

the Behavior Therapist

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PRESIDENT'S MESSAGE

Be the CHANGE (Leader)

*Jill Ehrenreich-May, University of
Miami*



AS BOTH President-Elect and now President of ABCT, I have concerned myself with the relative slowness with which things change in our organization. For example, even if members agree that prioritizing diversity, equity, inclusion, access, and justice (DEIAJ) in ABCT is a very worthy goal or a value they live by, how do we hasten the pace of goal-directed behavior in this domain within a professional organization such as ours? There are arguably a number of barriers to making meaningful changes in ABCT that one could address structurally, but as we await the feedback of BARE Mental Health and Wellness's mixed-method evaluation regarding our DEIAJ needs and recommendations for change, the ABCT Board of Directors advanced two new initiatives to address what we view as potential structural barriers to change in ABCT. One new program, the CHANGE (Challenging How ABCT Now Governs and Evolves) Leaders Program, is designed to both promote and sponsor diverse early career professionals, scholars, and students, as well as share ideas, dialogue, and decision-making between this group and ABCT leadership. We have also forwarded information about potential bylaws changes regarding who has the right to nominate and vote in ABCT elections to membership. I want to review each of these opportunities in turn and briefly highlight the ways in which each of these items might eventually modify our existent ABCT leadership and

[continued on p. 147]

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(212) 647-1890 | Fax: (212) 647-1865

Editor: Richard LeBeau

Editorial Assistant: Julia Yarrington

Associate Editors

RaeAnn Anderson

Trey Andrews

Lily Brown

Gregory Chasson

Amanda Chue

Nicholas Crimarco

Najwa Culver

Brian Feinstein

Resham Gellatly

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Membership & Marketing Manager:

Rachel Lamb

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| call for nominations |

ABCT's Champions of Evidence-Based Interventions

Submissions Open

2023 Champions Program

This award recognizes outstanding nonmembers and members who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT. Visit our website for details and nomination form: <https://www.abct.org/membership/abct-awards/abct-champions/>

Deadline for Submissions: May 1, 2023

INSTRUCTIONS for AUTHORS

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

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

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

structural organization to be more equitable and inclusive.

The CHANGE Leaders Program, led by Drs. Donte Bernard, Ana Bridges, and me, was spurred by a couple of inspirations, including successful career development programs in other organizations (e.g., Anxiety and Depression Association of America, etc.), such programs specifically for diverse students and early career professionals (e.g., Society for Child Clinical and Adolescent Psychology/Division 53 of APA, etc.), and reflections on the relative homogeneity of our existent leaders in ABCT. The current Board of Directors is composed, for example, of all White, cisgender women. And, while our ABCT central office staff, coordinators, and committees are slightly more diverse in their composition, there was a strong desire to craft solutions for the organization moving forward using an intersectional approach and to bring those with differing backgrounds and life experiences into “the room where it happens” (to quote Lin Manuel-Miranda) or where ABCT decisions are made.

So, what is the CHANGE Leaders Program? This is a new program aimed at engaging early career professionals, diverse scholars, and advanced students in a 2-year, co-governance activity with assigned leadership sponsors (similar to mentors that actively promote their assigned CHANGE Leader and their ideas) who have experience in ABCT leadership and are committed to supporting a new, more diverse generation of leaders. CHANGE Leaders will receive travel support to attend two consecutive ABCT conventions and will attend at least two Board meetings per year, meet regularly with their sponsor, and participate in monthly meetings with pro-

gram directors to help craft new ideas, gain feedback on existing programs and strategies, present their work, and support individual career development goals. Applications from ambitious terminal master's or doctoral students, early-stage investigators, or clinicians who identify as minority or historically excluded (e.g., by race, ethnicity, nationality, indigeneity, LGBTQIA+, first generation college graduate, neurodivergent, and/or those with disabilities), who are interested in clinical science, leadership opportunities, and making an impact on the future of ABCT, are currently being reviewed. We will announce the first cohort of CHANGE Leaders shortly.

Another approach to crafting a more diverse and engaged leadership for ABCT is to consider how we elect our Board of Directors. Currently, only a limited group of members (e.g., full members, fellow members, and new professional members) are eligible, per ABCT's bylaws, to nominate or vote for our elected leadership. This means that neither student members (graduate or undergraduate) nor associate or postbaccalaureate members can both nominate and vote for ABCT leadership. There have been several potential concerns raised about the exclusion of these groups from nominating and voting for ABCT leadership. The phrase “taxation without representation” has been used to reflect the idea that these currently nonvoting members are paying dues and attending our programming and convention at very high rates, and thus deserve a say in who leads the organization. Others have argued that interest and participation in ABCT elections has been at an all-time low, that the pool of nominees is insular and largely connected to powerful prior leaders of the

organization, and that, overall, nonvoting members are given relatively little agency to help craft the future of the organization to which they are paying dues, if they cannot vote. In November 2022, an ABCT Special Interest Group subcommittee conducted a survey of members regarding interest in changing voting rights. Of the 352 individuals who responded to this survey, 327 (92.9% of respondents) supported students being able to vote in ABCT elections. Thus, the Leadership and Elections Committee, led by Dr. Angela Fang, advanced a potential bylaws change to members for a 60-day comment period in February 2023. Comments were accepted through April 7, 2023. Leadership and Elections, along with the Board, will now consider these comments and determine whether to proceed with a vote on the proposed change to the bylaws.

Although these initiatives are only two initial steps toward structural change, there are several more being considered. We value your participation and feedback on these changes as we work to make ABCT a more inclusive and equitable space at a faster pace. You can use the feedback mechanisms cited above, use my ABCT Office Hours to speak with me directly, or contact me via email at j.ehrenreich@miami.edu to share your thoughts on these topics anytime.

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Correspondence to Jill Ehrenreich-May, Ph.D., University of Miami, 503 Almeria Ave., Miami, FL 33134-5703; j.ehrenreich@miami.edu

Updates on the 2023 ABCT Elections!

The Leadership and Elections Committee will be soliciting nominations for officers from June to September for President Elect, Secretary Treasurer, and Representative-at-Large and liaison to Convention and Education Issues. The election will be held November 1–30, 2023.

The June *tBT* will provide details on the process along with access to the nomination form. Keep in mind that we are working to enable students, postbaccalaureate, and associates to nominate candidates and vote in the ABCT annual election. Be on the lookout for a possible bylaws change in May!

What Is Happening at the ABCT Office

Mary Jane Eimer, *Executive Director*



WE HAVE SEVERAL staffing changes at the Central Office. First, we are delighted to welcome Ewan Johnson as our Senior Communications Manager. He is currently focused on a communications audit (internal and external) to provide insight on how we can improve our total communications with you, our membership. He has been working with our Social Networking Media Committee, Clinical Directory and Referral Issues Committee, Public Education and Media Dissemination and his ABCT colleagues. This will enable us to be more proactive in keeping you up-to-date on mental health observances, ABCT projects, and issues of interest.

We are pleased to inform you that Rachel Lamb has been promoted to our Membership and Marketing Manager. She will be working closely with our Special Interest Groups, membership retention and recruitment activities, running our webinars, and handling a multitude of other responsibilities.

Our newest hire is Maryilyn Brown, Administrative Secretary. Maryilyn's voice is most likely the one you will hear when you call the Central Office. She will be fielding multiple requests, and learning all aspects of ABCT operations.

Having new staff join our team is invigorating for all us. I hope you get the opportunity to know your staff. One way to make that happen is to serve on a committee. Please check our website under Professionals and Students and click on the Get Involved button.

Another way to get involved is to nominate colleagues. The Call for 2023 Champions is open with a May 1 deadline. See our website <https://www.abct.org/membership/abct-awards/abct-champions/> for a nominations form. It is a terrific way to give back to colleagues that have demonstrated exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and help advance the mission of ABCT.

Leadership and staff are gearing up for our triannual strategic planning retreat in early May. Current Board members and coordinators, along with our newly elected officers whose term begins this November and senior staff members will be reviewing our current strategic intent and will hear the report from BARE Mental Health and Wellness, our DEIJ consultants on how to make ABCT a more welcoming and responsive organization for our members.

ABCT is an active organization in the World Confederation of Cognitive and Behavioral Therapies. Member Keith Dobson is the current president who will be turning the gavel over to Lata McGinn this June. The mission for the "WCCBT is a global multidisciplinary organization dedicated to the promotion of health and well-being through the scientific development and implementation of evidence-based cognitive behavioral strategies designed to evaluate, prevent, and treat mental conditions and illnesses."

If you plan on attending the 10th World Congress of Cognitive and Behavioral Therapies over the dates of June 1-4, 2023 in Seoul, Korea, please be sure to stop by the ABCT booth. It will be a good gathering place to network with colleagues and meet new people. In addition to promoting ABCT, we will be serving as host for the 11th World Congress in San Francisco, CA over the dates of June 24-28, 2026.

Friendly reminder that ABCT has transitioned to forums and no longer has a list serve. Forums permit us to communicate and network with other ABCT members more easily. When you change your email address, it automatically is updated in our forums. Currently we have forums for general use, referrals, and job postings. Users of the ABCT forums will receive email notifications whenever a new thread is created and have the ability to subscribe to threads and receive email notifications whenever a new post is made on that thread. Users of the ABCT Forums will also have the ability to create new topics of discussion and message other ABCT members privately.

You can access the ABCT forums by visiting abct.org and clicking on ABCT

forums link, or by logging in to your ABCT account. If you have not already set up your ABCT forums profile, you will be prompted to do so. Our forums are an "opt in" option for members. Once that has been set up you will have complete access to the forums.

Please keep in mind that ABCT has many opportunities for members to get involved. If interested, please let me know. Members can also visit <https://www.abct.org/membership/get-involved/> to learn more about the work of our committees and how you can get involved. Although we just completed the Program Committee sign-up, we also need more members to assist us with membership, student membership, social media, and other areas of governance. Announcement for volunteers are made in tBT or on our forums. But always feel encouraged to let me know of your interest at mjeimer@abct.org

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Correspondence to Mary Jane Eimer, CAE, Association for Behavioral and Cognitive Therapies, 305 Seventh Ave., New York, NY 10001; mjeimer@abct.org

The Future of *the Behavior Therapist*: Results From a Survey of the ABCT Membership

Richard LeBeau, *Editor*

Gregory Chasson, *Associate Editor/Incoming Editor*

Shari Steinman, *Membership Issues Coordinator*

Stephanie Schwartz, *Managing Editor*

Julia Yarrington, *Editorial Assistant*

Susan White, *Publications Coordinator*

David Teisler, *Director of Publications*

Mary Jane Eimer, *Executive Director*

the Behavior Therapist (*tBT*) is a long-standing institution of the Association for Behavioral and Cognitive Therapies (ABCT). It was first published in 1978 under the editorship of Dr. Michael Cataldo. It is now in its 46th year. The history of the journal reaches back 12 years earlier to the very inception of our organization in 1966, back when ABCT was known as the Association for the Advancement of Behavioral Therapies (or AABT). That year, one of the organization's founders, Dr. Cyril Frank, began publishing an AABT newsletter that served as a precursor to the journal we know today.

tBT currently publishes 8 issues per year. Editors are appointed by the ABCT Board of Directors and typically serve a 3-year term. They in turn select an Associate Editorial Board and an Editorial Assistant who provide invaluable help in managing the journal. The journal has long been a critical tool for facilitating the exchange of information within our organization and one of the core benefits of being a member of ABCT. All ABCT members receive a hard copy of each issue of the journal in the mail. Additionally, access to the digital archive of the PDFs of past issues dating back to 2002 are freely available online.

One of the many unique aspects of *tBT* is that it is both a peer-reviewed scientific journal and an organizational newsletter. One of the benefits of this unique composition is that *tBT* has the flexibility to spotlight articles that are of great interest to the readership that are challenging to publish in other outlets. For example, the journal frequently publishes narrative literature reviews, open pilot trials, and commentaries related to clinical practice. *tBT* also prides itself on its inclusive nature and has

long provided opportunities for students and trainees to disseminate their work.

An effort to "modernize" *tBT* by transitioning it from hard copy format to online-only format has been occurring for many years. The primary impetus for this push is environmental, with many having noted the waste that goes into mass-producing and distributing a paper journal. However, there are additional benefits to transitioning to an online-only format, including cost savings for the organization, increased accessibility, and the addition of useful features not currently available (e.g., digital object identifiers, hyperlinks, search functions). Nevertheless, many members have been vocal about their desire to have the journal remain in its traditional hard copy format.

In early 2016, ABCT administered a survey that asked the ABCT membership to indicate their preference to retain the hard copy version or to move to an online-only version. The final decision was to retain the print version of *tBT*. A total of 377 individuals completed the survey. The vast majority of respondents indicated that they mostly read *tBT* in its print version (87.8%) as opposed to its PDF format on the web. A small majority (50.4%) said they would prefer *tBT* delivered in print versus on our website (5.0%) or as a downloadable PDF distributed via email (44.6%). A significant number of respondents (49.6%) indicated that they would be less likely to read *tBT* if it were in electronic-only format compared to the 14.9% who said they would be more likely to read it. The remainder (35.5%) said the amount they read *tBT* would be unchanged if it moved to an online-only format.

During the 6 years that have elapsed since the prior survey was administered, the ABCT membership has grown significantly in size and the calls for ABCT and other organizations to commit to environmentally conscious practices have intensified. Thus, the Editor of *tBT*, the ABCT Publications Committee, and the ABCT Central Office agreed that it was time to survey the membership again regarding this issue. The timing also coincides with an upcoming transition in *tBT* editorial leadership from Richard LeBeau (the current editor) to Greg Chasson (who will take over as Editor starting with the January 2024 issue).

Method

We used the previous survey that was administered to the membership in 2016 as a starting point. The survey was revised by a team that was comprised of the current *tBT* Editor (RL), the incoming *tBT* Editor (GC), the *tBT* Editorial Assistant (JY), the Coordinator of the ABCT Publications Committee (SW), the ABCT Publications Director (DT), the Membership Issues Coordinator (SS), and the ABCT Executive Director (MJE). The primary goals of revising the survey were to (1) update the information for accuracy, (2) revise wording for clarity, and (3) pare down the requested information for brevity.

