

the Behavior Therapist

Contents

At ABCT

Jill Ehrenreich-May and Mary Jane Eimer

Brief Update Regarding Ongoing Diversity, Equity, and Inclusion Efforts at ABCT • 181

Mary Jane Eimer

Update From the ABCT Office • 184

Literature Review

Annie Reiner, Justine Brennan, Alex Greenberg, Thompson Davis, Matthew Jarrett

A Review of Virtual Reality Exposure Therapy for Youth With Anxiety • 186

Original Research

Andreas Bezaehler, Brian A. Feinstein, Martha J. Falkenstein, Jennie M. Kuckertz

Emerging Trends in Sexual Minority Identification and Clinical Implications for Treating OCD and Related Disorders • 194

Op-Ed

Joseph R. Taliercio

Systematic Errors in Communication: Our Failure as Mental Health Providers to Reach the General Public • 199

Holly Bedotto

Modeling a Life Worth Living: A Dog's Career Working in a Third-Wave Practice • 203

Obituary

Antonette Zeiss, Paul Rohde, John R. Seeley

Peter M. Lewinsohn (1930–2022) • 206

Leadership & Elections

Angela Fang, Carrie Masia, Angela Moreland, Vaishali Raval, Michelle Roley-Roberts

Leadership and Elections Committee Final Proposal on ABCT Student Vote Bylaws Amendment • 207

Angela Fang, Carrie Masia, Angela Moreland, Vaishali Raval, Michelle Roley-Roberts

Renewing Our Leadership Vows at ABCT to Promote Equity and Inclusion • 208

At ABCT

Brief Update Regarding Ongoing Diversity, Equity, and Inclusion Efforts at ABCT

Jill Ehrenreich-May, University of Miami, ABCT President

Mary Jane Eimer, ABCT Executive Director

AS USUAL, there is a lot going on within ABCT. The Board of Directors, our four coordinators, and several staff members met in early May for our triannual strategic intent retreat. Those attending included: Jill Ehrenreich-May, President; Sandra Pimentel, 2022–2023 President Elect; Laura Seligman, Immediate Past President; Representatives-at-Large Katherine Baucom, Carolyn Becker, and Daniella Cavenagh; along with newly elected Steven Safren, 2023–2024 President Elect, and Colleen Sloan, Representative-at-Large; who will take office this November during our Annual Meeting of Members at our Annual Convention in Seattle. Coordinators Nate Herr, Academic and Professional Issues; Tina Boisseau, Convention and Education Issues; Shari Steinman, Membership Issues; and Susan White, Publications, also attended the retreat.

We began the meeting with a presentation by BARE Mental Health and Wellness consultants, Jess LoPresti and Tahira Abdullah-Swain. In the Fall of 2022, they developed a survey requesting feedback in addition to interviewing members and holding focus groups during the New York convention regarding

[continued on p. 183]

the Behavior Therapist

Published by the Association for Behavioral and Cognitive Therapies

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

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

Angela Haeny

Angela Moreland

Samantha Moshier

Alayna Park

Jae Puckett

Jennifer Regan

Amy Sewart

Tony Wells

Katherine Young

Lucas Zullo

ABCT President: Jill Ehrenreich-May

Executive Director: Mary Jane Eimer

Director of Publications: David Teisler

Director of Education & Meeting Services: Stephen Crane

Senior Communications Manager:
Ewan Johnson

Managing Editor: Stephanie Schwartz

Membership & Marketing Manager:
Rachel Lamb

Copyright © 2023 by the Association for Behavioral and Cognitive Therapies. All rights reserved. No part of this publication may be reproduced or transmitted in any form, or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without permission in writing from the copyright owner.

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

ABCT is committed to a policy of equal opportunity in all of its activities, including employment. ABCT does not discriminate on the basis of race, color, creed, religion, national or ethnic origin, sex, sexual orientation, gender identity or expression, age, disability, or veteran status.

All items published in *the Behavior Therapist*, including advertisements, are for the information of our readers, and publication does not imply endorsement by the Association.

► ABCT Happenings

Call for Candidates for Editor of *Behavior Therapy* • 205

Call for Applications: Fellows • 210

Leadership & Elections • 207-209 & back page



NYC Pride

ABCT is marching!

Sunday, June 25



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>): *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.

members' personal experiences or observations regarding how ABCT is working to be a more welcoming and inclusive organization. Some of their recommendations echoed those of the 2019–2020 Task Force to Create Equity, Inclusion, and Assess within ABCT. BARE Mental Health and Wellness consultants are working on a final report to share with the Board. Once they do, the Board will review their recommendations and share the report publicly with the membership.

The purpose of the triannual retreat was to think creatively and broadly about implementing long-standing and newly highlighted diversity, equity, inclusion, access, and justice (DEIAJ)-related goals for the organization. Some efforts are well under way:

1. President Ehrenreich-May working in coordination with members Drs. Ana Bridges and Donte Bernard have put together a new ABCT leadership program, CHANGE (Challenging How ABCT Now Governs and Evolves) Leaders, an effort to provide diverse early-career persons an opportunity to engage directly in leadership experiences within the organization. An application process with a vigorous review process resulted in 10 early-career members selected for the initial cohort of this 2-year program. Participants will attend various ABCT Board meetings, meet during the Seattle and Philadelphia conventions for in-depth training, and will be paired with an ABCT "sponsor" to help develop and refine programmatic initiatives. A list of the new cohort of CHANGE Leaders appears on this page.
2. ABCT is now a partner organization with the United States Joint Statement Partnering to End "Conversion Therapy" (<https://usjs.org/>).
3. ABCT, in collaboration with the American Psychological Association and the APA Division 12, Section 3—The Society for a Science of Clinical Psychology (SSCP), has partnered in the formation the Inter-organizational Scientific Task Force on the Iatrogenic Effects of Sexual Orientation and Gender Identity or Expression Change Efforts (SOGIECEs), as well as provided funding to support its goals. This task force is charged with conducting, and submitting for peer-review, a systematic literature review on psychosocial outcomes of sexual orientation and gender identity or expression change efforts, including recommendations and future directions for providing inclusive and affirmative care.
- The primary outcome of the task force's work will be a published report, but the task force may engage in activities beyond this initial goal at their discretion.
4. Our peer-review of abstract submissions for the 2023 Annual Convention in Seattle continues to be a masked review process. A future issue of *tBT* will provide more detail into the review process and data-driven decision-making process overseen by Emily Bilek, Program Chair, and Krystal Lewis, Associate Program Chair, along with Tina Boisseau, Convention and Education Issues Coordinator.
5. A second Student Travel Award is now added to our Annual Convention that is specifically aimed at underrepresented students, including in terms of primary discipline, who have their work accepted for presentation.
6. The Awards and Recognition Committee along with the Research Facilitation Committee continue to maintain data on award submissions and who receives our awards. More changes to our awards nomination and application processes were discussed at the retreat.
7. ABCT staff received training in structural racism and implicit bias last year. We continue to seek additional training opportunities for ABCT staff to ensure that our interactions with membership are sensitive and thoughtful at all times.
8. The Leadership and Elections Committee is working on a proposal to change the Bylaws of ABCT regarding inclusion in voting processes. We anticipate that this Bylaws change will be reviewed by the Board of Directors in June 2023.
9. We will continue to update our Code of Conduct for the Annual Convention and enforce it as needed to ensure members feel safe and welcomed at our Annual Convention.
10. ABCT is very excited to be supporting our LGBTQIA+ members and participating in the annual New York City Pride March for the first time. Members are invited to participate by registering and will be invited to a pizza party at central office to make signs for the march or get a small breakfast before the march, where they can also pick up their complimentary t-shirt. Please see our website for details.

President Jill Ehrenreich-May will elaborate on these initiatives, as well as new ones that received substantial discussion time at the triannual retreat, in the next issue of *the Behavior Therapist*. ■

ABCT Is Proud to Introduce Its 2023–2025 Cohort of CHANGE (Challenging How ABCT Now Governs and Evolves) Leaders:

Derrecka Boykin, *South Central Mental Illness Research, Education and Clinical Centers (MIRECCs), VHA*

Jasmin Brooks, *University of Houston*

Celenia DeLapp, *Montefiore Medical Center/Albert Einstein College of Medicine*

Alexandria Miller, *VA Boston Healthcare System*

Hannah Morton, *Oregon Health & Science University*

Regina M. Musicaro, *Psychiatric Research Institute for Montefiore Einstein*

Giovanni Ramos, *University of California, Los Angeles*

Ilana Seager van Dyk, *Massey University*

Tim Stahl, *Icahn School of Medicine at Mount Sinai*

Elliott R. Weinstein, *University of Miami*

Update From the Central Office

Mary Jane Eimer, *Executive Director*



I AM PLEASED to share that ABCT has three new staff members. Rachel Lamb has been promoted to our Membership and Marketing Manager position, handling our database, webinars, and marketing efforts.

Ewan Johnson is our new Senior Communications Manager, which is also a new position for ABCT. Among other things, he is overseeing our public communications, increasing our presence on social media, in addition to developing content that reflects the work of our members and our values. Maryilyn H. Brown is our Administrative Secretary. She is the first voice you will most likely hear when you call the central office. Maryilyn is mastering our database and operations in addition to learning the Cadmium system, which is the management system for our conventions.

Communications is a high priority for ABCT leadership. Ewan just created a LinkedIn page for ABCT (<https://www.linkedin.com/company/abctnow/>). We hope you will take a look and follow our page. And, if you haven't already done so, we hope you will follow Jill as President on Twitter (@ABCTPrez) in addition to ABCT on Twitter, Facebook, and Instagram.

Many of our members enjoy communicating with each other on a variety of topics via a list serve. The ABCT Forums is our list serve and powered by our new database. You need to log in as it is for members only. Forums permit us to communicate and network with other ABCT members more easily. 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 the 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. They are available in a digest format and allow members to choose whether to receive notifications or not. Forums content will always be available for review by thread.

We are working to expand the scope of our Forums topics over the coming months. We encourage you to post general discussion topics and share any job/internship opportunities or clinical referrals to the Forums. If you have any questions, please reach out to membership@abct.org.

The ABCT website is frequently updated. Checking our home page for the New and Noteworthy material keeps you updated without filling up your inbox. As a reminder, this past year we added an accessibility menu to the home page. There is an icon on the middle of the left-hand side that, when clicked, immediately brings the user to the options available.

The usefulness of our database rests entirely on you. You can look up members in the membership directory and participate in our Speakers Bureau. You can also be listed in our Find a CBT Therapist, if licensed. For those willing to pay an optional fee, you can include additional information useful to the public, such as insurance taken, your practice philosophy, languages spoken, and more. While on the website, visit our job bank (<https://www.abct.org/for-professionals/job-bank/>);

there are sections for job seekers (free to add your resume) and those looking to fill positions (attractively priced, and reaching only the target audience).

We made many changes to our database to capture more information and help ABCT be more inclusive and diverse in all areas of our activities. We are working to capture KPIs for our awards program, presentations, submissions, and governance. If you haven't done so recently, please take a moment to look at your record and make sure it is accurate. We won't know how we

are doing with our efforts to be inclusive without your input.

We now have 48 Special Interest Groups. Take a look at our website to see the full listing. Only ABCT members can participate in our SIGs program. Many are quite active at the Annual Convention, holding individual meetings, participating in the SIG Expo Friday night, and managing their own awards programs. Most of our SIGs are also active throughout the year producing newsletters, gathering for a "virtual coffee breaks," or more offering formal presentations.

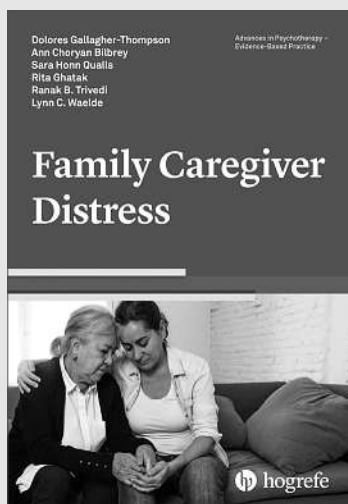
ABCT participated in the 2nd World CBT Day on April 7, which coincides with the World Health Organization's World Health Day. The purpose of this observation is to reflect the importance of the behavioral and cognitive therapies in global health. We sincerely thank members Richard Gallagher, NYU Grossman School of Medicine, who presented "Promoting Mental Health in an Age of Uncertainty: Cognitive Behavior Therapy for Youth," and Muniya Khanna and Sarah Olivio, of Lumate Health, who presented "Helping Teens Manage Stress and Anxiety in the Age of Uncertainty." Please take a look at New and Noteworthy section on the home page of our website to access these presentations. We are an active member of the World Confederation of Cognitive and Behavioral Therapies and will have a presence at the June 1–4, 2023 World Congress in Seoul, Korea. Please stop by the ABCT booth and say hello.

ABCT will be hosting the 11th World Congress of Cognitive and Behavioral Therapies in San Francisco over the dates of June 24–28, 2026. Amelia M. Stanton will serve as our Scientific Program Chair along with Alyssa M. Farley and Jasper S. Lee as Associate Scientific Program Chairs. In the not-too-distant future you will be made aware of the Call for Papers and other opportunities for involvement in planning this global event.

ABCT has many opportunities for members to get involved. We have added information on the home page to make it easy to see where your interests and skill sets fit. Although we just completed the Program Committee review, we also need more members to assist us with membership, student membership, social media, and other areas of governance. Announcements for volunteers are also made in *tBT* or on our Forums. Please always feel encouraged to let me know of your interest at mjeimer@abct.org. ■



Let science guide you on how to reduce stress in caregivers for people with dementia



*Advances in Psychotherapy –
Evidence-Based Practice, vol. 50*
2023, xii + 100 pp., \$29.80
ISBN 978-0-88937-517-8
Also available as eBook

Dolores Gallagher-Thompson / Ann Choryan Bilbrey / Sara Honn Qualls /
Rita Ghatak / Ranak B. Trivedi / Lynn C. Waelde

Family Caregiver Distress

This is the first book that takes a “deep dive” and provides science-based answers to the questions that mental health providers encounter when working with family caregivers. What are the unique issues that family members face? How does this impact their own mental health? What can you as a provider do to help?

Based on research and clinical experiences of the authors, this volume in our *Advances in Psychotherapy* series focuses on examining the specific issues that caregivers of people with Alzheimer’s disease or other forms of dementia face. Practitioners can learn about the best tools for assessment

and which evidence-based interventions help reduce caregiver distress – including cognitive behavioral therapy, acceptance and commitment therapy, and mindfulness and multicomponent intervention programs.

A key resource in the appendix is a caretaker intake interview, and the book is interspersed with clinical vignettes that highlight issues of diversity, equity, and inclusion – making this an essential text for mental health providers from a variety of disciplines including psychology, psychiatry, nursing, social work, marriage and family counseling.



www.hogrefe.com

 **hogrefe**

A Review of Virtual Reality Exposure Therapy for Youth With Anxiety

Annie Reiner, Justine Brennan, Alex Greenberg, Thompson Davis, Matthew Jarrett, *University of Alabama*

ANXIETY DISORDERS are among the most diagnosed mental health problems in U.S. children, with approximately 7.1% of youth aged 3–17 years (approximately 4.4 million) diagnosed with an anxiety disorder (Ghandour et al., 2019). Diagnoses in this DSM-5 class of disorders reflect difficulties with excessive fear and anxiety that interfere with one's life (American Psychiatric Association, 2013). There are a variety of evidence-based treatments and pharmacotherapy options for child anxiety disorders. For example, cognitive-behavioral therapy (CBT) is one of the most common treatments for pediatric generalized anxiety disorder, incorporating exposure (Barrett, 2000) and selective serotonin reuptake inhibitors (SSRIs) (Wehry et al., 2015). Additionally, evidence-based treatments for child social anxiety disorder include exposure therapy (Radtke et al., 2020) and social skills training (Spence et al., 2000). SSRIs and monoamine-oxidase inhibitors (MAOIs) are also medication options for the treatment of pediatric social anxiety disorder (Rodebaugh et al., 2004). In regard to child-specific phobia, efficacious treatments involve exposure therapy including exposure within a one-session treatment format (Davis et al., 2009) and longer-term exposure therapy (Odgers et al., 2022). There is also evidence that these treatments can serve to alleviate symptoms of multiple anxiety disorders. For example, a combination of CBT and SSRIs has been shown to effectively treat separation anxiety disorder, generalized anxiety disorder, and social anxiety disorder (Compton et al., 2010).

While efficacious treatments exist, a minority of children and adolescents do not respond to treatment (approximately 25%–50%) or at least do not seem to obtain or retain the full expected treatment response (i.e., partial response or refractory cases), and in some cases, evidence-based treatment might not even be accessible in the local community (Davis et al., 2011). As a result, a great deal of research has focused on the techniques that make up efficacious CBT, with the general consensus being that

exposure (in either in vivo, imaginal, or virtual formats) is a crucial component (e.g., Kendall et al., 2005). While the majority of research studies has focused on in vivo exposure, more recently, a growing number of studies have examined virtual reality exposure therapy (VRET). VRET is an additional treatment option for a variety of anxiety disorders. Although fewer studies have examined the efficacy of VRET in child than in adult clinical populations, several studies exist on this topic (St-Jacques et al., 2010). At the same time, it is unclear as to the overall efficacy of VRET for anxious youth. Thus, the present literature review sought to evaluate the efficacy of VRET for treating pediatric anxiety disorders, as well as for decreasing anxiety in nonclinical populations (e.g., children undergoing anxiety-provoking medical and dental procedures).

