

the Behavior Therapist

special issue

Harms

Caused by the Misapplication
of Cognitive Behavioral Therapies
(Part 1)

Guest Editors: Ilana Seager van Dyk
Alexandria Miller

Ilana Seager van Dyk and Alexandria Miller

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Introduction

to the Special Issue:

Harms Caused by the Misapplication of Cognitive Behavioral Therapies (Part 1)

Ilana Seager van Dyk, Massey
University

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AS READERS of *the Behavior Therapist* likely know, cognitive behavioral therapy (CBT) is a psychological framework that focuses on the interconnection between thoughts, emotions, and behaviors as they relate to a client's presenting problem. CBT has been shown to be effective in treating a wide range of psychological distress across the lifespan, including anxiety and worry (e.g., Watts et al., 2015), depression (Watts et al.), posttraumatic stress (e.g., Thielemann et al., 2022), insomnia (e.g., Trauer et al., 2015), and eating disorders (e.g., Linardon et al., 2017), among others. However, there is growing evidence that the misapplication of CBT principles can, at the least, invalidate, and at the worst, perpetuate oppressive systems and actively harm minoritized individuals.

One example of such harm was highlighted last year when ABCT apologized for the field of behavior therapy's role in the development of so-called "conversion therapies" aimed at changing clients' nonheterosexual and/or non-cisgender identities (ABCT, 2022). These largely behavioral interventions, while no longer endorsed by prominent psychological organizations, continue to be used today and are linked with increased psychological harm, up to and including suicide (e.g., Green et al., 2020). When this apology was announced, many ABCT members learned for the first time

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the Behavior Therapist

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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.

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about our field's involvement in harming sexual and gender minority individuals, leading some to question whether there are other domains in which CBT has been systematically misused, resulting in harm to clients (particularly minoritized clients). This question is at the center of this special issue of *tBT*.

The goal of this special issue is to understand how the misapplication of CBT has harmed certain client groups, including minoritized populations, and how we can start to undo those harms by applying CBT in an effective, affirming, and culturally sensitive way for these clients going forward. Due to overwhelming interest during our call for submissions, there will be two parts to this special issue, printed in the October 2023 and December 2023 issues of *tBT*. Each part includes literature reviews, original research, and commentaries on the ways in which the principles of CBT have been misapplied and, ultimately, caused harm to a wide range of communities.

In Part 1, we are delighted to introduce five phenomenal articles that investigate the misuse of CBT principles in relation to minoritized communities writ large, sexual and gender minorities, people with disabilities, and people undergoing weight-management programs. First, Ahuvia and Schleider (2023) discuss the challenges for cognitive behavioral therapists working with minoritized clients in the context of structural oppression. They provide recommendations for how to engage with both individual- and structural-level factors in clinical work. Next, Bergstrom and colleagues (2023) provide a review of clinical psychology's current and historical relationship to ableism, the impact of disability stigma in professional settings for mental health providers, and suggestions for increasing disability-affirming practice. Bharat et al. (2023) then present a framework for de-implementing strategies underlying sexual orientation and gender identity/expression change efforts (also referred to as so-called "conversion therapies"). Levinson and colleagues (2023) discuss the harms that can arise during the application of CBT for weight management using both research evidence and lived experience. They emphasize how societal beliefs around weight and associated attempts at losing weight, including weight stigma, restriction, diet culture, and weight loss practices, can increase the risk for developing eating disorders. Finally, Smith and colleagues (2023) examine anti-trans legislation through the lens of CBT principles, and propose a framework that

leverages CBT principles against the codification of anti-trans efforts into law.

Given the negative impact of these practices on minoritized communities (often by majority-identified researchers and practitioners), it was important to us that we uplift the voices of authors from the affected communities in this special issue. As editors, we acknowledge our own positionalities and perspectives that we bring to the editorial process. While we represent diversity in terms of nationality (USA, New Zealand), race/ethnicity (White, Māori, Black), and religion (spiritual, atheist), we share identities as disabled, cisgender, bisexual/queer women, and early-career psychologists. We are also both chairs or co-chairs of ABCT Special Interest Groups (SIGs) focused on minoritized communities (Sexual and Gender Minority SIG; Oppression and Resilience: Minoritized Mental Health SIG).

To assess whether we were meeting our goals of representing minoritized voices in this issue, we asked all authors to complete a brief demographic survey; 24 of the 30 authors responded. Authors were diverse in terms of sexual orientation (11 heterosexual/straight, 3 gay, 2 bisexual, 5 queer, 1 lesbian, 1 queer/bisexual, 1 lesbian/queer) and gender identity (8 cisgender women, 6 women/females, 1 cisgender man, 2 males, 2 nonbinary, 2 queer, 1 nonbinary trans man, and 2 cisgender). Although the majority ($n = 19$) identified their race/ethnicity as White, authors also identified as Asian, non-Hispanic Asian, South Asian, White/Middle Eastern, and White/Jewish ($n = 1$ each). Six authors identified as disabled or a person with a disability, and 9 authors identified as fat or larger-bodied. The mean age of authors was 38.4 years ($SD = 10.3$ years), and authors' career stages spanned from undergraduate/post-bacc ($n = 2$) to 21+ years post-graduation from graduate school ($n = 3$). Importantly, at least one author of each article indicated that they have lived experience of the issues described in their article (range: 1–7 authors), giving them a unique expertise and voice to discuss the topics covered in this special issue. We are grateful to these authors for being willing to use this personal experience for our benefit and educate us, the readers, and the field.

As CBT practitioners and trainers ourselves, acknowledging that these therapeutic techniques that benefit so many can be used to harm is uncomfortable. It is normal to want to look away from (or avoid) this topic and to dismiss the harms as happening outside our realms of influence. How-

ever, as many of these harms occur in subtle and insidious ways, we encourage you to join us in approaching and engaging with the evidence and arguments posed by the authors who have contributed to this issue. In so doing, we may be able to reduce the harms perpetuated against already minoritized individuals by CBT practitioners and become more effective, affirming, and culturally sensitive clinicians.

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The authors declare no conflicts of interest.

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Potential Harms From Emphasizing Individual Factors Over Structural Factors in Cognitive Behavioral Therapy With Stigmatized Groups

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Jessica L. Schleider, *Northwestern University*

EXPERIENCES of oppression and stigma¹ contribute to poor mental health among a wide variety of marginalized groups. Examples in the U.S. are not sparse. Race-based discrimination is associated with poor mental and physical health outcomes among African Americans (Mays et al., 2007; Soto et al., 2011). Exposures to interpersonal victimization, structural discrimination, and negative social attitudes are all associated with poorer mental health among LGBTQ+ youth (Russell & Fish, 2016). On college campuses, women and LGBTQ+ individuals are the most likely to be the victims of sexual assault, which can have severe consequences for mental health (Campbell et al., 2009; Carey et al., 2018; Ford & Soto-Marquez, 2016). Multiple overlapping stigmatized identities confer additional risk (Seng et al., 2012).

While oppression and stigma impact the mental health of individuals, their causes are structural (e.g., cultural norms, public policies). This poses a challenge for cognitive behavioral therapists who seek to

help clients affected by oppression and stigma, as the ultimate cause of the clients' problems are largely not within the control of either the client or the therapist. Generally speaking, cognitive behavioral therapists approach this challenging presentation by focusing on the individual-level factors that are in the client's control (e.g., a client's appraisal of an experience of discrimination, or how a client copes with experiences of victimization). Moreover, cognitive behavioral therapists strive to do this in a culturally responsive way (e.g., by validating the client's experiences of discrimination; Hays, 2009). In keeping with this approach, cognitive behavioral practitioners have developed interventions that effectively treat distress and mental illness in stigmatized groups (e.g., Pachankis et al., 2015; Williams et al., 2022), and have adapted evidence-based practices for work with these groups (e.g., the adaptation of cognitive restructuring described by Graham et al., 2013). However, there may still be ways that the individual-level focus

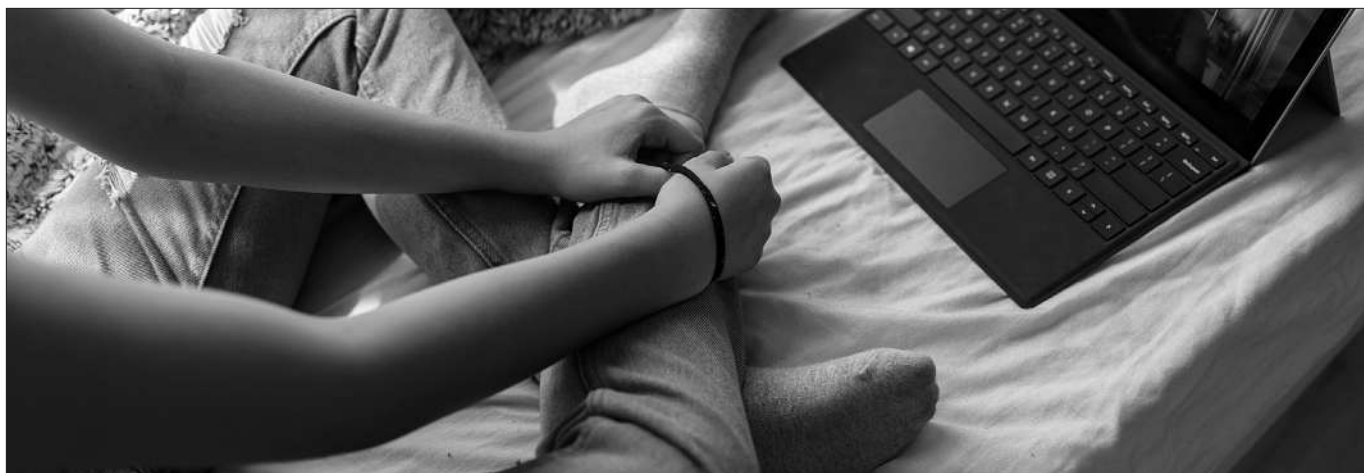
inherent to cognitive behavioral therapy (CBT) leads to unintended consequences for clients—even when it is applied in a culturally responsive manner. In this article, we outline some potential harms that could result from (over-)focusing on individual-level factors in CBT with oppressed groups. First, we review current knowledge of stigma processes, and how this knowledge is reflected in current cognitive behavioral approaches. Then, we outline potential unintended harms that could result from focusing on individual-level factors over structural factors in CBT with stigmatized groups. Finally, we discuss future directions for research and practice that can examine and, if necessary, remedy these harms.