The final survey comprised six items. The first four items asked respondents to report (1) their preference for transitioning *tBT* to online-only or retaining the current hard copy format (with supplemental PDF available online), (2) how they expect that a transition to an online-only format would impact the frequency with which they interact with *tBT*, (3) how much they interact with *tBT* in its current form, and (4) what types of articles they prefer reading in *tBT*. The fifth item asked for open-ended feedback about *tBT*. The sixth and final item asked respondents to identify their career stage, with options ranging from undergraduate to working professional. For the first item, we did not include a response option for transitioning *tBT* to online while simultaneously retaining the current hard copy format due to the financial and logistical barriers that renders this dual option infeasible for ABCT. In order to make the survey as brief as possible, we did not collect demographic information on the respondents.

The survey was administered via i4a Survey Builder. A link to the survey was emailed to the membership on 12/7/22.

Table 1. Impact of Transition on Readership

Impact of Transition to Online Format on Readership	N	%
Much More Likely to Read	116	19.6
Somewhat More Likely to Read	157	26.6
No Impact on Readership	128	21.7
Less Likely to Read	86	14.6
Much Less Likely to Read	104	17.6

Note. Percentages sum to 100.1% due to rounding.

Table 2. Current Interaction With *tBT*

Interaction With <i>tBT</i>	N	%
Read Every Issue	109	18.4
Read Multiple Articles Annually	173	29.3
Rarely Read Full Articles	249	42.1
Never Read	60	10.2

Additionally, the link to the survey was posted on the ABCT website, ABCT Forums, and ABCT's social media platforms. The survey was closed for new responses on 3/3/23.

Results

Sample

A total of 591 ABCT members completed the survey (approximately 13% of the current membership). The career stages of respondents were as follows: Full Professional ($n = 336$, 56.9%), Early Career Professional ($n = 96$, 16.2%), Graduate Student/Predoctoral Intern ($n = 95$, 16.1%), Undergraduate Student/Postbac ($n = 37$, 6.3%), and Postdoctoral Fellow ($n = 27$, 4.6%). This breakdown is fairly consistent with the career breakdown of career stage for current ABCT members: Professional: 51.1%; Early Career Professional: 12.2%; and Student: 36.7%.

Preferences Regarding *tBT* Format

Of the 591 respondents, 454 (76.8%) reported a preference for *tBT* to transition to an online-only format (HTML with interactive links), whereas 137 (23.2%) reported a preference to have it remain in print only with a supplemental PDF available for download on the ABCT website.

Impact of *tBT* Format Change on Readership

Despite the fact that the majority of respondents reported a preference for a transition to an online-only format, responses were mixed regarding how such a transition would impact their reading of *tBT*. See Table 1.

Current Degree of Interaction With *tBT*

We asked respondents to describe how they typically interact with *tBT*. Results were mixed, with about half the sample indicating frequent interaction with *tBT*

and about half endorsing little to no interaction with *tBT*. See Table 2.

Preferred Types of Articles in *tBT*

We asked respondents what types of articles they most enjoyed reading in *tBT*. A total of 508 respondents (86.0%) provided responses to this optional question. Respondents were allowed to select up to three types of articles. The article types most frequently were selected were articles presenting original research and review articles or commentaries regarding clinical practice, clinical training, and clinical science. See Table 3.

Additional Feedback Regarding *tBT*

At the end of the survey, respondents were provided the opportunity to provide open-ended feedback regarding *tBT*. Several respondents elaborated on their preference for a move to online-only (e.g., "It's environmentally irresponsible to continue with print," "searchability would be a big advantage," "a digital version is much more accessible to me as I can change font size, use text-to-speech, etc."). Others elaborated on their preference for remaining in print (e.g., "The APA Monitor went to electronic-only and I stopped reading it," "I proudly display [*tBT*] in my office for clients to see because it displays my values as a CBT provider," "research shows that we remember things we read in print better than online," "we tell our clients to minimize screens, let's do the same for ourselves!").

Several respondents endorsed support for a transition to an online-only format, but provided valuable feedback regarding how this should be handled. For example, a few respondents stated that they would like to ensure it is possible to download a PDF of an entire issue as opposed to having it only available in HTML format. Some requested that email alerts be sent out with

the link to each new issue and an easy-to-read table of contents. The importance of having the articles clearly archived on an easy-to-access website was also emphasized.

Additional feedback was provided about a variety of issues. Some requested transparency about how much money would be saved by a switch to online-only and what would be done with that savings. Some provided additional feedback regarding their preferred content, with respondents noting a desire for more articles about teaching, cultural diversity, the history of our field, and professional development. Others noted the importance of getting *tBT* indexed in major search engines (e.g., PsycINFO).

Discussion

tBT has been a mainstay of ABCT for nearly half a century and the ABCT Board of Directors and ABCT Central Office are committed to its continued success and longevity. There has been a significant push in recent years to "modernize" the journal by transitioning it to an online-only format and eliminating the hard copy versions that are mailed to members. This article presents on the results of a survey distributed to the ABCT membership that primarily focused on members' preference with respect to whether the journal should continue to be available in print or transition to an online-only format.

The survey had a large response rate, with nearly 600 people completing it. Although demographic data were not collected to reduce the time burden on respondents, career stage was ascertained and indicated that the survey was completed by a significant number of individuals at each career stage and that the breakdown of respondents' career stage was roughly consistent with the breakdown of

Table 3. Preferred Article Types

Preferred Article Type	N	%
Clinical Practice	316	62.2
Original Research	194	38.2
Clinical Training	176	34.6
Reviews of Scientific Research	152	29.9
Opinion Pieces from Members	109	21.5
Teaching and Mentorship	99	19.5
News	90	17.7
Updates from President and Board	75	14.7
Pieces by or for Undergraduate and Graduate Students	46	9.1

Note. This table presents responses to an optional question. As such, only a subset ($n = 508$) of respondents completed this question. Percentages do not total 100% because respondents were able to rank up to three preferred article types.

ABCT members' career stages. Nearly 90% of respondents indicated that they interact with *tBT* in its current form at least somewhat, although only half of the sample reported frequently engaging with the journal.

Results indicated a clear preference for moving the journal to an online-only format, with over three fourths of respondents endorsing the transition. This is a significant increase from the 2016 survey, when only one half of respondents endorsed the transition. While results were more mixed regarding how such a transition would impact the frequency of readership, two thirds of the respondents indicated that movement to an online-only format would have a positive or neutral impact on how frequently they read it. This was also a significant change from the 2016 survey, in which only one half of respondents indicated a positive or neutral impact of the transition on how much they would read *tBT*. When asked to identify their

favorite types of *tBT* articles, respondents most frequently cited articles about clinical practice, original research articles, articles related to clinical training, and articles that review scientific research.

The Future of tBT

In light of the strong preference for a transition to online-only format, the ABCT Publications Committee voted to initiate a transition of *tBT* to an online-only format. This change was subsequently approved by the ABCT Board of Directors. Specific details regarding the layout and distribution of the online version, as well as a timeline for its rollout, were

subsequently discussed by the committee that developed the survey. It is anticipated, but not yet confirmed, that the online-only version of *tBT* will launch in Fall 2023 and be available in both HMTL format with interactive links as well as downloadable PDFs.

We know that this news will be disappointing to some individuals who have enjoyed receiving the hard copies of *tBT* in the mail for many years. We will miss it, too. There were valid concerns about the transition to an online-only format, but we believe that many of them can be mitigated. For example, members will have the ability to download the online-only issues as a PDFs and print themselves if they wish to read it in hard copy format. Ultimately, we found the arguments for moving in line with the preferences of the vast majority of survey respondents and initiating a transition to online-only to be compelling. The transition will significantly reduce the carbon footprint of our organization

(which is of the utmost importance amidst the climate crisis), save ABCT significant amounts of money per year, optimize *tBT*'s searchability and dissemination potential, enhance its accessibility for individuals with different abilities (e.g., visual impairments), and significantly increase the flexibility of the publication schedule (which is currently constrained by frequent changes to mailing addresses, specifically for student members). Although it was not an easy decision, we felt it was the necessary one.

ABCT thoroughly appreciates the time and effort of all of those who completed the survey. The additional information provided by respondents is invaluable for facilitating key decisions about the rollout of the online-only format, as well as helping us determine the scope and content of *tBT* moving forward. Sharing the results of the survey and providing the rationale for the transition decision is consistent with ABCT's mission to increase transparency while also embodying the principles of evidence-based decision making.

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Richard LeBeau is at University of California, Los Angeles.

Gregory Chasson is at The University of Chicago.

Shari Steinman is at West Virginia University.

Julia Yarrington is at University of California, Los Angeles.

Susan White is at University of Alabama.

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

Correspondence to Richard LeBeau, Ph.D., Department of Psychology, University of California, Los Angeles, 1285 Franz Hall Box 951563, Los Angeles, CA 90095 rlebeau@ucla.edu

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Novel Assessment of Repetitive Negative Thinking During Exposure in OCD: Relationship to Symptom Cluster and Treatment Outcome

Kara N. Kelley, Jacob A. Nota, Sriramya Potluri, and Jason W. Krompinger, *McLean Hospital/Harvard Medical School*

REPETITIVE NEGATIVE thinking (RNT) refers to a category of thinking style that involves perseverative engagement with negatively valenced private experiences. Common examples of RNT include worry and rumination. Each has been variously defined. Worry tends to refer to a chain of thoughts and images that are “affect laden and relatively uncontrollable” and is often reported to function as a means of problem solving, coping with distress, or creating motivation (e.g., Dugas et al., 1998; Hebert et al., 2014). Rumination is often described as repetitive and passive focus on causes and consequences of symptoms and can be deployed as a means to gain understanding of or justification for current feelings of distress (Nolen-Hoeksema et al., 2008; Papageorgiou & Wells, 2001). Although these specific forms of RNT are traditionally studied in the context of particular disorders (generalized anxiety disorder [GAD] and major depressive disorder [MDD] for worry and rumination, respectively), RNT is increasingly acknowledged as a transdiagnostic process that underlies multiple other emotional disorders such as PTSD (Ehring et al., 2011); social anxiety disorder (Kashdan et al., 2014); and bipolar disorder (Johnson et al., 2008).

Although specific content and topography of RNT varies, a common function is that it serves to avoid unwanted inner experiences. Classic conceptualizations of worry by Borkovec and colleagues (cf. Borkovec et al., 2004) consider worry as a means to avoid distressing imagery by way of engagement in verbal processing of threats and feared outcomes. That is to say, it is more comfortable to engage in the cyclical, repetitive inner dialogue around “what if something bad happens to my child” than to passively allow contact with the images and sensations concomitant with the thought “something bad may happen to my child.” More recent studies posit that worry functions to avoid the experience of an emotional “contrast.” In this model, worry is deployed to prolong

negative affect to avoid an unexpected and unpleasant emotional “shift” that would occur in the event of a feared outcome (Newman & Llera, 2011). Rumination is similarly considered to serve avoidant functions. Individuals with positive beliefs about rumination report feeling as though they are gaining insight into their symptoms, feelings, and problems (Papageorgiou & Wells, 2001). Nolen-Hoeksema et al. (2008) posited that rumination can serve to build the case that a sufferer’s situation is hopeless, ostensibly stemming the tide of guilt and shame by justifying depressive behaviors such as withdrawal and isolation. Theoretically, rumination can be considered a maladaptive response to the difficult inner experiences that can arise in the context of goal-directed behavior (cf. Carver, 1996). Given that the promotion of goal-directed behavior is a core element of second- (behavioral activation; Jacobson et al., 2001) and third-wave (acceptance and commitment therapy; Hayes et al., 2012) CBT-based interventions, it is likely that the efficacy of these treatments is attributable to the extent that they break the negative reinforcement cycle that is perpetuated by the avoidant function of rumination.

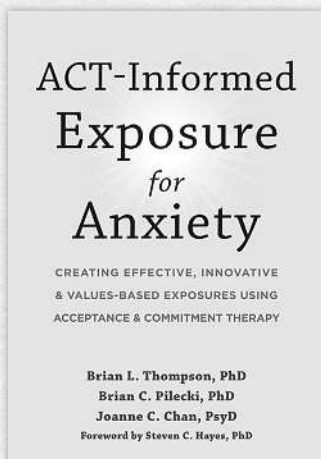
Obsessive-compulsive disorder (OCD) is characterized primarily by efforts to avoid difficult inner experiences. Specifically, individuals experience intrusive thoughts, images, and urges that are unwanted and distressing (i.e., obsessions) and engage in various overt and/or covert behaviors in order to avoid, eliminate, or control that distress (i.e., compulsions). Given the apparent transdiagnostic nature and avoidant functions of RNT, it stands to reason that the use of RNT is evident among those suffering from this disorder. However, relatively few studies have evaluated RNT in OCD to date. A study of the relationship between worry and OCD symptoms in an analogue sample found that individuals that were relatively high worriers experienced a greater degree of intrusive thoughts, provided that they were

also high on obsessive beliefs such as perfectionism, intolerance of uncertainty, and overestimation of threat (Fergus & Wu, 2010). Worry was also found to be strongly associated with such beliefs in a clinical sample (Calleo et al., 2010). With regard to rumination, Wahl and colleagues (2011) found that ruminative thinking style was strongly associated with obsessional thinking, even when controlling for depressive symptoms. They make the argument that rumination and obsessive thinking share “processual” features, including intrusiveness, repetitiveness, and difficulty to disengage. A more recent study found that rumination was uniquely associated with the “unacceptable thoughts” OCD symptom subtype in a sample of individuals seeking outpatient treatment for a variety of emotional disorders (Raines et al., 2017). While this evidence suggests RNT may be a risk factor in the development and maintenance of OCD, far less is known about how RNT impacts treatment outcome.