VRET

VRET is a less-studied approach to exposure therapy for anxiety disorders with many concerns about its use being related to cost, access, and its ability to adequately replicate stimuli, among other issues. Even so, there is growing evidence for its efficacy (Giotakos et al., 2007; Gujjar et al., 2019) and greater acceptance as technological, quality, and cost hurdles have been overcome. Zheng et al. (1998) defines VRET as “an advanced, human-computer interface that simulates a realistic environment” (p. 20). VRET is similar to other kinds of exposure therapy (in vivo, imaginal) in that the goal is to reduce anxiety symptoms by introducing the client to the feared situation/object in gradual amounts over time (Krijn et al., 2004). However, some studies have shown that many patients prefer to receive VRET over in vivo exposure (Garcia-Palacios et al., 2001; Garcia-Palacios et al., 2007). VRET provides a human–computer interaction that allows clients to feel a sense of presence and immersion in an anxiety-provoking virtual environment that includes both sensory and visual stimuli. This experience pro-

vides an opportunity to expose clinically anxious individuals to realistic scenarios, thereby reducing their reactivity to anxiety-provoking cues and helping them to learn meaningful coping skills that can be transferable to real-world settings (Parrish et al., 2016). When exposure is successful, more neutral memories are created, which replace anxiety triggers (Foa & Kozak, 1991). VRET has also been successful in facilitating this cognitive change (Krijn et al., 2004). Another unique benefit of VRET is that certain phobias are more challenging or expensive to address during therapy (e.g., storms, airplanes), so treatment would typically involve imaginal exposures. However, VRET may be a better alternative to this option due to its inclusion of immersive auditory and visual stimuli rather than solely auditory stimuli used to simulate the feared experience. Additionally, if in vivo exposure is initially too overwhelming for the patient, VRET may be a more viable option (Anderson et al., 2003).

Method

Search Strategy and Selection Criteria

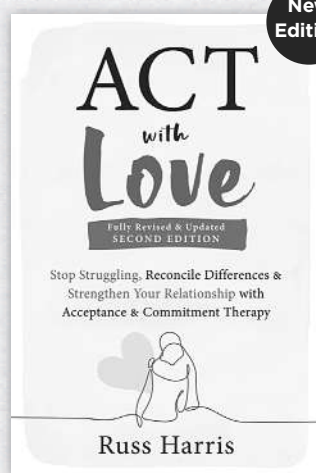
Articles related to VRET were identified that involved treatment of clinical and nonclinical anxiety in youth via electronic searches. Criteria for inclusion in this literature review consisted of studies (a) published in a peer-reviewed journal in English; (b) that described a data-based study; (c) that included children and adolescents (e.g., under the age of 18) undergoing VRET/VR as the focal participants; and (d) focused on decreasing anxiety in children. Keywords used in an electronic search of the PsycINFO, PubMed, and Google Scholar databases included *virtual reality*, *VR*, *children*, *adolescents*, *child*, *youth*, *anxiety disorders*, *anxiety*, *generalized anxiety disorder*, *social anxiety*, *social phobia*, *social anxiety disorders*, and *phobias*. The search was limited to peer-reviewed journal articles and did not include books, dissertations, and other publications that did not undergo peer review. The search resulted in a grand total of 266 articles that was ultimately reduced to 29 articles published between 2009 and 2022. Article results were read first, preceded by review of abstracts, and then full articles. Discrepancies in decisions to include/exclude articles in the review were handled based on whether all parties involved in the literature review process agreed. Articles were excluded for a variety of reasons. For example, studies were excluded if the partici-

CELEBRATING 50 YEARS!

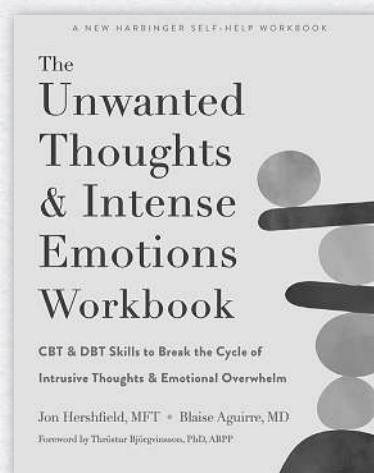
REAL TOOLS *for* REAL CHANGE, SINCE 1973



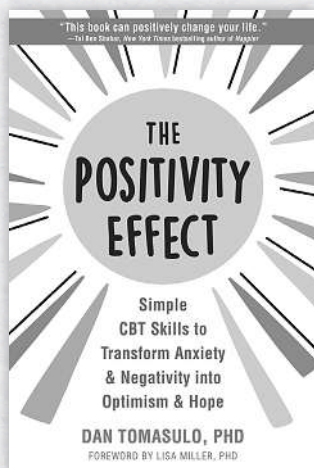
ISBN: 978-1648480997 | US \$18.95



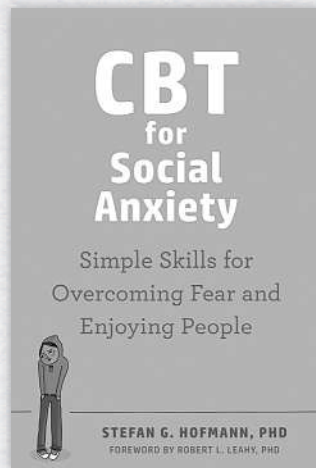
ISBN: 978-1648481635 | US \$18.95



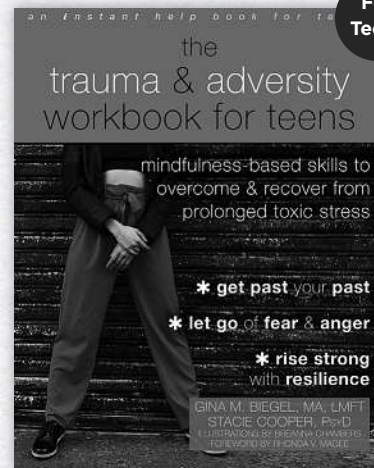
ISBN: 978-1648480553 | US \$24.95




ISBN: 978-1648481116 | US \$18.95



ISBN: 978-1648481208 | US \$19.95



ISBN: 978-1684037971 | US \$19.95

 newharbingerpublications

1-800-748-6273 | newharbinger.com

Learn more about evidence-based continuing education and training with

 PRAXIS praxiscet.com

CLINICIANS CLUB 

 newharbingerpublications

Join today for 35% off professional books, free e-books, client resources, and more at

newharbinger.com/clinicians-club

pants were partially or entirely adult populations. Additionally, there were several instances where article duplicates were identified. Also, multiple studies had different uses for VR, including but not limited to improving self-confidence, decreasing posttraumatic stress disorder symptoms, and reducing discomfort with fears. These studies were also excluded.

Results

Review of the articles led to a total of 29 articles for inclusion. Specifically, a total of 7 studies related to child social anxiety disorder, 6 studies focusing on specific phobia, and 16 studies on non-clinically significant levels of anxiety were included in the review. These studies are summarized separately below based on topic.

VRET and Childhood Social Anxiety Disorder

Using VRET to treat social anxiety, a mental health problem with hallmark

symptoms including fear of negative evaluations, poses a somewhat greater challenge to application of this technology due to the lack of strong physical cues relative to other anxiety disorders (e.g., strong vibrations, distance cues for heights; Anderson et al., 2003). However, several research findings have shown that despite this potential barrier, VRET can be used to successfully treat youth social anxiety disorder. Additionally, given the many challenges and stresses that adolescent populations specifically experience within a variety of peer contexts, VR may provide an optimal medium for youth to practice implementing coping skills for social anxiety before using them in social settings (Parrish et al., 2016).

For example, Beidel et al. (2021) developed an artificially intelligent, web-based application, Pegasys-VR, for treating childhood social anxiety disorder. Pegasys-VR was compared to Social Effectiveness Therapy for Children (SET-C), a behavioral intervention for children with social anxiety disorder.

Forty-two youths ages 7–12 were randomly assigned to either the SET-C or the Pegasys-VR intervention group. Results indicated that the groups were equally efficacious in decreasing anxiety and improving social skills, with 63% of children treated with SET-C and 60% of children treated with Pegasys-VR not meeting diagnostic criteria for social anxiety disorder at posttreatment. Results of this study suggest that using technology to replace the “hard to disseminate” treatment elements does not appear to weaken the treatment’s overall efficacy.

Sülter et al. (2022) examined the effects of VRET on anxiety related to public speaking in 89 children. Forty children were assigned to the VRET (virtual reality audience) condition, and 49 were assigned to the control (at-home presentation preparation) condition. Children did not need to be diagnosed with social anxiety disorder to participate. Findings revealed that children in the VRET condition experienced



Become an ABPP Board Certified Specialist
in Behavioral and Cognitive Psychology
—Virtual (Zoom) Exams Available—

Why Become Board Certified?

- **“Gold standard”** of professional practice
- **ABPP** is a **“trusted credential”** (i.e., psychologists have met their board’s specialty’s standards and competencies)
- Potential for **increased financial compensation** (VAs, PHS, DOD, some hospitals)
- **Reflects a higher standard of expertise** over a generalist license
- **Enhances one’s qualifications** as an expert witness; facilitates applying to insurance companies’ networks
- **Candidates will get up to 40 CE credits** after passing the exam (# CE accepted up to the state where candidates are licensed)

3 Steps to Board Certification:

1. Submission of educational/training materials.
2. Review of a practice sample (clinical case or supervision with a student), or senior option (≥ 15 years of experience)
3. Collegial exam.

- **We encourage applicants with diverse backgrounds**
- We offer a **discounted application fee** for graduate students, interns, and postdoctoral residents
- We conduct exams at **APA and ABCT conferences**, and other locations as possible (virtual and face-to face)
- Online application: <https://abpp.org/application-information/learn-about-specialty-boards/behavioral-cognitive-psychology/>

rienced significantly lower state anxiety during the presentation than children in the control condition. A reduction in general public speaking anxiety decreased from the first practice session until a week after the actual presentation for both conditions, but this reduction was larger for children in the VRET condition than children assigned to the control condition. Thus, these study findings suggest that the usage of VRET is promising when attempting to reduce public speaking anxiety symptoms.

Gutiérrez-Maldonado et al. (2009) explored the potential impact of VRET on children with school-related anxiety. The study included 36 children between the ages of 10 and 15 who had high scores on school phobia measures. They found that school-related fears were more significantly reduced in the VRET condition than the control (wait-list) group. However, no significant effect was found for general fears. Thus, these findings suggest that this particular form of VRET was particularly effective in the realm of school-related fears with less transfer to general fears. Additionally, we are aware that school phobia is different from social anxiety disorder, but due to several socially driven school-related anxiety symptoms (e.g., avoidance due to public speaking, being bullied, and being criticized in front of the class), we decided to include it under this diagnostic category. Additionally, in their research design, Gutiérrez-Maldonado et al. included several measures that assessed for social anxiety symptoms in the school setting.

Several feasibility studies have also found VRET to be a feasible approach for the treatment of pediatric social anxiety (Kahlon et al., 2019; Kwon et al., 2020; Maskey et al., 2019; Parrish et al., 2016; Sarver et al., 2014). For example, Sarver et al. (2014) found that, via self-report, both children and clinicians were satisfied with using the VR technology. These findings suggest that VRET is an acceptable and efficacious treatment option for youth with social anxiety disorder. Overall, although VRET has been shown to be a feasible intervention for both children with social anxiety disorder and children who are anxious about public speaking, more research

needs to be done to examine its efficacy for youth social anxiety, particularly with larger study samples.

VRET and Childhood-Specific Phobia

Specific phobias are among the most common mental health problems present in children, adolescents, and adults, with estimated lifetime prevalence rates of about 30% (Egger & Angold, 2006; Merikangas et al., 2010). For therapists, VRET may present a more manageable, efficient means of delivering exposures without the need to leave the clinic room or manage multiple phobic stimuli (including housing stimuli outside of the session). VRET may also facilitate exposure when in-vivo exposure is too challenging due to the accessibility and/or costs of acquiring stimuli (e.g., flying, storms, snakes; Farrell et al., 2021).

A variety of research findings have shown support for VRET as an efficacious intervention for the treatment of pediatric specific phobia. For example, St-Jacques et al. (2010) explored the impact of VRET on motivation to participate in therapy. This study included 31 children with arachnophobia between the ages of 8 and 15. Participants were randomly assigned to one of two treatment conditions: in vivo exposure alone or in vivo and VR exposure. The results were that children who received VR exposure did not show a higher level of motivation toward their treatment than those who received just in vivo exposure; however, motivation was a significant predictor of outcome. Additionally, participants in the combined treatment group were significantly less fearful after beginning treatment, although both treatments appeared successful. In summary, VRET combined with in vivo exposure did not prove to be superior to in vivo exposure in relation to motivation for therapy, but there appeared to be some evidence for greater efficacy in those with the combined treatment.

Up to 80% of autistic children¹ experience clinically significant levels of anxiety (Leyfer et al., 2006). Additionally, specific phobias are present in up to 40% of autistic children (Muskett et al., 2019). Thus, Maskey et al. (2014) explored the effects of VRET on specific phobias among autistic youth. Nine autistic males with no reported learning disability, aged 7–13 years, partic-

ipated in the study. Each child exhibited fear around a specific situation or stimulus. Results were that all children, with the exception of one, improved from their baseline ability to handle their feared situation that they worked on during VRET. Seven out of 9 (78%) participants had improvement in confidence ratings (e.g., confidence in tackling the target situation) from pre- to posttreatment, and 4 out of 6 (67%) participants who exhibited anxiety above the normal range (e.g., self and parent-reported score above 40 or 33 depending on age group on the Spence Children's Anxiety Scale) in pretreatment had anxiety within the normal range at posttreatment.

Maskey et al. (2019) conducted a similar study that also assessed VRET efficacy in autistic children between the ages of 8 and 12 years old with anxiety; however, this study integrated VRET with CBT. Eight autistic children with a comorbid phobia participated in the study. Results were that four of the eight participants (50%) were classified as responders to intervention and were able to function without the phobia impacting their life; however, one participant was lost to follow-up and three participants were nonresponders. Findings show that VRET in combination with CBT may be an efficacious intervention for autistic children with comorbid phobias. However, due to the small sample size, more research needs to be done in this area before drawing conclusions.

Other studies have found that VRET is a feasible therapeutic approach for treating child-specific phobias (Barceló et al., 2020; Maskey et al., 2019). Overall, a variety of findings show support for VRET as an effective and practical treatment for child-specific phobias. However, in the majority of these studies, participants did not have a prior diagnosis, small samples were used, and only one study utilized a randomized controlled design, suggesting that more research is needed on VRET for specific phobias.

VR and Anxiety Symptoms

In comparison to most of the VRET literature on child populations, which targets specific anxiety disorders, several studies have looked at the impact of VR on non-clinically significant levels of anxiety in children, particularly within the context of medical treatment. Although anxiety may not be at the clinical level, these study findings may provide a foundation for research exploring the impact of VR on populations with clinical levels of anxiety in medical

¹ There is a debate about terminology in this population; however, research has shown that members of the autism community prefer identity-first language (e.g., autistic person) whereas professionals are more likely to use person-first language (e.g., person with autism; Lei et al., 2021).

settings. The use of VR with the following populations differs from its use with clinical populations (e.g., mental health diagnoses) due to the intention—here, the intention is to distract from the procedure being done, whereas during VRET, the goal is to have the person pay close attention to the stimuli/situation. For example, Buyuk et al. (2021) examined the impact of VR on child pre- and postoperative anxiety. Participants were 78 boys between the ages of 5 and 10. Subjects were randomly assigned to either a control (e.g., no VR) or experimental (e.g., exposure to two VR programs before the procedure occurred) group. Results were that children in the experimental group reported significantly lower anxiety in both the pre- and postoperative group than children in the control condition. Thus, these findings suggest that VR can be utilized to decrease anxiety with nonclinical samples.

Shetty et al. (2019) looked at VR in the context of youth dental patients. This study included assessment of the impact of VR on pain and anxiety in 120 children between the ages of 5 and 8. Results were that the VR group had a significant reduction in pain perception and anxiety, and salivary cortisol levels decreased significantly more among children in the VR group relative to the control (without VR distraction) group. These findings suggest that VR is a successful technique in decreasing pain perception and anxiety among children undergoing invasive dental treatments.

Gerçeker et al. (2020) explored the impact of VR on anxiety in child patients during blood draw. The randomized control study included 136 children between the ages of 6 and 17, 45 of whom were assigned to a VR rollercoaster, 45 of whom were assigned to a VR ocean rift, and 46 of whom were assigned to a control (no VR exposure) group. A statistically significant difference was found between the VRET groups and the control condition post-blood draw; there was a greater decrease in self-, parent-, and researcher-reported fear and anxiety for both VRET groups relative to the control condition after blood draw.

Gold and Mahrer (2018) also examined the impact of VR, compared to standard of care (SOC), on the anxiety of children receiving blood draws. In a randomized controlled trial, 143 children and adolescents between the ages of 10 and 21 were assigned to either the SOC condition ($n = 73$) or the SOC plus VR condition ($n = 70$). Findings showed that children in the VR condition reported significantly less anxiety

and pain, as well as significantly better affect, compared to those in the SOC condition. Children in the VR condition with a high anxiety sensitivity also reported significantly less anxiety than those with a lower anxiety sensitivity or those in the SOC condition. Children and their caregivers in the VR condition also reported high levels of satisfaction, indicating that VR is a feasible and well-liked intervention to reduce anxiety during blood draws.

Wong et al. (2021a) also focused on the impact of VR on patients in medical settings; however, these individuals were pediatric cancer patients undergoing peripheral intravenous cannulation. Participants were 108 children between the ages of 6 and 17 who were assigned to either a VR distraction intervention or standard care. Results were that patients in the intervention group demonstrated a significant reduction in anxiety levels in comparison to the standard care group. Gold and colleagues (2006) used VR as a distraction tool to reduce anxiety during IV placement. They administered the treatment to 20 children (12 boys, 8 girls) and found significant reductions in anxiety after administering VR. Li and colleagues (2011) administered VR therapeutic play to 52 children with cancer and treatment-as-usual (routine nursing care) to the other 70 children in their sample. They found that after VR administration, the children in the VR group reported fewer depressive symptoms than the control group. There were no significant differences in anxiety scores between the two groups. At the same time, the authors noted that their intervention did not target anxiety and that the target was broader psychological well-being.

Similarly, Gerçeker et al. (2021) explored potential positive effects of VR on child cancer patients. However, in contrast with Wong et al. (2021a), Gerçeker et al. measured patient anxiety during port needle insertions. Participants were 42 patients, 21 of whom were assigned to the VR condition, and 21 of whom were assigned to the control (no VR exposure) condition. After the procedure, a statistically significant difference was found in that children assigned to the VR condition as well as parents of those children reported less fear and anxiety in comparison to children and parents in the control condition. Overall, these findings show support for VRET in decreasing patient anxiety across a variety of medical contexts.