Stigma Processes and CBT

Stigma impacts mental health through processes that play out at individual, interpersonal, and structural levels (Link & Phelan, 2001). Individual stigma processes are the internal, psychological responses individuals have to stigma, including self-stigma and concealment (Corrigan et al., 2009; Pachankis, 2007). Interpersonal stigma processes occur when nonstigmatized individuals discriminate against, harass, or otherwise inflict the consequences of stigma on stigmatized individuals (Hebl & Dovidio, 2005). Structural stigma² refers to societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized (Hatzenbuehler, 2016). Individual and interpersonal stigma processes can be reinforced by the presence of structural stigma—e.g., through cultural norms that enable discrimination and institutional policies that contribute to power differences between dominant and oppressed groups. Figure 1 outlines these processes. Ultimately, all stigma processes—including individual

¹Stigma is defined as labeling, stereotyping, separation, status loss, and discrimination, which occur in a context in which power is exercised (Link & Phelan, 2001). Unlike more narrow definitions of stigma (e.g., stigma as a mark held by individuals with a mental illness diagnosis), this definition includes a range of social processes relevant to many different groups.

²Like the term institutional racism, “structural stigma” draws attention to the fact that stigma processes can play out even when no single individual means harm to another (Hatzenbuehler, 2016)



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and interpersonal processes—are the manifestation of cultural systems of power through which stigmatized identities are devalued (Herek, 2009; Link & Phelan, 2001).

Clearly, stigma is a multilevel process that cannot be reduced to only individual factors like thoughts, feelings, and behaviors. However, cognitive behavioral therapists often opt to focus on these individual factors when working with individuals who are experiencing the psychological consequences of stigma. One reason for this focus is obvious: unlike the societal determinants of stigma, these individual factors can be targeted and (ideally) modified through therapy. Other reasons may contribute as well: for example, CBT's historical roots in behaviorism and individually focused sciences (Craske, 2017) and a historical view that CBT need not attend to macro-level cultural or societal factors (Hays, 2009).

While all cognitive behavioral therapies necessarily take an individual-level approach towards addressing the consequences of stigma, there are some that explicitly acknowledge (or otherwise attempt to account for) the role of social and structural factors in contributing to a client's problems. Examples of these interventions include the Effective Skills to Empower Effective Men (ESTEEM) therapy, which targets minority stress in young gay and bisexual men (Pachankis et al., 2015), and the Healing Racial Trauma protocol, which uses a variety of cognitive-behavioral techniques to help clients better understand and cope with experiences of racial trauma (Williams et al., 2022). Other research has outlined ways to incorporate such factors into existing cognitive-behavioral approaches, such as by integrating adaptive racial socialization into trauma-focused CBT for African American youth (Metzger et al., 2021), and by adapting cognitive restructuring strategies to focus on disputing thoughts that internalize stigma (e.g., "I am stupid") rather than the client's interpretation of experiences of stigma (e.g., "this person thinks that I'm stupid because of my race"; Graham et al. 2013). These interventions represent important steps forward in clinical care with stigmatized populations. Still, even when interventions acknowledge the macro-level processes that lead to experiences of stigma, it is possible that focusing on individual-level solutions can have unintended consequences.

Potential Consequences of Focusing on Individual-Level Factors

In cognitive behavioral practice, neglecting issues of culture altogether can result in harm to clients, as discussed elsewhere (Hays, 2009). However, even when clinicians are aware of cultural and structural factors, they may still inadvertently cause harm to clients by focusing on individual-level factors in how they frame (a) the causes of the client's problems and (b) the solutions to those problems.

Focusing on Individual-Level Causes

Focusing on individual-level stigma processes as a cause of the client's problems may cause harm when the client sees their problems as the result of higher-level structural forces. Misalignment between client and clinician in their explanatory models—the way that they understand the client's distress—can damage the therapeutic alliance and reduce treatment engagement (Dinos et al., 2017). For example, consider a transgender adolescent who is seeking help for depressive symptoms. A number of individual, social, and structural processes may be at play in the client's case. In discussing their case conceptualization with the client, the clinician emphasizes the role of interpersonal discrimination and internalized stigma in contributing to the client's symptoms. The client, on the other hand, believes that their problems are the result of anti-trans laws, rhetoric, and a political environment that is hostile to them. The clinician is not necessarily wrong in their conceptualization (nor is their explanatory model inconsistent with the client's), but by failing to explicitly name the role of structural factors in contributing to the client's distress, they might risk leading their client to feel invalidated and misunderstood, harming the therapeutic alliance, and reducing the client's motivation to engage in treatment. Examples of this process have been documented among trans and gender diverse clients' experiences in therapy (Puckett et al., 2023).

A commonly proposed path to mitigating this potential harm involves clinicians practicing in a culturally responsive manner, wherein they assess and account for the potential role of cultural factors in case conceptualization and treatment (Lewis-Fernández et al., 2015). However, it is possible to acknowledge the role of the culture (or cultures) that a client is exposed to without acknowledging the role of structural forces in causing their distress (Weiss et al., 2021). For example, in working with

this transgender adolescent, the clinician might rightfully acknowledge the role of cultural gender norms in shaping the adolescent's experience, but not acknowledge the role of anti-trans legislation. Again, there is potential for harm to the therapeutic alliance when the client is more aware of such factors than the clinician. Thus, even when a clinician is being responsive to cultural factors, responding to structural factors is also required to avoid harm (Hansen & Metzl, 2019; Weiss et al., 2021).

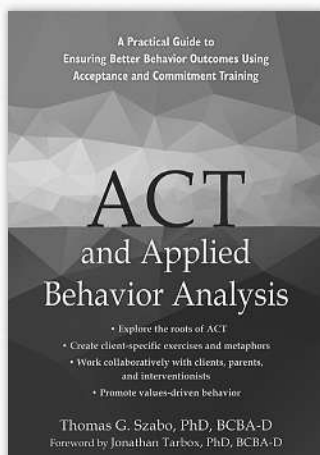
Focusing on Individual-Level Solutions

Though cognitive-behavioral therapists may acknowledge the role of structural factors in contributing to the client's distress, the work of therapy will nonetheless focus on the individual-level changes a client can make to reduce their distress. These include cognitive and behavioral changes that the client can make to improve how they cope with experiences of stigma. This approach is in line with evidence-based cognitive-behavioral practices, and interventions using this approach can effectively reduce distress in individuals experiencing stigma. However, it is possible that such practices are less effective for marginalized groups—especially when structural factors are central to the client's problems (Price et al., 2021, 2022). Accordingly, even when effective at the aggregate level, such an approach may have unintended consequences for some minoritized clients.

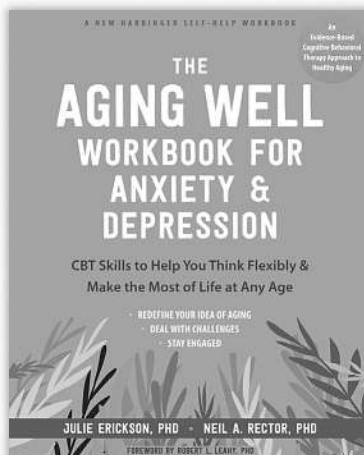
When the work of therapy focuses on the client's cognitive and behavioral responses to stigma—and the ways that they can respond differently—this places the onus of addressing the interaction on the client. This may inadvertently lead to self-blame in clients experiencing stigma and victimization. Self-blame is associated with adverse mental health outcomes (Wei et al., 2010), and in fact explains part of the relationship between discrimination and poor health (Blodorn et al., 2016). A client may also interpret the therapist's emphasis on their thoughts and behaviors as unfairly burdensome. A client who experiences racial discrimination may balk at the idea that the solution to this problem is a change to how they behaviorally or cognitively respond to these experiences. This, too, may harm the therapeutic alliance, or reduce the client's engagement in cognitive-behavioral treatment. Interventions that emphasize client empowerment and collective action may avoid these harms (Alex Wagaman, 2016). Such interventions are supported by research indicating that, among people experiencing discrimina-

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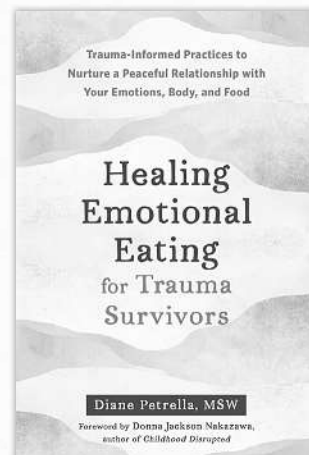
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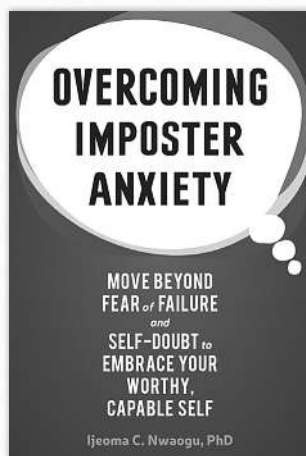
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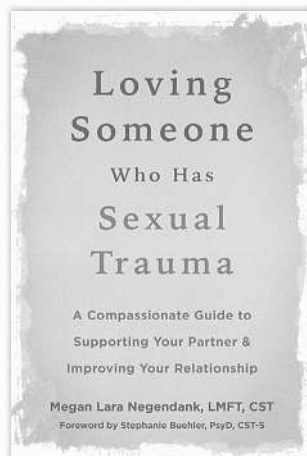
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The History of Clinical Psychology and Its Relationship to Ableism: Using the Past to Inform Future Directions in Disability-Affirming Care

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PEOPLE WITH DISABILITIES¹ (PWD) account for the largest minority group in the United States at 26% of the population—over 86 million people (Lund, 2021a). According to the Americans with Disabilities Act of 1990, PWD are defined as those who: (a) have a physical or mental impairment that significantly limits one or more "major life activities," (b) have a history of such an impairment, or (c) are thought to have such an impairment (Office of the Surgeon General, 2005). PWD are frequently exposed to ableism, the systematic discrimination by, exclusion, and oppression of people with physical or mental disabilities (Bogart & Dunn, 2019; Hehir, 2002). Experiencing discrimination appears to be related to increased substance use, depression, and suicidality among this group (Lund, 2021a). Through the lens of intersectionality,² PWD who are also members of other marginalized groups may experience greater stress. For example, youth reporting sexual and gender minority status and disability have reported higher rates of suicidality (Lund). Similarly, PWD who are members of racial and ethnic minority groups may be more likely to experience violence from police, considering that many of the Black individuals murdered by police also have disabilities (Lund et al., 2020). While clinical psychol-

ogy is uniquely poised to support individuals facing the psychological toll of ableism, the field itself has a long and complicated relationship with ableist practices.

