosen, 2005; The Center for Media and Democracy, 2021). ALEC has written many bills to weaken occupational licensing requirements in all industries (American Legislative Exchange Council, 2019; Lafer, 2017). Recently, it leveraged the ongoing healthcare provider shortage, worsened by the coronavirus pandemic, to propose legislation that lowers credentialing standards for physicians (American Legislative Exchange Council, 2021). These organizations are all part of a network that uses "dark money" funding channels (i.e., organizations that collect funds from undisclosed donors) to legally hide their donations (Lafer, 2017; Mayer, 2017). Guided by the writings of libertarian economist Milton Friedman, these business groups aim to undercut all government licensure programs and public health regulations (Friedman, 1962).

Altogether, this network of policymakers, attorneys, and donors has effectively pushed the increasingly conservative federal judiciary to undercut evidence-based policies more generally (Wuest & Last, 2021). One strategy has been to question the mainstream medical consensus on the safety of abortion practices. In 2007, pro-life organizations successfully defended a congressional ban on dilation and extraction abortion techniques, which its critics in fringe medical associations had erroneously termed "partial-birth abortions" (Gonzales v. Carhart, 2007). More recently, Koch-affiliated and funded legal groups have also been successful in challenging state and federal COVID-19 public health measures, deeming policies that dictate when church members can gather in large numbers as inappropriate violations of religious liberty (*Tandon v. Newsom*, 2021; Wiley, 2022). Outside of the courts, these groups have propagated misinformation about COVID-19's transmission and virulence to state and federal lawmakers and the public (Yamey & Gorski, 2021). This is the same agenda that fossil fuel industry leaders—notably, including Charles Koch and other funders of these social conservative causes—and tobacco executives have used to spread doubt about the dangers of climate change and tobacco use (Oreskes & Conway, 2011). In this context, ongoing efforts to rescind or overrule SOGICE bans are just one piece in this larger effort to undermine everything from regulations concerning professional licensing to broader public health and climate change policies.

Conclusion

Although every major professional medical and mental health association in the U.S. has renounced SOGICE as harmful or even deadly to those who receive such care, legal campaigns to constrict or eliminate SOGICE regulations have become increasingly successful. Where state governments and federal courts have not defeated SOGICE bans outright, they have created significant loopholes, thereby

allowing some licensed practitioners to continue offering care or recommending care from unlicensed, often religious, counselors. That unregulated religious counselors who have not received training in scientific principles and ethics provide the bulk of SOGICE should be a significant concern for the field. In all, policy disputes over mental health care for sexual and gender minorities are not only consequential for patients and their healthcare providers; rather, such conflicts concern the future of evidence-based care and the validity of professional scientific expertise.

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Appendix A Advocacy Groups Seeking to Protect Individuals From Sexual Orientation and Gender Identity Change Efforts

■ LGBTQ+ Advocacy Group Campaigns + Resources

The Trevor Project—"Protecting with Pride" Campaign
https://www.thetrevorproject.org/ending-conversion-therapy/
The Trevor Project is one of the largest nonprofits that focuses on issues on the mental health stressors and challenges faced by youth who identify as lesbian, gay, bisexual, transgender, queer, and questioning. "Protecting with Pride" is a campaign developed in partnership with mental health associations, Sexual Orientation and Gender Identity Change Effort (SOGICE) survivors, and policy and legal advocates. "Protecting with Pride" is a multi-pronged, multi-level advocacy effort that seeks to end SOGICE across the U.S. In addition to legal and policy action, the campaign also provides public education and works with faith communities to describe the harms and anti-scientific nature of SOGICE.

The National Center for Lesbian Rights—"Born Perfect" Campaign
https://bornperfect.org/
The National Center for Lesbian Rights is a nonprofit, public interest law firm that focuses on litigation, public policy, and legislative advocacy to support LGBTQ+ rights. The "Born Perfect" campaign is a joint effort by SOGICE survivors, lawyers, and policymakers to end SOGICE across the U.S. The main goals of this campaign involve drafting model legislation that protects children and their families from SOGICE.

Human Rights Campaign Resources on the Harms of SOGICE
https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy
The Human Rights Campaign engages in policy, legislative, and judicial advocacy to promote LGBTQ+ rights. The Human Rights Campaign has compiled resources on the research demonstrating the harms of SOGICE, descriptions of current advocacy efforts and legislative successes to protect youth from SOGICE.

■ LGBTQ+ Research Centers + Think Tanks

Williams Institute https://williamsinstitute.law.ucla.edu/
The Williams Institute, affiliated with the University of California Los Angeles Law School, is a research center that focuses on issues related to LGBT rights. The Williams Institute also promotes evidence-based policies related to LGBT rights and health.

The National Center for Civil and Human Rights—LGBTQ Institute
https://www.lgbtqinstitute.org/research
The LGBTQ Institute is a research center that connects scholars and advocates to collaborate on research and policy advocacy related to LGBTQ+ rights.

Movement Advancement Project https://www.lgbtmap.org/
The Movement Advancement Project is a nonprofit think tank that conducts systematic analyses, compiles reports, and issues policy briefs on all issues related to LGBTQ+ civil and economic rights.

Vanderbilt LGBTQ+ Policy Lab
https://www.vanderbilt.edu/lgbtq-policy-lab/
The Vanderbilt LGBTQ+ Policy Lab produces research on all policies related to LGBTQ+ rights, health, and economic equality.

■ Healthcare and Professional Association LGBTQ+ Advocacy Groups

GLMA: Health Professionals Advancing LGBTQ Equality
https://www.glma.org/
GLMA is a U.S.-based organization of healthcare professionals with the aim of advancing health equity for LGBTQ+ persons. GLMA engages in all forms of advocacy and public policy transformation to further LGBTQ+ health.

National Coalition for LGBTQ Health
https://healthlgbtq.org/about-us/
The National Coalition for LGBTQ Health is a U.S.-based advocacy group that promotes LGBTQ+ health through policy research, public education, and legislative advocacy.

American Psychological Association Office on Sexual Orientation and Gender Diversity https://www.apa.org/pi/lgbt
The American Psychological Association's Office on Sexual Orientation and Gender Diversity conducts research, provides best practice recommendations, and advocates for policies that will improve LGBTQ+ persons' psychological well-being.

Association of LGBTQ+ Psychiatrists (AGLP)
http://aglp.org/ The Association of LGBTQ+ Psychiatrists is an advocacy group within the American Psychiatric Association that promotes policies for LGBTQ+ mental health.

Center of Excellence for Transgender Health
https://prevention.ucsf.edu/transhealth
The Center of Excellence for Transgender Health promotes LGBTQ+ health through training healthcare providers in LGBTQ+ affirming care and promoting transgender health and well-being.

American Medical Association: LGBTQ Advisory Committee
https://www.ama-assn.org/member-groups-sections/advisory-committee-lgbtq-issues/about-lgbtq-advisory-committee
The LGBTQ advisory committee as part of the American Medical Association advocates both within the organization and outside it to promote policies that support LGBTQ+ health.

American Public Health Association: LGBTQ Health Caucus
https://aphalgbtq.org/policy
The LGBTQ caucus within the American Public Health Association pursues public health policies, both within the organization and in the U.S., to promote LGBTQ health. The caucus has recently made ending SOGICE a policy priority.

Association for Behavioral and Cognitive Therapies Sexual and Gender Minority Special Interest Group
https://www.abctsgmsig.com/
The Association for Behavioral and Cognitive Therapies (ABCT) Sexual and Gender Minority Special Interest Group advocates for LGBTQ+ well-being within ABCT and supports the scholarship of LGBTQ+ persons and allies.

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The authors would like to thank Alex R. Dopp and Bharat Bharat for their feedback on the manuscript. The authors declare no conflicts of interest.

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ORIGINAL RESEARCH

Timing of Suicidal Ideation Among Persons Living With HIV

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SUICIDE IS A LEADING cause of death worldwide, with 10.6 per 100,000 people dying by suicide each year (World Health Organization, 2019). In the United States, 15.3 per 100,000 people die by suicide each year (World Health Organization). Approximately 4% of adults endorsed suicidal ideation within the past year in the U.S. (Substance Abuse and Mental Health Services Administration, 2014) and 2–5% attempted suicide (Kessler et al., 1999; Kuo et al., 2001; Nock et al., 2009).

Persons living with HIV (PLWH) have a significantly higher rate of suicidal ideation (SI) than the general population (Anagnostopoulos et al., 2015; Feuillet et al., 2017), with 20.5% endorsing SI within 3 days of their diagnosis, and 28.8% endorsing SI a month and a half after their diagnosis (Schlebusch & Govender, 2015). Other estimates are even bleaker, suggesting that 78% of women with HIV endorsed SI after diagnosis and 26% attempted suicide (Cooperman & Simoni, 2005). Moreover, suicide deaths in PLWH are three times that of the general population (Ruffieux et al., 2019).

There are several risk factors for SI, including prior suicide attempts, self-harm history, family history of suicide, serious medical diagnoses, social isolation, history of abuse, emotional disorders, and psychotic disorders (Brent et al., 1996; Druss & Pincus, 2000; Joiner et al., 2002; Nock et al., 2010; Plunkett et al., 2001). Sleep disorder symptoms are important but underresearched risk factors for SI, suicide attempts, and suicide deaths in the general population and across the lifespan (Bernert et al., 2015; Goldstein et al., 2008). Of those who attempted suicide, 89% endorsed sleep disturbances (Sjöström et al., 2007). The relationship between sleep disorder symptoms and SI appears to be unidirectional, in that insomnia increases risk for SI, but not vice-versa (Zuromski et al., 2017). Significantly more deaths by suicide occur between the hours of 12:00 a.m. and 3:00 a.m. (McCarthy et al., 2019; Perlis et al., 2016). However, there are no existing studies to examine changes in SI on the basis of the circadian clock.

PLWH significantly endorse more sleep disturbances than the general population (Chaponda et al., 2018; Nokes & Kendrew, 1996; Phillips et al., 2005), including atypical sleep patterns with increased nocturnal wakefulness and decreased sleep efficiency (Wiegand et al., 1991). Between 47–58% of PLWH endorse a sleep disorder (Allavena et al., 2014; Wu et al., 2015). Sleep quality is a predictor of SI in PLWH, alongside anxiety and depression (Dabaghzadeh et al., 2015). Individuals who have both a sleep disorder and HIV have a substantially increased risk of attempting suicide (Ahmedani et al., 2017). However, as with the general population, it is unclear how SI fluctuates across a circadian clock in PLWH. It is important to understand the timing of SI among PLWH to develop and deliver targeted interventions to interrupt the transition from SI to suicide attempts in PLWH.