Van Rooij et al. (2016) also explored the effect of VR on anxiety in nonclinical populations; however, this study was unique

from other VR studies as it integrated biofeedback into a VR game. Specifically, this study included 86 children between 8 and 12 years of age who were exposed to a VR fantasy world that reinforces slow and deep breathing for a total of 7 minutes. Results were a significant decrease in self-reported state-anxiety after VR exposure, strong qualitative differences in diaphragm expansion patterns, no significant differences in negative and positive affect after VR exposure, and overwhelmingly positive feedback, suggesting design feasibility.

Finally, research has shown support for VRET as a feasible therapeutic approach for treating child anxiety at nonclinical levels (Chang et al., 2022; Gold & Mahrer, 2018; Gold et al., 2021; Goldman & Behboudi, 2021a, 2021b; Olbrecht et al., 2021; Ryu et al., 2018; Stunden et al., 2021; Wong et al., 2021b). These findings show support for VRET as an effective option for child anxiety in nonclinical samples, particularly in the context of reducing pain and anxiety for pediatric medical patients. However, due to the lack of control groups in some cases, as well as small sample sizes, more rigorous research is needed. Additionally, in comparison to clinical samples exhibiting anxiety, less research has been done on individuals with non-clinically significant anxiety levels.

Gaps in the Literature

Although a number of research studies have examined VRET for youth anxiety in both clinical and nonclinical populations, there are several areas that have not been studied. For example, no research was identified with VRET for generalized anxiety disorder in youth. However, research has been done showing support that VRET is effective in adult populations with generalized anxiety disorder (Gorini et al., 2010; Guitard et al., 2019; Pallavicini et al., 2009; Repetto et al., 2013). Additionally, although no studies were identified looking at the impact of VRET on children with panic disorder, multiple findings have shown the efficacy of this treatment for adult populations presenting with panic disorder (Botella et al., 2007; Pelissolo et al., 2012; Vincelli & Riva, 2002). Finally, no research to date has been published on the implementation of VRET in agoraphobic child populations. However, research has been conducted on this topic in adults as well, showing mixed findings for the effectiveness of VR on older populations (Bethencourt et al., 2015; Malbos et al., 2013). Although certain childhood anxiety disorders have been targeted in the litera-

ture in relation to VRET (e.g., social anxiety, specific phobia), it is clear that further research needs to be conducted on other anxiety disorders in youth.

Discussion

Although there are relatively few studies examining the efficacy of VRET in treating pediatric anxiety, several studies have shown encouraging results. For example, research has covered both clinical and non-clinical populations, suggesting the positive effects of VR on groups above and beyond individuals with mental health diagnoses. An additional strength is that multiple studies on this topic included the implementation of a randomized controlled trial design. A third strength is that research has started to explore the impact of VRET on pediatric populations with comorbid presenting problems. However, given the high comorbidity rates of pediatric anxiety disorders with other mental health problems (e.g., depression, ADHD; Garber & Weers-

ing, 2010; Jarrett & Ollendick, 2008), it is critical that more research be conducted in this area. One weakness is the range of presenting problems covered. Specifically, research in this area has primarily focused on children with social anxiety disorder and specific phobia. However, no research has looked at the other anxiety disorders in the DSM-5 (e.g., generalized anxiety disorder, panic disorder, agoraphobia, separation anxiety disorder, selective mutism). Also, although clinical populations were included in studies, many individuals did not have diagnoses, and the presence of symptoms was determined via self-reports, thus potentially threatening symptom identification accuracy. Another weakness was the use of small samples with limited diversity in relation to participant characteristics (e.g., race, ethnicity, gender). This lack of diversity has implications for knowledge regarding the feasibility and acceptability of this treatment approach for all groups. Additional research is needed to address this issue. Further, many of the

studies had control conditions that were not as active as VRET. Due to the high cost of VRET, more research needs to be done on making it more accessible. Studies should also explore methods to alleviate VR-related sickness (e.g., nausea, eye fatigue), which could negatively impact the overall VR experience (Chang et al., 2020). Additionally, more research should explore potential differences in the experience of VR (e.g., VR-related sickness, motivation, engagement) among children and adults, as well as within different developmental periods (e.g., adolescence). Finally, the treatments utilized tended to be more short-term in nature, although follow-up was implemented for several of the studies, showing evidence of sustained positive benefits (Farrell et al., 2021). Overall, future research on the impact of VRET for anxiety in clinical and nonclinical child populations should aim to target these shortcomings.

Barry Lubetkin, Ph.D., ABPP
Steven Fishman, Ph.D., ABPP
Founders



INSTITUTE *for* BEHAVIOR THERAPY

New York City

Celebrating Our 51st Year

Barry S. Lubetkin, Ph.D., ABPP, Director

Since 1971, our professional staff has treated over 30,000 patients with compassionate, empirically-based CBT. Our specialty programs include: OCD, Social Anxiety Disorder, Panic Disorder, Depression, Phobias, Personality Disorders, and ADHD-Linked Disorders, and Child/Adolescent/Parenting Problems.

Our externs, interns, postdoctoral fellows and staff are from many of the area's most prestigious universities specializing in CBT, including: Columbia, Fordham, Hofstra, Rutgers, Stony Brook, St. John's, and Yeshiva Universities.

Conveniently located in the heart of Manhattan just one block from Rockefeller Center. Fees are affordable, and a range of fees are offered.

For the safety and welfare of our patients and our mental health colleagues, the Institute is offering virtual individual therapy sessions, as well as virtual supervisory sessions by our senior staff members.

For referrals and/or information, please call: (212) 692-9288

— or call or text Dr. Lubetkin directly at 917-744-0131 —

20 East 49th St., Second Floor, New York, NY 10017 | e-mail: info@ifbt.com | web: www.ifbt.com

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>.
- Anderson, P., Rothbaum, B. O., & Hodges, L. F. (2003). Virtual reality exposure in the treatment of social anxiety. *Cognitive and Behavioral Practice*, 10(3), 240–247.
- Barceló, M. S., Sáez, B., & Mir, J. M. G. (2020). Feasibility of a virtual reality program to treat children with fear of darkness with nonexpert therapists. *Revista de Psicología Clínica con Niños y Adolescentes*, 7(2), 16–21.
- Barrett, P. M. (2000). Treatment of childhood anxiety: Developmental aspects. *Clinical Psychology Review*, 20(4), 479–494.
- Beidel, D. C., Tuerk, P. W., Spitalnick, J., Bowers, C. A., & Morrison, K. (2021). Treating childhood social anxiety disorder with virtual environments and serious games: A randomized trial. *Behavior Therapy*, 52(6), 1351–1363.
- Bethencourt, J. M., Roca-Sánchez, M. J., Acosta, L., Villaverde, M. L., & Gracia, R. (2015). The combined use of virtual reality exposure in the treatment of agoraphobia. *Actas Esp Psiquiatr*, 43(4), 133–141.
- Botella, C., García-Palacios, A., Villa, H., Baños, R. M., Quero, S., Alcañiz, M., & Riva, G. (2007). Virtual reality exposure in the treatment of panic disorder and agoraphobia: A controlled study. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 14(3), 164–175.
- Buyuk, E. T., Odabasoglu, E., Uzsén, H., & Koyun, M. (2021). The effect of virtual reality on children's anxiety, fear, and pain levels before circumcision. *Journal of Pediatric Urology*, 17(4), 567–e1–567–e8.
- Chang, E., Kim, H. T., & Yoo, B. (2020). Virtual reality sickness: A review of causes and measurements. *International Journal of Human-Computer Interaction*, 36(17), 1658–1682.
- Chang, Z. Y., Chun-Yun Kang, G., Yi Ling Koh, E., Jin Kai Fong, R., Tang, J., Goh, C. K., & Tan, N. C. (2022). Immersive Virtual Reality in Alleviating Pain and Anxiety in Children During Immunization in Primary Care: A Pilot Randomized Controlled Trial. *Frontiers in Pediatrics*, 10, 847257.
- Compton, S. N., Walkup, J. T., Albano, A. M., Piacentini, J. C., Birmaher, B., Sherrill, J. T., ... March, J. S. (2010). Child/adolescent anxiety multimodal study (CAMS): Rationale, design, and methods. *Child and Adolescent Psychiatry and Mental Health*, 4, 1–15.
- Davis III, T. E., May, A. C., & Whiting, S. E. (2011). Evidence-based treatment of anxiety and phobia in children and adolescents: Current status and effects on the emotional response. *Clinical Psychology Review*, 31, 592–602.
- Davis III, T. E., Ollendick, T. H., & Öst, L. G. (2009). Intensive treatment of specific phobias in children and adolescents. *Cognitive and Behavioral Practice*, 16(3), 294–303.
- Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: Presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47(3–4), 313–337.
- Farrell, L. J., Miyamoto, T., Donovan, C. L., Waters, A. M., Krisch, K. A., & Ollendick, T. H. (2021). Virtual reality one-session treatment of child-specific phobia of dogs: A controlled, multiple baseline case series. *Behavior Therapy*, 52(2), 478–491.
- Foa, E. B., & Kozak, M. J. (1991). Emotional processing: Theory, research, and clinical implications for anxiety disorders. In J. D. Safran & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 21–49). The Guilford Press.
- Garber, J., & Weersing, V. R. (2010). Comorbidity of anxiety and depression in youth: Implications for treatment and prevention. *Clinical Psychology: Science and Practice*, 17(4), 293–306.
- García-Palacios, A., Botella, C., Hoffman, H., & Fabregat, S. (2007). Comparing acceptance and refusal rates of virtual reality exposure vs. in vivo exposure by patients with specific phobias. *Cyberpsychology & Behavior*, 10(5), 722–724.
- García-Palacios, A., Hoffman, H. G., Kwong See, S., Tsai, A. M. Y., & Botella, C. (2001). Redefining therapeutic success with virtual reality exposure therapy. *CyberPsychology & Behavior*, 4(3), 341–348.
- Gerçeker, G., Ayar, D., Özdemir, E. Z., & Bektaş, M. (2020). Effects of virtual reality on pain, fear and anxiety during blood draw in children aged 5–12 years old: A randomized controlled study. *Journal of Clinical Nursing*, 29(7–8), 1151–1161.
- Gerçeker, G. Ö., Bektaş, M., Aydınok, Y., Ören, H., Ellidokuz, H., & Olgun, N. (2021). The effect of virtual reality on pain, fear, and anxiety during access of a port with huber needle in pediatric hematology-oncology patients: Randomized controlled trial. *European Journal of Oncology Nursing*, 50, 101886.
- Ghandour, R. M., Sherman, L. J., Vladutiu, C. J., Ali, M. M., Lynch, S. E., Bitsko, R. H., & Blumberg, S. J. (2019). Prevalence and treatment of depression, anxiety, and conduct problems in US children. *Journal of Pediatrics*, 206, 256–267.
- Giotakos, O., Tsirgogianni, K., & Tarnanas, I. (2007, September). A virtual reality exposure therapy (VRET) scenario for the reduction of fear of falling and balance rehabilitation training of elder adults with hip fracture history. In *Virtual Rehabilitation* (pp. 155–158). IEEE.
- Gold, J. I., Annick, E. T., Lane, A. S., Ho, K., Marty, R. T., & Espinoza, J. C. (2021). “Doc McStuffins: Doctor for a Day” Virtual Reality (DocVR) for pediatric preoperative anxiety and satisfaction: Pediatric medical technology feasibility study. *Journal of Medical Internet Research*, 23(4), e25504.
- Gold, J. I., Kim, S. H., Kant, A. J., Joseph, M. H., & Rizzo, A. S. (2006). Effectiveness of virtual reality for pediatric pain distraction during IV placement. *CyberPsychology & Behavior*, 9(2), 207–212.
- Gold, J. I., & Mahrer, N. E. (2018). Is virtual reality ready for prime time in the medical space? A randomized control trial of pediatric virtual reality for acute procedural pain management. *Journal of Pediatric Psychology*, 43(3), 266–275.
- Goldman, R. D., & Behboudi, A. (2021a). Pilot randomized controlled trial of virtual reality vs. standard-of-care during pediatric laceration repair. *Journal of Child & Adolescent Trauma*, 14(2), 295–298.
- Goldman, R. D., & Behboudi, A. (2021b). Virtual reality for intravenous placement in the emergency department—A randomized controlled trial. *European Journal of Pediatrics*, 180, 725–731.
- Gorini, A., Pallavicini, F., Algeri, D., Repetto, C., Gaggioli, A., & Riva, G. (2010). Virtual reality in the treatment of generalized anxiety disorders. *Annual Review of Cybertherapy and Telemedicine*, 3–43.
- Gujjar, K. R., van Wijk, A., Kumar, R., & de Jongh, A. (2019). Efficacy of virtual reality exposure therapy for the treatment of dental phobia in adults: A randomized controlled trial. *Journal of Anxiety Disorders*, 62, 100–108.
- Guitard, T., Bouchard, S., Bélanger, C., & Berthiaume, M. (2019). Exposure to a standardized catastrophic scenario in virtual reality or a personalized scenario in imagination for generalized anxiety disorder. *Journal of Clinical Medicine*, 8(3), 309–325.
- Gutiérrez-Maldonado, J., Magallón-Neri, E., Rus-Calafell, M., & Peñaloza-Salazar, C. (2009). Virtual reality exposure therapy for school phobia. *Anuario de Psicología*, 40(2), 223–236.

- Jarrett, M. A., & Ollendick, T. H. (2008). A conceptual review of the comorbidity of attention-deficit/hyperactivity disorder and anxiety: Implications for future research and practice. *Clinical Psychology Review*, 28, 1266–1280.
- Kahlon, S., Lindner, P., & Nordgreen, T. (2019). Virtual reality exposure therapy for adolescents with fear of public speaking: A non-randomized feasibility and pilot study. *Child and Adolescent Psychiatry and Mental Health*, 13(1), 1–10.
- Kendall, P. C., Robin, J. A., Hedtke, K. A., Suveg, C., Flannery-Schroeder, E., & Gosch, E. (2005). Considering CBT with anxious youth? Think exposures. *Cognitive and Behavioral Practice*, 12(1), 136–148.
- Krijn, M., Emmelkamp, P. M. G., Olafsson, R. P., & Biemond, R. (2004). Virtual reality exposure therapy of anxiety disorders: A review. *Clinical Psychology Review*, 24, 259–281.
- Kwon, J. H., Hong, N., Kim, K., Heo, J., Kim, J. J., & Kim, E. (2020). Feasibility of a virtual reality program in managing test anxiety: A pilot study. *Cyberpsychology, Behavior, and Social Networking*, 23(10), 715–720.
- Lei, J., Jones, L., & Brosnan, M. (2021). Exploring an e-learning community's response to the language and terminology use in autism from two massive open online courses on autism education and technology use. *Autism*, 25(5), 1349–1367.
- Leyfer, O. T., Folstein, S. E., Bacalman, S., Davis, N. O., Dinh, E., Morgan, J., Tager-Flusberg, H., & Lainhart, J. E. (2006). Comorbid psychiatric disorders in children with autism: Interview development and rates of disorders. *Journal of Autism and Developmental Disorders*, 36, 849–861.
- Li, W. H., Chung, J. O., & Ho, E. K. (2011). The effectiveness of therapeutic play, using virtual reality computer games, in promoting the psychological well-being of children hospitalized with cancer. *Journal of Clinical Nursing*, 20(15–16), 2135–2143.
- Malbos, E., Rapee, R. M., & Kavakli, M. (2013). A controlled study of agoraphobia and the independent effect of virtual reality exposure therapy. *Australian & New Zealand Journal of Psychiatry*, 47(2), 160–168.
- Maskey, M., Lowry, J., Rodgers, J., McConachie, H., & Parr, J. R. (2014). Reducing specific phobia/fear in young people with autism spectrum disorders (ASDs) through a virtual reality environment intervention. *PloS One*, 9(7), e100374.
- Maskey, M., McConachie, H., Rodgers, J., Grahame, V., Maxwell, J., Tavernor, L., & Parr, J. R. (2019). An intervention for fears and phobias in young people with autism spectrum disorders using flat screen computer-delivered virtual reality and cognitive behavior therapy. *Research in Autism Spectrum Disorders*, 59, 58–67.
- Maskey, M., Rodgers, J., Grahame, V., Glod, M., Honey, E., Kinnear, J., Labus, M., Milne, J., Minos, D., McConachie, H., & Parr, J. R. (2019). A randomized controlled feasibility trial of immersive virtual reality treatment with cognitive behavior therapy for specific phobias in young people with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 49(5), 1912–1927.
- Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(10), 980–989.
- Muskett, A., Radtke, S., White, S., & Ollendick, T. (2019). Autism spectrum disorder and specific phobia: The role of sensory sensitivity: Brief review. *Journal of Autism and Developmental Disorders*, 6, 289–293.
- Odgers, K., Kershaw, K. A., Li, S. H., & Graham, B. M. (2022). The relative efficacy and efficiency of single- and multi-session exposure therapies for specific phobia: A meta-analysis. *Behaviour Research and Therapy*, 159, 104203.
- Olbrecht, V. A., O'Connor, K. T., Williams, S. E., Boehmer, C. O., Marchant, G. W., Glynn, S. M., & King, C. D. (2021). Guided relaxation-based virtual reality for acute postoperative pain and anxiety in a pediatric population: Pilot observational study. *Journal of Medical Internet Research*, 23(7), e26328.
- Pallavicini, F., Algeri, D., Repetto, C., Gorini, A., & Riva, G. (2009). Biofeedback, virtual reality and mobile phones in the treatment of Generalized Anxiety Disorder (GAD): A phase-2 controlled clinical trial. *Journal of CyberTherapy & Rehabilitation*, 2(4), 315–327.
- Parrish, D. E., Oxhandler, H. K., Duron, J. F., Swank, P., & Bordnick, P. (2016). Feasibility of virtual reality environments for adolescent social anxiety disorder. *Research on Social Work Practice*, 26(7), 825–835.
- Pelissolo, A., Zaoui, M., Aguayo, G., Yao, S. N., Roche, S., Ecochard, R., Gueyffier, F., Pull, C., Berthoz, A., Jouvent, R., & Cottiaux, J. (2012). Virtual reality exposure therapy versus cognitive behavior therapy for panic disorder with agoraphobia: A randomized comparison study. *Journal of Cybertherapy and Rehabilitation*, 5(1), 35–43.
- Radtke, S. R., Stregé, M. V., & Ollendick, T. H. (2020). Exposure therapy for children and adolescents with social anxiety disorder. In T. Peris, E. Storch, & J. McGuire (Eds.), *Exposure therapy for children with anxiety and OCD* (pp. 193–219). Academic Press.
- Repetto, C., Gaggioli, A., Pallavicini, F., Cipresso, P., Raspelli, S., & Riva, G. (2013). Virtual reality and mobile phones in the treatment of generalized anxiety disorders: A phase-2 clinical trial. *Personal and Ubiquitous Computing*, 17(2), 253–260.
- Rodebaugh, T. L., Holaway, R. M., & Heimberg, R. G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review*, 24(7), 883–908.
- Ryu, J. H., Park, J. W., Nahm, F. S., Jeon, Y. T., Oh, A. Y., Lee, H. J., Kim, J. H., & Han, S. H. (2018). The effect of gamification through a virtual reality on preoperative anxiety in pediatric patients undergoing general anesthesia: A prospective, randomized, and controlled trial. *Journal of Clinical Medicine*, 7(9), 284.
- Sarver, N. W., Beidel, D. C., & Spitalnick, J. S. (2014). The feasibility and acceptability of virtual environments in the treatment of childhood social anxiety disorder. *Journal of Clinical Child & Adolescent Psychology*, 43(1), 63–73.
- Shetty, V., Suresh, L. R., & Hegde, A. M. (2019). Effect of virtual reality distraction on pain and anxiety during dental treatment in 5 to 8 year old children. *Journal of Clinical Pediatric Dentistry*, 43(2), 97–102.
- Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: The effectiveness of a social skills training-based, cognitive-behavioral intervention, with and without parental involvement. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 41(6), 713–726.
- St-Jacques, J., Bouchard, S., & Bélanger, C. (2010). Is virtual reality effective to motivate and raise interest in phobic children toward therapy? A clinical trial study of in-vivo with in-vitro versus in-vivo only treatment exposure. *The Journal of Clinical Psychiatry*, 71(7), 924–931.
- Stunden, C., Stratton, K., Zakani, S., & Jacob, J. (2021). Comparing a virtual reality-based simulation App (VR-MRI) with a standard preparatory manual and child life program for improving success and reducing anxiety during pediatric medical imaging: Randomized clinical trial. *Journal of Medical Internet Research*, 23(9), e22942.
- Sülter, R. E., Ketelaar, P. E., & Lange, W. G. (2022). SpeakApp-Kids! Virtual real-