Clinical psychology's history of ableism dates back to the beginning of the mental testing movement in the early 20th century when clinical psychology used standardized tests of supposed intelligence in an attempt to gain credibility among traditional lab-bench sciences (Benjamin, 2005). This testing movement, intertwined with racism (Annamma et al., 2018; Auguste et al., 2022), evolved into the widely accepted ableist eugenics movement and further harm committed in treating PWD in asylums. Almost 100 years later, clinical psychologists still play a significant role in defining or treating disability.

How people think of disability has evolved, and these viewpoints are called models of disability. While a full discussion of each model of disability is beyond the scope of this review, we provide a brief overview and refer the reader to the work of Dr. Julie Smart (Smart & Smart, 2006). The earliest model, called the moral model, is rooted in religion. According to the moral model, disability is a test of faith given only to those who can bear such a burden (Olkin, 2017). Likewise, the moral model saw disability as a divine interven-

tion to correct behavior deemed inappropriate by the community at large (Olkin). The dominant perspective transitioned from the moral model to the medical model in the mid-19th century, heavily informed by the work of clinical psychologists, where it would become the standard model for disability in treatment and public policy (e.g., the Americans with Disabilities Act, 1990). The medical model views disability through the lens of pathology, defining disability as a defect that must be fixed or cured (Olkin, p. 84). The medical model is therefore focused on the individual medical treatment of disability and assessment of how a person with a disability functions.

While the medical model aims to reduce disability stigma, it perpetuates a paternalistic view of how disability should be treated in its labeling of "good vs. bad parts" and overlooks voices within the disability community (Olkin, 2017, p. 93). Since the 1970s, PWD have pushed to adopt a social (or sociopolitical) model of disability. The key elements of the social model of disability are (a) the recognition of disability as a social construct and (b) how physical and social environments do not meet the needs of PWD (Olkin, 2002, 2017). In contrast to the medical model, the social model focuses more on acceptance and community support, and "depathologizes disability" (Olkin, 2017, pp. 80–84). The social model of disability evolved into the minority stress model, also known as the diversity model, of disability (Andrews, 2019, pp. 28–31). While both the social model and minority stress model focus on acceptance of disability, the latter emphasizes the direct displays of disability pride (Andrews, 2019). As applied to PWD, the minority stress model highlights ways individuals may experience distress in the context of their social environment (Lund, 2021a; Meyer, 2003). Minority stress describes the overabundance of stress that people from marginalized groups experience because of their identity (Meyer). Minority stressors can include discrimination or violence, expectations of rejection, hypervigilance, and internalized stigma. Experiencing these minority stressors may harm individual self-esteem by increasing identity-related shame (Pachankis, 2007). For example, one study of autistic individuals³ found that proximal and distal minority stressors, such as discrimination and internalized stigma, predicted increased levels of distress and poor well-being (Botha & Frost, 2020).

¹We will use the acronym PWD when referring to people with disabilities throughout this review. This follows current standards supporting the use of person-first language within the area of disability studies (APA, 2022b; United Spinal Association, 2022).

²Intersectionality, originally defined by Crenshaw (1989), is the idea that power relations of race, disability, gender, sexuality, and other marginalized identities are interrelated and shape one another (Collins & Bilge, 2020).

³Here, we use identity-first language as this is preferred by most, but not all, members of the autistic community (see APA, 2022b; Taboas et al., 2023; United Spinal Association, 2022).

For this review, we apply the social model of disability and the minority stress model to understand the history and future directions of disability within clinical psychology because of both models' emphasis on disability acceptance and recognition of how social environments impact the mental health of PWD. With this in mind, this review aims to: (1) provide a brief overview of the historical harms of clinical psychology on PWD,⁴ (2) highlight ways in which disabled communities view current treatment practices in clinical psychology settings, (3) discuss how disability stigma impacts professional and academic settings for clinical psychology, and (4) identify future directions for the disability-affirming practice of cognitive-behavioral therapies.

Historical Harms of Clinical Psychology on People With Disabilities

The Psychological Testing Era

Psychological testing and assessment is one of the earliest hallmarks of clinical psychology. Many historical factors contributed to the increased investment in testing and assessment in clinical psychology, including pressure both within and outside the field to conduct empirically based work, the rise of institutions and mental hospitals, and foundational research on individual differences in learning (Benjamin, 2005). This movement for assessing and testing individual differences began in the 1890s, starting with psychologists employed in mental hospitals and continued by prominent figures within the broader field of psychology, such as Francis Galton, James McKeen Cattell, and Alfred Binet (Benjamin). The field's early approach to testing influenced psychologists' views of individual differences and treatment that were often used to oppress and disenfranchise poor, disabled, and racial and ethnic minority populations (Auguste et al., 2022; Baynton, 2005). Robert Yerkes created the first mental tests, named Army Alpha and Beta, which were designed to assess a recruit's intellect and "mental stability" as defined by the absence of major mental illnesses such as psychosis during the start of World War I in 1914

(MacCurdy, 1918). The Alpha test was intended for use with English speakers, while the Beta test was used to "weed out" recruits who could not read or speak English (Benjamin, p. 7). Psychologist Henry Hebert Goddard is responsible for coining the term "feeble-minded" to describe individuals with low intelligence (Goddard, 1911). However, his definition of "feeble-mindedness" was subjective and soon became a catch-all for individuals who were poor, disabled, or from racial and ethnic minority groups (Dolmage, 2017). After returning from Europe, Goddard came across the work of Alfred Binet and Theodor Simon (Benjamin, p. 6). Binet's test, which came to be known as the Stanford-Binet intelligence test, focused on "skills for success in school," including comprehension and verbal fluency. Though Binet recognized the poor construct validity of the Stanford-Binet test (Kramer et al., 2019, p. 26), it soon became one of the gold standards in intelligence testing.

During this time, there was a rise in the forced institutionalization of PWD (Chapman et al., 2014; Crowe & Drew, 2021), which coincided with increased stigma towards individuals with visible disabilities and the passing of laws that supported forced institutionalization as a way to keep disability out of the community and out of the public eye (Chapman et al.; Schweik, 2009). This time intersects with the history of psychiatry and clinical psychology, as many practitioners spent the bulk of the 19th century working at "lunatic asylums," also known as hospitals for the insane, state hospitals, or mental hospitals (Benjamin, 2005). The language used to describe such institutions put the individual's mental illness or disability front and center as a problem to be remediated, consistent with the medical model of the time. These hospitals first appeared in the late 1700s. By the 1960s, there were more than 300 of these hospitals until federal legislation ended their dominance as America's method for treating the seriously mentally ill in that decade (Benjamin). Psychiatrists and psychologists were part of these facilities' treatment and planning teams, with most focusing on somatic treatments. While these treatments helped some patients with

mental illness in the short term, there was little evidence that the treatments resulted in long-term remittance of symptoms (Benjamin). This resulted in an increasing number of patients, few patients leaving institutional care, and a general overwhelm of the clinical teams due to increasing demand (Benjamin; Roulstone & Prideaux, 2012).

Other figures in psychology took a biological approach to individual differences, leading to stigmatizing observable traits associated with physical and mental disabilities. Franz Gall's "study of phrenology" was based on the belief that the size and shape of anatomic structures were measures of intelligence, focusing mainly on the brain (Kramer et al., 2019, pp. 24–25). Gall's work is considered pseudoscience today, yet the focus on biological differences continued. Francis Galton (1822–1911) extended Charles Darwin's work on biological determinism: the belief that characteristics, such as intelligence, were determined by genetics (Kramer et al.; Yakushko, 2019). Galton, alongside his student James McKeen Cattell, created sensorimotor-focused intelligence tests that measured inherited and immutable mental structures (Benjamin, 2005). Cattell's methods of capturing intelligence were influenced mainly by British empiricists who believed that knowledge came from our sensory experiences (Kramer et al.). He included measures of cognitive functioning, sensory abilities, and physical measurements like head size. However, some psychologists believed treatment could improve complex mental functions, including disability. In concert with the harms that PWD experienced in forced institutionalization, standardized testing and the beliefs of biological determinism were translated into what we know today as eugenics, with dire consequences for PWD.

The Role of Psychological Testing in the Eugenics Movement

Eugenics is the movement to control human reproduction of "feeble-minded" people to ensure that desirable traits (e.g., intelligence, self-control, and moral behavior) would be passed on to future generations (Yakushko, 2019, p. 4). The first law that supported forced sterilizations was enacted in 1907 in Indiana, and other states like Virginia soon followed suit (Cohen, 2016, pp. 5–6). The United States supreme court ruling in *Buck vs. Bell* (1927) upheld the forced sterilizations of nearly 70,000 American PWD, including Carrie Buck (Cohen). Carrie Buck was a woman who

⁴We note that in reviewing historical harms, we will be using historical language of the time to reflect the harms and framing of PWD across history. We want to make clear that the historical language promoted an ableist, albeit occasionally well-intentioned, approach to supporting PWD.

was deemed feeble-minded by her score on the Stanford-Binet test, and was later sterilized by the state of Virginia (Cohen, pp. 30–31). The Buck vs. Bell case ruling inspired others overseas, including policies of forced sterilization adopted soon after by the Nazi Party (Cohen, pp. 10–11). Following World War II, Nazis had completed 375,000 forced sterilizations, arguing that the Buck vs. Bell case ruling set a precedent for the sterilization of PWD (Cohen, p. 10).