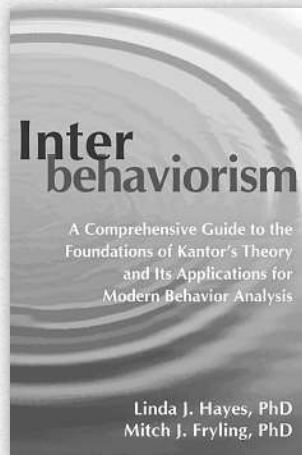
Exposure and response prevention (ERP) is the gold-standard cognitive-behavioral approach to treating OCD. Said succinctly, it involves facing one’s fears (exposure) and resisting efforts to eliminate contact with distress (i.e., rituals; response prevention). Rituals catalyze the negative reinforcement loop that maintains the disorder—their short-term “effectiveness” in reducing distress promotes their continued use in the face of obsessions—so heavy emphasis is placed on eliminating rituals in treatment to promote new learning. Given that RNT is thought to serve an avoidant function, it is possible that engagement in RNT during exposure therapy undermines this therapeutic process. Recent studies indicate that RNT plays an important role in predicting the course of cognitive-behavioral therapy across the depression and anxiety spectrum, insofar as change in RNT may serve as the mechanism for therapeutic efficacy (Kertz et al., 2015; Newby et al., 2014; Wadsworth et al., 2018). However, few studies to date have directly investigated the role of RNT in exposure therapy. One case study by Echiverri et al. (2011) illustrates the potential manner that RNT (in this case, rumination) can interfere with prolonged exposure (PE) for PTSD. In this case, the individual’s active engagement in ruminative responses to her traumatic memories, including persistent attempts to “understand” the trauma, were thought to interfere with her ability to allow for contact with the thoughts, images, sensations, and emotions tied to the memory in a manner

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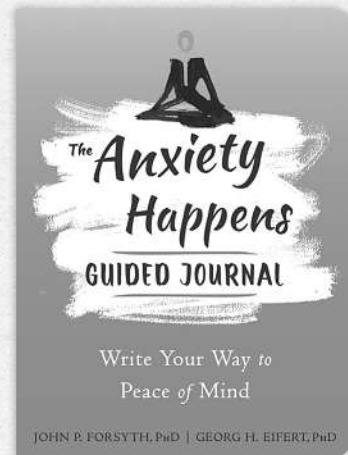
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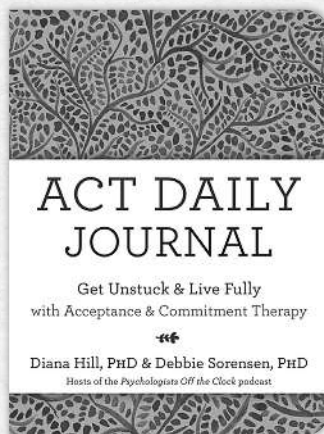
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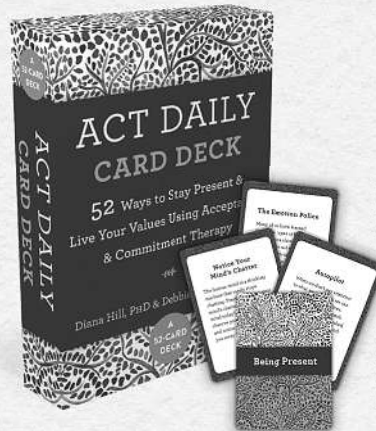
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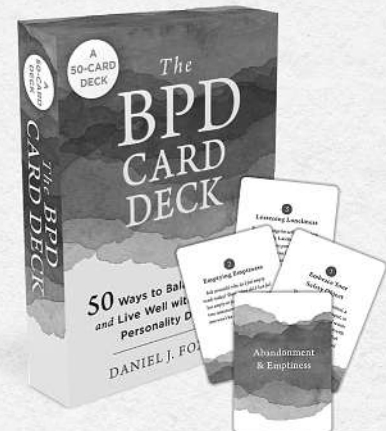
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Table 1. Descriptive Statistics ($n = 124$)

	<i>M(SD)</i>
Age	29.53 (10.75)
Age of Onset	11.98 (7.20)
	<i>N(%)</i>
Gender	
Male	65(52.4)
Female	57(46.0)
Other	2(1.6)
Ethnicity	
American Indian or Alaskan Native	2(1.6)
Asian	5(4.0)
Black	-
Latino/Latina	2(1.6)
Multiracial	2(1.6)
Native Hawaiian or Pacific Islander	-
White	98(79.0)
Not reported	15(12.1)

that would promote adaptive emotion processing. We know of no studies that have examined whether such a process may unfold for individuals undergoing ERP for OCD.

The current study serves three functions. The first is to develop and validate a measure of RNT in the context of treatment for OCD. The second is to examine the presence of RNT in a group of adults with OCD presenting to a residential OCD treatment facility. Given its transdiagnostic nature, we predict RNT to exhibit strong relationships with OCD symptom severity across the heterogeneous spectrum of OCD symptomatology. The third function is to evaluate whether RNT undermines ERP for OCD. We predicted that higher levels of RNT would indeed attenuate symptom change for individuals in our program, all of whom are undergoing intensive CBT. We predicted that such attenuations would be evident for each OCD symptom subtype (i.e., Contamination, Responsibility for Harm and Mistakes, Unacceptable Thoughts, and Symmetry/Incompleteness).

Method

Participants

Participants were recruited from an intensive/residential treatment program (IRT) for OCD and related disorders (the McLean Hospital OCD Institute; OCDI). This treatment program is based on princi-

ples of cognitive-behavioral therapy, with a focus on ERP. Each participant worked with a treatment team consisting of a psychiatrist, behavior therapist (doctoral-level and master's-level clinicians), and a family therapist (master's-level clinicians) who established idiographic treatment plans. Participants engaged in 4 hours of ERP per day (7 days per week) and received both individual and group therapy. The program has an average length of stay of 6 to 8 weeks, depending on clinical necessity and insurance coverage.

The total study sample consisted of 124 individuals. Informed consent was obtained from all participants included in the study, as approved by the Partners Institutional Review Board. This group was 46% female, 79% White, and had a mean age of 29.5 years ($SD = 10.75$). Demographic data for these individuals are provided in Table 1. The average length of stay from admission to discharge in this sample was 60.29 days ($SD = 21.90$).

Diagnostic criteria for OCD were assessed by the semistructured clinical interview for the DSM-5 (SCID-5; First et al., 2016). All diagnostic assessments were conducted within the first 2 weeks of treatment by trained research staff/practicum students under the supervision of a licensed clinical psychologist. Of this study sample, 89.5% met diagnostic criteria for OCD; the remaining 10.5% of participants did not complete a diagnostic assessment due to scheduling and time constraints.

These participants were assigned diagnoses by their program behavioral therapist.

Measures

Repetitive Responses to Exposure and Response Prevention Scale (RREPS; unpublished measure)

A common limitation in previous literature is the lack of a measure to assess RNT specific to OCD. While measures used to assess worry (Penn State Worry Questionnaire [PSWQ]; Meyer et al., 1990) and rumination (Ruminative Response Scale [RRS]; Nolen-Hoeksema, 1991) are long-established, these measures assess thinking styles as they relate to content that is commonly associated with GAD and MDD, respectively. The RRS, for example, asks respondents to consider ruminative responses specific to when they are sad, down, or depressed. There is not yet a measure that evaluates the initiation of RNT responses in the context of experiences relevant to OCD. We sought to address this gap in the literature by creating a measure of repetitive thinking that addresses the sort of content that individuals with OCD are more likely to perseverate on, in comparison to individuals with other mood and anxiety disorders.

We took several steps in order to assemble a measure of RNT in the context of OCD and exposure therapy. We drew inspiration from measures that capture both content-dependent and content-independent aspects of RNT. Specifically, we sought to capture maladaptive thinking responses to OCD/ERP-related affect, the cyclical and unproductive nature of the thinking style, and the extent that the thinking is intrusive and difficult to detach from.

In assessing maladaptive thinking responses to OCD/ERP-related affect, we took cues from the brooding subscale of the RRS. This scale is thought to capture the "moody pondering" aspect of rumination during which there is an ongoing, passive focus on self and depressive symptoms (cf. Treynor et al., 2003). We developed items that address brooding in response to OCD/exposure-relevant experiences (*I think a lot about what the experience means for the kind of person I am; I get stuck thinking I'm not feeling the right emotions*), rather than on depressive symptoms. This distinguishes our measure from previous measures based on content. We also drew inspiration from the Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) insofar as this measure assesses the use of RNT as a means of establishing problem



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Table 2. Factor Loadings of the RREPS with Varimax Rotation

Item	Factor 1 (Intolerance of Emotion)	Factor 2 (Brooding)	Factor 3 (Repetition)	Communalities
10	.82			.71
11	.81			.74
12	.74			.63
16	.70		.35	.66
9	.70	.45		.70
13	.69		.34	.64
8	.65	.59		.77
6	.62	.50		.64
20	.53			.40
3		.81		.76
7		.80		.67
1		.70	.32	.62
4		.61	.35	.55
5	.33	.55	.31	.50
2	.33	.52	.32	.48
14			.81	.70
15	.40	.31	.64	.66
18	.32	.39	.55	.56
Eigenvalue	8.8	1.6	1.1	
Total % of variance	48.7	8.6	5.9	

Note. Factor 1 included items 10, 11, 12, 16, 9, 13, 8, 6, 20; Factor 2 included items 3, 7, 1, 4, 5, 2; Factor 3 included items 14, 15, 18.

orientation (Dugas et al., 1995). We developed items that assess whether RNT is utilized to address the “problem” of whether or not the OCD/exposure-relevant experiences are appropriate to the situation (*It’s hard for me to focus because I can’t stop analyzing every emotion I feel*).

We took cues from the Perseverative Thinking Questionnaire (PTQ; Ehring et al., 2011) to address the cyclical and unproductive nature of RNT (*I keep replaying the same questions in my mind without finding an answer; I keep replaying past exposures*) and the extent that the thinking is intrusive and difficult to detach from (*I get stuck in my head so I can’t focus on what I’m doing; It’s hard for me to focus because I can’t stop analyzing how the ERP is going*).

The items were reviewed by clinicians with several years of experience working directly with individuals with OCD for the purposes of face and content validity. A total of 20 items were developed for use in the current study (see Appendix A). Items were rated on a 5-point scale: (5) *Always/Agree*, (3) *Sometimes/Neither agree nor disagree*, (1) *Never/Disagree*. High scores represent high RNT. Because we

were particularly interested in the extent to which RNT undermined exposure, we administered the RREPS during the third week of the participant’s stay at the OCDI, at which point the individual had had 3 weeks of exposure therapy.

Other Measures

Obsessive-compulsive symptom severity was assessed using the Yale-Brown Obsessive Compulsive Scale-Self Report (Y-BOCS-SR; Steketee et al., 1996). The Y-BOCS-SR is a 10-item self-report scale that measures overall severity associated with obsessions and compulsions over the past week. Items are rated on a scale from (0) *No symptoms or interference* to (4) *Extreme symptoms or interference*, with total scores ranging from 0 to 40. The Y-BOCS-SR has been found to have good psychometric properties, with a reported Cronbach’s α of .88 (Federici et al., 2010), and a moderate correlation with the clinician-administered version ($r = .64$). In the present study, the Y-BOCS-SR had strong internal consistency (admission: $\alpha = .85$; discharge: $\alpha = .92$).

The Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010)

was used to assess the severity of the four best-supported symptom dimensions: Contamination, Responsibility for Harm and Mistakes, Unacceptable Thoughts, and Symmetry/Incompleteness. The DOCS is a 20-item self-report questionnaire, each item rated on a scale ranging from (0) *No symptom* to (4) *Extreme symptoms*. The DOCS performs well on most indices of reliability and validity, with a reported Cronbach’s α of .90 (Abramowitz et al., 2010). In the current study, the DOCS demonstrated strong internal consistency (admission: $\alpha = .89$; discharge: $\alpha = .92$).

Depressive symptoms were assessed using the Hamilton Depression Scale (HAMD-6; Bech et al., 1981), a 6-item self-report measure of depression symptom severity over the past 3 days. Items are rated on a scale from (0) *Symptoms absent* to (4) *Extreme symptoms*, with total scores ranging from 0 to 22. The HAMD-6 has been shown to have good internal consistency, with Cronbach’s α ranging from .67–.8 (Bech, 2008). In the current study, internal consistency was strong for this measure (admission: $\alpha = .86$; discharge: $\alpha = .90$).

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The Ruminative Responses Scale (RRS; Nolen-Hoeksema, 1991) is a widely used self-report questionnaire designed to assess the tendency to demonstrate a ruminative response to depression. The RRS consists of 22 items rated on a scale from (1) *Almost never* to (4) *Almost always*. Total scores range from 22 to 88, with higher scores indicating greater ruminative symptoms. The RRS has been found to have good psychometric properties, with a reported Cronbach's α of .90 (Treynor et al., 2003). In the current study, internal consistency was high ($\alpha = .92$). The RRS was administered during the third week of treatment.

The Perseverative Thinking Questionnaire (PTQ; Ehring et al., 2011) is a self-report, content-independent measure of repetitive negative thinking. The PTQ consists of 15 items rated on a scale from (0) *Never* to (4) *Almost always*. Scores range from 0 to 60, with higher scores indicating a greater degree of RNT. The PTQ has demonstrated good reliability and validity in a clinical sample, with a reported Cronbach's α of .95 (Ehring et al.). In the current study, internal consistency was high for this measure ($\alpha = .93$). The PTQ was administered during the third week of treatment.

The Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) is a self-report assessment of worry. The PSWQ consists of 16 items rated on a 5-point Likert scale

from (1) *Not at all typical of me* to (5) *Very typical of me*, with total scores ranging from 16 to 80. Higher scores indicate a greater degree of worry. It has been shown to have good reliability and validity (Meyer et al., 1990). The PSWQ displayed good internal consistency in the current study (admission: $\alpha = .91$; discharge: $\alpha = .95$).

Statistical Analyses

SPSS 24 was used to conduct all statistical analyses. To investigate the construct validity of the RREPS, we performed a principal components analysis (PCA). We evaluated the internal consistency of each of the RREPS subscales generated by the PCA using Cronbach's alpha (Cronbach, 1951). We examined Pearson correlations among the RREPS and other established measures of RNT and OCD symptom severity in order to determine convergent validity. We expected the RREPS to be strongly correlated with purportedly convergent measures of RNT (i.e., r 's $> .50$). Furthermore, to explore whether the RREPS provides information about the relationship between OCD-specific RNT and symptom subtype severity at baseline beyond existing measures of RNT, we conducted a three-stage hierarchical regression. In predicting symptom subtype severity, we initially controlled for depression (HAM-D) and then convergent measures of RNT (PSWQ, RRS, and PTQ) before entering the RREPS.

Hierarchical regression analyses were also conducted to examine relations between the RREPS and changes in symptom severity from admission to discharge from the treatment program. A four-stage hierarchical regression analysis was used to test whether RREPS scores significantly predicted change in symptom subtype severity from admission to discharge. The HAM-D was entered at stage one of the regression to control for depressive symptoms; the Y-BOCS was entered at stage two to control for obsessive-compulsive symptoms at admission; preexisting RNT variables were entered at stage three, and the RREPS at stage four.

Results

Principal Components Analysis

Prior to analysis, the factorability of the 20 RREPS items was examined. All of the items correlated with at least one other item ($r = .3$ or greater). The Kaiser-Meyer-Olkin measure of sampling adequacy was .92, Bartlett's test of sphericity was significant, $\chi^2(153) = 1354.73$, $p < .01$, and the communalities were all above .3 (see Table 2). These indices suggested reasonable factorability; thus, a factor analysis was conducted with all 20 items.