Ecological momentary assessment (EMA) is a fine-grained methodology to investigate SI as it provides real-time observations of SI variation across short time periods while diminishing recall bias (Davidson et al., 2017; Kleiman et al., 2017). EMA assessment of SI also offers the benefit of increasing compliance with assessments while minimizing burden to participants (Glenn et al., 2020; Husky et al., 2014). Previous studies using real-time examination of SI have shown that there is considerable variation in SI over the course of most days (Kleiman et al., 2017). However, these studies did not explicitly evaluate changes in SI on the basis of time of day.

The purpose of the current study was to examine suicidal ideation and sleep in PLWH. To our knowledge, there is no prior research examining time of day and SI in PLWH. We used EMA with a community sample of PLWH who reported past month SI at the time of enrollment. Based on the prior literature in the general population (McCarthy et al., 2019; Perlis et al., 2016), we hypothesized that the most endorsed timepoint for highest suicidal urge would be between the hours of 12:00 a.m. and 3:00 a.m. We then explored variability in SI across 28 days among PLWH. Based on prior research in the general population (Kleiman et al., 2017), we hypothesized that there would be significant within-participant variability in SI over time.

Materials and Methods

Participants

Participants (N = 10) were adults 18 years or older (Age: M = 53.0, SD = 11.6 years) who were living with HIV, endorsed past-month suicidal ideation, and had access to a smartphone. Additionally, participants had no active psychosis and did not meet criteria for Bipolar I diagnosis with a past year manic episode (see Figure 1). Participants were recruited through flyers placed at community health facilities for PLWH or those at an elevated risk of contracting HIV in Philadelphia. The majority of participants were Black (60.0%, n = 6; 20.0%, n = 2 White, and 20.0%, n = 2 identifying as Other). The sample also included 70.0% (n = 7) males, 20% (n = 2) females, and 10% (n = 1) identifying as "bigender." Additionally, participants identified as 50.0% (n = 5) straight, 30.0% (n = 3) gay/lesbian, 10% (n = 1) bisexual, and 10% (n = 1) sapio/pansexual. See Table 1 for demographic information.

Measures

Suicide Visual Analog Scale (S-VAS)

The S-VAS (Bryan, 2019) assessed suicide urges ("urge to kill myself") on a horizontal sliding scale ranging from 0 (*none*) on the left anchor to 100 (*extreme*) on the right anchor. Initially, the S-VAS is presented with the slide indicator on the none position, and participants are instructed to indicate their response by moving the slide indicator. The S-VAS was administered four times daily for 28 days: twice at random periods to assess suicide urges in the moment at every hour of the waking day (i.e., 8:00 a.m. to 11:00 p.m.), once at awakening in the morning sleep diary, and once at night prior to sleep in the nighttime sleep diary. The morning sleep diary assessed strongest suicide urges in the prior night (from the point of getting into bed) alongside timing of strongest urges. The nighttime sleep diary assessed for strongest suicide urges in the day (from the point of awakening) alongside timing of strongest urges. The S-VAS has good convergent

validity and predictive validity for suicide attempts (Bryan, 2019). For all of the S-VAS responses, participants provided data for the following number of observations per occasion: random S-VAS urge 1 = 214 observations collected (76%, out of 280 possible responses); Random S-VAS urge 2 = 116 observations collected (41%, out of 280 possible responses); Morning diary (assessing highest urge in the middle of the night) = 239 observations collected (85%, out of 280 possible responses); Evening diary (assessing highest urges in the day) = 205 observations collected (73%, out of 280 possible responses).

Demographics

We assessed demographic information including age, gender, sexual orientation, ethnicity, marital status, employment status, and level of education. Participants optionally provided phone numbers for up to three emergency contacts, including friends, family members, and treatment providers, to facilitate contacting the participant in the event of an emergency.

Procedures

All study procedures were approved by the Institutional Review Board at the University of Pennsylvania. Participants who were interested in the study contacted the study team to complete a brief (5 to 10 min) phone screen to learn more about the study and determine initial study eligibility. The phone screen assessed self-reported HIV diagnosis, access to smartphone, suicide risk, and previous psychiatric diagnoses. Following the phone screening, participants who were initially eligible presented to the laboratory to complete informed consent and a comprehensive intake evaluation. During the evaluation, exclusion diagnoses (i.e., active psychosis and Bipolar I Disorder with a past-year manic episode) were determined using the Mini-International Neuropsychiatric Interview version 7.0.2 (MINI; Sheehan, 2016), a brief structured diagnostic interview for DSM-5 and ICD-10 with strong psychometric properties (Sheehan et al., 1998). Upon completion of the evaluation, eligible participants downloaded Metricwire, a mobile survey delivery application, onto their smartphone to begin receiving EMAs the next day for 28 days of study participation. Participants received training from a research assistant in answering EMA questions. Participants were provided with $40 for completion of the baseline evaluation. Additionally, participants were given the contact information for the research team in the event that they experienced technical difficulties with Metricwire or responding to EMA.

Table 1. Demographic Information

Baseline Characteristics	Total Sample (n = 10)
Age, *M* (*SD*)	53.0 (11.6)
Gender, *n* (%)	
Male	7 (70.0)
Female	2 (20.0)
Transgender	0 (0.0)
Gender Non-Conforming / Genderqueer	0 (0.0)
Bigender	1 (10.0)
Prefer not to disclose	0 (0.0)
Sexual Orientation, *n* (%)	
Straight	5 (50.0)
Gay/Lesbian	3 (30.0)
Bisexual	1 (10.0)
Sapio/pansexual	1 (10.0)
Prefer not to disclose	0 (0.0)
Don't know	0 (0.0)
Ethnicity, *n* (%)	
Black	6 (60.0)
White	2 (20.0)
Hispanic/Latinx/Spanish origin	0 (0.0)
American Indian or Alaska Native	0 (0.0)
Asian	0 (0.0)
Native Hawaiian or other Pacific Islander	0 (0.0)
Other	2 (20.0)
Marital Status, *n* (%)	
Single	5 (50.0)
Married	0 (0.0)
Separated	1 (10.0)
Divorced	3 (30.0)
Widowed	1 (10.0)
Education, *n* (%)	
Less than high school	1 (10.0)
High school/GED	1 (10.0)
Some college	6 (60.0)
2-year college	1 (10.0)
4-year college	1 (10.0)
Master's degree	0 (0.0)
Doctoral degree	0 (0.0)
Professional degree (e.g., MD or JD)	0 (0.0)
Employment Status, *n* (%)	
Full-time	2 (20.0)
Part-time	0 (0.0)
Retired	1 (10.0)
Student	0 (0.0)
Disabled	4 (40.0)
Unemployed - looking for work	2 (20.0)
Unemployed - not looking for work	0 (0.0)
Other	1 (10.0)

EMA Data Collection

Each day, participants received four surveys including two random S-VAS, one morning sleep diary, and one nighttime sleep diary. Metricwire delivered surveys 7 days a week between the hours of 6:00 a.m. and 11:00 p.m. Participants received $0.50 for completing each random S-VAS and $1.00 for completing at least one daily sleep diary. Each day, the morning sleep diary was activated at 6:00 a.m. and the nighttime sleep diary was activated at 9:00 p.m. There was a 5-hour completion window for the morning sleep diary (i.e., 11:00 a.m.) and a 2-hour completion window (i.e., 11:00

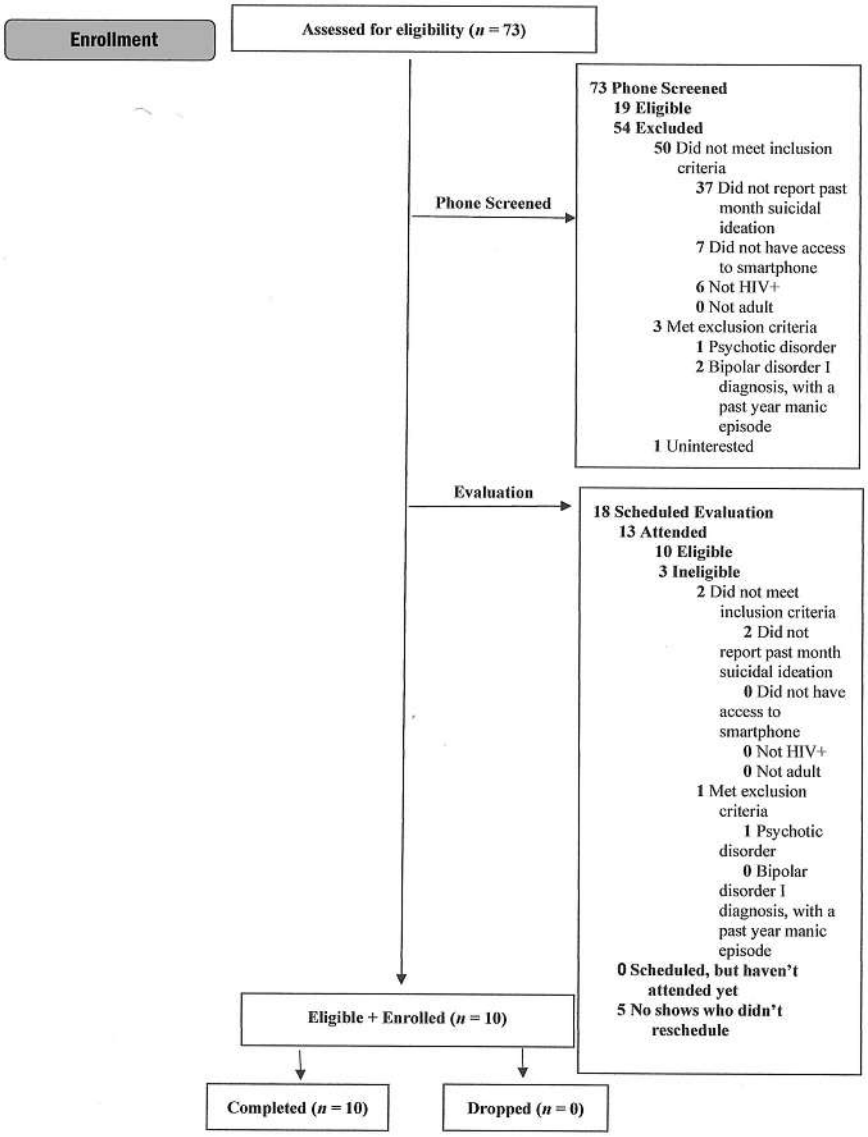

Figure 1. CONSORT diagram

p.m.) for the nighttime sleep diary. The random S-VAS was activated twice per day at randomly programmed times and had a 1-hour completion window. If participants did not complete a survey within the completion window, the survey was automatically removed from Metricwire. To encourage participants to respond to surveys as quickly as possible, participants were not informed about the completion windows.