Thirty-one prior presidents of the American Psychological Association supported or even led groups dedicated to the eugenics movement between 1892 and 1947. One prominent supporter was John B. Watson, a contributor to behavioral psychology or behaviorism (Yakushko, 2019). Watson argued for psychology to be a purely objective science to predict and control behavior (Watson, 1914). Watson's work in behaviorism borrowed values, strategies, terms, and descriptions from eugenics, going as far as saying that his work could be used to "socially engineer the evolutionary fit of individuals to act in reference with eugenic values" (Yakushko, p. 8). Throughout his book, *Psychology: From the Standpoint of a Behaviorist*, Watson uses the term "defectives" in reference to PWD (Watson, 1919). In conjunction with Yerkes, he founded the Committee on the Hereditary Measurement of Mental Traits of the American Eugenics Research Association. Watson denounced eugenics and revised his work to shift away from the heritability of behavior much later in his career (Yakushko). His position, alongside other behaviorists who denounced eugenics, remained influential and inspired a positive shift in behaviorism away from eugenics.

Mental Healthcare and Disability Rights Post–World War II:

The end of World War II was met with cascading needs for mental health services due to returning veterans' need for treatment following the rising incidences of posttraumatic stress symptoms (Benjamin, 2005). Around this time, the World Health Organization published the first ever mental health section in the *International Classification of Diseases* (ICD-6). The American Psychiatric Association followed by publishing the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), largely based on the ICD-6, to standardize how mental disorders were classified or diagnosed (Blashfield et al., 2014) and intended as a way to

support and treat people with mental health needs.

The call for deinstitutionalization was thought to have been motivated by the rise in mental illness following World War II and the stigma associated with confinement in an asylum (Benjamin, 2005). John F. Kennedy signed deinstitutionalization into law by passing the Community Mental Health Act of 1963 (Benjamin). This bill radically changed care delivery for mental health services: asylums reduced capacity and eventually closed their doors for good, and thus caring for disabled people fell upon family or the community at large (Benjamin). Unfortunately, the stigma associated with disability remained, and this time also saw a rise in the number of disabled people incarcerated and without access to mental health care (Crowe & Drew, 2021). Today, PWD account for nearly two-thirds of the incarcerated population in federal and state prisons (Bixby et al., 2022). This turning point also shifted the historical harms committed from within asylums to society at large, including modern treatments of individuals with disabilities and ableism within the professional spaces of clinical psychology.

Modern Harms: Perspectives on Current Treatments From PWD

Today, PWD continue to face challenges and harm when seeking psychological treatment. To illustrate, we will provide examples related to the treatment of autism and chronic pain from mixed-method studies.

Perspectives on Applied Behavior Analysis From Those Within the Autism Community

Decades since the eugenics movement and institutionalization ended, and the beginning of Watson's work in behaviorism, some autistic individuals have spoken out about their experiences with behavior therapies, particularly their feelings and attitudes toward Applied Behavior Analysis (ABA). ABA can be conceptualized as a group of interventions that utilize behavioral reinforcement to improve motor skills and communication. It was developed as a treatment to target symptoms of autism, and to apply conditioning principles to change social behavior. Anderson (2023) conducted qualitative interviews with autistic youth who discussed their feelings about ABA. The participants shared that they had gained valuable skills from ABA, such as using visual communication

boards and reading facial expressions, but also noted adverse long-term effects, such as flashbacks and nightmares, and taking twice as much effort to learn self-acceptance and unmask their autistic traits (Anderson, p. 9). Participants viewed ABA as unethical but suggested utilizing more treatments they perceived as helpful, such as occupational therapy or speech-language therapy, and the importance of feeling accepted and respected as autistic individuals in treatment delivery. Moreover, participants found it difficult to separate the attitudes of one of the pioneers of ABA (Lovaas) from his attitudes toward autistic people. In a 1974 interview, Lovaas stated,

You see, you start pretty much from scratch when you work with an autistic child. You have a person in the physical sense—they have hair, a nose, and a mouth—but they are not people in the psychological sense. One way to look at the job of helping autistic kids is to see it as a matter of constructing a person. You have the raw materials, but you have to build the person. (Anderson, 2023, p. 2)

Treatment founded on such beliefs should raise alarm. This inhumane and deficit-based view of autistic people drastically differs from the principles of neurodiversity, which began as a movement in the 1990s championing acceptance and inclusion of neurological differences. The term neurodiversity refers to perceived differences in cognitive, affective, and sensory functioning from the predominant neurotypical population (Rosqvist et al., 2020).

Behavior analysts have come a long way in identifying the ethical pitfalls of their practice, one example being the impermissibility of conversion therapy for sexual and gender minorities (DeFelice & Diller, 2019; Graber & Graber, 2023). Although we are not aware of active changes in ABA to address these ethical issues, we hope that clinicians and researchers remain cognizant of the perceived harms of treatments and these ethical concerns in their daily practice.

Perspectives on Treatments Continued: Chronic Pain

As noted in the feedback about ABA, treatments for other conditions, such as chronic pain, may benefit from focusing on acceptance as a treatment target for PWD. Kanzler et al. (2022) took a mixed methods approach to chronic pain treatment in their

randomized controlled trial of Focused Acceptance and Commitment Therapy (FACT-CP) in an integrated primary care setting. They conducted semistructured interviews to ascertain what treatment components were liked or disliked by participants and changes in how they thought about or managed their pain, in comparison to a standard-CBT-based treatment group. Participants appreciated the skills for learning to live with their pain. They reported increased chronic pain acceptance, suggesting that accepting one's condition or disability may serve as a mechanism of change. However, reviews of ACT for chronic pain have noted that studies are often underpowered to compare outcomes across racial and ethnic groups (Ehde et al., 2014; Meints & Edwards, 2018), suggesting that examining the overlap of racial/ethnic

minority and disability status should be a priority in future treatment studies.

Other Perspectives: Treatment in the Context of Minority Stress

Clinical psychologists must amplify the voices of the individuals directly impacted by the field's work. Perspectives from PWD strongly argue for using cognitive-behavioral treatments, such as dialectical behavior therapy (DBT), to target disability-related minority stress. From the perspective of Linehan's biosocial model of emotion dysregulation, distress may be caused by prolonged exposure to an invalidating environment (Cardona et al., 2022; Linehan, 1993). Interactions with institutions like higher education and healthcare systems may leave PWD with the sense that they are the problem. This suggests that DBT could be used to address shame and

emotion dysregulation related to disability.

DBT was originally designed to treat suicidal people susceptible to emotion dysregulation. PWD have higher rates of suicidal ideation, suicide planning, and suicide attempts than those without disabilities, and this finding is consistent across disability types (Lund, 2021a). Initial work suggests DBT can be beneficial when adapted for individuals with some disabilities, such as intellectual disabilities (McNair et al., 2017). However, future work is needed to specifically examine whether DBT could be beneficial for targeting disability-based minority stress. A balance of acceptance and change skills could help PWD accept their identity, regulate distress from interactions with invalidating systems, and reach their personal goals.

Table 1. Future Directions for Disability-Affirming Practice in Clinical Psychology

Current areas for improvement	Next steps
Disability stigma within the field	<ol style="list-style-type: none"> 1) Actively recruit people with lived experience of disability at all stages of training and career. 2) Create communities for people in the field with disabilities to connect and support one another (e.g., Disability Advocacy Research Network: https://darndisability.org/) 3) Outline explicit government and institutional policies that protect disclosures of disability status in workplaces of academic and practicing psychologists. 4) Issue a formal apology to people with disabilities for psychology's role in perpetuating ableism, similar to the APA's formal apology to people of color (APA, 2021).
Clinical Training and Research	<ol style="list-style-type: none"> 5) Increase training in working with people with disabilities. 6) Conduct research on disability-affirming treatments with input from disabled communities. 7) Adapt empirically supported treatments for targeting disability-minority stress, such as ACT and DBT. 8) Develop strengths-based disability-affirming therapies for people with disabilities to avoid the perpetuation of a deficits-based approach to disability. 9) Integrate the history of the disability rights movement and critical disability studies as part of the coursework and training for APA/PCSAS accredited doctoral programs

Future Directions for Disability-Affirming Practice in Clinical Psychology

To diversify our field and support PWD, we must put in sustained effort to ensure evidence-based treatments are accessible, train clinical psychologists about disability-affirming care, and support clinical psychologists with disabilities. We have outlined future directions for disability-affirming practice in clinical psychology treatment, training, and professional spaces (Table 1).

Moving Towards Evidence-Based Treatments for Disabled Patients

Rhoda Olkin's book on disability-affirming therapy (D-AT) argues that there are factors that clinical psychologists must consider beyond the biopsychosocial model, such as the specific financial burdens and the mental health impacts PWD experience from interacting with complex healthcare systems (Olkin, 2017). In addition, the most recent APA guidelines for assessing and treating PWD provide a good starting point for clinical psychologists looking to incorporate disability-affirming paradigms into their practice (APA, 2022a). The first section focuses on awareness, training, accessibility, and diversity. For example, Guideline 7 states, "Psychologists strive to recognize the intersectional identities of PWD" (APA, 2022a, p. 15). The second section focuses on testing and assessment. Guideline 15 suggests that the reliability and validity of assessments may be compromised if factors such as physical strength, attention/

processing speed, energy levels/stamina, and pain are not considered (APA, p. 32). The third and final section focuses on different treatment modalities and theoretical orientations. In essence, it states that it is better not to assume that a treatment modality is incompatible with certain disabilities (APA, p. 38). Rather, intervention plans are shaped by more than disability: they are shaped by the goals, strengths, therapeutic relationship, and relevance to the client's daily life—all of which vary in complexity.

Addressing Disability Stigma in Professional and Academic Settings in Clinical Psychology

The impact of disability stigma is evident in training practices around disability and the representation of disability in clinical psychology professional spaces. Though Congress passed the Civil Rights Act of 1964, disability was not a protected group until the passing of the ADA in 1990 after activism from PWD (e.g., The Capital Crawl Protests; Davis, 2015). Though it is three decades later, scholars and practitioners with disability continue to face barriers and are underrepresented in professional spaces.