A PCA using varimax rotation was completed to examine the factor structure of the initial 20 RREPS items. Results

Table 3. Correlation Matrix of the RREPS With Other Measures of RNT and Measures of OCD and Depression

	RREPS	PTQ	RRS	YBOCS O	YBOCS C	DOCS1	DOCS2	DOCS3	DOCS4	HAMD-6
PTQ	.72**									
RRS	.71**	.63**								
YBOCS O	.28**	.40**	.20*							
YBOCS C	.28**	.31**	.189	.65**						
DOCS1	-.07	-.07	-.01	.26**	.30**					
DOCS2	.18	.17	.05	.25**	.22*	.24*				
DOCS3	.26**	.33**	.00	.36**	.21*	-.05	.27**			
DOCS4	.12	.08	.23*	.24*	.26**	.23*	.26**	.14		
HAMD-6	.36**	.35**	.44**	.37**	.26**	.15	.18	.13	.20*	
PSWQ	.35**	.46**	.39**	.37**	.17	.13	.18	.15	.12	.36**

Note. RREPS = Repetitive Responses to Exposure and Response Prevention Scale; PTQ = Perseverative Thinking Questionnaire; RRS = Ruminative Responses Scale; YBOCS O = Yale-Brown Obsessive Compulsive Scale – Obsessions; YBOCS C = Yale-Brown Obsessive Compulsive Scale – Compulsion; DOCS1 = Dimensional Obsessive-Compulsive Scale – Contamination; DOCS2 = Dimensional Obsessive-Compulsive Scale – Responsibility for Harm and Mistakes; DOCS3 = Dimensional Obsessive-Compulsive Scale – Unacceptable Thoughts; DOCS4 = Dimensional Obsessive-Compulsive Scale – Symmetry/Incompleteness; HAMD-6 = Hamilton Depression Scale; PSWQ = Penn State Worry Questionnaire.

* $p < .05$ (2-tailed); ** $p < .01$ (2-tailed)

revealed three principal components with eigenvalues greater than 1; however, a number of items did not load significantly on any one factor (loading less than .6) and/or cross-loaded on multiple factors (with a difference of less than .15) between multiple loadings). After dropping non-loading and cross-loading items, 18 items remained. A subsequent PCA with varimax rotation was conducted on the remaining items. Results revealed a three-factor solution, which explained 63.22% of the total variance. The factors were labeled Intolerance of Emotion (9 items; e.g., *I get stuck thinking about how I shouldn't feel the way I do*), Brooding (6 items; e.g., *I think a lot about how I will never get better*), and Repetition (3 items; e.g., *I keep replaying past exposures over and over again in my mind*), accounting for 48.69%, 8.60%, and 5.92% of the variance respectively. The factor loading matrix for the final solution is presented in Table 2.

Internal Consistency

An examination of the reliability of the RREPS revealed strong internal consistency for the total scale ($\alpha = .94$), as well as adequate to strong internal consistencies among the three subscales (Intolerance of Emotion: $\alpha = .92$; Brooding: $\alpha = .86$; Repetitive: $\alpha = .73$).

Convergent Validity

We found that the RREPS largely related to existing measures of RNT in expected directions. Correlations between RREPS and other established measures of RNT are displayed in Table 3.

Cross-Sectional Analysis

A significant correlation, $r = .26$ ($p < .05$), was found between total RREPS scores and unacceptable thoughts symptoms (DOCS3). Results of the three-stage hierarchical regression model revealed that while the HAM-D did not contribute significantly to the regression model, the pre-existing RNT variables accounted for 19%

of the variability in DOCS3, and the change in R^2 was significant, $F(4, 103) = 5.911$, $p < .001$. The addition of the RREPS produced a 3.3% increase in the predictive capacity of the model, and this change in R^2 was significant, $F(5, 102) = 5.734$, $p < .05$. Together the five independent variables accounted for 22% of the variance in DOCS3 scores. Moreover, the RREPS was found to be a unique predictor of DOCS3 ($\beta = .290$, $p < .05$), such that increased rumination during ERP predicted increased unacceptable thoughts-based symptoms. The regression statistics are displayed in Table 4. No significant correlations were found between total RREPS scores and other OCD symptom dimensions (DOCS1, DOCS2, and DOCS4).

RREPS and Treatment Outcome

No relationships between total RREPS scores and raw YBOCS or DOCS changes were discovered. However, a significant correlation, $r = -.27$ ($p < .05$), was found between the largest RREPS factor, Intoler-

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Table 4. Summary of Hierarchical Regression Analysis for Variables Predicting DOCS3

	B	Std. Error	β	R ²	F Change
Model 1				.02	1.62
HAMD-6	.15	.12	.12		
Model 2				.19	7.25*
HAMD-6	.13	.12	.11		
PSWQ	.03	.11	.03		
RRS	-.20	.06	-.40*		
PTQ	.32	.07	.52*		
Model 3				.22	4.27*
HAMD-6	.12	.12	.10		
PSWQ	.04	.11	.04		
RRS	-.26	.07	-.52*		
PTQ	.24	.08	.38*		
RREPS	.12	.06	.29*		

Note. DOCS3 = Dimensional Obsessive-Compulsive Scale – Unacceptable Thoughts; HAMD-6 = Hamilton Depression Scale; PSWQ = Penn State Worry Questionnaire; RRS = Ruminative Responses Scale; PTQ = Perseverative Thinking Questionnaire; RREPS = Repetitive Responses to Exposure and Response Prevention Scale.

* $p < .05$

ance of Emotion (RREPS_IE) and contamination symptoms (DOCS1; see Table 5).

The four-stage hierarchical regression model was used to test whether RREPS_IE scores significantly predicted change in DOCS1 from admission to discharge. The regression statistics are displayed in Table 6. Results revealed that at stages one, two, and three, the HAM-D, Y-BOCS, and pre-existing RNT variables did not contribute significantly to the regression model. At stage four, introducing the RREPS_IE accounted for 14% of the variability in DOCS1 change scores, and the change in R^2 was significant, $F(6,91) = 2.466$, $p < .05$. RREPS_IE was found to be a unique predictor of change in DOCS1 ($\beta = -.346$, $p < .05$), such that increased RREPS_IE scores predicted attenuated change in contamination-related symptoms across treatment (see Figure 1).

Discussion

We set out to evaluate the extent to which RNT is related to OCD symptom dimensions and symptom change in a group of patients undergoing intensive ERP treatment. In doing so, we deemed it necessary to develop a novel measure of RNT related to symptoms and experiences associated with OCD. An exploratory factor analysis of our measure, the Repetitive Responses to ERP Scale (RREPS), yielded three principal factors, with the

largest representing items that reflected repetitive perseveration on elements of patients' inner experiences (i.e., Intolerance of Emotion). We found that our measure correlated with convergent measures of RNT, depression, and OCD symptom severity. Partially consistent with our hypothesis, we found that RNT, as measured by the RREPS, was significantly related only to the unacceptable thoughts symptom subtype when evaluated cross-sectionally. Also partially consistent with our hypotheses, we found that increased intolerance of emotion during ERP, as indicated by RREPS factor one scores, predicted attenuated change in contamination-related symptoms. These results provide evidence for the utility of evaluating and understanding RNT in OCD.

Cross-Sectional Relationship Between RNT and Unacceptable Thoughts

That RNT during ERP is particularly related to unacceptable thoughts speaks to the putative unique etiology and phenomenology of this symptom subtype. Unacceptable thoughts can include intrusive, violent, sexual, or blasphemous imagery and/or urges to act on related impulses. Lee and Kwon (2003) identified such thoughts as reflective of "autogenous" obsessions (i.e., experiences whereby the thoughts are seen as inherently threatening, and the evocation is less readily apparent), as distinguished from "reactive" obsessions that are

provoked by external stimuli and call for a clearly defined course of overt action (e.g., checking, washing). Prior studies find that these symptoms are related to higher beliefs concerning the importance of thoughts themselves and the importance of controlling thoughts (Lee & Kwon; Tolin et al., 2003). Further, autogenous obsessions were found to prompt efforts to engage in "avoidant control" strategies, which spanned the spectrum of mental rituals (i.e., thought-replacement, mental neutralization) but also included elements such as "worrying/thinking about other negative things, blaming, and self-punishment" (Lee & Kwon). RNT, then, may broadly be applicable to unacceptable thoughts, specifically, given that RNT may be more readily accessed by sufferers of these symptoms because of prevalent use of cognitive control strategies in this population. As mentioned before, RNT in this context may function to avoid contact with the content of the thought, perhaps by way of promoting engagement in verbal material vs. imagery. Further, RNT may be negatively reinforced by creating a relatively preferable inner experience among those with unacceptable thoughts. For example, an individual's intrusive thought (e.g., a thought about causing harm to a loved one) may bring about a sense of guilt. Engaging in RNT (e.g., thinking about what the experience means for the kind of person I am; I think a lot about how bad I

feel) may create a sense of self-punishment so as to allay those feelings of guilt and replace them with the sense that the sufferer is “aware of the problem” and is “working on it” or, at least, is appropriately despondent because of it.

Intolerance of Emotion and Treatment Outcome

Analyses of our novel measure indicated that 9 of the 20 initial items in the RREPS accounted for nearly half of the variance in respondents. Each of these items indicated an intolerance of emotion (I get stuck thinking that I shouldn’t feel the way that I do). Clinically, problematic relationships with emotions are at the heart of OCD, yet empirical investigations of this construct are still nascent. Recent evidence suggests that OCD symptom severity is concomitant with higher levels of anxiety sensitivity (for a review, see Robinson & Freeston, 2014), disgust propensity and sensitivity (Moretz & McKay, 2008; Olatjuni et al., 2007), and intolerance of distress (Laposa et al., 2015). Further, there is evidence suggesting that a sense of incompleteness (or “not just right experience” [NJRE]; cf. Coles et al., 2003) is a core precipitant of OCD symptoms over and above the oft-considered construct of harm avoidance (Taylor et al., 2014). Although the data are somewhat equivocal, there is evidence to suggest that experiential avoidance plays a role in the etiology and maintenance of OCD symptoms (Reumann et al., 2018; Wetterneck et al., 2014). The common thread running through each of these studies is an “antagonistic” relationship to particular feelings, such that the presence of the latter invites efforts to control and eliminate. That such feelings prompt repetitive thinking patterns and prolonged focus on them in OCD is consistent with experiential avoidance models of RNT. It further suggests that in a context that is ostensibly free of rituals (i.e., ERP), RNT may function in a similar manner and is utilized perhaps as a means to replace these compulsive behaviors.

We found that higher scores on the Intolerance of Emotion factor of the RREPS were associated with attenuated changes in contamination symptoms over the course of treatment. Although we do not know whether or not contamination symptoms were the primary target in any/all of the patients included in our sample, this finding does suggest that unaddressed RNT may limit the efficacy of contamination exposures. Some studies suggest that contamination-based OCD is

Table 5. Correlations of the RREPS Factor Scores With Other Measures of RNT and Measures of OCD and Depression

	Intolerance of Emotion	Brooding	Repetition
RREPS	.69**	.59**	.41**
PTQ	.50**	.38**	.38**
RRS	.54**	.41**	.24**
YBOCS O	.20*	.10	.20*
YBOCS C	.14	.19*	.17
DOCS1	-.27**	.16	.04
DOCS2	.14	.01	.18
DOCS3	.16	.14	.17
DOCS4	.08	.01	.14
HAMD-6	.24*	.30**	.03
PSWQ	.23*	.23*	.14

Note. RREPS = Repetitive Responses to Exposure and Response Prevention Scale; PTQ = Perseverative Thinking Questionnaire; RRS = Ruminative Responses Scale; YBOCS O = Yale-Brown Obsessive Compulsive Scale-Self Report – Obsessions; YBOCS C = Yale Brown Obsessive Compulsive Scale-Self Report – Compulsions; DOCS1 = Dimensional Obsessive-Compulsive Scale – Contamination; DOCS2 = Dimensional Obsessive-Compulsive Scale – Responsibility for Harm and Mistakes; DOCS3 = Dimensional Obsessive-Compulsive Scale – Unacceptable Thoughts; DOCS4 = Dimensional Obsessive-Compulsive Scale – Symmetry/Incompleteness; HAMD-6 = Hamilton Depression Scale; PSWQ = Penn State Worry Questionnaire.

* $p < .05$ (2-tailed); ** $p < .01$ (2-tailed)

perhaps the most common symptom subtype (e.g., McKay et al., 2004), and it is often used as a prototypical example of the disorder. Further, exposure-based approaches are shown to be particularly robust in addressing contamination (Abramowitz et al., 2003). These truths appear to precipitate the “clinical lore” that contamination-based OCD is a relatively straightforward presentation, and that simple application of exposure (e.g., deliberately coming into contact with contaminants, such as doorknobs and sink handles, cross-contaminating to person) and refraining from rituals (e.g., resisting hand-washes) should yield positive outcomes. Clinicians may assume that their patients will benefit from ERP, provided that they are nominally adhering to the overt elements of

treatment. Thus, it may be the case that relatively little time in treatment is spent addressing RNT, and potentially sabotaging effects thereof are dismissed as “treatment refractoriness.” For example, a patient who appears to be appropriately distressed during their contamination exposures may actually be “worrying

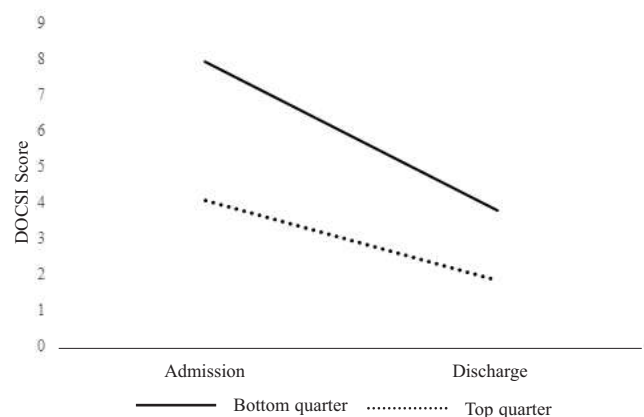


Figure 1. Quartile Split of High and Low RREPS Scores Predicting Change in Contamination Symptoms across Treatment

Note. DOCS1 = Dimensional Obsessive-Compulsive Scale – Contamination; Bottom quarter lowest 25% of scores on the Repetitive Responses to Exposure and Response Prevention Scale – Intolerance of Emotion; Top quarter highest 25% of scores on the Repetitive Responses to Exposure and Response Prevention Scale – Intolerance of Emotion.

through them” as opposed to allowing for the discomfort. This patient might be perseverating on potential consequences (“What if I get sick and die?” vs. “I could get sick and die”), which may keep embrace of uncertainty at arm’s length, potentially interfering with the development of new learning vis-à-vis tolerating perceived risk. Further study using a sample of patients with primary contamination symptoms undergoing ERP is necessary in order to investigate this possibility.