When participants reported suicide urges that were either 50 or greater, or a 25% increase in suicide urges from the previously reported score for the S-VAS, the research team was alerted through text messages and emails to check in on the safety of the participant. All participants completed the study in 28 days. At the end of the 28-day assessment, they returned to the clinic for a final evaluation and were compensated $50 for the postevaluation.

Data Analysis

The range of scores on a given day was calculated as the difference from the maximum response in that 24-hour cycle minus the minimum response. Linear mixed effects models were used to calculate intraclass correlation (ICC), as well as the change in S-VAS over time using an unstructured covariance matrix. These models included random intercepts, and a likelihood ratio test was run to evaluate whether inclusion of a random slope significantly improved model fit. For the morning diary assessment, 42 observations were missing (14.9%). For the nighttime diary assessment, 76 (27%) observations were missing. Due to Metricwire anomalies, there were a few additional surveys that were triggered and completed by participants. Two participants each had one additional random suicidal urge survey triggered and completed on a single day. Additionally, one participant had one additional morning sleep diary and another participant had one additional nighttime sleep diary triggered and completed in a single day. In these cases, only the highest reported suicidal urge scores for each type of survey completed were used for data analysis.

We then repeated analyses used by Perlis et al. (2016) to examine whether there were significant differences in the number of non-zero S-VAS observations for each hour (relative to expected observations) based on the morning sleep diary assessment, taking into account the American Time Use Survey (U.S. Bureau of Labor and Statistics, 2022) to account for the likelihood of being awake at a given hour. Specifically, we calculated a series of standardized incidence ratios (SIRs) by dividing the numbers of non-zero S-VAS observations per hour by the likelihood of being awake based on the ATUS estimates. We then repeated these analyses for the nighttime sleep diary assessment.

Results

S-VAS Magnitude

On days in which at least two observations were collected, the average daily range in suicide urges across all participants was 6.29 (SD = 9.63) units, with a minimum range of 0 and a maximum range of 73. The intraclass correlation (ICC) for range in suicidal urges on days in which at least two observations were collected was .341 (95% CI: .165–.576). In contrast, the ICC for the first EMA probe was .841 (95% CI: .682–.929), and for the second EMA probe was .793 (95% CI: .590–.910), and the ICC for the morning sleep diary was .816 (95% CI: .643–.916) and for the nighttime sleep diary was .900 (95% CI: .770–.957).

Change in S-VAS Magnitude

For the first EMA probe in a day, a quadratic (p = .274) and cubic (p = .460) effect of time did not significantly improve model fit relative to a linear model, whereas inclusion of a random linear slope signifi-

cantly improve model fit and was included in the model ($\chi^2 = 11.67$, $p = .0029$), though the main effect of Time was not significant ($p = .656$).

Similar results were observed for the second EMA probe, in that quadratic ($p = .980$) and cubic ($p = .933$) effects did not significantly improve the model, while inclusion of a random slope improved the model significantly ($\chi^2 = 8.84$, $p = .020$), though the main effect of Time was not significant ($p = .599$).

Similar results were also observed for the morning sleep diary assessment, in that in that quadratic ($p = .553$) and cubic ($p = .180$) effects did not significantly improve the model, while inclusion of a random slope improved the model significantly ($\chi^2 = 19.47$, $p = .0001$), though the main effect of Time was not significant ($p = .724$).

Finally, similar results were observed for the for the nighttime sleep diary assessment, in that quadratic ($p = .347$) and cubic effects ($p = .641$) did not significantly improve the model, the inclusion of a random slope improved the model significantly ($\chi^2 = 17.32$, $p = .0002$), and the main effect of Time was not significant ($p = .295$).

Raw Timing of Suicide Urges

During the morning sleep diary, when suicidal urges were endorsed with a non-zero response, 3:00 a.m. was the most frequently endorsed timing of the highest suicidal urge, followed by 6:00 a.m., and then 8:00 p.m. (see Figure 2). During the nighttime sleep diary, when suicidal urges were endorsed with a non-zero response, 7:00 p.m. was the most frequently endorsed timing of the highest suicidal urge, followed by 9:00 p.m. and 6:00 p.m. (tied for second most frequently endorsed times; see Figure 3).

Adjusted Timing of Suicide Urges

When evaluating the confidence intervals for the SIRs for the morning sleep diary, the following times were endorsed with significantly greater likelihood than expected: 3 a.m. (SIR 42.072, 95% CI: 25.331, 65.702); 2 a.m. (SIR 14.053, 95% CI: 5.651, 28.961), 4 a.m. (SIR: 5.802, 95% CI: 1.870, 13.540), 12 a.m. (SIR: 5.720, 95% CI: 2.300, 11.786), and 6 a.m. (SIR: 3.492, 95% CI: 1.909, 5.860). Noon was not endorsed at all. Six times were endorsed less frequently than would be expected, including 9 a.m., 11 a.m., 2 p.m., 3 p.m., 5 p.m., and 7 p.m. (see Table 2).

When evaluating the confidence intervals for the SIRs for the nighttime sleep diary, only 3 a.m. was endorsed more frequently than expected (SIR 14.024, 95% CI 4.554, 32.727) and only 12 p.m. was endorsed less likely than expected (SIR: 0.155, 95% CI: 0.004, 0.866). Three times (12 a.m., 5 a.m., and 6 a.m.) were not endorsed at all (see Table 3).

Discussion

Consistent with hypotheses, 3:00 a.m. was the most frequently endorsed time period in the night for the highest suicidal urges. Across both the morning and the night sleep diary, evening or early morning time-periods were the most commonly endorsed periods in which participants reported their highest suicidal urge. Also consistent with hypotheses, there was not a significant reduction in suicidal urges when measured at randomly sampled intervals (using EMA) or during the sleep diary assessment. Finally, there was notable variability in suicidal urges within and across participants, with a maximum of 73-unit difference in suicidal urges in a given day, and an average range of 6 units. Intraclass correlation values for variability in suicidal urges was low (.341), indicating that there was low similarity in S-VAS variability in a given day within participants. These findings have important implications for understanding the timing and variability in suicidal urges among PLWH which may have implications for the general population.

These findings are consistent with mortality studies in which suicide death occurred most frequently between 12:00 a.m. and 3:00 a.m. in the general population (McCarthy et al., 2019; Perlis et al., 2016). To our knowledge, this is the first study of its kind to demonstrate that participants with HIV similarly report heightened suicide risk (as indicated by suicide urges) in the middle of the night. We are not aware of any other studies that have evaluated the self-reported timing of spikes in suicidal urges using intensive assessments among patients at risk for suicide in either an HIV or general sample.

These findings are also consistent with our own prior research that demonstrated significant associations between nocturnal wakefulness and next-day negative affect among patients with suicidal ideation (Brown et al., under review). Specifically, in our prior research, we found that longer durations of objectively measured nocturnal wakefulness on a given night predicted higher severity of depression, anxiety, and perceptions of social disconnection during the next day (Brown et al.). Those effects were unique to participants with baseline suicidal ideation. Thus, negative affect and perceptions of social connection may be potential mechanisms of the effect observed between nocturnal wakefulness and suicidal ideation in the current study. This should be evaluated in future research.

The variability findings observed in the current study are consistent with prior reports in psychiatric inpatients and adults from the general population in which substantial variability was observed within participants on a given day (Kleiman et al., 2017). The current study is the first to replicate these effects in a sample of PLWH. This pattern of results is consistent with fluid vulnerability theory (Bryan et al., 2020) and suggests that assessing patients at an isolated time point is likely not a meaningful indicator of risk. In contrast, risk can fluctuate dramatically within a short time-period, even if it ultimately returns to a "set-point." As further support of this, the most commonly endorsed time (3:00 a.m.) was only endorsed by four participants (who endorsed this time 2, 3, 3, and 11 times each). Therefore, it is unlikely that there is a particular window that is high-risk for all individuals. Instead, clinicians might consider if there is utility in generating a personalized plan (such as through the Safety Planning Intervention or the Crisis Response Planning; Bryan et al., 2017; Stanley & Brown, 2012) to cope with increased urges in the middle of the night. Individual patients might identify unique risk factors and opportunities for distraction from suicidal thoughts in the middle of the night (relative to during the day) that could give them enough time for a suicidal crisis to pass. Even without access to technology-delivered EMA assessments, clinicians can use daily diary methods on paper and pencil to assess their patient's suicidal ideation in the middle of the night (or at other windows of importance to them) to further refine their crisis plan.