One hypothesis for the underrepresentation of PWD in the field is that many psychologists underreport their disability due to the stigma (Lund, 2021b; Victor et al., 2022). In 2021, only 6% of the psychology workforce reported having a positive disability status (APA, 2022c). Victor et al. noted that psychologists are not immune to psychopathology. Yet, open discussions of such experiences remain highly taboo within the field. Disclosing lived experiences of mental illness is named a “kiss of death” in graduate school applications (Appleby & Appleby, 2006; Victor et al.). Similarly, disclosure of disability status can negatively impact APA-accredited internship match rates, as Lund (2021b) found that PWD had lower mean match rates than those without disabilities. The largest differences in match rates were found among those reporting physical/orthopedic disability, blind/visual impairments, and those who did not specify disability type, ranging from -12% to -7.6% (Lund, 2021b). The fear of being viewed negatively or as difficult may impede disclosure among trainees and clinicians alike, especially when asking for academic and workplace accommodations. Victor et al. encouraged professional organizations (e.g., APA, ABCT) to develop a task force focused on promoting and reducing stigma around mental health in acad-

mia to “systematically investigate barriers to success for people with psychopathology in academic environments, facilitate implementation of policies and programs to remediate those barriers, and evaluate the success of these policies over time” (Victor et al., p. 6). Compounding the issue, many trainees receive little dedicated training for working with PWD—sometimes a single lecture—despite having PWD on their clinical caseloads (Andrews & Lund, 2015; Olkin, 2017). Clinicians with disabilities may be well poised to develop a strong therapeutic alliance with PWD and validate their experiences (Andrews, 2019, pp. 117–121). Research from Dr. Patrick Corrigan and others suggests that stigma associated with mental illness can be reduced through interventions involving education and contact (see Corrigan et al., 2012), and clinicians and trainees may also benefit from stigma-reducing interventions. Clear protections are needed to make disabled trainees and professionals in our field feel safe and supported as disabled psychologists.

Conclusion

This article aims to shed light on the historical and current interactions between the community of PWD and the field of clinical psychology, broadly defined. In addition to supporting disabled clinicians and trainees in clinical psychology's professional and educational spaces, we urge clinical psychologists to (a) become familiar with works from the field of critical disability studies⁵ and (b) incorporate aspects of disability-affirming mental health frameworks into their practice, including disability-affirming therapies and guidelines. Going forward, we should keep the history of clinical psychology salient as we support patients and providers with disabilities. As the recently passed disability rights advocate Judy Heumann said in her memoir:

Change never happens at the pace we think it should. It happens over years of people joining together, strategizing, sharing, and pulling all the levers they possibly can. Gradually, excruciatingly slowly, things start to happen, and then suddenly, seemingly out of the blue, something will tip. (Heumann & Joiner, p. 183)

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⁵Examples of works from critical disability studies, see Dolmage (2017), Watson and Vehmas (2020), and Olkin (2002). We also recommend works from emerging disability critical race theory, also known as DisCrit (Annamma, 2018).

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Deimplementation Strategies to End Sexual Orientation and Gender Identity and Expression Change Efforts: Undoing a Harmful Legacy of Behavior Therapy

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SEXUAL ORIENTATION and Gender Identity and Expression Change Efforts (SOGIECE) are harmful practices that seek to change an individual's sexual orientation (lesbian, gay, bisexual, queer, asexual, etc.) and/or gender identity and expression (transgender, nonbinary, intersex individ-

uals, etc; hereafter collectively referred to as LGBTQIA+) to heterosexual, cisgender behaviors and identities (American Psychological Association [APA], 2021a; APA, 2021b). SOGIECE are commonly known as "conversion therapies," but this term is misleading since sexual and gender minority identities are not mental disorders and the nature of SOGIECE is harmful and nontherapeutic (APA, 2021a). It should be noted that SOGIECE include various approaches. Historically, such efforts focused on aversive techniques implemented by behavior therapists (e.g., inducing nausea or vomiting, covert sensitization, or shame aversion; APA, 2009). But over time they became more social (e.g., teaching heteronormative dating skills, affection training to physically and/or socially reinforce sexual behaviors with the opposite sex) and cognitive (e.g., seeking to modify thought patterns by reframing desires, redirecting thoughts, or using hypnosis) to ultimately change sexual arousal, behavior, and orientation (APA, 2009). In fact, given the increased visibility of different sexual orientations and gender identities and expressions, efforts nowadays include clinicians gatekeeping life-saving hormonal interventions by encouraging clients to not commit to their transgender identity or initiate gender-affirming care until they are absolutely sure (sometimes

euphemistically called “gender exploratory therapy”), or even ascribing transgender identity or asexuality to trauma (Ashley, 2023). It should also be noted that sometimes the precise nature of these practices and how they have evolved is relatively unknown, in part because SOGIECE practitioners are not transparent about the kinds of techniques they use.

In February 2021, APA published resolutions opposing SOGIECE based on its extensively documented negative impacts, such as elevated risk of depression, anxiety, LGBTQIA+ identity stigma, suicidality, and death (APA, 2009, 2021a, 2021b; Daniel et al., 2015; Dehlin et al., 2015; Dromer et al., 2022; Fjellstrom, 2013; Green et al., 2020; Haldeman, 2002b; Maccio, 2011; Panozzo, 2013; Smith et al., 2004). Rare findings suggesting that SOGIECE is not harmful to mental health are consistently found to have serious methodological and conceptual flaws upon closer scrutiny (see e.g., Blossnich et al., 2023; Glassgold & Haldeman, 2023; Strizzi & Di Nucci, 2023). Some scientists have also apologized to the LGBTQIA+ community for harming them by using SOGIECE in research (Spitzer, 2012) or had their previously published erroneous findings retracted due to statistical flaws (Retraction notice, 2019). More fundamentally, SOGIECE wrongfully deny the natural diversity and complexity of sexual orientation and gender identity.

Globally, only 14 countries have nationwide bans on SOGIECE that are either partial (e.g., protecting only minors, applying only to licensed medical professionals) or full (protecting all LGBTQIA+ minors and adults; The Council for Global Equality, 2022). In the U.S., only 20 states and the District of Columbia (D.C.) have banned the use of SOGIECE (Human Rights Campaign, 2022), and city and county bans are in place in other states but often become the target of state-level attacks (e.g., 11th U.S. Circuit Court of Appeals in Florida issued injunctions barring localities from enforcing the bans in November 2020). About 20,000 youth currently aged 13–17 in the U.S. will be subjected to SOGIECE by licensed health care professionals before age 18, and another 57,000 from religious or spiritual advisors (Mallory et al., 2019). Minors are often coerced into SOGIECE by their caregivers or family, or otherwise compelled to participate through systems of oppression and societal norms privileging heterosexual, cisgender identities (APA 2009; APA 2021a; APA 2021b). Overall, nearly 700,000 LGBTQIA+ adults in the

U.S. were subjected to SOGIECE at some point in their lives, over half of whom experienced them as adolescents (Mallory et al.).

Mental health professionals have an ethical duty to stand against harmful SOGIECE practices, especially in a social and political climate that is increasingly hostile toward LGBTQIA+ people in many countries. This article outlines active and immediate strategies that cognitive-behavioral scientists and practitioners can use to pursue a systematic elimination of the incidence and maintenance of SOGIECE. The authors of this paper are all members of the Association for Behavioral and Cognitive Therapies (ABCT) and identify as either gay, queer, straight, or cisgender allies. None of us have been subjected to SOGIECE, but some have worked clinically with those who have; most of these individuals experienced aversive conditioning strategies such as being shocked or forced into 90+ days of inpatient treatment to “cure” their LGBTQIA+ identity, leaving them scarred with distrust in healthcare professionals, long-term traumatic stress symptoms, and even multiple suicide attempts. We collectively view this paper as an expression of committed allyship to all LGBTQIA+ people who have been harmed or are at risk of being harmed by SOGIECE, especially those who are particularly underrecognized within our community, such as bisexual people, trans people, and/or LGBTQIA+ people of color.

Furthermore, all cognitive-behavioral professionals have a particular responsibility to address SOGIECE, given our field’s contributions to these practices’ development. Specifically, SOGIECE were historically mainstream in this field—both in research and practice—and treated as a matter of behavioral conditioning, correction, and association (APA, 2009; Haldeman, 2002a). The concerted efforts of advocates highlighting the harms of such work and pushing for greater acceptance of LGBTQIA+ people in society led to a considerable decline in use of SOGIECE (and associated pathologizing diagnoses) in mainstream CBT (Drescher, 2015; Lewis, 2016; Wuest, 2021). Yet, SOGIECE is still widely practiced today (Mallory et al., 2019). Though most of the work is done by religious counselors, those efforts include mental health professionals who work in their religious capacities and are also informed by previous inaccurate behavioral research that remains published, unretracted, and cited in legal contexts. Thus, cognitive-behavioral scientists and

practitioners have a moral imperative to correct our field’s promotion of SOGIECE.

Applying Deimplementation Science to SOGIECE

The science of deimplementation provides useful guidance for efforts to eliminate SOGIECE. Deimplementation is a systematic process focused on stopping the use of harmful – as in SOGIECE—or otherwise low-value practices (Johnson et al., 2018). Conceptual frameworks and theories for deimplementation have been repurposed from implementation science, which primarily focuses on increasing use of beneficial, evidence-based practices (McKay et al., 2018; Nilsen et al., 2020; Parker et al., 2022). Both deimplementation and implementation require addressing multilevel barriers and facilitators to change across multiple phases of action. In many cases, implementation of evidence-based alternatives must proceed in parallel with deimplementation to ensure positive outcomes for service recipients (e.g., LGBTQIA+ clients). Nevertheless, the processes have distinct goals—unlearning something habitual and divesting of a practice versus learning and implementing something new—that should not be conflated (Wang et al., 2018).