Contrary to our predictions, we found that increased RNT during ERP was not associated with changes in harm obsessions, unacceptable thoughts, or symmetry/exactness. It is perhaps the case that, in these conditions, ERP approaches are robust enough as they stand so as to withstand engagement in RNT. Alternatively, it may be that the nature of ERP “treatment as usual” might actually be addressing repetitive thinking, at least for some of these symptom subtypes. As it pertains to both harm obsessions and unacceptable thoughts, ERP typically involves developing an imaginal script to delineate intrusive thoughts, thus serving as the feared stimulus for the exercise and/or augmenting an in vivo exposure. For example, standard practice for an individual with fears of causing harm and associated checking

behaviors might include an exposure wherein one uses their stove, resists checking, then repeatedly reads through a script that details the manner by which their house will now burn to the ground given their “negligence.” Given that such exposures emphasize coming face to face with the prompting thoughts and resultant imagery, they may serve as a means to practice resisting RNT in and of themselves. Indeed, patients are often instructed to maintain focus on the source of fears during imaginal exposures, implicitly encouraging resistance to RNT.

Limitations and Future Directions

Study limitations warrant consideration. First, only 89.5% of the current sample were administered the SCID-5; while the remaining participants were assigned diagnosis by their program behavior therapist, primary diagnosis was not confirmed with comprehensive diagnostic assessment. Second, we assessed RNT at a single time point and not during ERP itself, and thus it is possible that patient responses were subject to the typical shortcomings of retrospective self-report methodology. It would be prudent for future studies to further investigate RNT as it unfolds during ERP. Use of methods such as ecological momentary assessment (EMA) would allow us to better capture

this process as it is happening. Further, this approach may put us in a position to better assess and comment on the putative function of RNT. Although ostensibly functioning in a ritualistic (i.e., distress reducing/controlling) manner, we did not assess levels of distress before and after RNT in the current study. Additionally, the current study identified relationships between RNT and specific OCD symptoms, but did not group patients based on primary symptoms. The DOCS is a useful measure in that it treats OCD symptom subtypes as dimensions on which all patients vary to some extent, but there is not a means to identify primary symptoms (i.e., most contributing to functional impairment). Because we did not create a means to identify this, nor did we ask about specific exposure types (in vivo, imaginal, etc.), we are limited in the specificity with which we can comment on the effect of RNT for specific symptom subtypes. That is to say, although we have evidence that intolerance of emotion interferes with improvement in contamination symptoms, we did not evaluate this in a group of patients reporting primary contamination concerns. A future study that evaluates RNT using EMA in the context of exposures for groups of patients reflecting each of the commonly observed symptom sub-

Table 6. Summary of Hierarchical Regression Analysis for Variables Predicting Change in DOCS1

	B	Std. Error	β	R ²	F Change
Model 1				.01	.44
HAMD-6	.05	.08	.07		
Model 2				.02	1.31
HAMD-6	.02	.08	.03		
Y-BOCS	.09	.08	.12		
Model 3				.06	1.23
HAMD-6	.05	.09	.07		
Y-BOCS	.12	.08	.17		
PSWQ	.06	.08	.08		
RRS	-.02	.04	-.07		
PTQ	-.07	.06	-.19		
Model 4				.14	8.87*
HAMD-6	.04	.09	.05		
Y-BOCS	.13	.08	.18		
PSWQ	.06	.08	.09		
RRS	.02	.04	.05		
PTQ	-.04	.05	-.10		
RREPS_IE	-1.41	.47	-.35*		

Note. DOCS1 = Dimensional Obsessive-Compulsive Scale – Contamination; HAMD-6 = Hamilton Depression Scale; Y-BOCS = Yale-Brown Obsessive Compulsive Scale-Self Report; PSWQ = Penn State Worry Questionnaire; RRS = Ruminative Responses Scale; PTQ = Perseverative Thinking Questionnaire; RREPS_IE = Repetitive Responses to Exposure and Response Prevention Scale – Intolerance of Emotion.

* $p < .05$

types would address these limitations and further our understanding of this process. Finally, the demographic variability in our sample was limited, with 79% identifying as White, thus limiting the generalizability of these findings to more diverse samples.

Conclusions

We found that RNT related to exposure for OCD (as assessed by our novel measure, the RREPS) accounts for variability in OCD symptoms and treatment outcome over and above existing measures of RNT. Initial evidence suggests that RNT could theoretically undermine treatment, thus resulting in cases deemed “refractory.” Treatment approaches that incorporate interventions targeting RNT directly may unlock the potential of exposure therapy for those who have not benefited, furthering the reach of this powerful intervention.

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Appendix A

Repetitive Responses to Exposure and Response Prevention Scale (RREPS)

1	2	3	4	5
Never disagree		Sometimes Neither agree nor disagree		Always agree

During exposures do you...

1. I think a lot about how I will never get better
2. My mind goes back and forth a lot about how the treatment is not or may not be working
3. I think a lot about how bad I feel
4. I think a lot about bad things that have happened to me
5. I get so stuck in my head that I can't focus on what I am doing
6. I'm thinking a lot about why I feel the way I do
7. I often think "Why is this happening to me?"
8. I often think "Why do I feel like this?"
9. I get stuck thinking about how I shouldn't feel the way I do
10. I get stuck thinking that I'm not feeling the right emotions
11. I often wonder what the meaning is of my emotions
12. I think a lot about why I reacted the way that I did
13. I think a lot about what my experience means for the kind of person I am
14. I keep replaying past exposures over and over again in my mind
15. I keep replaying the same questions in my mind without finding an answer
16. It's hard for me to focus because I overanalyze every emotion I feel
17. It's hard for me to focus because I can't stop analyzing how the ERP is going*
18. It's hard for me to stay present because I can't stop thinking through things that happened earlier
19. I spend a lot of time wondering why this is so hard for me*
20. I am so in my head that I feel detached/numb

* Item dropped for final analyses

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Kara N. Kelley is now at the Department of Psychology, American University, Washington DC.

Jason W. Krompinger is now at the New England Center for OCD and Anxiety, Cambridge MA.

Sriramya Potluri is now at the Department of Psychology, University of Massachusetts Boston.

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Correspondence to Kara N. Kelley, 4400 Massachusetts Avenue NW, Washington DC 20016; kk7071a@student.american.edu



FACT SHEETS

New
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Treating Race-Based Traumatic Stress

Race-based traumatic stress (RBTs) is a significant source of psychological distress for those who are Black, indigenous, or people of color (BIPOC). Yet, many individuals from BIPOC communities are reluctant to seek professional help for this distress. The reasons for this reluctance are numerous and include an overall lack of cultural sensitivity in mental health services provided to the BIPOC community, as well as low numbers of mental health professionals who are also people of color. . . .

► **Download** <https://www.abct.org/fact-sheets/race-based-traumatic-stress-rbts/>

CLINICAL PRACTICE FORUM

LGBTQ+ Stress and Trauma Within the DSM-5: A Case Study Adaptation of the UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS)

Jenna M. Wolff, RaeAnn Anderson, and Katya Mickelson, *University of North Dakota*

THE PINK TRIANGLE marker of death during the Holocaust, the Stonewall Inn discriminatory, violent police raid that sparked protests for gay rights, Harvey Milk's murder for his sexuality, and the murder of Matthew Shepard in 1998 represent only a few of the heinous attacks against LGBTQ+ people. In 2020, more than 1 in 3 individuals and 75% of LGBTQ+ youth experienced some form of discrimination (Mahowald et al., 2020; Trevor Project, 2021). According to the FBI, approximately 20% of hate crimes in the United States are against the LGBTQ+ community (FBI, 2019). These are staggering statistics, considering 7.1% of adults in the United States identify as LGBTQ+ (Jones, 2022).

As the LGBTQ+ community continues to fight for equality, health professionals have an ethical and moral obligation to serve as allies to provide optimal care. Historically, the field of psychology has both advocated for and opposed LGBTQ+ rights. Clinicians and researchers in psychology should strive to provide inclusive, sensitive, and evidence-based mental

health care and assessment to the LGBTQ+ population rather than putting the onus on clients to educate their providers. The goal of this article is to promote affirmative clinical care for LGBTQ+ individuals via a case example of how trauma-focused assessment can be adapted to LGBTQ+ specific needs.

Discrimination and Inadequate Care

The LGBTQ+ population often experiences discrimination in healthcare, such as barriers to routine medical services and insurance and lack of cultural competency in providers (Alizaga et al., 2021; Whittington et al., 2020). Between 40% to 50% of transgender and gender-nonbinary individuals reported verbal harassment, physical assault, or denial of medical care in healthcare settings (Bauer et al., 2014; Shires & Jaffee, 2015). As many as 1 in 5 transgender and gender nonbinary individuals reported educating their healthcare provider about their medical needs (Bradford et al., 2013). Twice as many LGBTQ+ individuals compared to heterosexual individuals reported dissatisfaction with

mental health services, usually due to provider discrimination disrespect and failure to consider the client's goals in therapy (Avery et al., 2001; Israel et al., 2008).

Trauma-Related Care Needs

Identifying as LGBTQ+ has been associated with higher rates of victimization throughout life compared to those with a heterosexual identity, including sexual assault, physical assault, and abuse during childhood (Balsam et al., 2005). The rate of violent crime victimization for the LGBTQ+ population was 71.1 victimizations per 1,000 people, while the rate for the non-LGBTQ+ population was 19.2 victimizations per 1,000 people (Flores et al., 2020). According to the Centers for Disease Control and Prevention National Intimate Partner and Sexual Violence Survey, 26% of gay men and 37% of bisexual men have experienced rape, physical violence, or stalking by an intimate partner compared to 29% of heterosexual men (Black et al., 2011). Forty-four percent of lesbian women and 61% of bisexual women have experienced rape, physical violence, or stalking by an intimate partner compared to 35% of heterosexual women (Black et al.). Nearly half of bisexual women who experienced rape in their lifetime reported the first rape occurring between ages 11 and 17 (James et al., 2016).

Given the high rates of trauma, violence, and abuse, trauma-related care needs are high. As such, LGBTQ+ individuals are 1.5 times more likely to meet criteria for a diagnosis of depression, anxiety, or substance use disorder and two times more likely to have a history of suicide attempts compared to cisgender heterosexual peers

(King et al., 2008; Rutherford et al., 2021). Further, 18%–45% of transgender individuals meet criteria for PTSD compared to approximately 10% of the general population (Barr et al., 2021; Reisner et al., 2016).

In 1981, Virginia Brooks published a book titled *Minority Stress and Lesbian Women*, introducing a multilevel model of how sources of financial, cultural, and social stress contribute to sexual minority women's mental and physical health. Later, Brooks's sexual minority stress theory was applied to sexual minority men (Meyer, 1995) and gender diverse populations (Hendricks & Testa, 2012). Meyer (2003) elaborated on Brooks's work by emphasizing how chronic stress, stigma, and the accumulation of discriminatory experiences associated with living in a predominantly cisgender, heteronormative culture contribute to negative mental health outcomes for LGBTQ+ individuals. This distress is commonly manifested as trauma symptoms (Alessi et al., 2013; Coker et al., 2010; Keating & Muller, 2020; Russell & Fish, 2016). Many standard trauma and PTSD assessment approaches may not capture the unique experiences of repeated discrimination and identity-related harassment. However, some organizations employ a broad definition of trauma. The American Psychological Association (2013) and Substance Abuse and Mental Health Services Administration (2014) define trauma as a direct or observed event that threatens one's physical or psychological safety, produces feelings of anxiety and helplessness, and jeopardizes functioning and well-being. Trauma has also been defined as an event or series of events that threaten one's sense of control, autonomy, self-esteem, and safety (Ellis, 2020; Williams et al., 2018). However, the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines trauma as experiencing, witnessing, learning about, or continuous "exposure to actual or threatened death, serious injury, sexual violence" (APA, 2013). Under this definition, discriminatory experiences do not meet DSM-5 criteria for trauma or qualify for a PTSD diagnosis unless they result in tangible injury, threats, or violence. Yet, common discriminatory experiences, such as threats of being outed (i.e., unwanted disclosure of one's sexual orientation), can result in direct harm. For example, approximately one-third of LGBTQ+ youth have become homeless, been kicked out of their family's home, or run away from home after disclosing their LGBTQ+ identity (Morton et al., 2018;

Trevor Project, 2021). The current definition of trauma in the DSM-5 maintains a narrow perspective of trauma and stressful experiences that significantly impact the LGBTQ+ population and other marginalized groups.

Existing Trauma Assessment for the LGBTQ+ Population

Thorough assessment of LGBTQ+ clients' trauma history, including discussion about discriminatory and nonaffirmative experiences, is essential for a comprehensive understanding of trauma. Case conceptualization lacking this intersectionally informed, contextual information likely provides an inadequate picture of the client's experiences and symptomology regardless of the diagnostic model (Richmond et al., 2012, 2017).

Livingston and colleagues (2020) reviewed existing evidence-based self-report assessments for trauma, PTSD, and related symptoms. They found none of the commonly used measures to assess PTSD symptoms in relation to discrimination or trauma that may arise as a result of marginalized identities, such as race, ethnicity, sexuality, or gender identity. One remarkable exception is a semistructured interview tool developed by Williams and colleagues (2018) called the UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS). The UnRESTS can be used to promote discussion about racial identity, racial trauma, and discrimination and evaluate whether a PTSD diagnosis is warranted based on experiences related to a traumatizing event, institutional racism or barriers to treatment, invalidation, overt and covert racism, and cultural trauma. Currently, the LGBTQ+ equivalent of the UnRESTS, a tool for assessing racial trauma and discrimination, does not exist. Thus, given the available tools and strengths of the UnRESTS, we adapted the UnRESTS to assess experiences related to gender identity and sexuality in this case study of a young, transgender, queer woman seeking services related to ADHD, mood, and substance use concerns.

Case Study and Methods

Clinic Setting

The client received services at a training clinic in the upper Midwest for students earning graduate degrees in counseling psychology, clinical psychology, and communication science. Nearly all providers in the clinic are student clinicians who receive supervision from a licensed professional.