ity training to reduce fear of public speaking in children—A proof of concept. *Computers & Education*, 178, 104384.

Van Rooij, M., Lobel, A., Harris, O., Smit, N., & Granic, I. (2016, May). DEEP: A biofeedback virtual reality game for children at-risk for anxiety. In *Proceedings of the 2016 CHI conference extended abstracts on human factors in computing systems* (pp. 1989–1997).

Vincelli, F., & Riva, G. (2002). Virtual reality: A new tool for panic disorder therapy. *Expert Review of Neurotherapeutics*, 2(3), 377–383.

Wehry, A. M., Beesdo-Baum, K., Hennelly, M. M., Connolly, S. D., & Strawn, J. R. (2015). Assessment and treatment of anxiety disorders in children and adoles-

cents. *Current Psychiatry Reports*, 17(7), 1–11.

Wong, C. L., Li, C. K., Chan, C. W., Choi, K. C., Chen, J., Yeung, M. T., & Chan, O. N. (2021a). Virtual reality intervention targeting pain and anxiety among pediatric cancer patients undergoing peripheral intravenous cannulation: A randomized controlled trial. *Cancer Nursing*, 44(6), 435–442.

Wong, C. L., Li, C. K., Choi, K. C., So, W. K. W., Kwok, J. Y. Y., Cheung, Y. T., & Chan, C. W. H. (2021b). Effects of immersive virtual reality for preventing and managing anxiety, nausea and vomiting among pediatric cancer patients receiving their first chemotherapy: A

study protocol for an exploratory trial. *PloS One*, 16(10), e0258514.

Zheng, J. M., Chan, K. W., & Gibson, I. (1998). Virtual reality. *Ieee Potentials*, 17(2), 20–23.

...

No conflicts of interest or funding to report.

Correspondence to Matthew Jarrett,

Ph.D., Department of Psychology, University of Alabama, Tuscaloosa, AL 35487

majarrett@ua.edu

ORIGINAL RESEARCH

Emerging Trends in Sexual Minority Identification and Clinical Implications for Treating OCD and Related Disorders

Andreas Beahler, *Fordham University*

Brian A. Feinstein, *Rosalind Franklin University of Medicine and Science*

Martha J. Falkenstein and Jennie M. Kuckertz, *Obsessive Compulsive Disorder Institute, McLean Hospital, and Harvard Medical School*

SEXUAL MINORITY (SM; e.g., gay, lesbian, bisexual) people are at significantly increased risk for developing psychopathology (e.g., anxiety, depression) compared to heterosexual individuals (Eaton, 2014; Meyer, 2003; Semlyen et al., 2016; Wittgens et al., 2022). For example, SM adults are more likely to endorse symptoms of generalized anxiety disorder, panic disorder, social anxiety disorder, posttraumatic stress disorder, and depression compared to heterosexual individuals (Cohen et al., 2016). The minority stress model is the predominant conceptual framework used to explain the health disparities affecting SM people (Brooks, 1981; Meyer, 2003). It posits that SM individuals experience unique stressors related to their stigmatized social status, which in turn contributes to their disproportionate rates of psychopathology. Meyer described a continuum of minority stress experiences, ranging from distal or external experiences (e.g., prejudice, microaggressions, discrim-

inatory laws and policies) to proximal or internal experiences (e.g., internalization of negative societal attitudes, expectations of rejection, identity concealment).

Mental health disparities between SM and heterosexual people are particularly striking for obsessive-compulsive disorder (OCD). In a sample of 702 undergraduate students who were also members of the U.S. Armed Services, the rate of having been diagnosed with or treated for OCD within the last 12 months was nine times higher for SM individuals (9%) compared to heterosexual individuals (1%; Pelts & Albright, 2015). Further, SM individuals represented 18% of patients in a recent study of an OCD treatment program (Beahler et al., 2022), which is disproportionate to the percentage of SM individuals in the general population (3.5–7.1%; Gates, 2011; Jones, 2022). While these data demonstrate sexual orientation disparities in OCD diagnosis and treatment, additional research is needed to determine the

magnitude of these disparities in more representative samples. Given that Pelts and Albright (2015) examined these disparities in a sample of undergraduate students who were also members of the U.S. Armed Forces, their experiences may not generalize to the larger population and they may experience unique stressors related to their military service. Moreover, the SM population is heterogeneous and there is some evidence of differential risk for developing OCD among specific subgroups. For example, one study found that bisexual men are twice as likely as gay men to be diagnosed with OCD (Batchelder et al., 2021). Still, further research is necessary to understand diagnosis and treatment rates in more representative samples and among specific sexual orientation subgroups.

Exposure and response prevention (ERP; Ferrando & Selai, 2021; Öst et al., 2021) is the first-line treatment modality for OCD and is associated with significant reductions in OCD symptoms and related clinical concerns (e.g., distress intolerance, dysfunctional beliefs; McKay et al., 2015). However, the support for evidence-based interventions in general has overwhelmingly been based on studies with nonminoritized samples (i.e., White, heterosexual, cisgender individuals) and emerging evidence supports the efficacy of interventions for SM individuals that incorporate a focus on minority stress (Pachankis et al., 2022). Moreover, past research on the efficacy of ERP among racial, ethnic, and gender minority individuals has demonstrated worse treatment outcomes and longer lengths of stay in treatment compared to White and cisgender individuals (Pinciotti, Nuñez, et al., 2022; Williams et al., 2015), which may extend to SM indi-

viduals, although this requires further investigation. As such, the increased rate of SM identification and high rate of SM people diagnosed with and treated for OCD are particularly important, as prior findings highlight the need for treatment providers to be able to provide culturally competent services to minoritized patients.

In recent years, SM identification has significantly increased among youth (Phillips et al., 2019) and adults (Jones, 2022), further underscoring the importance of attending to their unique health-related needs. Given (a) increases in SM identification in the general population (Jones, 2021; Phillips et al., 2019), (b) evidence of sexual orientation disparities in mood and anxiety disorders (Cohen et al., 2016; Meyer, 2003; Semlyen et al., 2016; Wittgens et al., 2022), and (c) emerging evidence of sexual orientation disparities in OCD (Pelts & Albright, 2015), we sought to examine whether similar increases in SM identification were present in a sample of adult patients attending an OCD treatment program. If we observe similar trends in a treatment-engaged sample, it will support the necessity for affirming OCD treatment for the growing population of SM individuals. As such, in the current article, we seek to: (a) report on rates of SM identification over the past 5 years in a sample of adults with OCD and related disorders; (b) discuss potential explanations for observed trends; and (c) advocate for the necessity of

providing identity-affirming OCD treatment for SM individuals.

Method

Participants

This study was reviewed and approved by the hospital system's Institutional Review Board. Participants ($n = 470$) included SM ($n = 102$) and heterosexual ($n = 366$) adults (aged ≥ 18 ; $M = 29.20$, $SD = 19.69$) who participated in partial hospital or residential treatment for OCD and related disorders in the Northeastern United States between April 2018 and December 2022. Over the 5-year period, 23% of patients identified as SM individuals: 6% gay or lesbian ($n = 28$), 8% bi+ (i.e., bisexual or pansexual, $n = 36$), 3% asexual ($n = 12$), 2% queer ($n = 11$), and 3% reported that their sexual orientation was not listed ($n = 15$). For individuals who did not wish to disclose their sexual orientation (1.9%, $n = 9$), their data were not analyzed. The majority of the sample identified as cisgender (96%, $n = 451$), while the remaining individuals identified as gender nonconforming ($n = 7$), transgender ($n = 4$), nonbinary ($n = 4$), or as a gender that was not listed ($n = 4$). Of note, participants of all genders were categorized by their sexual orientation (SM vs. heterosexual). Most participants were White (80%, $n = 376$) and not Latinx (96%, $n = 452$). All participants were individuals in a partial hospital or residential treatment program

for OCD who consented to have their deidentified data added to a research database. Given that the data were collected in a naturalistic treatment setting, potential participants included all individuals who entered treatment from 2018–2022. As such, participants were not specifically recruited for this study. Full demographic information is listed in Tables 1 and 2.

Treatment Setting

The McLean Hospital OCD Institute (OCIDI) includes partial hospital and residential levels of care for OCD and related disorders. Partial hospital care was delivered in person (2018–2020) or virtually (2020–2022). Treatment across both levels of care includes individual behavior therapy, group therapy, family therapy, and medication management with psychiatrists. All clinicians are licensed psychologists, social workers, psychiatrists, or trainees working under the supervision of a licensed clinician (i.e., psychology postdoctoral fellows, clinical research assistants, and clinical externs). For more information about the treatment program, refer to Krompinger et al. (2017) and Stewart et al. (2005).

Demographic Measures

Our demographic questionnaire, administered at program admission, included questions related to age, race, ethnicity, sexual orientation, gender identity, socioeconomic status, and specific questions related to prior treatment. Of note, our demographic form changed in February 2022 to provide patients with two more response options for sexual orientation. The older form, administered from April 2018 to February 2022, included five response options for sexual orientation (gay, lesbian, bisexual, heterosexual, queer, and not listed with a write-in option), whereas the newer form included two additional response options (pansexual and prefer not to answer).

Results

Rates of SM identification increased over the 5 years of data collection (2018–2022) and were as follows: 17% in 2018, 16% in 2019, 24% in 2020, 22% in 2021, and 38% in 2022. See Table 1 for the breakdown of specific SM identities by year. To test whether or not this change was statistically significant, we tested a logistic regression model using the nlme package (Pinheiro et al., 2022) in R (R Core Team, 2022). The result indicated that there was a significant linear trend, such that rates of

Table 1. Rates of Sexual Minority Identification Across 5 Years (2018–2022)

Year	n (%)				
	2018 ¹	2019	2020	2021	2022
Sexual Orientation					
Asexual	2 (1.7%)	4 (3.0%)	1 (2.0%)	0 (0.0%)	5 (5.4%)
Bisexual	6 (5.0%)	8 (6.0%)	3 (6.0%)	4 (6.1%)	15 (16.1%)
Gay	5 (4.2%)	5 (3.8%)	3 (6.0%)	5 (7.6%)	7 (7.5%)
Heterosexual	101 (83.0%)	112 (84.0%)	41 (76.0%)	54 (78.0%)	58 (62.0%)
Lesbian	0 (0.0%)	1 (0.8%)	0 (0.0%)	1 (1.5%)	1 (1.1%)
Not Listed	5 (4.2%)	3 (2.3%)	2 (4.0%)	2 (3.0%)	3 (3.2%)
Pansexual ²	N.A	N.A	N.A	N.A	2 (2.2%)
Queer	2 (1.7%)	0 (0.0%)	4 (7.4%)	3 (4.3%)	2 (2.2%)
SM Total	20 (17%)	21 (16%)	13 (24%)	15 (22%)	35 (38%)

¹ Only includes participants who admitted to the program in April 2018, due to not collecting data about sexual orientation prior to April, 2018

² Demographic forms were updated in February of 2022 to include pansexual and prefer not to answer.

SM identification significantly increased across years, $B = .28$, $t(469) = 3.75$, $p < .001$, with a medium effect size ($d = 0.43$). Given that the demographic form was updated with two additional sexual orientation response options in February 2022, we also examined whether there was a significant change in SM identification from before this change to after using a chi-square test. The results indicated that there was a significant increase in SM identification, $\chi^2(1) = 12.96$, $p < .001$, with a moderate effect size (Cramer's $V = .17$). Due to the chi-square test being significant, the linear trend analysis was rerun excluding the data from 2022, which had a larger proportion of SM individuals. After excluding the data from 2022, the linear trend was no longer statistically significant, $B = .15$, $t(376) = 1.23$, $p = .217$, $d = .16$.

Discussion

Our primary finding was a significant increase in SM identification over the last 5 years (2018–2022) among patients in treatment for OCD. Among SM patients, bi+ identities were the most commonly endorsed in 4 of the 5 years. In the most recent year of data collection (2022), over half of SM patients (54%) identified as bi+. The trends observed in our program mirror broader trends of increases in SM identification over time in the United States. For example, from 2005 to 2015, there were significant increases in SM identification among adolescents, and these increases were larger for bisexual identification (4.6% to 9.4% for female youth; 1.6% to 2.8% for male youth) than for lesbian/gay identification (0.8% to 1.9% for female youth; 1.2% to 2.1% for male youth; Phillips et al., 2019). Similarly, from 2008 to 2018, there was a significant increase in the proportion of adults in the United States who identified as bisexual (1.1% to 3.3%), but not gay/lesbian (1.6% to 1.7%; Bridges, 2019).

While our findings are consistent with these national trends, the proportion of SM individuals in our sample (16–38% depending on the year) was 4 to 9 times higher than rates of SM identification in the broader population (3.5–7.1%; Gates, 2011; Jones, 2022). This finding highlights the overrepresentation of SM individuals in treatment for OCD. Sexual orientation disparities in OCD (Pelts & Albright, 2015) are likely a key contributor to this overrepresentation, but additional research is needed to examine rates of OCD among SM versus heterosexual individuals in

more representative samples. As SM individuals represent a substantial proportion of individuals seeking OCD treatment, there is a critical need to ensure that clinicians are providing affirming care for SM individuals and especially for bi+ individuals. Prior studies have found that bi+ people continue to report worse mental health compared to heterosexual and gay/lesbian people even after treatment (Beard et al., 2017; Rimes et al., 2019). Further, bi+ people have described negative experiences with mental healthcare providers (e.g., having their bisexuality dismissed and pathologized; Eady et al., 2011), and they report worse perceptions of mental healthcare compared to heterosexual and gay/lesbian people (Beard et al.). Of note, prior research has found that clinicians report lower levels of perceived competence for affirmative practice with bisexual clients compared to gay/lesbian clients (Ebersole et al., 2018), and clinicians' negative attitudes toward bisexuality are associated with lower levels of bisexual counseling competence (Brooks & Inman, 2013). These findings underscore the need for clinicians to receive training to ensure they have basic knowledge about bisexuality and the unique stressors that bi+ people experience, and that they are aware of (and, if necessary, that they challenge) their own attitudes toward bi+ identities.

There are several potential explanations for the increase in SM identification from 2018–2022 that we observed in our sample. First, the mean age of our sample was 29.2, suggesting that many of our participants were born in more recent generations (e.g., Millennials and Generation Z). This is consistent with recent evidence that younger generations are especially likely to endorse SM identities. For example, 20% of people born between 1997–2003 (Generation Z) reported SM identities compared to 3.5–7.1% of all combined age groups (Gates, 2011; Jones, 2022). This may represent a sociocultural shift in the extent to which people feel comfortable disclosing SM identities. However, given the lack of published data on changes in the demographic composition of patient populations over time, we do not know if the trend observed in the current study is unique to the specific treatment setting. We encourage treatment programs to make these data available to advance our understanding of the changing demographics of patients across settings, which would help clarify whether our findings are unique to the specific treatment setting or representative of a larger cultural shift in self-identification.

Although we observed a significant increase in SM identification after we updated our demographic form to include pansexual as a response option, only two patients identified as pansexual in 2022. As such, the change to the demographic form is unlikely to account for the significant increase in SM identification. Although we cannot determine why we observed such a large increase in SM identification from 2021 to 2022, these findings highlight the importance of paying close attention to patients' identities and continuously updating demographic forms and services offered to foster inclusivity in research and healthcare settings. Last, although speculative, the large proportion of SM individuals in the current treatment program may suggest that SM patients perceive partial hospital and residential treatment for OCD as acceptable treatment modalities.