McKay and colleagues’ (2018) comprehensive description of deimplementation outlines three cases in which interventions should be deimplemented: (a) intervention lacks evidence or is harmful, (b) alternative interventions are more effective or efficient, or (c) the issue of concern is resolved. SOGIECE is a harmful intervention under case (a) (see also Johnson et al., 2018); its use has been justified by framing LGBTQIA+ identities as a treatable mental health problem, yet research shows SOGIECE results in harmed or worsened mental health—the opposite of the purported outcome. (Cases (b) and (c) do not apply to SOGIECE because LGBTQIA+ identities are not actually mental health problems.) Once the case for deimplementing is articulated, McKay et al. (2018) detail four key phases of deimplementation: (1) select the scope of practice(s) to be deimplemented, (2) assess multilevel contextual barriers and facilitators to end the practice, (3) use active strategies to deimplement (addressing barriers and leveraging facilitators), and (4) evaluate deimplementation outcomes. In the following sections, we provide illustrative examples of applying each phase to SOGIECE deim-

plementation while also highlighting challenges encountered in this context.

Lessons can surely be learned from deimplementation successes in other areas, but SOGIECE differs from many other kinds of low-value and harmful healthcare services in notable ways. Political advocacy and changing social mores led to mental health professionals' rejection of SOGIECE, not the (ostensibly) politically neutral results of randomized controlled trials or developments in scientific theories. Indeed, scientific progress emerged from social progress. As Dr. Jack Drescher, renowned psychiatrist and LGBTQIA+ advocate, noted about the American Psychiatric Association's decision to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM): "The most significant catalyst for diagnostic change was gay activism" (Drescher, 2015). Thus, unlike deimplementing, for example, low-value cancer screening, SOGIECE is deeply entangled with political and moral questions about civil rights and inequality.

Phase 1: Selecting the Scope of a SOGIECE Deimplementation Effort

The selection phase identifies specific harmful or low-value practices to target for deimplementation. SOGIECE refer to a loose collection of practices that promote heterosexual and/or cisgender identities as well as maintain heteronormative and cissexist social ideals. These practices are not well defined or scientifically sound interventions, and the relevant barriers, facilitators, and deimplementation strategies to consider depend on the particular form of SOGIECE targeted. Some key features of SOGIECE (see Kinitz et al., 2021) include whether the practices are (a) performed in mental health versus religious settings (which are shaped by different laws, policies, and ideologies); (b) used on LGBTQIA+ minors versus adults (with youth experiencing more overt coercion); and (c) focused on changing sexual orientation, gender identity and expression, or both. All forms of SOGIECE are certainly harmful and worthy of deimplementation, but we focus our examples on SOGIECE enacted by mental health professionals with LGBTQIA+ minors, as youth are the primary targets of SOGIECE (Mallory et al., 2019). Furthermore, the pathways to deimplementation in mental health settings are clearer than in religious settings and more relevant to the *tBT* readership (Last & Wuest, 2022). Our examples are inclusive of all SOGIECE, but we note

when differentiating sexual orientation versus gender identity and expression is important.

Phase 2: Assessment of Context to Inform SOGIECE Deimplementation Strategies

Assessment of the context in which deimplementation occurs helps identify, consider, and understand what factors may facilitate or hinder the process before deimplementation strategies are chosen. Determinants of deimplementation include characteristics of LGBTQIA+ youth and their families (e.g., knowledge, family expectations, demographic characteristics), individuals who have implemented SOGIECE (e.g., knowledge, attitudes, professional identity, role), within-organization or "inner" context (e.g., culture, mission, leadership expectations), and extra-organization or "outer" context (political and social trends, legal and policy landscape, community demand). Augustsson et al. (2021) provide the most comprehensive published accounting of deimplementation determinants, although most of the reviewed literature focused on discrete, billable clinical procedures that are overused (e.g., prescribing, imaging, screening, testing) rather than inherently harmful interventions; there are likely additional determinants of SOGIECE deimplementation beyond what prior research has captured. Some factors can be assessed with existing measures (e.g., organization-level assessments), while others are more likely to be discovered and understood through a qualitative process (Niven et al., 2015). Input from individuals impacted by deimplementation—including those who support and oppose it, when feasible—allows for a better understanding of an appropriate and effective plan for deimplementation.

It is essential to include input from those with lived experiences of SOGIECE, and to privilege their perspectives and needs, while limiting the burden on them and ensuring that they feel safe sharing their histories. This can help provide deeper insight into assumptions, attitudes, and perspectives of LGBTQIA+ youth subjected to SOGIECE (including those who continue to participate in or otherwise endorse SOGIECE as adults) that researchers may not fully recognize due to their own biases and emotional investment when assessing context to develop deimplementation strategies. However, the risk of retraumatizing SOGIECE survivors by asking them to recall their experiences

must also be assessed carefully before engaging in this strategy.

Furthermore, it is vital to assess differential impacts of SOGIECE on LGBTQIA+ youth subgroups, particularly those at the intersection of multiple marginalized identities and systemic oppressions. As multiple social categories (e.g., race, ethnicity, sexual orientation, gender identity, and class) intersect at the micro level to reflect multiple interlocking systems of privilege and oppression at the macro-level (e.g., racism, ethnocentrism, heterosexism, and even SOGIECE in this context; Bowleg, 2012), intersectionality refers to the mutually reinforcing vectors of race, gender, class, sexualities, and other identities (Nash, 2008). In that way, intersectional racial and ethnic minority LGBTQIA+ youth can be placed at a greater risk for SOGIECE based on their gender assigned at birth, poverty level, and religious affiliation, such as Hispanic/Latinx youth and Black transgender individuals from the South (Green et al., 2020; Hipp et al., 2019). Assessments must consider context-specific experiences with SOGIECE at the individual and community levels in order to develop just, equitable deimplementation strategies.

Phase 3: Deploying Active Strategies to Achieve SOGIECE Deimplementation

Once contextual assessment of barriers and facilitators is complete, it can guide selection and use of deimplementation strategies. Recent reviews have outlined deimplementation strategies at the individual, organizational, policy, and societal levels (Ingvarsson et al., 2022; Rietbergen et al., 2020). Much like the literature on determinants, most studies of deimplementation strategies focused on overused clinical procedures and have limited applicability to SOGIECE, although there is considerable literature from nursing on deimplementation of physical restraints—which can be harmful, traumatizing, and sometimes deadly (Rietbergen et al., 2020). We outline examples of SOGIECE deimplementation strategies that address barriers and facilitators at the individual, organization, policy, and societal levels in Table 1, and describe them in more detail in the following sections.

Individual-Level Strategy Examples

To complement structural SOGIECE deimplementation efforts, deimplementation strategies targeting individual youth and families are also necessary. Effective individual-level strategies for deimple-

menting other inefficacious and harmful health interventions have tended to focus on reducing provider willingness to offer the practice (i.e., limiting supply), especially when it is feasible and ethically appropriate to have the same providers offer evidence-based practices instead (McKay et al., 2018; Wang et al., 2018). However, those who use SOGIECE perpet-

uate serious, lasting harm against LGBTQIA+ people, so it would be unethical in most cases to have those same individuals attempt to provide affirming care; it is also unclear how readily SOGIECE practitioners' attitudes and behaviors can be shifted. Strategies focused on guiding youth and families toward alternative responses to the youth's LGBTQIA+ iden-

tities (i.e., limiting demand for SOGIECE) and expanding better access to LGBTQ-affirming care through other providers may be most effective at the individual level.

Youth and families. Most youth do not actively seek SOGIECE, but instead are coerced into it by family members on religious grounds (Green et al., 2020; Kinitz et

Table 1. Examples of Multilevel, Tailored Deimplementation Strategies, as Well as Key Barriers and Facilitators, for SOGIECE

Domain	Deimplementation Strategy Examples	Key Barriers	Key Facilitators
Individual	Engage families of LGBTQIA+ youth and community members to reduce demand for SOGIECE	Negative attitudes and beliefs toward LGBTQIA+ youth	Connection between faith community and affirming providers
	Reduce LGBTQIA+ prejudice in families through attachment-based family interventions and perspective shifting narrative strategies	Conflict between faith community and LGBTQIA+ status Difficulty changing attitudes of SOGIECE proponents	Trusted individuals who can connect community members to affirming providers Shared values with family about the youth's well-being
Organization	Create community advisory boards specifically for addressing SOGIECE	Organizations may not know that their providers engage in SOGIECE	Organization values that center on affirming care
	Publish organizational statements that explicitly disallow use of SOGIECE practices	Legal protections for religious freedom may render organizational policies on SOGIECE illegal or difficult to enforce	Commitment and knowledge from relevant parties (e.g., Human Resources, advisory committee) to develop and approve policies
	Whistleblowing mechanisms to detect SOGIECE use, followed by corrective actions/disincentives		Audit-and-feedback mechanisms to detect SOGIECE use and respond
	Provide trainings in affirmative care		
Policy	Partner with state mental health professional associations and engage in their legislative, diversity, and/or social justice-oriented committees to advocate for legislative bans of SOGIECE	Legislators prioritize other political positions (e.g., religious freedom, anti-LGBTQIA+ bills)	Legislative and social justice committees in mental health professional organizations
	Assist professional organizations to develop, disseminate, and promote guidelines for affirmative care	Advocacy training and science communication not prioritized in cognitive-behavioral field	Trusting relationships with legislators from advocates, LGBTQIA+ organizations, and professionals
			Resources (like model legislations) from states banning SOGIECE
Societal	Political and social reforms that promote equality among all people (e.g., expanding healthcare access for all)	Limited knowledge and extensive disinformation about LGBTQIA+ people and SOGIECE in society	Solidarity around political and social reforms that improve societal conditions
	Information, advocacy, and social media campaigns for LGBTQIA+ issues	Rising income inequality and threats to political equality	Mental health professional and researcher advocacy for healthcare reforms
		Mechanisms that limit representativeness of legal decision-making, (e.g., voter suppression)	Increasing awareness of harms perpetuated through SOGIECE as people speak out
		Limited healthcare access, particularly LGBTQIA+ affirming care	Increased representation of LGBTQIA+ people in media

Note. SOGIECE = sexual orientation and gender identity and expression change efforts. LGBTQIA+ = lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other queer identities.

al., 2022). In the U.S., approximately 75% of youth who underwent SOGIECE reported their family members used religion to make negative remarks about LGBTQIA+ persons (Green et al., 2020). Thus, clinicians seeking to reduce demand for SOGIECE among families in the community they serve may need to (a) reduce families' prejudice against LGBTQIA+ people, and (b) explicitly engage with youth and family members' faith-based concerns.