These findings provide proof of concept for the feasibility and safety of collecting suicide urge data from participants with HIV. No participants died by suicide or were psychiatrically hospitalized during the study. Suicide is an underresearched topic area among PLWH, and this study

[continued on p. 304]

Table 2. Morning Sleep-Diary Comparison of Observed Frequency of S-VAS Maximum Timing Compared to Expected Frequency

Time	ATUS % Awake	Scaled % Awake	Expected to be Awake	Scaled Expected Awake	Observed Frequency	Observed %	Adjusted %	Scaled %	SIR	Lower 95% CI for SIR	Upper 95% CI for SIR	*p*
12:00 AM***	14.47%	0.92%	1.45	1.22	7	5.26	4.84	6.36	5.72***	2.30	11.79	<.001
1:00 AM	8.36%	0.53%	0.84	0.71	3	2.26	3.59	4.72	4.24	0.88	12.40	.07
2:00 AM***	5.89%	0.37%	0.59	0.50	7	5.26	11.88	15.63	14.05***	5.65	28.96	<.001
3:00 AM***	5.34%	0.34%	0.53	0.45	19	14.29	35.58	46.78	42.07***	25.33	65.70	<.001
4:00 AM**	10.19%	0.65%	1.02	0.86	5	3.76	4.91	6.45	5.80**	1.88	13.54	.004
5:00 AM	21.89%	1.39%	2.19	1.85	5	3.76	2.28	3.00	2.70	0.88	6.30	.08
6:00 AM***	47.40%	3.01%	4.74	4.01	14	10.53	2.95	3.88	3.49***	1.91	5.86	<.001
7:00 AM	69.92%	4.45%	6.99	5.91	8	6.02	1.14	1.50	1.35	0.58	2.67	.49
8:00 AM	82.66%	5.26%	8.27	6.99	8	6.02	0.97	1.27	1.14	0.49	2.26	.80
9:00 AM**	89.80%	5.71%	8.98	7.59	1	0.76	0.11	0.15	0.13**	0.00	0.73	.009
10:00 AM	93.82%	5.97%	9.38	7.93	6	4.51	0.64	0.84	0.76	0.28	1.65	.64
11:00 AM*	95.63%	6.08%	9.56	8.08	2	1.50	0.21	0.27	0.25*	0.03	0.89	.03
12:00 PM***	96.34%	6.13%	9.63	8.15	0	0	0	0	0***	0	0.45	<.001
1:00 PM	95.92%	6.10%	9.59	8.11	3	2.26	0.31	0.41	0.37	0.08	1.09	.08
2:00 PM*	96.01%	6.11%	9.60	8.12	2	1.50	0.21	0.27	0.25*	0.03	0.89	.03
3:00 PM**	96.46%	6.13%	9.65	8.16	1	0.75	0.10	0.14	0.12**	0.00	0.68	.005
4:00 PM	96.81%	6.16%	9.68	8.19	3	2.26	0.31	0.41	0.37	0.08	1.07	.07
5:00 PM*	97.26%	6.18%	9.74	8.23	2	1.50	0.21	0.27	0.24*	0.03	0.88	.02
6:00 PM	97.43%	6.20%	9.74	8.24	5	3.76	0.51	0.67	0.61	0.20	1.42	.34
7:00 PM**	96.80%	6.16%	9.68	8.19	1	0.75	0.10	0.14	0.12**	0.00	0.68	.005
8:00 PM	93.09%	5.92%	9.31	7.87	13	9.77	1.40	1.85	1.65	0.88	2.82	.12
9:00 PM	79.91%	5.08%	7.99	6.76	7	5.26	0.88	1.15	1.04	0.42	2.13	1.00
10:00 PM	53.28%	3.39%	5.33	4.51	6	4.51	1.13	1.48	1.33	0.49	2.90	.60
11:00 PM	27.96%	1.78%	2.80	2.36	5	3.76	1.79	2.35	2.11	0.69	4.93	.18
SUM	1572.64%	100.00%	157.26	133	133	100	76.05	100	-	-	-	

Note. ATUS – American Time Use Survey (ATUS), SIR – Standard Incidence Ratio, CI – Confidence Interval
*$p < .05$, **$p < .01$, ***$p < .001$

Table 3. Nighttime Sleep-Diary Comparison of Observed Frequency of S-VAS Maximum Timing Compared to Expected Frequency

Time	ATUS % Awake	Scaled % Awake	Expected to be Awake	Scaled Expected Awake	Observed Frequency	Observed %	Adjusted %	Scaled %	SIR	Lower 95% CI for SIR	Upper 95% CI for SIR	*p*
12:00 AM	14.47%	0.92%	1.45	0.97	0	0	0	0	0	0	3.82	.76
1:00 AM	8.36%	0.53%	0.84	0.56	2	1.90	2.39	8.90	3.58	0.43	12.94	.22
2:00 AM	5.89%	0.37%	0.59	0.39	1	0.95	1.70	6.31	2.54	0.06	14.17	.65
3:00 AM***	5.34%	0.34%	0.53	0.36	5	4.76	9.36	34.81	14.02***	4.55	32.72	<.001
4:00 AM	10.19%	0.65%	1.02	0.68	2	1.90	1.96	7.30	2.94	0.36	10.62	.30
5:00 AM	21.89%	1.39%	2.19	1.46	0	0	0	0	0	0	2.52	.46
6:00 AM	47.40%	3.01%	4.74	3.16	0	0	0	0	0	0	1.17	.08
7:00 AM	69.92%	4.45%	6.99	4.67	1	0.95	0.14	0.53	0.21	0.01	1.19	.11
8:00 AM	82.66%	5.26%	8.27	5.52	4	3.81	0.48	1.80	0.72	0.20	1.86	.71
9:00 AM	89.80%	5.71%	8.98	6.00	4	3.81	0.45	1.66	0.67	0.18	1.71	.57
10:00 AM	93.82%	5.97%	9.38	6.26	4	3.81	0.43	1.59	0.64	0.17	1.63	.50
11:00 AM	95.63%	6.08%	9.56	6.38	5	4.76	0.52	1.94	0.78	0.25	1.82	.77
12:00 PM*	96.34%	6.13%	9.63	6.43	1	0.95	0.10	0.39	0.16*	0.00	0.87	.02
1:00 PM	95.92%	6.10%	9.59	6.40	3	2.85	0.31	1.16	0.47	0.10	1.37	.24
2:00 PM	96.01%	6.11%	9.60	6.41	7	6.67	0.73	2.71	1.09	0.44	2.25	.92
3:00 PM	96.46%	6.13%	9.65	6.44	5	4.76	0.52	1.93	0.78	0.25	1.81	.76
4:00 PM	96.81%	6.16%	9.68	6.46	9	8.57	0.93	3.47	1.39	0.64	2.64	.41
5:00 PM	97.26%	6.18%	9.73	6.49	8	7.62	0.82	3.06	1.23	0.53	2.43	.65
6:00 PM	97.43%	6.20%	9.74	6.51	10	9.52	1.03	3.82	1.54	0.74	2.82	.25
7:00 PM	96.80%	6.16%	9.68	6.46	11	10.48	1.14	4.22	1.70	0.85	3.05	.13
8:00 PM	93.09%	5.92%	9.31	6.22	4	3.81	0.43	1.60	0.64	0.18	1.65	.51
9:00 PM	79.91%	5.08%	7.99	5.34	10	9.52	1.25	4.65	1.87	0.90	3.45	.09
10:00 PM	53.28%	3.39%	5.33	3.56	6	5.71	1.13	4.19	1.69	0.62	3.67	.30
11:00 PM	27.96%	1.78%	2.80	1.87	3	2.86	1.07	3.99	1.61	0.33	4.70	.57
SUM	1572.64%	100.00%	157.26	105	105	100	26.90	100	-	-	-	

Note. ATUS – American Time Use Survey (ATUS), SIR – Standard Incidence Ratio, CI – Confidence Interval
*$p < .05$, ***$p < .001$

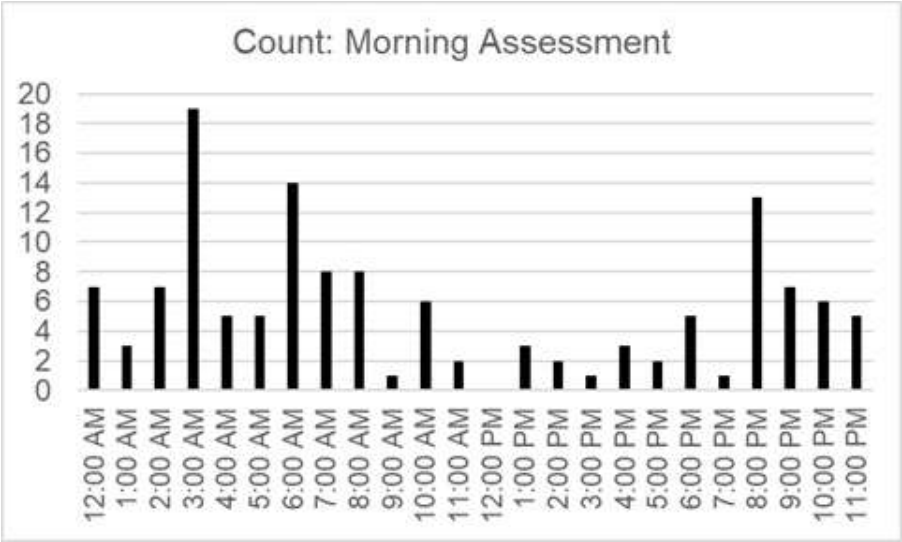

Fig. 2. Timing of highest suicide urges during the morning assessment
Note. This figure represents a frequency distribution of self-reported answers to the question: "At what time did you experience the highest urges for suicide last night?" This question was only administered when participants endorsed a non-zero response to S-VAS prompt for the time period "at any time last night."

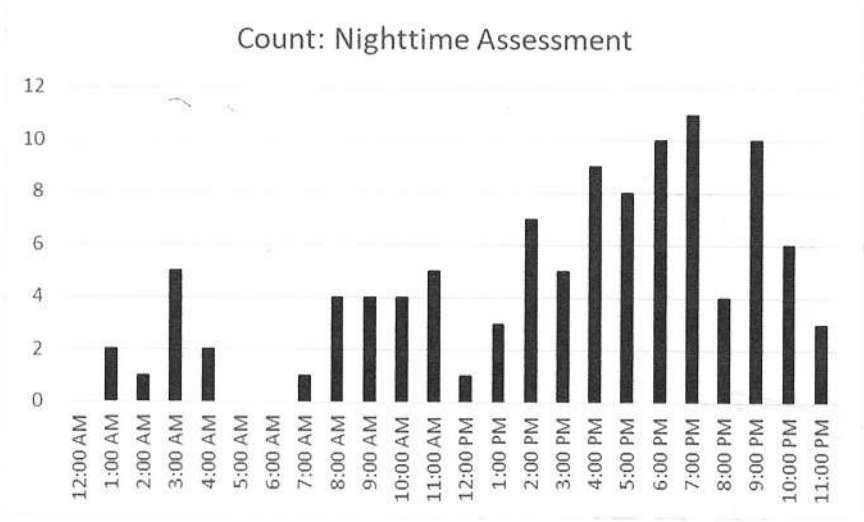

Fig. 3. Timing of highest suicide urges during the nighttime assessment
Note. This figure represents a frequency distribution of self-reported answers to the question: "At what time did you experience the highest urges for suicide today?" This question was only administered when participants endorsed a non-zero response to S-VAS prompt for the time period "at any point today."

demonstrates the great potential, safety, and need for more research in this area.