Implications for Providing Affirming OCD Treatment to SM Patients

As noted, the large proportion of SM patients in our treatment program, especially in 2022, highlights the critical need for OCD treatment that is affirming of SM individuals. Based on our emerging results (i.e., rates of SM identification ranging from 16–38%), we encourage clinicians treating OCD to consider the following: (a) assess potential negative bias held toward SM individuals by providers, (b) seek out opportunities to learn about the unique stressors that SM individuals face, and (c) consider the extent to which minority stress may be contributing to more severe OCD symptoms. Past research examining CBT among SM individuals has suggested that identity-affirming adjunctive modules can enhance treatment acceptability for SM people (Pachankis et al., 2022). Based on these findings, we suggest a similar approach to ERP, which could benefit SM individuals by pulling in strategies focused on identifying and addressing minority stressors. Examining one's own biases and remaining humble and open to learning is important in providing high-quality care for everyone.

The implementation of ERP has often perpetuated problematic ideologies, with providers reinforcing harmful stereotypes about certain populations during exposures. This has commonly been the case when targeting sexual orientation obsessions, which may include intrusive thoughts about possibly being gay. Many providers treating sexual orientation obsessions (among both SM and heterosexual individuals) have staged exposures utiliz-

Table 2. Demographic Characteristics

Sample (N) = 470	M (SD) or N (%)
Age	29.2 (10.7)
Average length of stay (in days)	59.7 (25.3)
Gender ¹	
Gender Non-Conforming	7 (1.5)
Man	213 (46.0)
Not Listed	4 (0.9)
Transgender	4 (0.9)
Woman	238 (51.1)
Race/Ethnicity	
African American/Black	12 (2.6)
Asian	18 (3.9)
Do not know	12 (2.6)
Latinx	14 (3.0)
Middle Eastern	8 (1.7)
Native American/Alaskan Native	4 (0.9)
Native Hawaiian or Pacific Islander	0 (0.0%)
Not listed	26 (5.5)
White	376 (80.0)
Education	
8th grade or less	1 (0.2)
Some high school	8 (1.7)
High school graduate/GED	61 (13.0)
Some college	151 (32.1)
Associates degree (e.g., community college or vocational/technical school)	26 (5.5)
Bachelor's degree	155 (33.0)
Graduate or professional degree	68 (14.5)

¹Gender may not be reflective of participants' identities as we did not initially include adequate response options in our demographic form to allow participants to endorse a range of transgender and nonbinary identities. We have since modified our demographic form to be more inclusive. Specifically, before February 2022, response options included: *male*, *female*, *transgender*, *gender nonconforming*, and *not listed*. After February 2022, response options were updated to include: *woman*, *man*, *transgender woman*, *transgender man*, *gender nonconforming*, *genderqueer*, *nonbinary*, *not listed*, and *prefer not to answer*.

ing negative stereotypes about SM individuals (e.g., having an individual “act gay” to engage in stereotypical behaviors, or having an individual write out harmful words describing SM individuals; Pinciotti et al., 2022). The impact of using negative stereotypes within the context of treatment perpetuates an environment where it is not safe for SM people to disclose their sexual orientation for fear of experiencing negative treatment. ERP should be imagined through an identity-affirming lens, such that treatment of obsessions related to marginalized populations (e.g., fear of being gay, fear of being racist) avoids utilizing harmful stereotypes within the context of exposure. Specifically, when obsessions relate to a marginalized group, it is critical that clinicians use extra caution

when staging exposures and provide an emphasis on addressing minority stressors (e.g., discussing how microaggressions can affect mental health) impacting the client.

Given our finding that over one-third of patients in a partial hospital/residential program seeking OCD treatment were SM individuals, it is critical that all providers have the expectation and training to competently deliver ERP treatment to SM populations, including SM subgroups (e.g., bi+ individuals). This clinical need is consistent with a larger movement emphasizing that providing identity-affirming care should not be an optional part of providers' education but mainstreamed into all training curricula, acknowledging the multifaceted impact of stigma on treatment efficacy (Wadsworth et al., 2020).

Limitations and Challenges for Future Research

There were several limitations to the current study. First, it is difficult to disentangle the effects of generational shifts, geographic differences in sociocultural/political environment, and the impact of COVID-19 on SM individuals seeking treatment for OCD and related disorders. Second, we were only able to capture rates of those willing to self-disclose a SM identity and are mindful that SM individuals may not have disclosed due to perceived negative consequences of doing so. Therefore, rates reported here may represent an underestimate of current representation of SM individuals in our treatment program. Third, despite updates to our demographic form in 2022, it was still not as inclusive as it could have been (i.e., many SM identities were not included as response options), which may have impacted responses. Furthermore, prior to 2018 our demographic form did not include questions about sexual orientation or gender identity, so we are unable to speak to longer-term trends. Fourth, a major limitation of our study is the lack of racial and ethnic diversity in the sample, as only 20% identified themselves as non-White. Previous research highlights the importance of understanding how intersecting identities uniquely impact mental health (e.g., the impact of both homophobia and racism; Huang et al., 2020; Wadsworth et al., 2020), thus, further research should examine trends of identification in a more racially, ethnically, and gender diverse sample. Last, demographic information about providers was not systematically collected, and most often program clinicians identified as White, cisgender, and heterosexual, and varied widely in their training and ongoing efforts related to diversity, equity, and inclusion. As such, future research should collect data on the level of training and competency of healthcare providers to deliver affirming care to SM individuals.

Conclusions

Rates of SM identification in OCD treatment settings are high and our data suggest that they are increasing over time. Given that SM individuals represented 16–38% of those in our treatment program for OCD, clinicians must be equipped to deliver identity-affirming ERP therapy. Commonly used exposure exercises that perpetuate negative stereotypes of SM individuals need to be reimagined from an identity-affirming framework. Suggestions include improving clinical training curric-

ula, examining and challenging one's own biases, requiring supervision with an individual who has experience implementing SM identity-affirming interventions, and using the most up-to-date language when asking questions regarding SM identities in demographic forms. The National Academies of Sciences, Engineering, and Medicine (NASEM) recently published their recommendation for how to assess sexual identity (NASEM, 2022). Their recommendation includes four specific response options (lesbian/gay, straight, bisexual, and two-spirit), but it does not include response options for other SM identities (e.g., pansexual, queer, asexual). Although they recommend including a write-in for "I use a different term," providing a wider range of response options is likely to be more affirming of SM peoples' diverse identities. We emphasize that treatment for SM individuals cannot be a special-interest topic; instead, providers must expect to see clients who are diverse in sexual orientation and be competent in providing affirming treatment. Last, we emphasize the need for providers to be humble, continuously seek diversity education, and ask for help from colleagues from a variety of training levels, backgrounds, and identities when questions arise regarding implementing affirming treatment.

References

- Batchelder, A. W., Fitch, C., Feinstein, B. A., Thiim, A., & O'Leirigh, C. (2021). Psychiatric, substance use, and structural disparities between gay and bisexual men with histories of childhood sexual abuse and recent sexual risk behavior. *Archives of Sexual Behavior*, 50, 2861–2873. <https://doi.org/10.1007/s10508-021-02037-1>
- Beard, C., Kirakosian, N., Silverman, A. L., Winer, J. P., Wadsworth, L. P., & Björgvinsson, T. (2017). Comparing treatment response between LGBTQ and heterosexual individuals attending a CBT- and DBT-skills based partial hospital. *Journal of Consulting and Clinical Psychology*, 85(12), 1171–1181. <https://doi.org/10.1037/ccp0000251>
- Bezahler, A., Kuckertz, J. M., Schreck, M., Narine, K., Dattolico, D., & Falkenstein, M. J. (2022). Examination of outcomes among sexual minorities in treatment for obsessive-compulsive and related disorders. *Journal of Obsessive-Compulsive and Related Disorders*, 33, 100724. <https://doi.org/10.1016/j.jocrd.2022.100724>
- Bridges, T. (2019, April 12). 2018 GSS update on the U.S. LGB population. *Inequality by (Interior) Design*. Retrieved March 3, 2023, from <https://inequality-byinteriordesign.wordpress.com/2019/04/12/2018-gss-update-on-the-u-s-lgb-population>
- Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington Books.
- Brooks, L. M., & Inman, A. G. (2013). Bisexual counseling competence: Investigating the role of attitudes and empathy. *Journal of LGBTQ Issues in Counseling*, 7(1), 65–86. <https://doi.org/10.1080/15538605.2013.756366>
- Cohen, J. M., Blasey, C., Taylor, C. B., Weiss, B. J., & Newman, M. G. (2016). Anxiety and related disorders and concealment in sexual minority young adults. *Behavior Therapy*, 47(1), 91–101. <https://doi.org/10.1016/j.beth.2015.09.006>
- Eady, A., Dobinson, C., & Ross, L. E. (2011). Bisexual people's experiences with mental health services: A qualitative investigation. *Community Mental Health Journal*, 47(4), 378–389. <https://doi.org/10.1007/S10597-010-9329-x>
- Eaton, N. R. (2014). Transdiagnostic psychopathology factors and sexual minority mental health: Evidence of disparities and associations with minority stressors. *Psychology of Sexual Orientation and Gender Diversity*, 1(3), 244. <https://doi.org/10.1037/sgd0000048>
- Ebersole, R. C., Dillon, F. R., & Eklund, A. C. (2018). Mental health clinicians' perceived competence for affirmative practice with bisexual clients in comparison to lesbian and gay clients. *Journal of Bisexuality*, 18(2), 127–144. <https://doi.org/10.1080/15299716.2018.1428711>
- Ferrando, C., & Selai, C. (2021). A systematic review and meta-analysis on the effectiveness of exposure and response prevention therapy in the treatment of obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, 31, 100684. <https://doi.org/10.1016/j.jocrd.2021.100684>
- Gates, G. J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* UCLA School of Law Williams Institute. Retrieved from: <https://williamsinstitute.law.ucla.edu/publications/how-many-people-lgbt/>
- Huang, Y. T., Ma, Y. T., Craig, S. L., Wong, D. F. K., & Forth, M. W. (2020). How intersectional are mental health interventions for sexual minority people? A systematic review. *LGBT Health*, 7(5), 220–236. <https://doi.org/10.1089/lgbt.2019.0328>
- Jones, J. M. LGBT Identification in U.S. Ticks up to 7.1%. *Gallup*. <https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx>
- Krompinger, J. W., Monaghan, S. C., Gironde, C. M., Garner, L. E., Crosby, J. M., Brennan, B. P., & Elias, J. A. (2017). Early response is predictive of outcome in intensive behavioral treatment for obsessive compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, 15, 57–63. <https://doi.org/10.1016/j.jocrd.2017.10.001>
- McKay, D., Sookman, D., Neziroglu, F., Wilhelm, S., Stein, D. J., Kyrios, M., ... Veale, D. (2015). Efficacy of cognitive-behavioral therapy for obsessive-compulsive disorder. *Psychiatry Research*, 225(3), 236–246. <https://doi.org/10.1016/j.psychres.2014.11.058>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674. <https://doi.org/10.1037/0033-2909.129.5.674>
- National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Committee on National Statistics; Committee on Measuring Sex, Gender Identity, and Sexual Orientation. (2022). Becker, T., Chin, M., Bates, N. (Eds.). *Measuring sex, gender identity, and sexual orientation*. National Academies Press <https://www.ncbi.nlm.nih.gov/books/NBK578625/>
- Öst, L. G., Havnen, A., Hansen, B., & Kvale, G. (2015). Cognitive behavioral treatments of obsessive-compulsive disorder. A systematic review and meta-analysis of studies published 1993–2014. *Clinical Psychology Review*, 40, 156–169. <https://doi.org/10.1016/j.cpr.2015.06.003>
- Pachankis, J. E., Harkness, A., Maciejewski, K. R., Behari, K., Clark, K. A., McConocha, E., ... Safren, S. A. (2022). LGBTQ-affirmative cognitive-behavioral therapy for young gay and bisexual men's mental and sexual health: A three-arm randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 90(6), 459–477. <https://doi.org/10.1037/ccp0000724>
- Pelts, M. D., & Albright, D. L. (2015). An exploratory study of student service members/veterans' mental health characteristics by sexual orientation. *Journal of American College Health*, 63(7), 508–512. <https://doi.org/10.1080/07448481.2014.947992>
- Pinciotti, C. M., Nuñez, M., Riemann, B. C., & Bailey, B. E. (2022). Clinical Presentation and Treatment Trajectory of Gender Minority Patients with Obsessive-Compulsive Disorder. *Journal of Cognitive Psychotherapy*, 36(1), 42–59. <https://doi.org/10.1891/jcpsy-d-20-00022>
- Pinciotti, C. M., Smith, Z., Singh, S., Wetterneck, C. T., & Williams, M. T. (2022). Call to action: Recommendations for justice-based treatment of obsessive-com-

pulsive disorder with sexual orientation and gender themes. *Behavior Therapy*, 53(2), 153-169. <https://doi.org/10.1016/j.beth.2021.11.001>

Pinheiro, J., Bates, D., & R Core Team (2022). *nlme: Linear and Nonlinear Mixed Effects Models*. R package version 3.1-159, <https://CRAN.R-project.org/package=nlme>.

Phillips, G., 2nd, Beach, L. B., Turner, B., Feinstein, B. A., Marro, R., Philbin, M. M., Salamanca, P., Felt, D., & Birkett, M. (2019). Sexual Identity and Behavior Among U.S. High School Students, 2005-2015. *Archives of Sexual Behavior*, 48(5), 1463-1479. <https://doi.org/10.1007/s10508-019-1404-y>

R Core Team (2022). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing, Vienna, Austria. <https://www.R-project.org/>.

Rimes, K. A., Ion, D., Wingrove, J., & Carter, B. (2019). Sexual orientation differences in psychological treatment outcomes for depression and anxiety: National cohort study. *Journal of Consulting and Clinical Psychology*, 87(7), 577-589. <https://doi.org/10.1037/ccp0000416>

Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental

disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, 16, 1-9. <https://doi.org/10.1186/s12888-016-0767-z>

Stewart, S. E., Stack, D. E., Farrell, C., Pauls, D. L., & Jenike, M. A. (2005). Effectiveness of intensive residential treatment (IRT) for severe, refractory obsessive-compulsive disorder. *Journal of Psychiatric Research*, 39(6), 603-609. <https://doi.org/10.1016/j.jpsy-chires.2005.01.004>

Wadsworth, L. P., Potluri, S., Schreck, M., & Hernandez-Vallant, A. (2020). Measurement and impacts of intersectionality on obsessive-compulsive disorder symptoms across intensive treatment. *American Journal of Orthopsychiatry*, 90(4), 445-457. <https://doi.org/10.1037/ort0000447>

Williams, M. T., Sawyer, B., Leonard, R. C., Ellsworth, M., Simms, J., & Riemann, B. C. (2015). Minority participation in a major residential and intensive outpatient program for obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, 5, 67-75. <https://doi.org/10.1016/j.jocrd.2015.02.004>

Wittgens, C., Fischer, M. M., Buspavanich, P., Theobald, S., Schweizer, K., & Trautmann, S. (2022). Mental health in people with minority sexual orientations: A meta-analysis of population-based stud-

ies. *Acta Psychiatrica Scandinavica*, 145(4), 357-372. <https://doi.org/10.1111/acps.13405>

...

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

From the OCD Institute (OCIDI), we thank Olivia Woodson, Junjia (Judy) Xu, Heather Martin, Devin Dattolico, Kara Kelley, Sri-ranya Potluri, Alexandra Hernandez-Vallant, Eric Tiffit, Lauryn Garner, Jason Krompinger, and Diane Davey for their contributions to the development and ongoing support of the OCIDI's research program. Brian Feinstein's time was supported by a grant from the National Institute on Drug Abuse (K08DA045575). Martha Falkenstein's time was supported by a grant from the National Institute of Mental Health (1K23MH126193). The content is solely the responsibility of the authors and does not necessarily represent the official views of the funding agency.

Correspondence to Andreas Bezahlter, 441 E Fordham Rd, The Bronx, NY 10458 abezahler@fordham.edu

OP-ED

Systematic Errors in Communication: Our Failure as Mental Health Providers to Reach the General Public

Joseph R. Taliercio, *Cognitive & Behavioral Consultants, White Plains, NY*

AS THE ASSOCIATION for Behavioral and Cognitive Therapies (ABCT) conference concluded this past November, I was left reflecting on the previous days and the incredible therapeutic potential. And yet, even with the near two-decade delay from idea formulation to clinical practice (Morris et al., 2011), I was struck with the realization that so few will learn of these advancements. For in reality, a grand dilemma exists in mental healthcare, one that many of us who identify as mental health providers cannot easily observe. For years, my friends and family who are employed within communications, from public relations to television production,

have vocalized a unified message: Our field is inaccessible to the public. While there remains a growing interest in studying mental health (Bureau of Labor Statistics, 2022; Clay, 2017), to the outside world we appear as insular, communicating only with ourselves and utilizing incomprehensible jargon (Abrams, 2022). In talking with those who reside outside of our field, I am reminded that we need to improve our communication style. And more recently, in talking with peers about my growing concern and observation, I have been met with similar concern and agreement, only highlighting the need to be more direct in discussing this systematic disconnect. Even

with ongoing dissemination efforts, such as through ABCT's Public Education and Media Dissemination Committee (n.d.), or the establishment of The World Confederation of Cognitive and Behavioural Therapies (2019), significant additional effort is required.

Before we can initiate change, it is important to first acknowledge that real barriers exist related to this communication divide, some of which we do not have immediate control over. For example, for those of us who identify as researchers, many people simply do not trust our professional identity, with 77% of Americans expressing at least some reservation towards scientists (Pew Research Center, 2016). And for those of us who identify as practitioners, nearly half of Americans view seeking our services as a sign of personal weakness (McNally, 2021). Further, it is important to recognize what potential impact our growing political advocacy (APA, 2023; Garrison et al., 2017; Stapleton et al., 2022) might also have on our image. Ninety-seven percent of the public expresses some hesitation of politicians' motives (Pew Research Center, 2016).