As for reducing LGBTQIA+ prejudice, according to a scoping review of the literature, one of the only studies that has examined how to reduce family-based stigma and discrimination against LGBTQIA+ youth is an attachment-based family intervention, which demonstrated positive preliminary outcomes in reducing family prejudice and supporting LGBTQIA+ youths' distress (Diamond et al., 2012; Parker et al., 2018). Outside of the psychotherapy literature, a review of field experiments including interventions designed to reduce sexual orientation and gender identity and expression prejudice found that common across effective interventions are strategies that prompt prejudiced individuals to shift perspectives and cultivate empathy with LGBTQIA+ persons to build a sense of solidarity between minority and majority group members (Cramwinckel et al., 2018). In particular, perspective shifting narrative strategies that involve learning about the experiences of an outgroup member appear to be the most potent and durable strategies to combat prejudice (Broockman & Kalla, 2016; Kalla & Broockman, 2023).

Clinicians must also directly and openly discuss youths' and family members' religious values, which may be driving the demand for SOGIECE. SOGIECE survivors report that mental health providers who were educated and informed about LGBTQIA+ issues and their religious backgrounds were most beneficial to their recovery (Dromer et al., 2022). When youth and their family members experience a conflict between their faith and the youth's sexual and gender identity, mental health professionals can help families identify the conflict and seek to resolve it around shared values—e.g., a desire for the youth to have a good life (Kashubeck-West et al., 2017). Researchers have developed the GRACE framework (Goals, Renewal, Action, Connection, and Empowerment) to help U.S.-based LGBTQIA+ Christians maintain their diverse sexual and gender identities while also connecting to aspects of their faith that are empowering and con-

sistent with their values (Bozard & Sanders, 2011).

Though to our knowledge there has been less research developing interventions to integrate faith-based values and LGBTQIA+ identities for other religions, researchers have proposed strategies to support LGBTQIA+ people by, for example, helping families identify houses of worship and clergy that are more affirming (Liboro, 2015). More broadly, some precedents exist for mental health practitioners to engage religious and faith-based community members in mental health treatment (Milstein et al., 2008), although it is not always possible or advisable to engage with religious leaders when they oppose the rationale for treatment. For example, community mental health centers treating Muslim individuals may work with clergy to reduce shame and stigma around alcohol use disorder given that alcohol is prohibited in Islam, but given the diversity of perspectives and approaches to substance use among Muslim American imams, engaging with clergy can potentially be counterproductive to treatment goals (Mallik et al., 2021). Similarly, clinicians working with LGBTQIA+ youth and their families must first carefully assess whether engaging religious community members or clergy members in treatment is feasible and affirming of LGBTQIA+ youths' identities. They must also collaboratively understand and research the specific cultural factors and motivations about the religion/faith in question before implementing any treatment. Therefore, future research on developing interventions integrating LGBTQIA+ values into different religions is recommended given the current paucity of literature.

If the conflict between faith and LGBTQIA+ identities cannot be resolved, clinicians can provide youth (and even families, when appropriate) with coping strategies to manage the tremendous loss and mourning of their faith-based communities (Beagan & Hattie, 2015). These would include connecting youth to LGBTQIA+ organizations and identifying alternative social supports that affirm their integrated identities (Toomey et al., 2018).

Individuals seeking SOGIECE. In some cases, adolescents or young adults may seek SOGIECE from mental health providers without any active involvement from influential adults (though of course coercion within personal relationships may still be a motivating factor). For individuals seeking SOGIECE in this way, outright denial of services may be an undesirable option, as

they may disengage from the mental health provider and seek SOGIECE elsewhere. A dialectical approach may be more appropriate, in which the therapist conveys that a client's LGBTQIA+ identity is valid and worthy of affirmation and also that their desire to change is understandable in the client's context.

Organization-Level Strategy Examples

Identification of deimplementation strategies in this domain is challenging, because SOGIECE is often performed at dedicated facilities; external pressures or policies such as state-wide bans may be necessary to enact change in such settings. However, in settings where SOGIECE occurs despite an organizational commitment to LGBTQ-affirming care (perhaps with specific providers), organizational strategies can be a critical pathway to deimplementation. Organizations may require support to be able to institute policies that foster an affirming culture and ban SOGIECE to protect LGBTQIA+ youth. For example, organizational leadership might create a community advisory board that can provide relevant information, consider policy issues related to SOGIECE (e.g., hiring, employee training, performance reviews), and propose specific policy solutions for adoption in keeping with relevant laws and professional guidelines.

Furthermore, mental health professionals and researchers invested in ensuring that LGBTQIA+ persons can access evidence-based, equitable care can organize their workplaces and advocate for antidiscrimination protections for all employees and patients (Frank, 2014; Frymer & Grumbach, 2021).

If organizations are concerned that SOGIECE practices are potentially being used by their mental health providers, they could distribute action-oriented statements to current and potential clients indicating that SOGIECE are not permitted at their organization, and provide a whistleblowing mechanism to detect SOGIECE and allow for immediate corrective actions. Depending on the extent and severity of a provider's SOGIECE usage, training and performance improvement plans might be feasible, and disciplinary actions like termination or filing an ethical violation report with the state licensing board could be permitted under some states' laws. However, SOGIECE providers may fight sanctions legally by arguing that religious freedom allows them to practice SOGIECE—when graduate-level mental health programs

have dismissed students on ethical grounds for refusing to treat LGBTQIA+ clients, citing religious protections has sometimes been successful in fighting the dismissal (Wise et al., 2015). Safeguards (e.g., licensing board complaints) should be in place to ensure that these clinicians do not have contact with LGBTQIA+ youth regardless of legal decisions about their employment.

Policy-Level Strategy Examples

On a policy level, the goal for deimplementation is to shift the legal and regulatory environment to be as inhospitable as possible to SOGIECE. Laws impact quality of life for LGBTQIA+ persons, and passage of state-level protective policies show particular connections between LGBTQIA+ status, psychiatric disorders, and suicide attempts. LGBTQIA+ individuals living in states without LGBTQIA+ protective policies exhibited greater mental health symptoms such as generalized anxiety disorder, posttraumatic stress disorder, and dysthymia (Hatzenbuehler et al., 2009). Alternatively, 32 states that implemented same-sex marriage policies by 2015 had a 7% overall decrease in suicide attempts by high school students, and a 14% relative decrease in suicide attempts by high school students identifying as sexual minorities (Raifman et al., 2017).

Achieving a national ban on SOGIECE is unlikely in the current political atmosphere of the U.S., so advocates have concentrated efforts on protecting LGBTQIA+ youth through state- and local-level bans instead. Additionally, the Biden administration released an executive order on advancing equality for LGBTQIA+ individuals in June 2022 (Executive Order No. 14075, 2022) that included recommendations to issue guidance that SOGIECE does not meet criteria for use in federally funded health and human services programs, increase public awareness about the harms endured by LGBTQIA+ youth and families due to SOGIECE, and implement services to support SOGIECE survivors. This order has the potential to act as a sociopolitical facilitator promoting state-level, and even national, bans.

Cognitive-behavioral scientists, practitioners, and organizations could support state-level legislative bans on SOGIECE by detailing the practices' harmful impacts on LGBTQIA+ youth for relevant decision-makers (e.g., state legislators and their aides). This requires coordinated efforts to communicate scientific evidence highlighting the ineffectiveness and harms of SOGIECE in ways that appeal to the politi-

cal aims of legislators (e.g., protecting religious freedom or free speech), but also proactively address the scientific misinformation or intentional disinformation that policymakers may use to counter the ban. Indeed, in states where SOGIECE are legal, some state legislators have made anti-LGBTQIA+ bills (e.g., banning affirming healthcare for trans youth) their legislative priorities to garner votes and maintain their positions of power, reinforcing heteronormativity as a societal ideal. The skills needed to operate in this political context are both a barrier—science communication and advocacy training are not yet core skills in training programs—and a key facilitator when done well, either by cognitive-behavioral experts or in partnership with advocacy groups or LGBTQIA+ community-based organizations.

To date, the strategy used by most advocacy groups seeking legislative bans on SOGIECE has been to partner with state and/or national mental health professional associations (e.g., for psychology, psychiatry, school counseling, social work). Cognitive-behavioral researchers and practitioners can contribute to this strategy by becoming association members and specifically joining legislative and social justice-oriented committees. These committees consist of key mental health professionals and lobbyists who have established political relationships with their state legislators and legislative aides. Actions to support SOGIECE bans may include drafting model legislation by researching other states' bills that ban SOGIECE, writing position statements with scientific evidence, or supporting or opposing pieces of legislation that specifically involve SOGIECE. Attention to details is critical for a given bill, e.g., whether it applies to change efforts for sexual orientation, gender identity, or both. Legislative committees can draw on lessons learned from the 20 states (and D.C.) that already banned SOGIECE for minors, although there are notable differences in political climate between states with and without bans. Concerted state-level efforts could help ensure enough local SOGIECE bans are in place to shift the climate in favor of a national SOGIECE ban.

Societal-Level Strategy Examples

Long-sighted societal strategies are needed to generate favorable social conditions to deimplement SOGIECE. Currently, we face serious and increasing economic inequality, threats to democracy, and activity from far-right groups in the

U.S. and abroad. For instance, in the past several years, corporate-funded conservative (often religiously affiliated) groups have used litigation to expand interpretations of the U.S. Constitution's religious liberty and free speech protections to include discrimination against LGBTQIA+ people (see *Masterpiece Cakeshop v. Colo. Civil Rights*, 2018; *Fulton v. City of Philadelphia, Pennsylvania*, 2021; Sepper, 2015; Wuest & Last, 2021). This interpretation has already produced rulings that mental health professionals have religious and free speech rights to offer SOGIECE and deny mental health services to LGBTQIA+ persons (*Otto v. City of Boca Raton, Florida*, 2020; Last & Wuest, 2022). More broadly, numerous anti-LGBTQIA+ pieces of legislation have gained national momentum, particularly legislation that targets trans youths' access to gender affirming care (Turban et al., 2021a). This is despite strong public support for LGBTQIA+ civil rights—e.g., Nevada recently enshrined protections for sexual orientation and gender identity in their state constitution through a ballot initiative (Stern, 2022).