Because of the rural nature of the upper Midwest, clients may travel long distances to seek help for a diverse range of presenting problems. In 2021, the clinic served 486 children and adults for speech-language pathology, audiology, individual therapy, group therapy, family and couples therapy, and psychological assessments.

Referral Question

The client identified as a White, working class, homoflexible and demisexual transgender woman in early adulthood. The client initially sought mental health intervention at a local private practice clinic to address feelings of anxiety, sadness, and financial stress, worsened by furlough due to the COVID-19 pandemic. The client reported she was in a monogamous relationship with her girlfriend. The client's girlfriend identified as polyamorous and was married to her husband. Later, the client identified her relationship as consensual nonmonogamy. The client resides with her girlfriend, her girlfriend's husband, and her girlfriend's two biological children. Due to quarantine and requirement to stay indoors, the client reported heightened levels of sadness and anxiety related to spending more time at home and witnessing romantic interactions between her girlfriend and her girlfriend's husband. The client reported she would often yell, cry, and shake when experiencing elevated sadness and anxiety, which occurred at least three times per week over the previous 3 months. She explained these symptoms increased strain in her relationship. She reported difficulty regulating emotions and self-soothing, stating that time alone with her girlfriend typically calmed her. The client transferred care to the training clinic to maintain consistency with her primary therapist. In late 2021, the student therapist and client collaboratively sought further diagnostic assessment for ADHD and symptoms related to mood and suicidality. The student assessor and student therapist shared a supervisor, a licensed psychologist, and collaborated in gathering collateral information and completing a thorough diagnostic assessment.

Background

The client self-identified as a woman with pronouns she/her/hers, acknowledging most heteronormative cisgender individuals would identify her as transgender. Sexual orientation was self-identified as homoflexible and demisexual, explaining that she is mostly attracted to women and

requires an emotional connection prior to sexual attraction. She reported experiencing gender-identity-related stress starting in early childhood, explaining she felt societal pressure as a child to fit into a stereotypical male gender role (e.g., mock fighting, playing with toys made for boys). She began questioning her gender identity in early adulthood during college and began transitioning shortly thereafter. The client participates in feminizing hormone therapy and has had a vasectomy. Although the client reported desire for further gender affirmation procedures, she reported financial barriers hindering current plans for these procedures.

The client reported a largely happy childhood in the rural Midwest with her mother, father, and two brothers. Throughout childhood, the client and her family belonged to the Lutheran faith. Her father remained heavily involved in the faith, and the client indicated he expressed sadness when she left the religion in young

adulthood. She reported a close relationship with her mother and younger brother and positive relationship with her family; she stated her family has supported her LGBTQ+ identities and gender transition. She reported earning high grades throughout school and took medication for ADHD until graduation of high school. She reported a history of bullying during elementary and middle school, which mostly abated during high school. She detailed a history of difficulty in higher education, as she experienced difficulty concentrating, depressive episodes, and alcohol dependence while maintaining high-achieving expectations for herself. The client had difficulty maintaining coursework and discontinued higher education; although the client returned to higher education multiple times, she did not obtain a degree.

During the client's experiences in higher education, she was in a relationship with a previous girlfriend, during which the client experienced emotional abuse and

became dependent on alcohol. After this relationship ended, the client became sober and began a polyamorous relationship with her current girlfriend and girlfriend's husband. This relationship soon shifted to a consensual nonmonogamous relationship with the client in a monogamous relationship with her girlfriend, while her girlfriend remained committed to the client and her husband. The client explained she has a nonparental role with the children (e.g., does not provide discipline, is not involved with their education) and has no plans to have biological children.

The client reported she enjoys her full-time job working in a managerial position at a technology company, and often works 40 to 50 hours per week. She would like to stay at the company and expand her role in the company.

Over the last 10 years, the client reported prior mental health interventions for suicidal ideation and historical diagnoses of depression and anxiety. She also



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reported previous individual therapy for body dysmorphia, which was a possible misdiagnosis prior to transitioning. The client was also seeing a psychiatrist for medication management of psychological symptoms for ADHD, sleep disturbance, anxiety, and depression.

Assessment

Over the course of eight sessions, the student assessor completed a thorough assessment for presence and severity of ADHD symptoms as well as a differential diagnosis for symptoms unaccounted for by an ADHD diagnosis. The assessment battery included psychosocial background, the UnRESTS, the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2016), and neurocognitive testing. The UnRESTS and DIAMOND were part of the supervisor's standard intake, while the personality and neurocognitive testing battery was selected for this particular client. Data are summarized in Table 2.

Adaptation of the UnRESTS to Assess LGBTQ+ Specific Trauma

To assess discrimination and stigmatizing experiences related to ethnic and racial identity, the student clinician administered the UnRESTS (Williams et al., 2018). The measure begins with questions regarding the client's racial and ethnic identities to better understand the context of racism and discrimination. The second section of the UnRESTS evaluates the client's socialization to race and ethnicity. This allowed the clinician to better understand the context of the client's identification with the larger group. The following sections of the measure evaluate explicit and overt racism, racism experienced by loved ones, vicarious experiences with racism, and covert racism and microaggressions. The final section of the UnRESTS, based on DSM-5 criteria and the PTSD Symptom Scale–Interview for DSM-5 (PSSI-5; Foa et al., 2016), is similar to a symptom checklist evaluating whether the client is experiencing PTSD symptoms related to racist and discriminatory experiences. The client reported identification as White and denied experiences of discrimination or trauma related to race.

After first discussing racial identity, the student assessor repeated the interview and adapted the tool to evaluate discriminatory and stressful experiences related to the client's self-identified gender and sexual orientation. See Table 1 for example items from a modified UnRESTS. The client

reported that her experience of gender dysphoria and transition to womanhood “has been a constant stressor” for as long as she could remember. She endorsed stress and discrimination related to both her sexual identity and her gender identity. The client reported feeling distressed that people treat her girlfriend poorly because of the client's transgender identity. She indicated salient conflict with her girlfriend's mother, who reportedly treats both the client and the client's girlfriend poorly due to their LGBTQ+ identities. Additionally, the client reported that many acquaintances and friends from adolescence now ignore her due to her gender and sexual orientation. The client reported uncertainty about whether these painful experiences were due to reactions to her gender or sexual orientation, highlighting the complexity of their intersectionality. Based on the client's responses, symptoms did not meet PTSD criteria. However, the interview allowed the client and student assessor to engage in conversation about the client's identities, intersectionality, and challenging experiences related to these identities.

Diagnostic Assessment

Upon intake, the client also completed the DIAMOND (Tolin et al., 2016), endorsing two-thirds of the possible items, suggesting high distress. Nine interview modules were administered based on the most salient reported symptoms. Based on these diagnostic interviews, the client met DSM-5 criteria for ADHD, generalized anxiety disorder (GAD), major depressive disorder (MDD), and moderate risk for suicide. The client did not meet DSM-5 criteria for obsessive-compulsive disorder (OCD), manic or hypomanic episodes, hallucinations, binge eating disorder, or body dysmorphia (Tolin et al.).

Self-report questionnaires were also administered to assess the severity of the diagnoses identified (see Table 2). Finally, trauma history questionnaires were administered as part of the supervisor's standard intake. Scores on the *Childhood Trauma Questionnaire* (Bernstein & Fink, 1998) suggested minimal to no history of child maltreatment, consistent with report (Bernstein & Fink). On the *Life Events Checklist* (Weathers et al., 2013) the client endorsed multiple adult victimization experiences, including a history of multiple unwanted sexual experiences in adulthood; one of these experiences she chose to report to the police. The client also reported a physical assault during adolescence (Weathers et al.).

Personality Assessment

Due to the complexity of the client's experiences, high distress, varied symptomology, and collateral information from her therapist, the client also completed the *Millon Clinical Multiaxial Inventory*, 4th Edition (MCMI-IV; Millon et al., 2015), and *State-Trait Anger Expression Inventory*, 2nd Edition (STAXI-2; Spielberger, 1999). Consistent with observation, self-report, and collateral information, the STAXI-2 suggested feelings of anger due to current circumstances rather than temperament, suggesting the client may frequently express this anger verbally in the form of criticism, sarcasm, and profanity. The MCMI-IV suggested the client endorsed items related to feelings of emptiness, impulsiveness, self-criticism, depressive cognitions and feelings, uncertainty about self-identity, inner conflict, and behavior that may lead to greater conflict.

As the collected data was suggestive of borderline personality disorder, the client completed the self-report *Borderline Symptom List-23* (BSL-23; Bohus et al., 2009) and the *McLean Screening Instrument* (MSI-BPD; Zanarini et al., 2003). BSL-23 score was 0.7, exceeding the cut point of 0.64 to differentiate between controls and individuals who likely meet criteria for borderline personality disorder (BPD). MSI-BPD score was 7, meeting the cut point of 7, suggesting the client likely meets criteria for BPD. The client endorsed a pattern of interpersonal difficulties, deliberate self-harm, chronic suicidality and a past suicide attempt, impulsivity (e.g., substance use, verbal outbursts), extreme moodiness, frequent feelings of anger, dissociation, and chronic feelings of emptiness (Bohus et al.; Zanarini et al.).

Neurocognitive Assessment

The client completed a series of standardized cognitive assessments (see Table 2). The battery suggested the client demonstrated exceptional intellectual and memory skills, although performance was significantly poorer on tasks involving working memory. *Wechsler Adult Intelligence Scale*, 4th Edition (WAIS-IV; Wechsler, 2008) and *Wechsler Memory Scale*, 4th Edition (WMS-IV; Wechsler, 2009) scores were consistent with previously identified profiles of individuals with ADHD, such as a 10-point difference between General Ability Index (GAI) and Full Scale Intelligence Quotient (FSIQ) as well as significant weaknesses in the *Arithmetic and Digit Span* subtests (Theiling &

Petermann, 2014). Data suggested minimal-to-no difficulty in executive function tasks (e.g., planning, response inhibition, cognitive flexibility).

Self-report psychodiagnostic tests included the *Conners' Adult ADHD Rating Scale – Self-Report: Long Version* (CAARS – S:L; Conners et al., 1999) and *Barkley Deficits in Executive Functioning Scale Short-Form: Self-Report* (BDEFS-SF: Self-Report; Barkley, 2011). Data suggested likely difficulty with inattention, memory, hyperactivity, impulsivity, self-concept, emotional lability, self-management, and organization.

Collateral Information

Collateral information was collected from the client's psychiatrist, therapist, and girlfriend. Her psychiatrist suggested an appropriate diagnosis may be bipolar disorder, reporting a history of interpersonal difficulty, variable compliance with medication instructions, and periods of impulsivity and activation. The client's therapist reported information consistent with the client's history and self-report. More specifically, the clinician reported chronic interpersonal and intrapsychic instability, emotional lability, and chronic feelings of emptiness, suggesting borderline personality disorder. Additionally, the clinician supported the client's reports of discriminatory experiences and trauma related to the client's LGBTQ+ identities. Per clinician report, the client was in the early stages of remission for alcohol use disorder. Last, the client's girlfriend completed the *Conners' Adult ADHD Rating Scale Observer-Report: Long Version* (CAARS–O:L; Conners et al., 1999), indicating presence of ADHD symptoms.

Case Conceptualization

The client was referred for assessment in late 2021 for ADHD, anxiety, depressed mood, and suicidality. The client was diagnosed with ADHD in early childhood and discontinued medication for ADHD symptoms in late adolescence. Depressed mood episodes, anxiety, difficulty concentrating, academic-related impairment, and alcohol dependency began in early adulthood, which corresponded with beginning higher education and a romantic relationship in which the client experienced emotional abuse. After this relationship ended, the client began a romantic relationship with her current girlfriend and her husband, which shifted into a consensual non-monogamous relationship. Depressive symptoms, anxiety, and attentional diffi-

culties continued interfering with work performance and her romantic relationship, which prompted the client to seek professional intervention.

The client's identity as a homoflexible, demisexual, transgender woman in a consensual monogamous relationship challenges Western culture's heteronormative and cisgender norms. Further, the client worked in a male-dominated workplace. Unfortunately, the client reported discrimination and microaggressions related to the client's gender identity, relationship orientation, and sexuality throughout her lifetime. These experiences created a pattern of chronic invalidation beginning in early childhood of the client's innermost experiences and identity, which is a key causative factor of later borderline personality symptomology (Linehan, 1993; Sloan et al., 2017). The client's family and current friends have been supportive of her identities and relationship orientation, which has served as a significant protective factor for this client.

Socially, the client typically engaged with others in a friendly and confident manner; however, she reported feeling frustrated with herself due to interrupting others frequently. Additionally, the client appeared to have difficulty expressing emotional, physical, and social needs in romantic relationships. The client typically placed loved ones' needs before her own. When problems arose in personal relationships, the client typically engaged in self-blame, increasing depressive symptoms, withdrawal, and cravings to drink alcohol. The client reported difficulty navigating her role as a nonparental figure to her girlfriend's children, as she often disagreed with her girlfriend's and husband's parenting style and discipline practices. She reported that her relationship with her girlfriend's husband became strained over time. She reported feeling tasks at home and income were not fairly distributed across adults in the household, as she provided primary income for the five-person family unit.

Financial stress increased during the pandemic, and the client began working over 50 hours per week. The client experienced work-related exhaustion and burnout. She reported difficulty maintaining her physical and mental health and felt she was unable to fully engage in her relationship with her girlfriend. Consequently, conflict increased within their relationship. To cope with relationship strain, the client avoided being home and worked more hours at work, creating a cyclical pattern of

burnout, relationship conflict, and depressive and anxiety symptoms. The client typically blamed herself for problems in the relationship. The client endorsed negative cognitions about self (e.g., I am a failure; I must try harder to fix the problem) and the world (e.g., The system is hopeless). She reported feelings of intense anger, self-hatred, and periods of emotional numbness. She was unable to engage in future-oriented thinking and identify personal values and beliefs.

Despite the client's reported symptoms and stressors, the client maintained a strong sense of humor and positive beliefs about others (e.g., People generally have good intentions). The client reported a strong support system including family members, her girlfriend, and coworkers. She enjoyed engaging in hobbies, such as cooking and art. She looked forward to beginning new projects at work and furthering her position in the company. She maintained an open and hopeful perspective regarding therapy and learning new skills.

Based on information gathered during the assessment process and consultation with the student clinician's supervisor, the following diagnoses best fit the client's symptomology: ADHD, combined presentation; BPD; MDD, moderate severity, recurrent episodes; and alcohol use disorder in early remission. Prognosis was favorable, considering the client was highly engaged in previous therapy and open to learning new skills.