Therefore, while such political and social advocacy remains vital, and should be expanded, we must also recognize the potential that our image could be further challenged due to our growing enrollment in politics. (However, I would argue this potential cost is worth the chance of achieving significant systematic change.) Overall, we are attempting to encourage change by communicating information about evidence-based treatments and mental health in a world that is challenged by distrust and may view working with us as a sign of a personal deficit.

Potentially related to this issue of mistrust, another of our failures relates to our inability to generate—as my wife, an experienced New York City-based publicist plainly puts it—“good PR.” Mental healthcare providers need to invest in their own image. Many of my friends, family, and first-time patients imagine Freud and his analysis as the exemplifier of our work. Upon first meeting us, people jokingly express concern that we are “analyzing them.” When presented in popular media, mental healthcare providers are often portrayed as unreliable, untrustworthy, or even evil. (What inaccurate and harmful portrayals of therapy or mental health come to mind for you when thinking across television and cinema?) Further, our field’s painful histories continue to be discussed (rightly so), from studying the use of aversion therapy with LGBTQ+ clients (ABCT, 2022) to providing a scientific basis to justify racism in the form of IQ testing (Beit-Hallahmi, 1994), understandably adding to the public’s distrust of scientists and clinicians.

Despite ongoing attempts to foster open discussions of such past wrongs, this message is not effectively communicated to the mass public. Ineffective treatments persist, false narratives spread, and pseudoscience thrives (Lilienfeld et al., 2009). Even more egregious is the fact that we have the knowledge and tools to provide guidance and encourage effective change with some of the most concerning issues today, including reducing deaths from mass shootings (Peterson et al., 2021), curbing vaccine hesitation (Li et al., 2021), and diminishing the impact of the loneliness pandemic (Deckx et al., 2018). Yet the public remains hesitant of our recommendations. We must do better!

With all of these challenges, how exactly do we further implement effective change in our communication styles? I propose three methods to foster our public perception. First, we need to utilize popular

media. While providers are increasingly more likely to utilize social media, from LinkedIn to Facebook, we are most likely reaching those who were already listening. We are not spreading our message as far as we think (Alipourfard et al., 2020). We need to utilize other mediums for communication, such as television, popular news, radio, and podcasts (Shankar, 2015–present; van Sant, 1996). Relatedly, we need to do better at ensuring accurate mental healthcare treatment and knowledge is portrayed in such popular mediums. The recent online discussion that resulted from a comic book–based television show accurately describing dialectical behavioral therapy (DBT; Gao & Coiro, 2022) only hints at the potential of effective communication within popular media. We know that science communication can be well received by the mass public—just observe the influences of and public familiarity with Bill Nye or the late Dr. Carl Sagan. Furthermore, as we come out of the COVID-19 pandemic, take note of the public’s interest in Dr. Anthony Fauci. Despite attempts to discredit him, and even advocate for his criminal prosecution, overall, most Americans have retained trust for Dr. Fauci (Annenberg Public Policy Center, 2021). Mental healthcare needs its own version of such public figures, while simultaneously recognizing not all mental health providers are without controversy or would be valid spokespeople (Bowles, 2018). Perhaps the Director of NIMH can become a more public position?

Second, and essential when utilizing popular media, we need to reduce our use of scientific jargon with nonscientific audiences. We need social skills training in communicating effectively with those who do not share our in-group terminology. Regular use of jargon appears pretentious, and makes information inaccessible to both the general public (Shulman et al., 2020) and even across scientific audiences (Martínez & Mammola, 2021). Luckily, and in recognition of this issue, resources are becoming available to aid with science communication (Alan Alda Center for Communicating Science, 2022; Banks et al., 2019). We need to begin following the recommendations from our own research on effective communication: We need to utilize emotion-focused words rather than statistics in our persuasion while personalizing our message to the target audience (Chou & Budenz, 2020; ironically, unlike this op-ed, which is more scientific in nature). This is not to say we must alter our scientific writing style within peer-

reviewed journals; however, we must be aware of the “us-vs-them” mentality such language invokes. More personally, consider how we as scientists and providers also have a limit in how much scientific information we can aggregate at once. I encourage you to speak to your peers at the next scientific conference regarding their energy levels over the duration of the conference. We were trained in this world, and yet, we also experience scientific fatigue.

My third and final recommendation that can improve our public relations is to be more vocal with our prior mistakes and related amendments. We must be vocal in combating the continued use of sexual orientation and gender identity change efforts (SOGICES) and advocate for their outlaw, as they still remain prevalent in the United States (APA, 2021; Last & Wuest, 2022). We need to make the public and popular media aware of psychotherapies that lack evidence but that continue to be circulated as legitimate (Sakaluk et al., 2019). We should discuss the historical misuse of electroconvulsive therapy while noting the advances and benefits it can award individuals today (Sadeghian et al., 2019). We ought to discuss unethical studies and treatments conducted in the past (Whitaker, 2002) in an effort to foster trust. Finally, we must be direct in validating and recognizing the discomfort that some people may have in speaking to someone whose profession is to study your behavior and underlying motives. There can be an inherent eeriness in such an interaction.

The ongoing effort by mental health professionals on the implementation and dissemination of science and treatments is vital; however, this too needs further work. We must learn how to communicate both across our field as well as outside it, to communicate with the “them” in addition to the “us.” We must also be vocal regarding our ongoing efforts to do so. And, we need to recognize how our continued failure to enact such change limits our effectiveness as a field. I propose that we pivot to more unconventional mediums to allow for this change to occur. We must learn to advocate for our work and prove that we can be trusted as a field. I recognize the issues addressed here represent a variety of problematic areas and span across specialties; however, I would argue our professional diversity at ABCT provides the best fit for this challenge. We are advocates, practitioners, and scientists united by our appreciation for evidence-based practices. Who best to correct our public image than those of us who are devoted to expanding its

related knowledge and value? Further, considering the composition of our organization, from teachers within a classroom to psychiatrists in private practice, from psychologists in hospitals to social workers within community organizations, we already have access to regular face-to-face interactions across various public spheres. Let us use these diverse intimate settings to initiate change! Finally, the mere fact you are reading this sentence indicates you are dedicated to continued education and self-expansion. Continuously educating ourselves on our faulted public image—across various subfields, from social psychology to neuroscience—will only make us more effective at disentangling fact from fiction, thereby increasing the chance we can improve our public image and subsequently help those in need.

While I have reserved the entirety of this op-ed to be directed at mental health providers, researchers, and allies, I do not wish to express my belief this is a concern solely reserved for mental health professionals. I would argue this is a concern across all healthcare and scientific fields. Personally, I encourage you to reflect on your own experiences feeling invalidated or subjected to poorly communicated medical advice or guidance. In fact, there is growing advocacy within medical healthcare to recognize the impact of poor communication on treatment noncompliance and hesitation (Haverfield et al., 2020; Peimani et al., 2020; Tekeste et al., 2019). I am not proposing all healthcare providers and researchers become experts in scientific communication and historical treatments; however, considering the prevalence of mental health stigma (Maunder & White, 2019), the impact of the ongoing mental health crisis (Panchal et al., 2023), and the somber, and even infamous, history of mental healthcare (Whitaker, 2002), we all need at least a basic awareness of the complexities and historical facets that shape the field and treatment recipients. Further, I do not fault or criticize researchers, providers, or allies for the concerns outlined here. Instead, my goal is to foster a broader conversation over the repeated missteps the field has made, in an attempt to foster professional growth and systematic change.

During a particular symposium at the ABCT conference this past year, researchers discussed the need to be more typical in our communication when attempting to encourage systematic change. They argued we must be more conversational, decrease our use of statistics,

and appeal to emotional experiences and expression when attempting to encourage change (O'Neill, 2022). This very result emphasizes our disconnect. For many researchers and practitioners, we are disconnected. We utilize uncommon jargon, an unorthodox writing style, and are entranced by statistical outcomes. Further, for us clinicians, close to half of all United States citizens view working with us as an admittance to weakness. While great strides have been made recently, and there is increased demand for mental health resources, we continue to have a PR problem. We must recognize that change is needed. For so long science has been accused of operating from an ivory tower, distinct from the real world and self-aggrandizing. During this year's ABCT conference, I looked down nine stories onto the streets of New York City, to the people walking by. As we all discussed the underlying motives of those walking on the streets below, I realized, even those of us who do not identify as scientists may be inadvertently perpetuating this stereotype. For there we were, sitting in a tower, discussing those who were below us. Only one small step was needed to foster a comparison between us and those pedestrians to Skinner and his rats. No wonder we are looked upon by the public with concern and worry. We could benefit from being a bit more "typical."

References

- Abrams, Z. (2022). These psychologists want to put societal problems at the center of research. Here's why. *Monitor on Psychology*, 53(8), 40-47.
- Alan Alda Center for Communicating Science. (2022, February 15). *History of the Alda Center*. https://aldacenter.org/about/our_history.php
- Alipourfard, N., Nettasinghe, B., Abeliuk, A., Krishnamurthy, V., & Lerman, K. (2020). Friendship paradox biases perceptions in directed networks. *Nature Communication* 11(707). <https://doi.org/10.1038/s41467-020-14394-x>
- American Psychological Association. (2021, February). *Resolution on Sexual Orientation Change Efforts*. <https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf>
- American Psychological Association. (2023, April 28). *Advocacy*. <https://www.apa.org/advocacy>
- Annenberg Public Policy Center. (2021). *Public trust in CDC, FDA, and Fauci holds steady, survey shows* [Survey report]. Annenberg Public Policy Center. <https://www.annenbergpublicpolicycenter.org/public-trust-in-cdc-fda-and-fauci-holds-steady-survey-shows/>
- Association for Behavioral and Cognitive Therapies. (2022, June). *ABCT apology for behavior therapy's contribution to the development and practice of sexual orientation and gender identity and expression change efforts: History and next steps* [Press release]. <https://www.abct.org/wp-content/uploads/2022/06/Untitled-document-6.pdf>
- Association for Behavioral and Cognitive Therapies. (n.d.). *Public education and media dissemination committee interest form*. <https://services.abct.org/i4a/forms/index.cfm?id=19>
- Banks, K. H., Beach, S., Ferguson, A., Gobin, R. L., Ho, I., Liang, C. T. H., Maton, K. I., Miles-McLean, H. A., & Toporek, R. L. (2019). *Community advocacy: A psychologist's toolkit for state and local advocacy*. American Psychological Association. https://www.apa.org/images/community-advocacy_tcm7-301694.pdf
- Beit-Hallahmi, B. (1994). Science, ideology, and ideals: The social history of IQ testing. *The Centennial Review*, 38(2), 341-360. <http://www.jstor.org/stable/23740148>
- Bowles, N. (2018, May 18). Jordan Peterson, Custodian of the patriarchy. *The New York Times*. <https://www.nytimes.com/2018/05/18/style/jordan-peterson-12-rules-for-life.html>
- Bureau of Labor Statistics. (2022). *Occupational outlook handbook, social workers*. U.S. Department of Labor. <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-1>
- Chou, W. -Y. S., & Budenz, A. (2020). Considering emotions in COVID-19 vaccine communication: Addressing vaccine hesitancy and fostering vaccine confidence. *Health Communication*, 35(14), 1718-1722 <https://doi.org/10.1080/10410236.2020.1838096>
- Clay, R. A. (2017). Trend report: Psychology is more popular than ever. *Monitor on Psychology*, 48(10). <https://www.apa.org/monitor/2017/11/trends-popular>
- Deckx, L., van den Akker, M., Buntinx, F., & van Driel, M. (2018). A systematic literature review on the association between loneliness and coping strategies. *Psychology, Health, and Medicine*, 23, 899-916. <https://doi.org/10.1080/13548506.2018.1446096>
- Gao, J. (Writer), & Coiro, K. (Director). (2022, August 18). *A normal amount of rage* (Season 1, Episode 1) [TV series episode]. In K. Feige, L. D'Esposito, V. Alonso, B. Winderbaum, K. Coiro, J. Gao., & W. Jacobson (Executive Produc-

- ers), She-Hulk: Attorney at Law. Marvel Studios.
- Garrison, E. G., DeLeon, P. H., & Smedley, B. D. (2017). Psychology, public policy, and advocacy: Past, present, and future. *American Psychologist*, 72(8), 737–752. <https://doi.org/10.1037/amp0000209>
- Haverfield, M. C., Tierney, A., Schwartz, R., Bass, M. B., Brown-Johnson, C., Zions, D. L., Safaeinili, N., Fischer, M., Shaw, J. G., Thadane, S., Piccininni, G., Lorenz, K. A., Asch, S. M., Verghese, & Zulman, D. (2020). Can patient–Provider interpersonal interventions achieve the quadruple aim of healthcare? A systematic review. *Journal of General Internal Medicine*, 35, 2107–2117. <https://doi.org/10.1007/s11606-019-05525-2>
- Last, B. S., & Wuest, J. (2022). Science on trial: Policy disputes over sexual orientation and gender identity change efforts. *the Behavior Therapist*, 45(8), 285–297.
- Li, L., Wood, C. E., & Kostkova, P. (2021). Vaccine hesitancy and behavior change theory-based social media interventions: A systematic review. *Translational Behavioral Medicine*, 12(2), 243–272. <https://doi.org/10.1093/tbm/ibab148>
- Lilienfeld, S. O., Lynn, S. J., Ruscio, J., & Beyerstein, B. L. (2009). *50 great myths of popular psychology: Shattering widespread misconceptions about human behavior*. Wiley-Blackwell.
- Martínez, A., & Mammola, S. (2021). Specialized terminology reduces the number of citations of scientific papers. *Proceedings of the Royal Society B: Biological Sciences*, 288(1948). <https://doi.org/10.1098/rspb.2020.2581>
- Maunder, R. D., & White, F. A. (2019). Intergroup contact and mental health stigma: A comparative effectiveness meta-analysis. *Clinical Psychology Review*, 72. <https://doi.org/10.1016/j.cpr.2019.101749>
- McNally, V. (2021). Shocking number of Americans say 2020 pushed them to try therapy for the first time. *South West News Service* [Survey report]. <https://swnsdigital.com/us/2021/01/shocking-number-of-americans-say-2020-pushed-them-to-try-therapy-for-the-first-time/>
- Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, 104(12), 510–520. <https://doi.org/10.1258/jrsm.2011.110180>
- O'Neill, P. (2022, November 19). Experimental evidence for increasing the reach of research messages to state and federal policymakers in evaluating strategies to disseminate information about evidence-based practices to stakeholders. In M. E. Crane [Chair], *Evaluating strategies to disseminate information about evidence-based practices to stakeholders* [Symposium]. Association for Behavioral and Cognitive Therapies Annual Convention, New York, NY.
- Panchal, N., Saunders, H., Rudowitz, R., & Cox, C. (2023). *The implications of COVID-19 for mental health and substance use*. Kaiser Family Foundation [Brief]. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use>
- Peimani, M., Nasli-Esfahani, E., & Sadeghi, R. (2020). Patients' perceptions of patient–provider communication and diabetes care: A systematic review of quantitative and qualitative studies. *Chronic Illness*, 16(1), 3–22. <https://doi.org/10.1177/1742395318782378>
- Peterson J., Densley J., & Erickson G. (2021). Presence of armed school officials and fatal and nonfatal gunshot injuries during mass school shootings, United States, 1980–2019. *JAMA Network Open*. 4(2), e2037394. <https://doi.org/10.1001/jamanetworkopen.2020.37394>
- Pew Research Center. (2016). *The politics on climate* [Survey report]. Pew Research Center. <https://www.pewresearch.org/science/2016/10/04/the-politics-of-climate/>
- Sadeghian, E., Rostami, P., Shamsaei, F., & Tapak, L. (2019). The effect of counseling on stigma in psychiatric patients receiving electroconvulsive therapy: A clinical trial study. *Neuropsychiatric Disease and Treatment*, 15, 3419–3427. <https://doi.org/10.2147/NDT.S233094>
- Sakaluk, J. K., Williams, A. J., Kilshaw, R. E., & Rhyner, K. T. (2019). Evaluating the evidential value of empirically supported psychological treatments (ESTs): A meta-scientific review. *Journal of Abnormal Psychology*, 128(6), 500–509. <http://dx.doi.org/10.1037/abn0000421>
- Shankar, V. (Host). (2015–Present). Hidden brain [Audio podcast]. Hidden Brain Media. <https://hiddenbrain.org/>
- Shulman, H. C., Dixon, G. N., Bullock, O. M., & Amill, D. C. (2020). The effects of jargon on processing fluency, self-perceptions, and scientific engagement. *Journal of Language and Social Psychology*, 39(5–6), 579–597. <https://doi.org/10.1177/0261927X20902177>
- Stapleton, L. T., Parikshak, S., & Schreier, A. (2022). Roles and opportunities for child- and family-focused psychologists in the federal executive branch. *the Behavior Therapist*, 45(8), 285–297.
- Tekeste, M., Hull, S., Dovidio, J. F., Safon, C. B., Blackstock, O., Taggart, T., Ker-shaw, T. S., Kaplan, C., Caldwell, A., Lane, S. B., & Calabrese, S. K. (2019). Differences in medical mistrust between Black and White women: Implications for patient-provider communication about PrEP. *AIDS and Behavior*, 23(7), 1737–1748. <https://doi.org/10.1007/s10461-018-2283-2>
- van Sant, G. (Director). (1996). *Good Will Hunting* [Film]. Be Gentlemen.
- Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Perseus Publishing.
- World Confederation of Cognitive and Behavioural Therapies. (2019, December). *eNews*. https://www.wccbt.org/Downloads/WCCBT_e-News_Dec-2019.pdf
- . . .
- The author has no conflicts of interest, grants, or funding sources, to disclose. The opinions and thoughts expressed here solely represent that of the author's, and do not necessarily reflect those of Cognitive and Behavioral Consultants, or its staff.
- Correspondence to** Joseph R. Taliercio, Coordinator of Research at Cognitive and Behavioral Consultants, 1 North Broadway, Suite 704, White Plain, NY 10601 jtaliertcio@cbc-psychology.com

Modeling a Life Worth Living: A Dog's Career Working in a Third-Wave Practice

Holly Bedotto, *DBT by Design, South FL DBT Consortium, Center for Third Wave CBT, and University of Miami Miller School of Medicine*

Working Animals

Dogs, and many other animals, work quietly beside humans in large numbers. According to Share America (<https://share.america.gov>), an online platform for the United States Department of State, there are currently about 500,000 service dogs (canines trained specifically to aid humans with certain tasks) assisting people with disabilities. According to the U.S. Department of Defense, 1,600 dogs serve in the U.S. Military (<https://www.defense.gov/Multimedia/Experience/Four-Legged-Fighters/>). Therapy dogs certified by the American Kennel Club (AKC) work in hospitals and nursing homes accompanied by their owners. According to Search and Rescue Dogs of the United States, there are about 1,500 to 2,000 canines working tirelessly to rescue people in disaster situations. Police and the Federal Bureau of Investigation have canine partners as well. And, of course, dogs work in traditional settings on farms, alongside hunters, and as guard dogs.