Clinically, these findings suggest the importance of intervening on sleep disorder symptoms among PLWH who are at risk for suicide. Given the high prevalence of sleep disorders among PLWH (with some estimates up to 58%; Allavena et al., 2014; Wu et al., 2015), intervening to improve sleep quality and quantity is essential. When patients are regularly awake in the middle of the night (even if it is due to shift-work) and their sleep schedule is causing functional impairment, they might meet criteria for a sleep disorder that requires specialized care. Fortunately, evidence-based treatments like cognitive behavior therapy for insomnia (CBT-I) are extremely effective at reducing sleep disorder symptoms (Taylor & Pruiksma, 2014). In addition, several brief interventions to reduce suicide risk exist, including safety planning (Stanley & Brown, 2012), crisis response planning (Bryan et al., 2017), and the coping long-term with active suicide program (CLASP; Miller et al., 2016; Miller et al., 2017). To our knowledge, only two studies have been conducted on CBT-I or related interventions among PLWH, both of which had positive outcomes (Buchanon et al., 2018; Dreher, 2003). We are not aware of any studies of safety planning, crisis response planning, or CLASP for PLWH.

There are several limitations of this research. First, this is an extremely small sample size. Second, participants were mostly male, limiting generalizability. More research is needed in this area in women and transgender individuals. Third, an average of 27% of data were missing across all data types. Given the frequency of assessments, this is an encouragingly small proportion of missing data. However, research in other areas (e.g., schizophrenia) has revealed that missing EMA data may occur during, or reflect, high-risk periods (Staples et al., 2017). Therefore, more evaluation of patterns of missingness is necessary in larger samples. Fourth, it would be helpful for future research to evaluate whether the timing of suicide risk fluctuations varies as a function of viral load—that data was not collected in this study. Fifth, some responses to the morning assessment about timing of highest urges in the middle of the night reflected times that were outside of nighttime hours. It is unclear whether these responses were due to an error in entering the time, a misunderstanding of the question, or a response that reflects a shifted sleep schedule. In our subsequent ongoing research, we have opted to use military time wherever possible (especially in military context) to prevent a "1 p.m. response" when the participant intends to select "1 a.m.." It also may be helpful to send a follow-up question with unlikely responses to request that the participant confirm their choice. Last, the morning sleep assessment was a retrospective report on urges from the prior night (in contrast to the two random EMA probes during each day).

This changes the nature of the assessment, and in our ongoing research we are now sending silent EMA probes in the middle of the night that participants are asked to answer if they are already awake.

More research is needed to understand suicide risk among PLWH. Despite advances in HIV care, PLWH continue to experience discrimination and hostility in the healthcare system and in their communities. Furthermore, while PLWH can lead long and fulfilling lives due to availability of antiretroviral therapies, many PLWH still struggle with hopelessness and suicidal thoughts, as demonstrated by our research and others (Anagnostopoulos et al., 2015; Feuillet et al., 2017). Evidence-based practices for suicide prevention may assist PLWH to work through suicidal crises and build meaningful lives, but more research is needed to evaluate whether these interventions require adaptations to optimize efficacy and effectiveness in PLWH.

Conclusions

In summary, this is the first study of its kind to demonstrate that the middle of the night is a high-risk period for increased suicidal ideation among PLWH. These findings suggest the need for future research to understand strategies to intervene on suicidal urges in the middle of the night to interrupt their escalation to suicide behavior. In addition, these findings provide further evidence that SI varies significantly within individuals over time, suggesting that attempts to characterize individuals as "high-risk" or "low-risk" for suicide may be unsuccessful.

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We would like to acknowledge the participants who provided their time and energy for this study.

This publication resulted (in part) from research supported by the Mid-Atlantic CFAR Consortium (MACC) Scholars Program, an inter-CFAR collaboration between the District of Columbia Center for AIDS Research (P30 AI117970), the University of Pennsylvania CFAR (P30 A1 045008), and the Johns Hopkins University CFAR (P30 A1 094189). This collaboration is supported by the following NIH Co-Funding and Participating Institutes and Centers: NIAID, NCI, NICHD, NHLBI, NIDA, NIMH, NIA, FIC, NIGMS, NIDDK, and OAR. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

The authors declare no conflicts of interest.

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Roles and Opportunities for Child- and Family-Focused Psychologists in the Federal Executive Branch

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AMERICAN FAMILIES are currently facing soaring levels of adversity, stress, trauma, and uncertainty (Centers for Disease Control and Prevention, 2022; Lebrun-Harris et al., 2022). The COVID-19 public health emergency highlighted critical gaps in the infrastructure that undergirds the health and well-being of America's families, including child care, education, economic safety nets, public health coordination, and health and mental health care access and capacity, while high-profile incidents of racially based violence and injustice have further elevated the need to prioritize equity across systems. This confluence of epidemics, also referred to as a syndemic, highlights the range of mental health needs currently facing children and families (Hunter & Horen, 2021). This moment has made clear the need for federal leadership to help states and communities respond effectively, and for psychologists and other mental health experts to play a central role in that response.

To address these needs, several recent federal actions have highlighted mental health. In January 2021, President Biden released an Executive Order on Supporting the Reopening and Continuing Operation of Schools and Early Childhood Education Providers, which identified the need to support the promotion of mental health and social-emotional well-being as schools and early childhood education settings reopened to in-person schooling (Exec. Order No. 14000, 2021). The White House also released a Fact Sheet on Improving Access and Care for Youth Mental Health Conditions and Substance Use Conditions, which highlighted efforts to increase access to school-based behavioral health supports and invest in community-based youth mental health and substance use care (White House, 2021). Further, the American Rescue Plan Act (2021) included significant investments in federal, state, and local programs that provide critical supports to children and their families.

More recently, in December 2021, the U.S. Surgeon General issued an Advisory—a public statement reserved for significant public health challenges that need immediate action—to highlight the urgent need to address the nation's youth mental health crisis. The Advisory includes essential recommendations to address mental health in the institutions that surround children in their day-to-day lives, including child care settings, schools, community organizations and health care systems (Office of the Surgeon General, 2021). In March 2022, the White House announced a strategy to address the nation's mental health crisis by improving access to mental health services, integrating intervention in early care and education as well as schools, and building up the mental health workforce including training social and human service professionals in basic mental health skills (White House, 2022a, 2022b).

In addition to this "Big-P policymaking," or the more formal policy and regulation created by the government, there are countless "little-p" policy actions, or activities at the programmatic or local level encompassing organizational rules, regulations, and practices (Collins, 2019), that occur on a routine basis. Neither could occur without the contributions of psychologists and other mental health experts across the federal government. While this article focuses on the executive branch of the government and specific examples of child and family policy, we note that experts in mental health and psychology also work to inform the legislative process by serving as Congressional representatives, Congressional staffers, and advocates outside of government who shape legislation and federal policy across a range of populations.

Psychologists in the Federal Executive Branch

An earlier article in *the Behavior Therapist* described ways in which psychological science can be applied in state and local behavioral health systems and settings, highlighting different functional roles for psychologists (Regan et al., 2020). These roles included developing policy and proposals; collaborating through cross-system and cross-setting partnerships; conducting research analysis and reporting/outcomes monitoring; program evaluation; quality improvement; and enhancing data inputs. The purpose of the current article is to complement Regan et al. by describing the roles that psychology experts play in policymaking in the federal executive branch, with a focus on early childhood, and offering an overview of how federal policy interacts with state and local policies and procedures to guide systems and services for young children and their families. We highlight six key activities: program administration, training and technical assistance, policy development, communications and agenda-setting, research and evaluation, and interagency coordination.

Specifically, we give examples of how psychologists provide value and expertise across the executive branch, with a focus on our experience within the U.S. Department of Health and Human Services (HHS) and our areas of topical expertise—supporting early childhood development, promoting social-emotional well-being and mental health, and increasing preventive services and supports for families with young children. While we write from our vantage points as clinical psychologists with combined training in science and practice, many of the skill sets and roles described in the article apply to other psychologists and mental health experts as well, such as social workers, counselors, and psychiatrists. We also share considerations for professionals or trainees who may be interested in applying their training in

direct federal service or as external collaborators. Each author works in a different agency or office, described below, which serves a range of functions to achieve the government's goals, including administering programs for young children and families, funding and conducting research and evaluation, analyzing early childhood policies and their impact, and making recommendations for cross-governmental action.

The Maternal and Child Health Bureau within the Health Resources and Services Administration funds national, state, and community organizations and academic institutions to improve the health and well-being of America's mothers, children, and families, through programs, leadership and workforce development, and data and research (Health Resources and Services Administration, 2022a), including administration of federal home visiting and early childhood systems programming. The Office of Head Start within the Administration for Children and Families administers grant funding and oversight to the 1,600 agencies that provide Head Start services in communities across the country. The Office also provides federal policy direction and a training and technical assistance system to help grantees in providing comprehensive services to low-income children ages birth to 5 and their families in core areas of early learning, health, mental health, and family well-being (Office of Head Start, 2022). The Office of the Assistant Secretary for Planning and Evaluation is a policy research office within HHS that serves as the principal advisor to the HHS Secretary on policy development and is responsible for major activities in policy coordination, legislation development, strategic planning, policy research and analysis, evaluation, and economic analysis; this includes analysis of early childhood policy issues and topics within the Office of Human Services Policy (Office of the Assistant Secretary for Planning and Evaluation, 2022).

Program Administration

Often the most well-known efforts of the federal government are programs that provide services and resources related to a specific condition or that support a specific population. Usually, federal staff do not deliver these services directly, but instead administer grants to state or local government agencies or to private entities. For example, public funds under Medicaid, the Children's Health Insurance Program, and Medicare paid for 40% of mental health services in the United States in 2015 (Substance Abuse and Mental Health Services Administration, 2019). Many large-scale programs offer flexible funding to states to support direct services and service delivery or other health infrastructure, such as the Community Mental Health Services and the Substance Abuse Prevention and Treatment Block Grants (administered by the Substance Abuse and Mental Health Services Administration) and the Title V Maternal and Child Health Block Grant (administered by the Health Resources and Services Administration). Other programs target more specific outcomes by funding discrete services or defining specific beneficiary groups, such as federal home visiting programs, services for children with special health care or educational needs, and training and other workforce development programs. In addition, some programs support the coordination and improvement of systems that are necessary for ensuring holistic and family-centered services (e.g., Project LAUNCH–Linking Actions for Unmet Needs in Children's Health, Early Childhood Comprehensive Systems grants, and Preschool Development Grants). These funding streams help create common platforms and processes, such as data exchange standards and tools, state and local level advisory councils, and mechanisms for family and community representatives to inform and guide the systems that affect them.