Feedback and Treatment Plan

Assessment closed with a feedback session to discuss results, diagnoses, and future treatment with the client. First, psychoeducation was provided regarding the client's diagnoses. The client reported feeling understood and relieved, as she was finding answers to long-held questions (e.g., appropriate mental health diagnoses). The client was advised to revisit her psychiatrist for possible prescription medication changes due to assessment findings. Dialectical behavior therapy (DBT) was recommended, as DBT is particularly effective for BPD (Linehan, 2015). Last, affirmative care using the ESTEEM model was encouraged to promote positive cognitions about her trans and homoflexible identity (Burton et al., 2017). The client expressed openness and hopefulness regarding the recommended treatment plan, expressing a desire to begin DBT soon thereafter.

Table 1. Example Items From Adaptation of the UnRESTS to Assess Gender and Sexual Identity Related Trauma and Discrimination

Item	Interview Questions	Guide for Interviewer
A	Introduction to the Interview (Total: 2 items)	
A1	Sometimes people have very bad experiences that cause feelings of stress or even trauma. Some people have several difficult experiences over a lifetime that are manageable individually, but together they lead to feelings of stress or trauma. I want to talk to you about some of your experiences of stress or trauma as it relates to your gender or sexual identity. <i>How would you describe your gender? How would you describe your sexual identity?</i> ¹	Note the difference between <i>gender</i> and <i>sexual identity</i> .
B	Gender and Sexual Identity Development (Total: 7 items)	
B1	Are there other <i>gender identities</i> or <i>sexualities</i> that people assume you belong to based on your appearance?	
B2	When was the first time you became aware of <i>gender</i> or <i>sexuality</i> ? When was the first time you remember feeling different, excluded, or singled out because of your apparent <i>gender</i> or <i>sexual identity</i> ?	
B3	What sort of things, positive or negative, did you learn about your <i>gender</i> or <i>sexual identity</i> growing up?	E.g., messages from parents, peer-groups, media, stereotypes, etc.
B4	I want to understand a bit more about how you feel about being a(n) [<i>gender</i> or <i>sexuality</i>] person. 2. Would you say that you have a lot of pride in being a [<i>gender</i> or <i>sexuality</i>] person and your accomplishments as a [<i>gender</i> or <i>sexuality</i>] person? Very much (2) – Somewhat (1) – No (0) 5. Would you say that you think a lot about how life is affected by your <i>gender</i> and/or <i>sexual identity</i> ? Very much (2) – Somewhat (1) – No (0)	Assess for feelings of pride, stigma, and shame. Get an example for each item. Gender & Sexual Identity Total Score: _____
C	Experiences of Direct Overt Discrimination (Total: 14 items)	
C1	Can you share with me a time you were <i>discriminated against because of your gender</i> or <i>sexual identity</i> ? This could be something someone else either said or did to you. I am especially interested in any experiences where you were concerned about your safety and the event was very upsetting. <i>Prompt if needed: What about being called names, being followed, harassed at work or school, etc.?</i>	
C2	How old were you when this happened?	
C3	What led you to believe this event happened due to your <i>gender</i> or <i>sexual identity</i> ?	
C4	How upset were you by this experience? Are you still upset by it?	Assess for feelings of anger, depression, anxiety, etc.
C5	Did you fear for your life, health, or safety? How?	
C6	How did you cope with this experience?	Determine if experience was a trauma.
C7	How did other important people in your life respond when you told them about this?	Assess for adaptive versus maladaptive coping strategies. Assess for availability and use of support system.

—Table continued on next page—

Table 1 continued

F		Experiences of Covert Discrimination (Total: 7 items)	
F1	Often minorities are the target of subtle or covert discrimination in the form of what we sometimes call "microaggressions." Microaggressions may be seemingly innocent comments, subtle or dismissive gestures, and tones that send condescending messages. How often would you say that you experience microaggressions based on <i>gender or sexual identity</i> ?		
F2	Can you give me a recent example?		
F3	Can you give another example?		
F7	Have you experienced any changes in your ability to manage microaggressions?		
G		Gender & Sexual Identity Trauma Assessment (Total 25 items)	
		Negative Changes in Cognition & Mood (Need 2 for PTSD diagnosis – count only 1 from #9 and/or #10)	
G10 a	Have you blamed yourself for your discriminatory experiences, or for things that have happened afterwards due to <i>discrimination based on gender or sexual identity</i> ?		Yes No

¹Italicized words indicate edits or additions to the original UnRESTS.

Discussion

Clinical standards in inclusive practice have changed rapidly in recent decades. In February 2021, the American Psychological Association (APA) published updated guidelines for providing competent care for sexual minority individuals, building on prior publications and resources (APA, 2021). There are separate guidelines on working with transgender and gender non-conforming individuals (APA, 2015). These guidelines are based on the theoretical frameworks of sexual minority stress theory, intersectionality, and affirmative care, all to address the unique needs of the LGBTQ+ population (Meyer, 2003; Crenshaw, 1989; Moradi & Budget, 2018). Considering the APA guidelines, the current responsibility of clinicians is to reduce stigma within clinical settings and to open conversations about LGBTQ+ stressors and trauma. This study attempted to bridge the gap between the APA guidelines and cognitive-behavioral therapies specifically, especially the need for culturally sensitive, evidence-based assessment and intervention. This study explored how the UnRESTS could be used to assess trauma specific to LGBTQ+ lived experiences. The client's self-report and our case conceptualization suggest this was a helpful and affirmative approach.

Consistent with extant literature and research, our client endorsed experiencing harassment and discrimination related to her LGBTQ+ identities despite having both a supportive family and social relationships. Although reported symptoms did not meet criteria for PTSD, understanding her experiences of discrimination and harassment was key to developing the case conceptualization and accurate diagnosis of BPD. The biosocial model of BPD (Burrock & Mellor, 2013; Lee et al., 2021) suggests that a chronically invalidating environment may promote symptoms relating to traumatic stress and personality disorders in conjunction with a biological sensitivity. For this client, the chronically invalidating environment was not the home, but the culture. This client reported multiple instances of bullying, abuse, and assault related to her sexual and gender minority identities, starting in childhood. While her home environment was healthy, it could not fully protect her from the stress of a world that saw and continues to see her as "other," an invalidating experience in itself. This is consistent with the minority stress model and epidemiological data investigating disparities in borderline diagnoses. Specifically, minority stress and associated rejection sensitivity would understandably increase emotion regulation needs and subsequent struggles with relationships

and impulsivity. Further, given heteronormativity and structural stigma, these responses would be an understandable reaction to chronic invalidation of LGBTQ+ identity. We wholeheartedly concur with Rodriguez-Seijas et al. (2021) that these symptoms should be conceptualized as "expectable reactions to chronic stigma." Thus, we also recommend providers use structured interviews to assess borderline personality symptoms and transdiagnostic approaches, such as the alternative model of personality disorders, which better characterize the distinct, trait-like personality features associated with BPD (e.g., negative affectivity, disinhibition). Structured interviews are less subject to provider bias compared to information that may be elicited during an unstructured interview (Rodriguez-Seijas et al.). When working with a minoritized person, additional tools should be used to help evaluate the possible range of experiences on presenting symptoms. For example, in this study, the UnRESTS was used to evaluate experiences of trauma and discrimination; but, there are other self-report tools, such as the *Everyday Discrimination Scale* (Williams et al., 1997) and *Gender Minority Stress and Resilience Scale* (Testa et al., 2015). Understanding connectedness to marginalized communities can also help provide important context for developing

case conceptualization and identifying sources of strength. Information from these additional sources can help providers better understand the complex interaction between the chronic invalidation experienced by the LGBTQ+ community and symptoms that may be related to other biopsychosocial factors.

Continued efforts to adapt the UnRESTS should be done collaboratively with additional clinical expertise, research, and consultation. This team-based approach should focus on refining the items included in the UnRESTS and collecting normative data. The UnRESTS was somewhat challenging to adapt in order to address intersectionality. The client experienced both sexual and gender minoritized identities. We attempted to inquire about these identities side-by-side rather than rank-ordered and considered separately, but it is unclear if we were successful. We chose this approach to be consistent with the spirit of intersectionality, especially since it may be nearly impossible for some individuals to conclusively identify an experience of trauma or discrimination as related to only one aspect of their identity.

For example, if this client was overlooked for a promotion in a male-dominated workplace, it is plausible that discrimination against the client's gender identity, sexual identity, relationship orientation, or a combination of these identities may have contributed. Further, requiring the client to sort these experiences could be emotionally invalidating, as this client, like many others, experiences multiple identities as a whole person in one integrated experience. This approach is also consistent with the findings from Salomaa and colleagues' work (2002) that, for the minoritized person, the difference between identity-based trauma and other experiences of trauma is minimal, as both experiences of trauma were perceived through a minority stress lens. This challenge highlighted one of the issues in conducting evaluations for individuals with multiple minoritized identities. Assuming one element of a client's identity as having precedence over another can be inherently invalidating, thus promoting the nonaffirming environment many clients initially find distressing. However, we recognize that from a precise, scientific perspective, providers would ide-

ally evaluate experiences related to each discrete identity. Future work should focus on how to capture a multitude of minoritized identities rather than focusing on one at the exclusion of others.

Conclusion

In conclusion, this case study demonstrates the importance of assessing LGBTQ-related trauma and discrimination in order to conduct an integrative case conceptualization. By intentionally asking questions about trauma and discrimination commonly experienced by LGBTQ+ individuals, this client felt better understood, validated, and supported. Additionally, investigating how the cultural climate created a chronically invalidating experience for this client was critical to diagnosis of BPD, as many providers misunderstand that abuse or trauma during childhood is a prerequisite for meeting criteria. It is essential to consider identities of clients and potential trauma-related symptoms, despite the limited definition of trauma according to current diagnostic standards. Otherwise, this client's experience of trauma and discrimination related to her

Table 2. Selected Assessment Data

Domain or Construct	Assessment	Score	Interpretation
Psychopathology	DIAMOND	Screened positive for 2/3 of conditions; met criteria for ADHD, GAD, and MDD	High distress with notable ADHD, anxiety, and depression symptoms
	Beck Depression Inventory	24	Moderate depression
	Dissociation Experiences Measure, Oxford	Numb/Disconnected subscale = 20	Moderate symptoms
	BSL 23	Mean 0.70	Moderate severity symptoms
	McLean	7	Possible borderline personality disorder
	STAXI	State Anger – 80th percentile Trait Anger – 25th percentile	Significant lability of anger
	Conners	Self-report percentile ranks: 95-99th Observer percentile ranks: 76-98th	Significant inattention (2 SDs above the mean)
	Barkley	Total Score 96th percentile	Significant inattention (2 SDs above the mean)
Personality	MCMI	Scale C = BR 81 Scale 2B = BR 83 Scale 3 = BR 81 Scale 2A = BR 80 Scale 8A = BR 78 Scale 8B = BR 77	Significant elevations on borderline, melancholic, dependent, avoidant, negativistic, and masochistic scales
Cognition	WAIS	FSIQ = 99th percentile General ability = 99th percentile Working memory index = 50th percentile	Superior FSIQ, average working memory
	DKEFS	Trail-making, Scaled score 13-15 Tower, Scaled scores 4-13	Significant inattention (2 SDs above the mean)

LGBTQ+ identities would have likely been overlooked.

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Correspondence to Jenna Wolff, 501 N Columbia Rd Stop 8380, Grand Forks, ND 58202-8380; j.wolff@und.edu (or RaeAnn Anderson: raeann.anderson@und.edu).

Treating Misophonia in a Naturalistic Setting: A Case Series Report

Rachel A. Schwartz and Lily A. Brown, *University of Pennsylvania*

MISOPHONIA is a disorder characterized by intense anger, disgust, or anxiety in response to specific sounds. Common misophonic triggers include oral sounds (e.g., chewing, swallowing), nasal sounds (e.g., sniffing, breathing), and sounds produced by inanimate objects (e.g., clock, keyboard; Schwartz et al., 2011), though recent evidence suggests that triggers often include visual in addition to auditory stimuli (e.g., sight of food; Swedo et al., 2022). Although not yet recognized in the DSM-5 (APA, 2013), some suggest that misophonia should be classified as an obsessive-compulsive (OC) spectrum disorder due to shared clinical features (e.g., preoccupation with an intrusive stimulus, sensory overresponsivity, behavioral strategies to reduce distress) and as half of individuals with misophonia also display OC symptomatology—particularly OC personality (Cusack et al., 2018; Guetta et al., 2022; Schröder et al., 2013).

Although misophonia appears to be prevalent (affecting 6–20% of individuals; Ferrer-Torres & Giménez-Llort, 2022) and very functionally impairing (Cavanna & Seri, 2015; Jager et al., 2020), research into this disorder is in its infancy. As the bulk of extant research has focused on phenomenology, little is known about how to treat misophonia. To date, only one randomized controlled trial (RCT) has been conducted on misophonia. This trial found that, compared to a waitlist control, a group cognitive-behavioral therapy (CBT) protocol consisting of psychoeducation, attention retraining, positive affect labeling, misophonic stimulus manipulation (via computer software), relaxation training, and reevaluating (eating) norms produced better improvement (Jager et al., 2021). However, there are no RCTs that used an active control or evaluated an individual therapy protocol.

Given the paucity of evidence and absence of treatment guidelines for misophonia, how misophonia is treated in real-world settings remains an open question. Specifically, it is unclear what kind and dose of treatment clinicians elect to deliver, whether patients find such interventions

acceptable and credible, and whether these treatments produce positive outcomes. Moreover, given the dearth of treatment studies in this population, limited cross-sectional data are available for clinical or treatment-seeking samples. This prevents a clear understanding of the significance of misophonia among treatment-seeking individuals.

This study aims to use data from a naturalistic treatment setting to address gaps in knowledge about treatment-seeking and response in patients with misophonia. We present three adult cases who entered into treatment for misophonia at an anxiety and obsessive-compulsive specialty clinic as a preliminary step toward understanding: (a) treatment-seeking patients' clinical presentation, functional impairment, and prior psychiatric treatment utilization, (b) how clinicians elect to treat misophonia when patients present in real-world clinical settings, and (c) treatment trajectories and outcomes in these settings. Exploring the uncontrolled efficacy of treatments delivered at a specific clinic can lay the groundwork for future controlled treatment development and evaluation research. Moreover, examining treatment outcomes in the context of an anxiety and OCD specialty clinic may be particularly informative, given the open question as to whether misophonia should be classified and treated as an OC-spectrum disorder (Ferrer-Torres & Giménez-Llort, 2022).