My working canine was a beautiful European Golden Retriever named Biella. Over the course of her short life, she nudged and sometimes pushed me in the direction of further understanding what dogs know. I became curious about working animals, training animals, and animal-assisted therapies. Her final lesson for me was grieving her, my working canine who was closer to me than any other dog or cat I have lived with. Biella was 6 ½ when she died due to complications from a congenital liver condition. Despite her struggles, from 8 weeks old she worked with me and my team in our office modeling what we call in Dialectical Behavior Therapy (DBT) “a life worth living” or, in the Acceptance and Commitment Therapy (ACT) world, “valued living.” While at work, Biella would lay by the feet of a patient who was expressing sadness or anxiety. She would push her head into the patient's hands for pets. There is a growing body of research suggesting the canine nose can detect

human distress in our breath and sweat (Wilson et al., 2022). When Biella's nose was not on alert, she would sleep behind my chair either because she did not feel the need to move toward the patient or because she was not feeling well, and she needed to take care of herself. Here she modeled limit-setting and self-care.

In sessions, patients would inquire about her health status and showed incredible empathy for her struggles. Patients were also engaged in behavioral training. For instance, Biella shied away from one male patient who desperately wanted to pet and talk to her. This patient was in our DBT program so his therapist and I came up with a bit of a game for man and dog. He would walk into the office, pick up a toy, and ignore Biella by having no eye contact. Just before he got too close to her, he would drop the toy and walk straight to the rear waiting room. After a few weeks, the man saw that Biella no longer retreated. At first, she stayed put and eventually she came to him on her own terms. This DBT patient, along with others in the waiting area, saw the effectiveness of consistent behavioral training. Patients became curious watching me interact with Biella. I believe she raised the expectations for my patients in what they could expect from their own animals. Biella raised the bar for emotional support animals and the letters we clinicians are often asked to write. Because of my experience working and traveling with Biella, patients who requested emotional support letters for their dogs were required to train their dogs to be civilized travelers and to be behaviorally specific about how their dogs helped them. A few patients pursued a more rigorous course of training like Biella had: the AKC Canine Good Citizen certification and Service Dog status.

Animal-Assisted Interventions

Animal-Assisted Intervention (AAI) can be seen in the mental health literature as far back as the 1960s. Currently, the field is experiencing a rapid expansion. Cynthia

Chandler and Tiffany Otting (2018) edited a book of wonderful conversations with pioneers in the AAI field. Again, no surprise to pet owners, these professionals comment on the relaxing nature of fish tanks in their offices and the intuitive nature of animals, particularly dogs who can move in when they sense growing distress in a patient. Equine-Assisted Counseling (EAC) is thought to help patients become aware of thoughts, feelings, and behavioral patterns through experiential exercises. There are a variety of equine-assisted interventions both on horseback and on the ground. I have been a certified equine therapist through Equine Assisted Growth and Learning Association (EAGALA) for several years. This group leads the field in moving toward an evidence base and has a code of ethics guiding its members. EAGALA work is done on the ground, not on horseback. The team must include a mental health professional, an equine specialist, and a herd of horses. The ethical principles extend to the care of the horses.

In a first-of-its-kind randomized controlled trial with typically developing children, Kerstin Meints and colleagues (2022) showed that when compared to a control group and a relaxation intervention group, the experimental group of school children who were in the presence of a dog and its handler twice per week for 20 minutes showed lower cortisol levels over a period of 4 weeks. This data is not a surprise to folks who work in the AAI world. And it is no surprise to my patients. Upon Biella's death I received a slew of emails and texts from patients remembering how calm they felt upon walking into the office and seeing and interacting with her. Parents chose our DBT program for their teens because they saw Biella's page on our website.

As I researched the literature on how animals help humans, I encountered a bit of my own bias. Recently, *The Washington Post* (Free, 2022) ran a story about an emotional support alligator who behaved against type and became an intuitive provider of support and companionship to a struggling man. Granted, this gentleman was quite familiar with these large reptiles, helping to rescue and place them in appropriate sanctuaries to live out their lives. But my initial thought was, “An emotional support alligator?” After reflecting, however, I thought, “Who am I to judge?”

Understanding Animal Cognition

Biella worked and interacted with me most hours of everyday. In her short life, we were only separated for a total of 3 weeks. As I looked into those soulful eyes, I wanted to know what was going on in that mind of hers. We are only beginning to understand from a scientific perspective what canines and other animals know (Horowitz, 2009) and how they learn (Fugazza, 2014; Hare & Woods, 2013). I grew up in the late 60s and 70s—a time when dog and cat owners were accused of anthropomorphizing pets. Present research in the fields of cognitive neuroscience and evolutionary anthropology by Drs. Brian Hare, Claudia Fugazza, and Alexandra Horowitz influenced my knowledge of canine cognition and helped me more effectively train Biella to be the best dog she could be in her personal and professional life. Researchers in our field are quite specific that human language sets us apart from our animal friends (Hayes, 1989; Torneke, 2010). Canine cognition researchers agree (Hare & Woods). But the tide may be turning. Federico Rossano's work at the University of California, San Diego (the researcher behind Bunny the Talking Dog on TikTok), along with Leo Trotter, another cognitive scientist in San Diego, is showing us that dogs (and cats) have a lot to say. Alexis Devine, Bunny's owner, posted often during the pandemic. Her TikTok videos showed Bunny (@whataboutbunny), a Sheepadoodle puppy, learning to communicate with her owner using an augmentative and alternative communication (AAC) board (buttons). Could it be we just haven't been good listeners or had effective modes of understanding them? Research on animal communication using AAC boards is currently ongoing, with particularly notable work being conducted by speech pathologist Christina Hunger (2021). Bunny and her buttons have become famous on social media and science is following.

If we really open ourselves up and become curious about our animal friends, they can tell us things about themselves. Yes, I said their "selves." Bunny is teaching us that dogs have a sense of themselves in the world and she just might understand her own existence. Dr. Rossano is intrigued and understandably skeptical. In an interview with *The Washington Post* (2021), he expressed concern about the Clever Hans Effect. If you remember your introductory psychology class in high school, you might recall Hans was a horse living in Berlin in

the early 1900s that was thought to perform arithmetic by tapping his hoof when given a math problem. When a psychologist was called to observe the phenomenon, it was noted that Hans was picking up on subtle cues of the handler (Pfungst, 1911). Dr. Rossano will control for inadvertent non-verbal reinforcement by using constant video monitoring of the canines and humans interacting with the AAC boards in the last phases of their study. This research could potentially affect veterinary medicine as it allows for potential communication of pain or discomfort between animal and vet.

And it does not stop with canines. Research by Mejdell and colleagues (2016) has shown that horses, when taught to use symbols, could communicate their preference for a blanket when the temperature drops. Evolved horse trainers, like Warwick Schiller (2019) and Pat Parelli (2022), help humans work on their relationship with horses. A Hollywood film about Buck Brannaman's work with humans and their horses made famous the term "horse whisperer," which is not a term he is comfortable using. From his perspective, his work is about observation and consistent training (Brannaman & Reynolds, 2001). Schiller uses mindfulness skills to help horse owners slow down and observe their horses' signals. They are building upon natural horsemanship skills from pioneers Ray Hunt (1991) and Tom Dorrance (1987). Thankfully, the belief of dominating a horse, a prey animal, is receding into history. We see the same in small animal training with the use of clicker training and modeling using Social Learning Theory (Fugazza, 2014). Any DBT clinician can tell you, Karen Pryor's 2006 book *Don't Shoot the Dog* is essential reading. The book teaches principles of positive reinforcement and shaping for training dogs and—with some humor—small children, without having to rely on punishment, threat, force, and guilt. Small animals have evolved from pet status to family member. Something is shifting in our relationship with animals and scientists are noticing.

Remembering Biella

When a pet dies, we, along with our family and friends, feel the tremendous impact of that loss. When a service animal, or in my case, a working canine, dies, a whole community grieves.

I say all of this to pose the question that I asked myself over and over through my grief: How does a human do justice to an

animal companion who was also a coworker? How do I support my small community of humans who mourn with me while I grieve myself? What I learned is that, like any grief, it is a process and the answers come if you allow yourself to be open, curious, and engaged. So, I wrote Biella's obituary and posted it on her page on my website. (Thank you, Dr. Horowitz [2022], for setting that fine example with your dog, Finnegan.) I started a fund at the university veterinary school where Biella was given world-class care. I wanted to honor the practitioner-scientists who made her care possible. And I wanted to honor my dear companion, Biella, who helped so many.

A friend and colleague gave me a beautiful book by Bartels (2022) on grieving our pets. Since then, the author and I have been communicating through email. She shared with me how terrifying it is to have her book out in the world, especially on a topic so personal as grief. I wholeheartedly agree and we are both demonstrating vulnerability by sharing our grief. Every Tuesday, Ms. Bartels posts a pet tribute on her Instagram page and people are sharing their losses. Healing is in the connection with others. Biella's veterinarians shared their reactions to her obituary, and one painted a beautiful portrait of her. I am beginning to be able to talk about her with patients again and use her as an example of the wonderful things that dogs can bring to the lives of humans, how they profoundly change us in ways we never imagined. In her small universe, Biella had a significant influence on the lives of many people and beautifully modeled a life worth living.

References

- Bartels, E.B. (2022). *Good Grief: On loving pets, here and hereafter*. Mariner Books.
- Brannaman, B., & Reynolds, W. (2001). *The Faraway Horses*. Lyons Press.
- Chandler, C.K., & Otting, T.L. (Eds.). (2018). *Animal-assisted interventions for emotional and mental health*. Routledge.
- Dorrance, T., & Porter, M.H. (1987). *True unity: Willing Communication between horse and human*. Steve Dorrance.
- Free, C. (2022, August 29). His emotional support animal is an alligator: They sleep in the same bed. *The Washington Post*. <https://www.washingtonpost.com/lifestyle/2022/08/29/emotional-support-alligator-wally-henney/>
- Fugazza, C. (2014). *Do as I do: Using social learning to train dogs*. Dogwise.

- Hare, B., & Woods, V. (2013). *The genius of dogs: How dogs are smarter than you think*. Penguin Group.
- Hayes, S.C. (1989). Nonhumans have not yet shown stimulus equivalence. *Journal of the Experimental Analysis of Behavior*, 51(3), 385-392.
- Horowitz, A. (2009). *Inside of a dog: What dogs see, smell, and know*. Simon & Schuster.
- Horowitz, A. (2016). *Being a dog: Following the dog into a world of smell*. Scribner.
- Horowitz, A. (2022, February 21). Finnegan, dog known for his exemplary nose, dies at 14. *The New York Times*. <https://www.nytimes.com/2022/02/21/opinion/dogs-animals-obituaries.html?searchResultPosition=10>
- Hunger, C. (2021). *How Stella learned to talk: The groundbreaking story of the world's first talking dog*. William Morrow.
- Hunt, R. (1991). *Think harmony with horses*. Pioneer.
- Judkis, M. (2021, August 6). Can these dogs really talk or are they just pushing buttons? *The Washington Post*. <https://www.washingtonpost.com/lifestyle/2021/08/06/talking-dogs-aac-devices-buttons/>
- Meints, K., Brelsford, V.L., Dimolareva, M., Marechal, L., Pennington, K., Rowan, E., & Gee, N.R. (2022). Can dogs reduce stress levels in school children? Effects of dog-assisted interventions on salivary cortisol in children with and without special educational needs using randomized controlled trials. *PLOS ONE*. <https://doi.org/10.1371/journal.pone.0269333>
- Mejdell, C.M., Buvik, T., Jorgensen, G.H.M., & Boe, K.E. (2016). Horses can learn to use symbols to communicate their preferences. *Applied Animal Behaviour Science*, 184, 66-73. <https://doi.org/10.1016/j.applanim.2016.07.014>
- Parelli, P. (2022). *Horsenality*. <https://shopus.parelli.com/collections/horsenality>
- Pfungst, O. (1911). *Clever Hans (the horse of Mr. Von Osten): A contribution to experimental animal and human psychology*. Holt, Rinehart and Winston.
- Pryor, K. (2006). *Don't shoot the dog! The new art of teaching and training*. Ringpress Books.
- Schiller, W. (2019, April 11). *Work with the horse you have today (relationship)*. <https://videos.warwicksschiller.com/additional-videos/the-human-factor/>
- Theycantalk.org (2022). *Our approach to research*. <https://www.theycantalk.org/research>
- Torneke, N.T. (2010). *Learning RFT: An introduction to relational frame theory and its clinical application*. Context Press.
- Wilson, C., Campbell, K., Petzel, Z., & Reeve, C. (2022). Dogs can discriminate between human baseline and psychological stress condition odours. *PLOS ONE*. <https://doi/10.1371/journal.pone.0274143>
- ...
- The author has no conflicts of interest or funding to disclose.
- Correspondence to** Holly Bedotto, Psy.D., DBT by Design, 4770 Biscayne Boulevard, Suite 740, Miami, FL 33137 dbtbydesign@gmail.com



Call for Candidates for Editor of *Behavior Therapy*

Candidates are sought for Editor-Elect of *Behavior Therapy*, Volumes 57–60. The official term for the Editor is January 1, 2026, to December 31, 2029, but the Editor-Elect should be prepared to begin handling manuscripts at least 1 year prior and have gathered together an editorial team well prior to that.

Candidates should send a letter of intent and a copy of their CV to Susan White, Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008 or via email to teisler@abct.org

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Publications, will provide you with more details at the appropriate time. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647.1890.

Letters of intent MUST BE RECEIVED BY July 15, 2023.

Vision letters will be required by August 31, 2023.

The Editor will be selected at ABCT's Board of Directors meeting in November.

Peter M. Lewinsohn (1930–2022)

Antonette Zeiss, *Department of Veterans Affairs (retired)*

Paul Rohde, *Oregon Research Institute*

John R. Seeley, *University of Oregon and Oregon Research Institute*



PETER MICHAEL LEWINSOHN was an award-winning clinical scientist who made major contributions to the theory, scientific knowledge, and advancement of clinical psychology practice. He passed away in Portland, Oregon, on December 18, 2022, at the age of 92, surrounded by his family.

Pete was born in Berlin, Germany, on March 17, 1930. Pete's family was able to immigrate to Shanghai, China, in 1941 on the Trans-Siberian Railroad, escaping the persecutions inflicted on German Jews. They were able to leave Berlin in 1941 as a result of a visa issued by a heroic Japanese consul, who wrote as many visas for European Jews as he could, before being recalled to Japan. The original intention was to go from Japanese-occupied Shanghai to the United States, but while they were on the train, Pearl Harbor was bombed and they had to stay in Shanghai through the war years, under difficult conditions. Pete left Shanghai in 1947 to attend Yeshiva College in New York City, with the intention of becoming a rabbi. However, 2 years later, he transferred to Allegheny College in Pennsylvania, with the help of a scholarship, where he majored in psychology and graduated in 1951. Others in his family also were able to migrate to the U.S. from Shanghai, and he had happy memories of working together with his brother Tom, as waiter and busboy in resort hotels, to help pay for his education.

Pete continued studies in psychology at Johns Hopkins University, receiving his Ph.D. in clinical psychology in 1955. Following graduate studies, he served on the staff of numerous hospitals and clinics to develop clinical experience and facility with psychological treatment and neuropsychological evaluation. Ultimately, he developed an important, distinguished career in clinically relevant research in a university setting. He first accepted a position as Associate Professor in Psychology

at Southern Illinois University in 1963. He became a member of the clinical psychology faculty at the University of Oregon (UO) in 1965, where he remained until retirement in 1987. He then joined the Oregon Research Institute (ORI), where he continued to collaborate with colleagues in numerous research projects into his 80s. Throughout his career, he was always full of energy, creativity, and commitment to advancing knowledge that could make a positive difference in people's lives.

While at UO, Pete pioneered development of a cognitive-behavioral treatment of depressed individuals and research on its efficacy. He emphasized a collaborative approach with patients, with the goal of helping depressed people identify meaningful positive activities that would guide increased activity and positive experience. With his graduate students, he compared three common and promising treatments for depression: his positive activities approach, an approach focusing on positive social interactions, and a cognitive approach. When all three were found to be more effective than a wait-list control, and none relatively more powerful compared to each other, he continued to develop his approach to incorporate meaningful elements of each. These were incorporated in a pioneering project in translating cognitive-behavioral mechanisms into bibliotherapy, in the book *Control Your Depression*, which still is in print. This was written as a potential self-help book but was most often used to guide treatment with a mental health professional. With a next generation of graduate students, he used the concepts in this book to create the *Coping With Depression Course*, which has been translated into many languages, adapted for older adults and for adolescents, and used around the world. Ultimately, his approach was taken up by professionals who coined the term Behavioral Activation, a widely used, highly effective treatment of depression.

In addition to numerous contributions in field of Clinical Geropsychology, Pete and colleagues made extensive contributions to our understanding of adolescent depression, conducting one of the most comprehensive longitudinal studies on psychopathology, encompassing adolescence and early adulthood (the Oregon Adolescent Depression Project). The study contributed to several key discoveries regarding the epidemiology, comorbidity, suicidality, and etiology of depression and other mental disorders. This groundbreaking research had profound influence on understanding, prevention, and treatment of depression across the lifespan.