The role of federal staff in grant programming can take many forms. Staff may be closely involved in operationalizing legislative statute through program design, including defining the major goals, objectives, and policy priorities for award competitions. They may also make decisions about how grant recipients track their progress and report outcomes. Project officers maintain oversight of activities and spending under the award; provide guidance and assistance to help grant recipients achieve their goals; and work to analyze and share results from performance reports and evaluations. These functions can benefit from expertise gained through graduate-level psychology and similar training, including subject matter expertise in behavioral health conditions, prevention, and intervention; appreciation for the complexity of mental health promotion and treatment systems; and an understanding of how to apply principles of human development, behavior change, psychosocial processes, and group dynamics. Psychologists' methodological skills and scientific ways of thinking also help ensure that the information gathered about program activities and outcomes provides a valid foundation for understanding and communicating impact and guiding future planning. Managerial and strategic thinking skills are also critical, to ensure accountability and synergy across investments.

Training and Technical Assistance

Beyond direct services and programs, the federal government also funds training and technical assistance, through which experts (typically external to government) provide support and resources to program administrators or other state and local leaders as they advance key health and well-being priorities. Training and technical assistance providers act as trusted interpreters and messengers to guide on-the-ground implementation, blending the latest research findings with knowledge of emerging and industry best practices, important contextual considerations, and implementation science toward real-world application.

The training and technical assistance system can look different depending on the intended recipient. For example, the 2020–2025 Office of Head Start Training and Technical Assistance System has three components that have distinct and complementary functions: national centers, a regional network, and grant recipient funding. The National Centers—many of which employ psychologists and other mental health specialists—provide high-quality, evidence-based training and practical resources to regional leads, early childhood program staff, and parents to build early childhood education program capacity across a variety of topics, including behavioral health. The Regional Network provides targeted support to individual grant recipients, clusters of grant recipients with similar interests or needs, and at state and regional events. Individual grantees also receive funds to address training or technical assistance needs that are specific to their local program.

In addition to support within a specific program, many agencies and offices support training and technical assistance centers that provide resources and guidance to a wide audience on a specific topic area. For example, the Substance Abuse and Mental Health Services Administration's Center of Excellence on Infant and Early Childhood Mental Health Consultation maintains a robust public-facing website with training, evaluation, and practical implementation resources for consultants and organizations that are considering or using consul-

tation services, and provides tailored technical assistance to individual organizations. Other investments include training programs for students (e.g., Maternal and Child Health Leadership Education in Neurodevelopmental and Other Related Disabilities, Developmental Behavioral Pediatrics network, Behavioral Health Workforce Education and Training) and consultation or professional development for current practitioners (e.g., Pediatric Mental Health Care Access).

Federal staff overseeing these investments work to ensure that implementing partners are reaching the desired audiences, providing high-quality, timely and research-based information, aligning their content and messaging with administration priorities and work from other training and technical assistance centers, and producing meaningful knowledge and practice change among recipients. For example, to address priorities related to equity, Office of Head Start psychologists guided the review and revision of training and technical assistance materials on challenging behaviors and suspension and expulsion practices for preschoolers. Mental health experts within federal agencies also inform the development and delivery of training and technical assistance products and strategies, and may provide direct technical assistance to grantees, partners and stakeholders, broader health and social service systems, and the public. Through these systems and other partnerships, psychologists and related professionals in federal service can further provide a bridge to the academic and research world, facilitating connections that inform policy and program implementation.

Policy Development

While the legislative branch of the federal government is primarily responsible for the legislation that authorizes programs that support young children and their families, the executive branch develops the regulation and policy guidance that drives program implementation and operation. Federal agencies may use regulations to implement and enforce legislation passed by Congress. For example, after Congress passed the Improving Head Start for School Readiness Act of 2007 (P.L. 110-134) to reauthorize the Head Start program, the Office of Head Start created the Head Start Program Performance Standards (45 CFR Chapter XIII) as the corresponding regulation that outlines the administrative procedures and program requirements for Head Start grantees. Additional guidance for program operation is often provided in Program Instructions or Information Memoranda. For guidance that addresses program implementation or specific considerations (cf. Administration for Children and Families, 2020), expertise in child development and behavioral health is often critical to ensuring accuracy and relevance.

Federal agencies also produce various documents for communicating federal policy direction and priority to the field, including state and local policymakers and agency leaders, service providers, researchers, and advocacy organizations. For example, HHS and the Department of Education released a joint Dear Colleague Letter in June 2022 that featured four recommendations and associated action steps to target resources and ensure that all young children and their caregivers have access to high-quality resources that equitably support social-emotional development and mental health (U.S. Department of HHS & U.S. Department of Education, 2022). Federal staff with content expertise worked closely with leadership on the development of this letter and the recommendations, tapping into skills such as reviewing the research literature, identifying evidence-based strategies, understanding behavioral health disparities and social determinants of health, and translating research into plain language. Other similar guidance documents have been informed by psychological experts, such as the Policy Statement on Family Engagement (U.S. Department of HHS & U.S. Department of Education, 2016a), Policy Statement on the Collaboration and Coordination of the Maternal, Infant, and Early Childhood Home Visiting Program and the Individuals with Disabilities Education Act Part C Programs (U.S. Department of Education & U.S. Department of HHS, 2017), Policy Statement on Expulsion and Suspension Policies in Early Childhood Settings (U.S. Department of HHS & U.S. Department of Education, 2016b), and a Dear Colleague Letter on investing American Rescue Plan Act and Preschool Development Grant funds to address the early childhood workforce shortage (Administration for Children and Families, 2021).

Communications and Agenda Setting

Federal initiatives can also send a message to the field and raise the profile and priority of specific competencies or strategies for research and service and systems improvement. Challenge competitions are one way in which the government can call attention to a public need and incentivize new approaches to solving problems. The Maternal and Child Health Bureau has sponsored several competitions in recent years that have highlighted child development and behavioral health issues such as disparities in early language environments, opioid use among pregnant women and new mothers, and access to well-child visits and immunizations in pediatric primary care (Health Resources and Services Administration, 2022b). Psychological subject matter expertise and field awareness are useful in assessing the state of the evidence and articulating focal questions or goals to drive new approaches and generate change.

In April of 2020, the Office of Head Start launched a public messaging campaign called Head Start Heals, to increase awareness about how early childhood programs are uniquely qualified to address early childhood mental health, cope with adversity and promote resilience for children and families (Office of Head Start, 2020). Topics include supporting a trauma-informed approach; child abuse and neglect; substance use disorder and the opioid epidemic; and supporting children and families during a pandemic. To date, this initiative has garnered national attention across early childhood providers with over 90,000 participants in online events. The widespread interest of these webinars speaks to the intense need for broader education and training around early childhood mental health, trauma, and resilience. The messages and resources were developed through close collaboration of federal subject matter experts and Head Start National Center expertise.

Research and Evaluation

Psychologists in the federal government serve an important role by bridging the gap between policymakers and researchers, helping to translate the findings of complex science, identify the relationship between evidence and relevant policy issues, and communicate the evidence alongside cultural, economic, pragmatic, and political factors (Ager, 2013; McKnight et al., 2005). Psychologists' expertise is also critical to delivering on the federal government's commitment to making decisions based on the best available evidence about the effectiveness of government programs (cf. Foundations for Evidence-Based Policymaking Act of 2018, 2018). This includes overseeing a range of research and evaluation efforts through grants, contracts, and technical partnerships. For example, the

Administration for Children and Families's Office of Planning, Research, and Evaluation employs several psychologists (both clinical and nonclinical) and other experts to design studies, monitor implementation, and guide the interpretation and dissemination of findings related to program effectiveness and efficiency, such as the Mother and Infant Home Visiting Program Evaluation.

Federal psychologists and mental health analysts also conduct internal research, which can take multiple forms based on the types of research questions and office structure. Some internal research involves data analysis using federal datasets, such as the Current Population Survey and the National Survey of Children's Health (NSCH). Each year, HHS' Office of the Assistant Secretary for Planning and Evaluation uses the Current Population Survey along with administrative data from the Office of Child Care to estimate the number of children eligible for child care subsidies and those who are most likely to receive subsidies (Chien, 2021). In addition to funding, directing, and co-authoring publications of findings from the NSCH, the Maternal and Child Health Bureau also supports a Data Resource Center, which takes the results from the survey and makes them easily accessible to parents, researchers, community health providers, and anyone interested in maternal and child health. Staff may also use their methodological expertise and extensive training in clinical interviewing and research design to conduct qualitative research, such as key informant interviews or focus groups.

Federal staff and measurement experts also contribute to the review and interpretation of existing evidence, such as developing criteria for what counts as an evidence-based program and determining which programs are eligible for implementation within federally funded programs (e.g., the Home Visiting Evidence of Effectiveness review, the Title IV- E Prevention Services Clearinghouse). Expertise in psychological science further helps inform decisions about conceptual definitions, articulating key questions with relevance to both policymakers and field practitioners, and framing messaging to align with stakeholder interests. The federal government also increasingly applies human-centered design to research and implementation, an approach based in human empathy and psychological science (Lyon et al., 2020).

Interagency Coordination

Mental health professionals' collaboration and facilitation skills support agencies' participation in cross-governmental planning and advisory groups, to tackle specific issues from a "whole of government" perspective. Earlier this year, subject matter experts from across HHS, including psychologists, came together to elevate relevant data trends, prioritize focus areas, and craft language related to improving access to behavioral health services, promoting health behaviors, strengthening early childhood development, and responding effectively to neglect, abuse, violence, and other trauma as part of a new 4-year Strategic Plan (U.S. Department of HHS, 2022). Staff with psychological expertise also contribute to interagency policy committees and coordinating councils to analyze policy and make recommendations that inform Presidential policy direction (e.g., the Biden-Harris policy priority to "explore, identify barriers, and establish policy to help pregnant women with substance use disorder obtain prenatal care and addiction treatment without fear of child removal"; ONDCP, 2021) and facilitate collaboration and strategic planning in the Department's behavioral health agenda. Other interagency bodies where mental health experts are represented include the Interagency Working Group on Youth Programs, which coordinates across programs that serve youth ages 10 to 24, and the Interagency Task Force on Trauma-Informed Care, which is developing a cross-government approach to identifying and evaluating best practices for children and families who have experienced trauma. Within these forums, staff use their knowledge of research and the field to elevate topics of critical importance to public health and well-being, identify the relevant basic research and programmatic learnings that should drive decision-making, craft objectives or action steps that will lead to meaningful improvement, and recommend messaging or framing that will resonate across federal, state, and local partners and communities.