Method

Participants and Setting

The Center for the Treatment and Study of Anxiety (CTSA) is an outpatient, fee-for-service clinic in Philadelphia that specializes in cognitive-behavioral treatments for anxiety, obsessive-compulsive, and trauma disorders. To identify patients who entered into treatment for misophonia, a search of all available data in REDCap (a secure online database used to collect patient data; Harris et al., 2009) was conducted in July 2022, such that records for all adult patients who contacted the CTSA between December 2014–June 2022

were searched using the following search terms: *misophon**, *misaphon** (common misspelling), *noise*, and *chew*. After removing false positives and patients who did not initiate treatment or consent to research, this search yielded 7 patients. Of these, 3 patients entered into treatment where misophonia was the primary focus; these patients represent the focus of the present report. All 3 patients were seen by different doctoral-level clinicians (two women, one man).

Patient 1 was a White man in his early-40s who held a bachelor's degree and worked full-time. His primary misophonic trigger was S-sounds, particularly when articulated by women. **Patient 2** was a mid-20s, White man who held a bachelor's degree and worked full-time. Primary misophonic triggers included chewing and associated noises (e.g., silverware clanking, other mouth sounds). **Patient 3** was a Black woman in her mid-30s who had earned an associate's degree and was a full-time student. Her misophonia symptoms were primarily triggered by loud or ambient noises (e.g., airplanes, radio, others speaking on the phone). All three patients were single/never married and non-Hispanic.

Procedure

Study participants completed the clinic's normal procedures, which included a brief (20–30 minute) phone screen with a research assistant, followed by a 2-hour intake evaluation using a structured diagnostic interview (DIAMOND or MINI; Sheehan et al., 1998; Tolin et al., 2016) by a master's- or doctoral-level clinician to assess appropriateness for the clinic. Exclusion criteria for the clinic included: having a primary diagnosis other than an anxiety or related disorder, active suicidality, unmanaged psychosis or mania, evidence of intellectual disability, and active substance dependence. Participants provided informed consent during the intake evaluation. All study procedures were approved by the Institutional Review Board at the University of Pennsylvania.

Self-Report Measures (Patient-Reported)

As part of standard clinic procedures, a battery of validated self-report measures was administered using REDCap at the intake evaluation, mid-treatment (roughly corresponding to Week 14 after the baseline evaluation), and posttreatment (roughly corresponding to 24 weeks after the baseline evaluation, or when the patient terminated, whichever came first). Mea-

sures included (see Table 1 for interpretation guidelines): Anxiety Sensitivity Index (ASI; Peterson & Reiss, 1992), which measures the degree of fear associated with physiological aspects of anxiety; Beck Depression Inventory (BDI-II; Beck et al., 1996), a measure of depressive symptom severity; Insomnia Severity Index (ISI; Bastien et al., 2001), which assesses the severity of sleep-onset and maintenance insomnia; Obsessive-Compulsive Inventory (OCI-R; Foa et al., 2002), a measure of the presence and severity of OCD symptoms; and Sheehan Disability Scale (SDS; Sheehan, 1983), a measure of social, family, and vocational impairment. The intake battery also included questions about demographic information and prior psychiatric treatment.

Once treatment had initiated, at the second session patients were also prompted to complete the Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000) and Working Alliance Inventory (WAI; Tracey & Kokotovic, 1989) to assess (a) perceived credibility of treatment and expectations of improvement, and (b) the strength of the therapeutic alliance, respectively.

Treatment Data (Therapist-Reported)

A week prior to patients' mid- and post-treatment assessment points, clinicians were asked to fill out a brief questionnaire describing features of the treatment, including primary diagnosis treated, treatment protocol used, number of sessions attended, and treatment outcome.

Results

Clinical Characteristics at Baseline

Only Patient 3 was given a comorbid psychiatric diagnosis (secondary OCD) at the intake evaluation, while misophonia was the sole diagnosis for the other two patients. As reported in Table 1, at the start of treatment Patient 1 was characterized by high levels of functional impairment (particularly in the social domain), moderate depression, subthreshold levels of OCD and insomnia, and low levels of anxiety sensitivity. Patient 2 was characterized by low levels of functional impairment and anxiety sensitivity, as well as minimal symptoms of depression, OCD, and insomnia. Patient 3 did not provide complete baseline data but scored a 1 on the BDI-II and a 13 on the OCI-R. Two of three patients endorsed a history of trauma (Patients 1, 3) and one (Patient 1) reported a history of self-injurious behaviors. Two

of three reported no suicidal ideation (SI) at intake, with Patient 1 endorsing passive SI on the BDI-II. No patients reported a history of suicide attempts or psychiatric hospitalizations.

Prior Treatment Utilization

Prior to contacting the CTSA, Patient 1 had received both psychotherapy and psychotropic medications and Patient 3 had received psychotherapy only, whereas Patient 2 had never received psychiatric care of any kind. Only Patient 1 was taking psychotropic medications at intake and reported having previously pursued treatment for misophonia, specifically from two different psychiatrists: one who provided medication management only (meeting every other month) and the other providing both medication management and talk therapy (meeting 4–6 times a year). When asked to rate how helpful these interventions had been (from 1 = *completely unhelpful* to 7 = *extremely helpful*), the patient rated both courses of treatment as a 6 (indicating high levels of perceived helpfulness). None reported a history of CBT for misophonia, anxiety, or OCD.

CTSA Treatment and Outcome

Referral Source

Two patients were referred to the CTSA by another mental health provider, with

Table 1. Pre-, Mid-, and Posttreatment Clinical Data for Three Patients Who Entered Treatment for Misophonia

Measure	Patient 1			Patient 2			Interpretation
	Baseline	Mid	Post	Baseline	Mid	Post	
SDS Total	24	17	4	6	1	0	0-30 (higher = more functionally impaired)
SDS-Work	7	2	1	0	0	0	0-10 (higher = more occupationally impaired)
SDS-Social	10	10	2	2	0	0	0-10 (higher = more socially impaired)
SDS-Family	7	5	1	4	1	0	0-10 (higher = more family-role impaired)
ASI	22	33	24	7	2	1	Anxiety sensitivity: 0-17 = almost none; 18-35 = low; 36-53 = moderate; 54-72 = high
BDI-II	27	26	3	1	0	0	Depression severity: 0-13 = minimal; 14-19 = mild; 20-28 = moderate; 29-63 = severe; diagnostic cutoff = 17
ISI	9	6	4	2	1	1	Insomnia severity: 0-7 = none; 8-14 = sub-threshold; 15-21 = moderate; 22-28 = severe; and probable diagnostic cutoff = 10
OCI-R	16	20	14	4	2	0	OCD severity: 0-72 (higher = more symptoms; probable diagnostic cutoff = 21)

Note. All measures are self-report. SDS = Sheehan Disability Scale (with three subscales reported separately); ASI = Anxiety Sensitivity Index; BDI-II = Beck Depression Inventory; ISI = Insomnia Severity Index; OCI-R = Obsessive Compulsive Inventory; OCD = Obsessive-Compulsive Disorder.

the third learning of the clinic by word of mouth.

Treatment Protocols Utilized

According to therapist descriptions of the treatments employed, Patient 1 received “EXRP for misophonia” (i.e., Exposure and Response Prevention) delivered in 90-minute once weekly sessions. Patients 2 and 3 received “CBT (Mindfulness and exposure) for misophonia” and “CBT for misophonia” delivered in 60-minute once-weekly sessions, respectively.

Indicators of Tolerability and Acceptability

Retention. One patient (Patient 3) dropped out of treatment prematurely after being lost to follow-up after three sessions. Patients 1 and 2 completed a full course of therapy following 10 and 17 sessions, respectively.

Credibility and Expectancy. In terms of treatment credibility, both treatment completers perceived therapy to be highly credible at Session 2 (Patient 1 = 7, Patient 2 = 8 out of a maximum score of 9). However, Patient 2 appeared to have somewhat higher expectations for improvement in treatment than Patient 1: When asked to rate how much they “really feel” that therapy would help to reduce symptoms (from 1 = *not at all* to 9 = *very much*), Patients 1 and 2 responded with a 3 and 7, respectively. Similarly, on items asking how much symptom improvement patients “think” and, separately, “really feel” would occur by the end of therapy, Patient 1 responded 50% and 20%, respectively, while Patient 2 answered 80% on both items. Patient 3 did not provide CEQ data.

Working Alliance. Both treatment completers reported strong therapeutic alliance at Session 2 (6.92 for Patient 1 and 6.67 for Patient 2 out of a maximum score of 7). Patient 3 did not provide WAI data.

Indicators of Treatment Outcome

Self-Reports. See Table 1 for full pre-, mid-, and posttreatment self-report data. Although the clinic’s standard battery of questionnaires did not include a measure of misophonia severity specifically, both treatment completers showed improvements over treatment in functional impairment, obsessive-compulsive symptoms, depression, and sleep quality. Improvements in anxiety sensitivity were less consistent. Particularly of note, Patient 1’s SDS score dropped from the high range of functional impairment at baseline to the low range at post and showed decreases in impairment across all three domains assessed.

Treatment Response. Further indicating positive treatment outcomes, both treatment completers were deemed treatment responders by their providers. Both therapists reported that they and their patients had “mutually decided to end treatment because of satisfactory progress.”

Discussion

This case series lends preliminary support for the use and continued study of cognitive-behavioral therapies for misophonia. Despite the lack of robust research supporting this approach, patients nonetheless found CBT treatments in a naturalistic setting to be highly credible, and two of three went on to become therapy responders in addition to showing reductions in functional impairment, depression, and OCD symptoms. Although this study examined individual CBT, these findings are consistent with evidence from the sole RCT on misophonia indicating the efficacy of group CBT (Jager et al., 2021).

All three therapists elected to use forms of CBT, though with slight variations: One therapist applied an Exposure and Response Prevention for OCD framework, while another incorporated elements of mindfulness. Two of three made specific mention of the use of exposures, and their patients went on to become treatment responders—a finding relevant to the ongoing debate around exposure’s appropriateness for misophonia (Ferrer-Torres & Giménez-Llort, 2022). Although therapists also opted for different weekly doses (90 vs. 60 minute sessions), the two treatment completers ultimately received similar overall doses of therapy before achieving response (15 and 17 hours for Patients 1 and 2, respectively).

That said, one patient did drop out of therapy. It is possible that this patient, who had a secondary OCD diagnosis, may have viewed therapy’s potential benefits less favorably if her misophonia symptoms were more severe. Indeed, there is increasing evidence that comorbid OCD increases the severity of misophonia due to overlapping symptomatology (Ferrer-Torres & Giménez-Llort, 2022). Future studies should examine whether and how misophonia treatment should be adapted when OCD is present.

Only one in three had a comorbid psychiatric diagnosis of any kind. This pattern is consistent with evidence that half of individuals with misophonia do not have any psychiatric comorbidities (Rouw & Erfan-

ian, 2018), and half experience OC symptomatology (Guetta et al., 2022). Together, these studies suggest that while misophonia may be related to the OC-spectrum, it should be conceptualized as a distinct diagnostic entity as opposed to a symptom or subtype of an existing diagnosis (Ferrer-Torres & Giménez-Llort, 2022).

Only one patient in this report had previously pursued psychiatric care for misophonia and received medication management and talk therapy. Although those treatments were perceived as helpful, the patient nonetheless presented for additional misophonia treatment and reported high initial levels of functional impairment. This may indicate that prior treatments were not sufficient, consistent with the lack of evidence supporting the efficacy of pharmacological treatments or talk therapy for misophonia (Ferrer-Torres & Giménez-Llort, 2022).

Study limitations include the reliance on self-report measures, small sample, and lack of experimental design. The lack of a direct measure of misophonia symptoms is also a limitation, particularly with the more recent validation of several self-report scales (e.g., Amsterdam Misophonia Scale, Schröder et al., 2013; Misophonia Questionnaire, Wu et al., 2014; for a review, see Ferrer-Torres & Giménez-Llort, 2022). Moreover, the limited data describing the interventions delivered prevents a more nuanced understanding of what treatment entailed, and which specific treatment components might represent the focus of future research. While also a strength in certain senses, the anxiety and OCD specialty clinic setting might also be a limitation in that, relative to more generalist providers, CTSA clinicians may have been less likely to use non-CBT interventions as a function of their training and background. Larger scale, more systematic examinations of clinicians’ treatment decisions for patients with misophonia represents an important future direction.

Conclusion

Misophonia can lead to high levels of distress and impairment, yet an evidence-based treatment does not yet exist. This case series suggests that CBT therapies—particularly those that incorporate exposure and mindfulness techniques—are acceptable to patients, viewed as credible, and may be effective in providing relief and reducing impairment. As such, this study provides an impetus for future clinical trials evaluating CBT’s efficacy for misophonia.

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Correspondence to Lily A. Brown, Ph.D., University of Pennsylvania, Dept. of Psychiatry, 3535 Market St., Philadelphia, PA 19104, LilyBr@upenn.edu

ABCT's Fellows Committee | Call for Nominations for Two New Members

The ABCT Fellows Committee (FC) is currently soliciting nominations for two new Fellows Committee members for 3-year terms starting 11/2023 thru 11/2026. The committee consists of 7 members, one of whom serves as Chair. New FC members must be current Fellows when appointed. Solicitations are through multiple sources (e.g., *tBT* ads, ABCT Forum, emails). Given the importance of Fellow status in ABCT, it is crucial that the FC members reflect the full range of diversity in ABCT, including disciplines, professional settings, and cultural diversity. A list of current Fellows can be found at:

<http://www.abct.org/Members/?m=mMembers&fa=Fellow>

The Fellows Committee meets virtually several times a year to review processes, review and discuss applications for Fellow status, and vote on those applications, with the committee's recommendations sent to the ABCT Board of Directors for final decision. Potential new FC members can be nominated by a colleague or can self-nominate. To nominate yourself or a colleague, please send a copy of the person's CV and a brief bio-sketch to fellows@abct.org and in the subject heading write Serving on Fellows Committee.

The nomination deadline this year is May 1, 2023.

Call for Applications

FELLOWS

ABCT Fellow Status for 2023
Application Deadline: July 31

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 is sensitive to the environment in which the applicant was functioning, and we weigh the contributions against the scope of the applicant's current or primary career.

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ABCT now offers 6 areas of consideration for Fellowship status: (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.

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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 <https://www.abct.org/Members/?m=mMembers&fa=Fellow>. While these guidelines provide examples of what the Fellows committee considers outstanding, sustained contributions, they are far from exhaustive.

Deadline for Fellow Status Applications: July 31, 2023, is the deadline for both applicants and letter writers to submit their materials. 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>

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