Pete was a prolific scholar, publishing more than 250 articles in peer-reviewed journals with over 75,000 citations. His legacy continues through ongoing depression research conducted at ORI, other U.S. research centers, and around the world. His distinguished career has been recognized by numerous awards, including the Distinguished Scientist award (Society for the Science of Clinical Psychology), Gold Medal Award for Lifetime Achievement in the Application of Psychology (APA), and several article of the year awards.

In addition to being a prolific scholar, Pete embraced life fully and modeled a balance of career and personal life. He and his beloved wife, Cynthia, raised two sons who have successful careers and family lives. Pete enjoyed a broad host of pleasant activities himself, including (but not limited to) hiking, camping, fishing, skiing, gardening, guiding financial investments, traveling, and exploring the beautiful Oregon countryside. While he had a strong work ethic for both himself and his students, he also encouraged similar rich, full lives for his students and colleagues; it was an inspiration to see such an important scholar also live so fully.

Perhaps Pete's greatest legacies have been the many graduate students and early career professionals he inspired to pursue careers in research and other paths to improving the health care system. His positive efforts to educate providers and improve the mental health care delivery system, along with his scientific legacy, have greatly improved people's lives. ■

Leadership and Elections Committee Final Proposal on ABCT Student Vote Bylaws Amendment

Angela Fang, *University of Washington*

Carrie Masia, *Montclair State University*

Angela Moreland, *Medical University of South Carolina*

Vaishali Raval, *Miami University*

Michelle Roley-Roberts, *Creighton University School of Medicine/CHI Health*

THE LEADERSHIP and Elections Committee of ABCT would like to propose an amendment to Bylaws Article V on “Voting,” which currently states:

“There are six classes of ABCT membership. Full and Fellow members may nominate, vote, and hold office. New Member Professionals may nominate and vote. Students, Postbaccalaureates, and Associate members may not nominate, vote, or hold office.”

We would like to amend this to allow all membership categories to nominate and vote, to read as follows:

“There are six classes of ABCT membership. Full and Fellow members may nominate, vote, and hold office. New Professionals, Students, Postbaccalaureates, and Associate members may nominate and vote, but may not hold office.”

Our recommendation for this bylaws amendment is based on multiple sources of information, including input from SIG leaders; Board members; public comments from ABCT members obtained from February 3, 2023, to April 7, 2023; research evidence on voting practices of young voters; and experiences of allied organizations, such as the American Psychological Association.

To summarize the public comments we received regarding the proposed bylaws change: We received 89 responses (representing approximately 2% of the membership) from Emeritus, Full, or Associate

members (66%), Students or Postbaccalaureate members (19%), New Professional members (9%) and other members (unknown/prefer not to disclose, 6%). Responses were generally in favor of the bylaws change, with a third against student voting. There were several themes that emerged from the feedback. Main arguments for student voting were that students are more representative of the future of the field, students are paying members, allowing student voting is aligned with the goals of ABCT, and students are the labor of the field. The main arguments against student voting were that students lack perspective, may not make well-informed decisions about leadership, and may undermine expertise in the organization. Surveys and polls have known limitations due to sampling bias and high nonresponse rates, which may produce inaccurate estimates for predicting election results and determining organizational attitudes (Jamieson et al., 2023). We acknowledge the comments we received may not be representative of views held by the general membership; however, it was important to us to be transparent and accountable to the bylaws amendment by including all relevant stakeholders in the development of the proposal.

We also consulted SIG leaders across several intimate meetings, as they represent members with long-standing commitments to the values of ABCT, who have actively promoted the science of cognitive and behavioral principles in diverse areas of scholarship. SIG leaders were largely in support of student voting for similar reasons expressed in public comments. Many

SIGs are primarily comprised of, and even led by, students and early-career professionals, further supporting that students are well-positioned to make leadership decisions due to their proximity to the latest scientific developments as part of their training. This is consistent with developmental evidence that young American adults as young as 16 years of age possess capacities for citizenship, such as civic knowledge, political skills, political efficacy, and tolerance (Hart & Atkins, 2011), as well as research supporting the political literacy of youth and their capacity for organizing complex political initiatives (Bessant, 2000). SIG leaders also questioned how students were likely to vote and influence elections. Research on youth voting practices shows that, in general, young people in the U.S. are much less likely to vote compared to older citizens (Fraga & Holbein, 2020). Furthermore, a longitudinal study of over 2,000 young people in Australia showed that their voting patterns were highly heterogeneous and varied considerably in their degree of political knowledge and investment of cognitive effort toward voting (Laughland-Booÿ et al., 2018), which suggests that young people are not monolithic voters who will vote in a uniform way. SIG leaders also asked about the proportion of the ABCT membership that students constituted and their sociodemographic composition relative to other members to understand the potential impact of their missing voices in electing future leaders. ABCT central office staff confirmed that the student membership category comprises approximately one third of the entire ABCT membership and that they represent the most demographically diverse membership category.

We considered an alternative to the bylaws amendment that involved allowing graduate students, but not undergraduate students, to vote, as this would address one of the arguments that students lack knowledge or experience in the field to make informed leadership decisions. However, the problems with this alternative were that (a) it assumed that undergraduates were even less informed than graduate students and contradicted research described above on the political acumen of young people as young as 16 years of age; (b) it assumed that undergraduates would be ill-equipped to vote on issues concerning the organization despite having the right to vote in national elections, and that the issues facing ABCT are somehow more complex than those facing the nation; and (c) creating a sepa-

rate membership category for undergraduate students would create unnecessary delays and administrative burden for the organization. Indeed, the American Psychological Association followed this path of splitting graduate and undergraduate membership categories first before amending their bylaws to allow graduate students to vote, which resulted in major delays to get the vote passed at all.

In sum, our decision to recommend a formal change to the bylaws amendment on voting was motivated by our goal of enabling more members of ABCT to feel represented in leadership decisions and providing a voice from more diverse members. We hope that providing transparency in our decision-making process, regardless of the outcome of the vote, helps explain the multiple factors and sources of information that weighed into our proposal to the Board, and unites us as an organization that values equity in the voting process.

References

- Bessant, J. (2000). From denizen to citizen: Contesting representations of young people and the voting age. *Journal of Applied Youth Studies*, 3, 223-240.
- Fraga, B., & Holbein, J. (2020). Measuring youth and college student turnout. *Electoral Studies*, 65, 102086.
- Hart, D., & Atkins, R. (2011). American sixteen and seventeen year olds are ready to vote. *Annals of the American Academy*, 633, 201-222.
- Jamieson, K. H., Lupia, A., Amaya, A., Brady, H. E., Bautista, R., Clinton, J. D., ... McNutt, M. K. (2023). Protecting the integrity of survey research. *PNAS Nexus*, 2, pgad049. <https://doi.org/10.1093/pnasnexus/pgad049>
- Laughland-Booy, J., Skrbis, Z., & Ghazarian, Z. (2018). The voting strategies of young people: A conceptual framework. *Australian Journal of Political Science*, 53(2), 143-159. ■

LEADERSHIP AND ELECTIONS

Renewing Our Leadership Vows at ABCT to Promote Equity and Inclusion

Angela Fang, *University of Washington*

Carrie Masia, *Montclair State University*

Angela Moreland, *Medical University of South Carolina*

Vaishali Raval, *Miami University*

Michelle Roley-Roberts, *Creighton University School of Medicine/CHI Health*

LEADERS ACROSS scientific institutions and professional organizations have been challenged to reevaluate their core values in response to the many inequities exposed by the racial and COVID-19 pandemics. ABCT is no exception. In many corners of our organization, from the Board of Directors, governance committees, special interest groups, workshops, live webinar series, and others, ABCT leaders have been engaged in active conversation about ways to reduce inequities and to make evidence-based principles for enhancing health and well-being more accessible. As new members to the Leadership and Elections Committee, we are joined by our common goals to help members feel represented in the leadership, cultivate future leaders, promote long-term engagement in ABCT, and ultimately renew our metaphorical vows to a collective vision of what it means for ABCT to be an organizational leader in 2023 and beyond.

The Leadership and Elections Committee has a dual charge to develop a slate of candidates for each election cycle and cultivate leadership within the organization. For the upcoming 2024 election, we are seeking nominations for the following three positions: **President-Elect** (2024–2025; President, 2025–2026; Immediate Past President, 2026–2027); **Representative-at-Large Liaison to Convention and Education Issues** (2024–2027); and **Secretary Treasurer** (2025–2028). Whereas the President-Elect and Representative-at-Large would join the regular ABCT Board of Directors meetings starting June 2024 and attend the November 2024 Board of Directors Meeting at the Annual Convention, the Secretary Treasurer will have a full year to learn the position before taking

office. You can put forward an unlimited number of nominations and nominate any full member for any position on the slate. Candidates with the most nominations will be the only official names on the ballot once voting begins November 1, 2023. **To reduce barriers to nomination, this year you can email your nomination to membership@abct.org** (Subject line: *Nominations*) with the names of individuals for each position on the slate: President-Elect (2024–2025), Representative-at-Large (2024–2027) Liaison to Convention and Education Issues, and Secretary Treasurer (2025–2028). **Nominations will be accepted until Friday, September 1, 2023.** We are interested in cultivating leaders regardless of their career trajectory, sociodemographics, and geographic location who have a vision for where ABCT needs to go in the future.

Who Can Nominate?

This question relates to a recent bylaws change that the Leadership and Elections Committee has been working on together with Special Interest Group leaders and the Board of Directors (see our article in this issue, pp. 207–208). In January 2023, our committee put forward a proposal for an amendment in the bylaws to allow all ABCT members to be able to nominate and vote in elections. Current bylaws only allow Full, Fellow, and New Professional Members to nominate and vote, and not Associates, Students, or Postbaccalaureate members. We received public comments on this proposal through the ABCT website for 60 days (which ended April 7). We received 89 responses (representing approximately 2% of the membership) from Emeritus, Full, or Associate members (66%), Students or Postbaccalaureate

members (19%), New Professional members (9%) and other members (unknown/prefer not to disclose, 6%). Responses were generally in favor of the bylaws change, with a third against student voting. There were several themes that emerged from the feedback. Main arguments for student voting were that students are more representative of the future of the field, students are paying members, allowing student voting is aligned with the goals of ABCT, and students are the labor of the field. The main arguments against student voting were that students lack perspective, may not make well-informed decisions about leadership, and may undermine expertise in the organization. This month, our committee will be making a formal recommendation to the Board on this bylaws proposal based on the feedback received in public comments, in addition to research evidence on voting practices of young voters and experiences of allied organiza-

tions. We will make this recommendation public by posting on the ABCT website under "New and Noteworthy" (home page). The Board will first vote on the proposal before passing it to voting by full membership. The outcome will determine who will be able to nominate candidates in this year's election cycle.

In line with moving the needle toward a more equitable ABCT, the Leadership and Elections Committee is working with the Board to support the addition of a dedicated position focusing on issues of diversity, equity, and inclusion, as well as a seat for students to have their voices represented on the Board.

Membership on the Leadership and Elections Committee is approved by the Board of Directors and includes a chair and four members. We welcome input on our work in the committee and questions regarding the roles and responsibilities of elected positions on the Board. You may

reach out to any one of us: Angela Fang, Chair (angfang@uw.edu); Carrie Masia (masiac@montclair.edu); Angela Moreland (moreland@muscedu); Vaishali Raval (ravalvv@miamioh.edu); Michelle Roley-Roberts (michelle.e.roley@gmail.com), as well as the ABCT Executive Director, Mary Jane Eimer (mjeimer@abct.org). Keeping an open line of communication with us is an important measure of engagement that we hope to increase this year, together with greater voter turnout, in the November election.

As we work toward an ABCT that represents multiple and diverse perspectives, we hope to continue to draw upon our foundations as behavior change agents to create a vision of mental health and well-being that proactively addresses challenges and opportunities in our field, rather than retroactively responding to them. Please join us in this effort! ■

*Call for Nominations for President-Elect,
Representative-at-Large, & Secretary-Treasurer*

EMAIL YOUR NOMINATIONS to

membership@abct.org

(Subject line: *Nominations*)

➔ **Deadline: Friday, September 1, 2023**

Webinar

July 21

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

Dr. Jeffrey Lackner | Cognitive Behavior Therapy for Irritable Bowel Syndrome: The Fundamentals of an Evidence-based Transdiagnostic Approach

Irritable bowel syndrome (IBS) is the most common gastrointestinal (GI) disorder seen by primary care and GI physicians, accounts for considerable personal suffering, and is largely refractory to medical therapies. Its physical symptoms (pain, diarrhea and/or constipation) commonly co-occur with other psychological complaints (e. g. GAD, depression) that behavior therapists effectively treat and thus offer a gratifying way of expanding one's clinical practice. Clinical trials assessing the efficacy of CBT for IBS have established it as a gold standard psychological treatment, yielding dramatic, rapid, broad, and sustained symptom improvement that compares favorably to pharmacological or dietary treatments. After a brief overview of IBS, this workshop will describe the conceptual underpinnings of CBT for IBS, its rationale, goals and technical components using didactic instruction and detailed case examples from actual patients enrolled in a landmark NIH trial (Lackner, Jaccard, et al., *Gastroenterology*, 2018) that affirmed CBT's status as the most widely endorsed empirically validated psychological treatment (Black, et al., *GUT*, 2020) and arguably the most effective behavioral treatment for any chronic pain disorder. Attendees will learn practical strategies to trouble shoot around difficult clinical issues to maximize outcome, patient engagement, and clinician satisfaction.

1:00 a.m.- 12:30 p.m. Eastern
10:00 a.m. – 11:30 a.m. Central
9:00 a.m. – 10:30 a.m. Mountain
8:00 a.m. – 9:30 a.m. Pacific

\$15 Student ABCT Members / \$25 ABCT Members / \$35 Non-Members

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.

Multiple Routes to ABCT Fellow Status

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.

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

The Fellows Committee strongly recommends that potential Fellow applicants as well as their letter writers describe the applicant's specific contributions that are outstanding and sustained. To aid in writing these letters, the Fellows Committee prepared Guidelines for Applicants and Letter Writers for how to write fellow status contributions <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>

APPLICATION
DEADLINE:
July 31, 2023



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

Take advantage of these advertising, sponsorship, and exhibit offerings at the ABCT Annual Convention

ADVERTISING

PROGRAM BOOK ADDENDUM

Ad Placements

interior pages	regular rate	nonprofit rate	width x height
<input type="checkbox"/> Full page	\$2,500	\$2,000	7" x 9.25"
<input type="checkbox"/> 1/2 page horizontal	\$1,000	\$800	7" x 4.625"
<input type="checkbox"/> 1/2 page vertical	\$1,000	\$800	3.5" x 9.25"
<input type="checkbox"/> 1/4 page	\$850	\$680	3.5" x 4.625"

Reserve your space: August 7 | Materials due: Sept. 8

→ Advertising Contact:

Stephanie Schwartz: sschwartz@abct.org

The **program addendum** is a separate, supplemental publication that accompanies ABCT's online program content. Received by all convention attendees, the addendum lists exhibitors, sponsors, program changes, SIG meetings, schedule-at-a-glance, maps, and highlights invited speakers and the presidential address.

- Trim size: 8 1/2" x 11", perfect bound
- All color artwork should be submitted as CMYK
- High-resolution (300 dpi) PDFs preferred
- TIFFs also accepted
- no bleeds

SPONSORSHIP OPPORTUNITIES

Show your commitment to ABCT

- ☐ Hotel key cards \$6,500 or (2) available at \$3,200 each
- ☐ Pens \$5,500
- ☐ Mobile app \$10,000 or (4) available at \$2,500 each
- ☐ Charging station \$5,000 or (5) available at \$1,000 each
- ☐ Photo booth \$2,400 or (2) available at \$1,200 each
- ☐ Mobile app banner ad \$600 each
- ☐ Column wrap \$3,000 or (3) available at \$1,000 each
- ☐ Wellness room \$5,000 or (5) available at \$1,000 each
- ☐ Coffee/Water Tumbler \$10,000 or (4) available at \$2,500 each

Exhibit Hall Refreshment Break/Popcorn Break

- ☐ Friday \$7,000 (Refreshment & Snacks) or (4) at \$1,750 each
- ☐ Saturday \$7,000 (Refreshment & Snacks) or (4) at \$1,750 each
- ☐ Sunday \$7,000 (Refreshment & Snacks) or (4) at \$1,750 each
- ☐ Friday \$2,500 (Popcorn) or (2) at \$1,250 each
- ☐ Saturday \$2,500 (Popcorn) or (2) at \$1,250 each
- ☐ Sunday \$2,500 (Popcorn) or (2) at \$1,250 each

Each sponsor will be listed in the final program flipbook, on a PowerPoint slide in each meeting room, and on signage on the exhibit hall entrance unit.

EXHIBITOR OPPORTUNITIES

\$1,800 for a 10 X 10 booth | \$1,500 non-profit rate

Booth cost does not include furnishings or utilities such as electric or internet. Two exhibitor badges per booth are included. Participating companies qualify for a 50-word description of their product or services, which will appear on the ABCT website and in the program addendum.

→ Exhibit and Sponsorship Contact:

Tonya Childers: tchilders@abct.org

the Behavior Therapist

Association for Behavioral
and Cognitive Therapies

305 Seventh Avenue, 16th floor

New York, NY 10001-6008

212-647-1890 | www.abct.org

PRSR STD
U.S. POSTAGE
PAID
Hanover, PA
Permit No. 4

Leadership & Elections

Nominate Yourself or a Colleague for ABCT Elections This Year!

Nominations portal opens June 28, 2023

- 2024 – 2025 President Elect
- 2024 – 2027 Representative-at-Large (RAL) and liaison to Convention and Education Issues
- 2025 – 2028 Secretary Treasurer



ABCT ASSOCIATION *for*
BEHAVIORAL *and*
COGNITIVE THERAPIES

For more information contact Angela Fang:
Email: angfang@uw.edu