Mental health experts bring a specific grounding in systems of care approaches and the importance of understanding families' multiple needs to these discussions, ultimately improving planning. Staff also play a critical role in maintaining an awareness of complementary programming and developing relationships across offices and agencies in order to call attention to opportunities for cross-program collaboration and more effective policies and services (e.g., U.S. Department of Education & U.S. Department of HHS, 2017).

Considerations for Psychologists or Trainees

The federal government provides a wide range of opportunities for psychologists and other mental health experts to apply their training and skills to public service. Each federal agency or office operates toward a specific mission or function, but specialists working at the career staff level (in contrast to political appointees) share a common commitment to serve across political administrations and apply their skills in a nonpartisan manner. There can be a delicate balance when making recommendations and interpreting data to align current evidence with legislative and executive directives and priorities, especially in the face of polarizing public discourse.

The immediate audience for these activities also varies, from the individuals who are recipients of federally funded services, to the grantees who administer federal programs, to academic audiences in multiple settings, to federal colleagues, to the public at large. While this vantage point can seem daunting or distant at times, compared to more personal encounters, the potential for widespread reach and influence across multiple systems helps reinforce the importance of the work.

For the authors of this article, we found that our robust training as clinical psychologists prepared us to be successful in the federal government. Our training in research design and methods, measurement, data analysis and statistics, and evaluation enabled us to engage in research and evaluation and to inform the development of evidence-based policy and programming with attention to issues of equity and health disparities. Our clinical training and experience with diverse clients and communities provided us with valuable perspective about the impact of federal programs and policy on the various populations these programs support. Our training also equipped us to empathize with a range of perspectives and competing demands, to facilitate productive relationships, and to communicate with broad audiences, from researchers, to policymakers, to program participants. At the same time, we found it equally important to explore nonstandard training experiences and to consider new ways of framing and communicating our skills in order to

understand and access federal employment opportunities.

Several avenues exist for both established mental health professionals and trainees who are interested in working with the federal government to gain relevant experience, such as participating in policy-oriented research, partnering with state or local federal program recipients, and working with individuals and families who use federally sponsored services and supports. Applying for and serving as a reviewer for federal funding opportunities offers insights into the grant-making process. Attendance at conferences, such as the National Home Visiting Summit, National Research Conference on Early Childhood, and the Research and Evaluation Conference on Self-Sufficiency, provides opportunities to stay up to date on policy-relevant research and interact with federal staff.

Formal fellowship programs also provide an excellent opportunity for Ph.D.-level psychologists to apply their research skills and clinical training to inform public policy. The American Psychological Association has funded an Executive Branch Science Fellowship since 1995 and the Society for Research in Child Development has a similar fellowship open to developmental scientists (the authors are three proud alumni of this program). The American Association for the Advancement of Sciences, the Society for the Psychological Study of Social Issues, and the American Educational Research Association also run fellowship programs for Ph.D.-level scientists to learn about federal policymaking. Fellows are placed in federal agencies for a yearlong, immersive experience where they produce research materials, develop funded research opportunities, review scientific research at peer review panels, participate in scientific task forces and committees, and advise policymakers (Garrison et al., 2017).

Conclusion

This article describes many ways in which psychologists and allied health professionals in the federal government can help advance early childhood development and support social-emotional and mental health promotion and prevention. The strategies and examples described in this article can also apply to a broader range of federal programs, including those serving adults and individuals across the lifespan. We sought to highlight these functions and experiences as a complement to federal roles that may be more familiar to psychologists, such as direct clinical service provided by staff of the Department of Veterans Affairs or basic and applied research funded by the National Institutes of Health. Often the additional opportunities outlined in this article are not apparent to those working in other sectors and settings, yet they offer a variety of career options—not only through direct employment, but also through the many public and private entities with which federal agencies partner. As the need for large-scale, evidence-driven supports for mental health grows, so too does the need for a committed and capable workforce to design and deliver those supports.

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Find a CBT Therapist

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

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

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

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

The views expressed in this article are solely the opinions of the authors and do not necessarily reflect the official policies of the U.S. Department of Health and Human Services (HHS), the Health Resources and Services Administration, the Administration for Children and Families, or the HHS Office of the Assistant Secretary for Planning and Evaluation, nor does mention of the department or agency names imply endorsement by the U.S. Government.

We greatly appreciate the contributions of Marissa Abbott, David de Voursney, Kelsey McKee, and Maya Thirkill in providing feedback on this manuscript.

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Additional information on many of the programs and resources referenced in this article can be found online at https://www.abct.org/wp-content/uploads/2022/11/Tanner-Stapleton-Suppl.docx

2023

Call *for* Award Nominations

to be presented at the 57th Annual Convention in Seattle

The ABCT Awards and Recognition Committee, chaired by Sara R. Elkins, Ph.D., University of Houston Clear Lake, is pleased to announce the 2023 awards program. Nominations are requested in all categories listed below. Applicants from traditionally underrepresented backgrounds are particularly encouraged to apply. Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, Marsha Linehan, Dianne L. Chambless, Linda Carter Sobell and Mark B. Sobell, Philip C. Kendall, Richard G. Heimberg, Patricia A. Resick, and Dean G. Kilpatrick. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line. ***Nomination deadline:*** March 1, 2023.

Outstanding Clinician Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Recent recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, Jacqueline Persons, Judith Beck, Anne Marie Albano, and Cory Newman. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Clinician" in the subject line. ***Nomination deadline***: March 1, 2023

Outstanding Training Program This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, the Charleston Consortium Psychology Internship Training Program, the Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University, the Florida State University's Clinical Psychology Ph.D. program, and the Beck Institute. Applications should include a nomination form (available at www.abct.org/awards) and two letters of support. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. ***Nomination deadline:*** March 1, 2023

Michael J. Kozak Critical Inquiry and Analytical Thinking Award "Clarity of writing reflects clarity of thinking." This statement reflects the overarching goal that Michael J. Kozak sought to achieve himself and that he vigorously encouraged others to reach as well. His penchant for critical inquiry cut across contexts: whether in providing cognitive-behavioral treatment itself, offering supervision of treatment, in scientific inquiry and writing, or in advising investigators about how to put their grant applications in the best possible position for success. Dr. Kozak was always in search of clarity. Accordingly, recipients of the Michael J. Kozak Critical Inquiry and Analytical Thinking Award from ABCT should embody this same spirit in their own work. Michael was able to achieve this high standard and promote its achievement in others with great skill and kindness, so recipients should also conduct themselves in such a way in their professional lives. This award will be given in alternate years. The recipient will receive $1,500 and a plaque. Please complete the online nomination materials at www.abct.org/awards. Then email the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Michael J. Kozak Award" in the subject line. ***Nomination deadline:*** March 1, 2023.

The Francis C. Sumner Excellence Award The Francis Cecil Sumner Excellence Award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the "Father of Black Psychology," he is recognized as an American leader in education reform. This award can be given on an annual basis, awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree. Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and

professional members of ABCT at the time of the nomination. The award is intended to acknowledge and promote the excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional within 10 years of award of the PhD/PsyD/EdD/ScD/MD who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. The Francis C. Sumner Excellence Award is meant to reflect the overarching goal of ABCT supporting its members of color. The 2021 early career recipient of this award was Isha Metzger, Ph.D., and the 2022 student recipient was Tia Tyndal, M.A. The recipient will receive $1,000 and a certificate. Please complete the online nomination materials at www.abct.org/awards. Email the nomination materials as one pdf document to ABCTAwards@abct.org, and include "Francis C. Sumner Award" in the subject line. ***Nomination deadline***: March 1, 2023

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. The 2022 recipient of this award was Anu Asnaani, Ph.D. This award includes a cash prize of $1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 10 years of receiving his/her the doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, the nominee's curriculum vitae, and a personal statement up to three pages. Application materials should be emailed as one pdf document to ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line.
Nomination deadline: March 1, 2023

Charles Silverstein Lifetime Achievement Award in Social Justice

Members of the Association are encouraged to nominate individuals who have made significant and sustained lifetime contributions to advancing social justice initiatives over many years. This award is given at the discretion of the Board of Directors and is primarily designed to recognize the critical, and often underrecognized, contributions from cognitive and/or behavior therapy (CBT) grassroots activists who are from and primarily work with minoritized and oppressed communities. In very rare instances, the award may be given to allies from the CBT field if nominations arise from minoritized members and their perspective is centered. A key element of this award is recognition that grassroots CBT activists typically have less access to power to directly change systems secondary to structural injustice and oppression. Thus, contributions to advancing social justice by grassroots CBT activists may look different than those of allies, even though grassroots activist contributions are no less important and typically confer increased risk for the individual. Eligible candidates for this award do not need to be a current ABCT member but must have a strong historic connection to the CBT field. ABCT membership at some point in the candidate's career is desirable. The awardee will be chosen by the ABCT Board of Directors. The President will verify that all materials are completed and that Board members agree with the recommendation. Nominations for this award should include a letter of nomination/support as well as a curriculum vitae of the nominee or other significant evidence of the nominee's social justice work. Application materials should be emailed as one pdf document to ABCTAwards@abct.org. Include candidate's last name and "Silverstein Award" in the subject line.
Nomination deadline: March 1, 2023

Distinguished Friend to Behavior Therapy

This award is given annually to an individual or organization that supports the aims of ABCT in providing awareness, advocacy, or evidence-based behavioral health services in the field of cognitive and behavioral therapies. Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Candidates are nominated by an ABCT member and applications should include a letter of nomination/support and a curriculum vitae of the nominee. Recent recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, Vikram Patel, Benedict Carey, and Bivian "Sonny" Lee III. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line. ***Nomination deadline***: March 1, 2023

President's New Researcher Award

ABCT's 2022-23 President, Jill Ehrenreich-May, Ph.D., invites submissions for the 45th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent, innovative work published in high-impact journals; and promise of contributing to cognitive and behavioral theory to advance the field. Scholars who trained in smaller labs or who work in less research-intensive environments are also encouraged to apply, as the quality and potential impact of one's work, not the number of publications, will be the focus.
Requirements: must have had terminal degree (Ph.D., Psy.D., M.D., etc.) for at least 1 year but no longer than 5 years (i.e., completed during or after 2016); must submit a peer-reviewed, empirical article for which they are the first author (in press, or

published during or after 2019); 2 letters of recommendation must be included; self-nominations are accepted; the author's CV, letters of support, and paper must be submitted in electronic form. Applicants from traditionally underrepresented backgrounds, or whose work advances our understanding of behavioral health disparities, are particularly encouraged to apply. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org. Include candidate's last name and "President's New Researcher" in the subject line. ***Nomination deadline***: March 1, 2023.

Student Dissertation Awards

• Virginia A. Roswell Student Dissertation Award ($1,000) • Leonard Krasner Student Dissertation Award ($1,000)
• John R. Z. Abela Student Dissertation Award ($500)

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2023. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted, or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards. Email the nomination materials (including letter of recommendation) as one pdf document to ABCTAwards@abct.org, and include candidate's last name and "Student Dissertation Award" in the subject line.
Nomination deadline: March 1, 2023

Graduate Student Research Grant The ABCT Research Facilitation Committee is sponsoring a grant of up to $1000 to support graduate student research. The grant will be awarded based on a combination of merit and need. Eligible candidates are graduate student members of ABCT seeking funding for an unfunded (including internal sources of funding) thesis or dissertation project that has been approved by either the faculty advisor or the student's full committee. Applications should include all of the materials listed in GSRG Application Guidelines (https://www.abct.org/membership/abct-awards/) and one letter of support from a faculty advisor. Please email the application, excluding the advisor letter, in a single pdf to the chair of the Research Facilitation Committee, Ryan Jacoby, Ph.D. Include "Graduate Student Research Grant" in your subject heading. Please ask your faculty advisor to e-mail a letter of support separately. ***Application deadline:*** March 1, 2023

Student Travel Award This award recognizes excellence among our student presenters and is intended to defray some of the travel costs associated with presenting at the convention with a cash prize of $500. This award money is to be used to facilitate travel to the ABCT convention. To be eligible, students must 1) have their symposium or panel submission for the 2023 ABCT convention accepted for presentation; 2) be a symposium presenter (i.e., first author on a symposium talk) at the ABCT annual convention; 3) be a student member of ABCT in good standing; and 3) be enrolled as a student at the time of the convention, including individuals on predoctoral internships, but excluding post-baccalaureates. Awards are highly competitive and preference is given to projects demonstrating student initiation and independence, and innovation for the field. Two awards are given annually, with one granted to an underrepresented student member, defined broadly as race, ethnic background, sexual orientation, or discipline. Additional requirements and submission instructions are available on the Student Travel Award Application found online at www.abct.org/awards. Award winners will be announced in mid-September 2023.
Application deadline: July 22, 2023

Elsie Ramos Memorial Student Poster Awards This award is given to student first authors whose posters have been accepted for presentation at ABCT's Annual Convention. The winners each receive an ABCT Student Membership and a complimentary general registration at the next year's ABCT's Annual Convention. To be eligible, students must 1) have their poster submission for this year's ABCT convention accepted for presentation; 2) be student members of ABCT in good standing; and 3) be enrolled as a student at the time of the convention. Awards are highly competitive and preference is given to projects demonstrating student initiation and independence and innovation for the field. Three awards are granted annually. Additional requirements and submission instructions are available on the Elsie Ramos Memorial Student Poster Award Application found online at www.abct.org/awards. Award winners will be announced in mid-September 2023.
Application deadline: July 22, 2023

Outstanding Service to ABCT This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form found online at www.abct.org/awards/. Email the completed form and associated materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Service" in the subject line. ***Nomination deadline:*** March 1, 2023

ABCT's 57th Annual Convention
Seattle | November 16-19, 2023

Cultivating Joy With CBT

Call *for* Abstracts — General Sessions

Program Chair: Emily Bilek, Ph.D. • **Associate Program Chair:** Krystal Lewis, Ph.D.
ABCT President: Jill Ehrenreich-May, Ph.D.

The past few years have been difficult. COVID-19 and other health emergencies, climate change, political instability, and the worsening mental health crisis are taking a toll. Recently, a bright spotlight has also been cast on the historical and present-moment pain caused by pervasive racism and discrimination targeting minoritized and marginalized groups. These recent and ongoing challenges have greatly impacted health and well-being on a global, local, organizational, and individual scale. As a field, we are also reckoning with the ways we've contributed to injustice, navigating barriers to care, addressing mental health stigma, contending with the replication crisis, bringing attention to financial hardship experienced by many trainees and early-career professionals, and coping with professional and personal burnout.

As we work to address these challenges head-on, and atone for our roles in creating them, how can we begin to heal? How can we connect with our values and demonstrate a spirit of perseverance in our research, teaching, and clinical positions? How can we use our expertise to savor and create moments of joy in our own and others' lives? How can we improve our treatments, or construct new ones, to address injustice, to center and celebrate populations that have and continue to face discrimination, inequity, and exclusion by the mental health field? How can we cultivate and sustain our own well-being while working in a meaningful but demanding profession?

ABCT is well positioned to address these questions. The 2023 Convention will highlight advances across research, practice, and education that feature approaches to addressing inequity and injustice within our field, as well as improving mental health, physical health, meaning, and well-being in the world. Please join us in Seattle in 2023 as we say, "It's been a minute, tell me how you're healing"[1] and celebrate the convention theme of **Cultivating Joy With CBT.**

We interpret this theme broadly and encourage related submissions. Topics consistent with this theme include, but are not limited to:

- Improving well-being by reducing burden of disease (broadly defined) or overcoming large-scale challenges.
- Examining interventions that focus on improving well-being, meaning-making and fulfillment, in addition to reducing burdens.
- Increasing inclusivity to combat systemic injustice and historical exclusion of minoritized populations in research, clinical practice, and educational settings.
- Highlighting scientific advances that ignite excitement or passion for your work.
- Identifying facilitators of dissemination and/or implementation of interventions.
- Improving access to evidence-based care through technological advances or other avenues.
- Understanding risk factors and systemic barriers facing mental health professionals and identifying strategies for overcoming burnout or pandemic fatigue.
- Increasing joy in the field of mental health through teaching and/or supervision.
- Combating stigma in mental health and clinical research by centering scholars, change agents and collaborators with lived experience, including public figures.

[1]Slatkin, B., Frederic, E., Price, L., McLaren, M., Jefferson, M., Larkins, R., Hague, S., Thomas, T.M. (2022). *About damn time* [Song recorded by Lizzo]. On Special. Nice Life and Atlantic Records.

► *Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters. Submissions outside of this theme are also welcome and will not be penalized. Submissions that are judged to be especially thematic will be recognized in the online program for the 2023 Convention.*

Information about the convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2023. Online submission portal for general submission will open on February 7, 2023.

ABCT

Cultivating Joy With CBT

57th Annual Convention SEATTLE

November 16–19, 2023

Call *for* Continuing Education Ticketed Sessions

Workshops & Mini Workshops | Workshops cover concerns of the practitioner/ educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than 4 presenters. Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than 4 presenters. When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

► For more information or to answer any questions before you submit your abstract, contact the **Workshop Committee Chair, workshops@abct.org**

Institutes | Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than 4 presenters.

► For more information or to answer any questions before you submit your abstract, contact the **Institute Committee Chair, institutes@abct.org**

Master Clinician Seminars | Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday and Saturday. Please limit to no more than 2 presenters.

► For more information or to answer any questions before you submit your abstract, contact the **Master Clinician Seminar Committee Chair, mastercliniciansseminars@abct.org**

Research and Professional Development | Presentations focus on "how to" develop one's own career and/or conduct research, rather than on broad-based research issues (e.g., a methodological or design issue, grantsmanship, manuscript review) and/or professional development topics (e.g., evidence-based supervision approaches, establishing a private practice, academic productivity, publishing for the general public). Submissions will be of specific preferred length (60, 90, or 120 minutes) and format (panel discussion or more hands-on participation by the audience). Please limit to no more than 4 presenters, and be sure to indicate preferred presentation length and format.

► For more information or to answer any questions before you submit your abstract, contact the **Research and Professional Development Chair researchanddevelopmentseminars@abct.org**

Submission deadline: ***February 7, 2023 3:00 a.m. EST***

Submissions will be accepted through the online submission portal, which will open after January 1, 2022. Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on "Convention and Continuing Education."

ABCT Election Results

President-Elect (2023–2024)

Steven A. Safren, Ph.D.

Representative-at-Large and Liaison to Membership Issues (2023–2026)

Colleen A. Sloan, Ph.D.

Learn More

about ABCT governance, history, mission:

ABCT.org > About ABCT

- ▶ Mission
- ▶ Bylaws
- ▶ Strategic Plan
- ▶ History of ABCT
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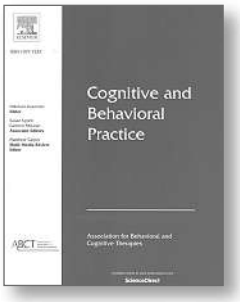
CALL FOR PAPERS | *Cognitive and Behavioral Practice*



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.

- ▶ **Manuscript submission portal:** https://www.editorialmanager.com/candbp
- ▶ **Deadline for Submissions:** February 2023

ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

Call for Applications

FELLOWS

ABCT Fellow Status for 2023

ABCT Fellows Class of 2022

Amanda Jensen-Doss, Ph.D.
Barry S. Lubetkin, Ph.D.
David C. Hodgins, Ph.D.
David W. Pantalone, Ph.D.
Kenneth E. Freedland, Ph.D.
Matthew D. Skinta, Ph.D.
Monnica T. Williams, Ph.D.
Thompson Elder Davis III, Ph.D.
Laura D. Seligman, Ph.D.

The ABCT Fellows committee is pleased to announce that 9 new members have been recognized. For a complete list of all Fellows, please see https://www.abct.org/membership/fellow-members/. This past year the Fellows Committee used the revised Fellows guidelines in selecting new Fellows. In brief, ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role. Because members' career paths come with unique opportunities, the committee was sensitive to the environment in which the potential applicant was functioning, and we weighed the contributions against the scope of the applicant's current or primary career.

Multiple Routes to ABCT Fellow Status

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

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

ABCT Fellows Committee

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

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

APPLICATION DEADLINE:
June 1, 2023

Deadline for Fellow Status Applications: June 1, 2023, is the deadline for both applicants and letter writers to submit their references. Applicants will be notified of the decision on their application by mid-October 2023. For more information, please visit the Fellowship application page **https://www.abct.org/Members/?m=mMembers&fa=Fellow**

the Behavior Therapist
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