Given these challenges, societal-level strategies to deimplement SOGIECE must expand beyond advocacy for LGBTQ-specific issues to broadly promote greater political and economic equality. For example, expanding healthcare access for all would specifically provide LGBTQIA+ persons more options to select affirming providers. Enhancing access to economically redistributive programs would support LGBTQIA+ individuals who might otherwise seek SOGIECE to avoid the loss of financial support from nonaffirming family members (Turban et al., 2021b). Mental health professionals and researchers can also develop their own advocacy groups or work alongside other organizations to guarantee that all Americans have universal access to healthcare.

Social scientists have observed that in times of growing economic inequality, minoritized groups are vulnerable to scapegoating from corporate-funded conservative groups whose goal is to distract from their upwardly redistributive agenda (such as cuts to public spending, deregulation, and privatization; Lafer, 2017; Stein, 2022). Political and social reforms that limit the role of money in politics, increase donor transparency, expand voting rights, strengthen labor unions, and reduce economic inequality through redistributive social programs (such as expanded healthcare access, employment programs, and

public assistance) provide an important foundation for specific goals like deimplementing SOGIECE. These reforms would increase economic and political equality for all people, but especially for sexual and gender minorities.

Outside the political impact of societal strategies, cognitive-behavioral researchers and practitioners (especially those who identify as LGBTQIA+) can also contribute to the media's portrayal of LGBTQIA+ individuals and their lives, including experiences with SOGIECE, and correct misinformation about the research on SOGIECE and gender-affirming care. They can serve as media consultants on various social media platforms, write op-eds that reach a variety of audiences (especially for those outside of academia, such as families, youth groups, and religious organizations), and work with schools by providing them with referral sources in case any LGBTQ-identifying youth do inform teachers about potentially being coerced into SOGIECE. In fact, the visibility of more LGBTQIA+ role models and people in society helped SOGIECE survivors accept themselves and recover from previous harms (Dromer et al., 2022). Overall, it should be noted that each aforementioned strategy that strives for deimplementation of SOGIECE across various levels serves as a societal-level strategy given its potential to influence global societal norms and expectations. While the rate of societal change may be slower compared to other levels, all strategies act as social agents of change that work synergistically to socially de-emphasize and deimplement SOGIECE.

Phase 4: Evaluation of SOGIECE Deimplementation Strategies

Outcome evaluations should be designed to track the impact of each deimplementation strategy. For individual deimplementation strategies, changes in clinician behaviors (i.e., the elimination of SOGIECE approaches from their practices) and youth and family mental health outcomes should be assessed. Given the lack of transparency surrounding SOGIECE, patients need confidential and/or anonymous ways to report when mental health clinicians are employing SOGIECE. Surveying licensing board complaints regarding the use of SOGIECE is another tracking option. When measuring youth outcomes, it is important to assess LGBTQIA+ youths' mental health, feelings of acceptance and affirmation, minority stress, sexual and gender identity concealment, and internalized identity stigma—both

among youth subjected to SOGIECE and in the general community. Family affirmation of LGBTQIA+ youths' identities and behaviors are also an outcome of interest (Ryan et al., 2010).

Furthermore, there are ways of gaining such information indirectly, for example, from an online forum community of “ex-gay survivors” (individuals who survived SOGIECE efforts, which were also historically known as “ex-gay” efforts) describing their detailed experiences (Beyond Ex-Gay, n.d.; Dreshcher et al., 2016), and by accessing publicly available consumer reports that highlight adverse patient incidents when interacting with therapists who practice SOGIECE (Shidlo & Schroeder, 2002). Outcome measurements should also be flexible enough to include a variety of perspectives on SOGIECE, including from individuals who would not self-identify as LGBTQIA+ on a research survey, for example.

At the organizational level, the number of training and policy changes focused on deimplementing SOGIECE and providing LGBTQ-affirmative care could be measures of deimplementation success, as could measurement of clinician attitudes. Adoption of evidence-based practice guidelines and statements that unambiguously condemn SOGIECE could all be suitable measures of SOGIECE deimplementation. At the policy level, observing increases in political advocacy and lobbying efforts by measuring the number of legislative bans prohibiting SOGIECE, the population(s) to which the protections apply, and limitations on religious freedom exemptions to these laws would be appropriate metrics of success. Similarly, tracking whether state licensing boards institute clear guidelines (and consequences) about SOGIECE would be beneficial. Finally, at the societal level, public attitudes toward LGBTQIA+ persons and SOGIECE using public opinion polling would capture the effectiveness of SOGIECE deimplementation efforts. In addition, general population-level social and health outcomes for LGBTQIA+ persons could help gauge the success of societal deimplementation strategies.

Conclusions

The deimplementation of SOGIECE requires concerted and coordinated efforts, to which cognitive-behavioral scientists and practitioners are well equipped to contribute. First, we can work toward establishing SOGIECE as a harmful practice that

merits deimplementation (McKay et al., 2018). Building upon the remarkable work led by advocates and organizations like APA, we must continue highlighting harms caused by SOGIECE and conduct high-quality research on affirmative therapies (Dromer et al., 2022). In doing this work, it is essential to center LGBTQIA+ individuals' experiences through engaging in self-reflection, practicing humility, and amplifying the voices of LGBTQIA+ members of the field, service recipients, and communities more broadly. Second, we can work toward understanding individual, organizational, policy, and societal barriers and facilitators to deimplementing SOGIECE in various contexts. As an example, academic institutions and professional organizations that fail to take concrete actions against SOGIECE tacitly create barriers to deimplementation by directing members of the field to focus their time and talents on other activities that are professionally rewarded. Third, we can engage in a variety of deimplementation strategies, such as: educate clients and colleagues about the harm caused by SOGIECE; obtain formal commitments to abandon SOGIECE; ban the delivery of SOGIECE in our organizations; identify opinion leaders who oppose SOGIECE and can shift public attitudes, knowledge, and practices; form and solicit feedback from an advisory board, including LGBTQIA+ individuals; develop cognitive-behavioral interventions for and with LGBTQIA+ individuals; train and support practitioners in the delivery of affirmative, evidence-based psychotherapy; and incentivize application of affirmative psychotherapies. Of course, we emphasize again that these efforts will be challenging, sensitive, context-dependent, and time-consuming to execute—requiring major shifts in our professional systems and incentives.

This article focused primarily on SOGIECE deimplementation in the context of youth mental health services, but, as mentioned, SOGIECE is also used outside of this context. For adults who seek SOGIECE, the same methods of (a) selection, (b) assessing multilevel contextual barriers and facilitators, (c) using active strategies for deimplementation, and (d) evaluation (McKay et al., 2018) can be applied in these contexts, but the approach must be tailored to each. The same approach applies to SOGIECE in religious institutions and communities, where the motivations for using these practices and the decision to deimplement have different drivers, particularly if people view using

SOGIECE as an expression of faith. Religious freedom protections in the U.S. also make it nearly impossible to regulate use of SOGIECE in this setting, so collaboration and advocacy by mental health professionals, families, and individuals both inside and outside faith communities will be needed to educate, shift social norms, and advocate for active deimplementation.

Finally, efforts to provide education about SOGIECE and its harms can be paired with implementation of evidence-based care, such as affirmative psychotherapy for sexual minorities (Pachankis, 2018), gender-affirming social transition or hormone and surgical treatments (Byne et al., 2012), and affirming assessment practices that enable tailored supports for LGBTQIA+ identity and mental health concerns (Brown et al., 2020). SOGIECE survivors may need evidence-based treatment for PTSD, depression, and other mental health symptoms caused by SOGIECE (Dromer et al., 2022). Coordinated efforts are needed to ensure an adequate supply of providers who offer affirming, culturally competent, and accessible treatment for LGBTQIA+ individuals. This represents a separate implementation effort in parallel to SOGIECE deimplementation (likely involving different providers and even different organizations), and both are equally important. Furthermore, all the individual strategies discussed here will be limited in efficacy if states continue to pass laws and regulations that prohibit or even criminalize caregivers for engaging in affirming care.

In summary, we call on all cognitive and behavioral professionals to stand by our ethical duty and support SOGIECE deimplementation efforts. The strategies needed to eliminate SOGIECE are complex, long term, and multilevel, but each member of our field can play a part. Only through such coordinated efforts—in partnership with the LGBTQIA+ communities for whom we undertake this work—can this profession finally repair the harm caused by misguided, unethical SOGIECE research that legitimized these practices. If we are truly sorry, that repair is an essential next step and should include not only deimplementation of SOGIECE but also ensure that affirmative care is available and affordable for every LGBTQIA+ person who seeks it. As Harvey Milk, fervent activist and first openly gay elected official in California, once said: “Hope will never be silent.”

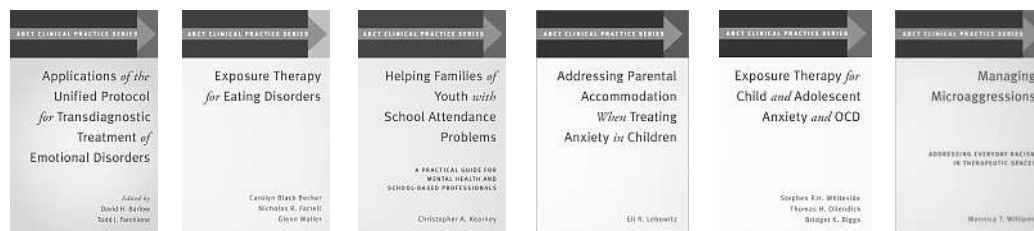
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The Unintentional Harms of Weight Management Treatment: Time for a Change

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Cognitive-Behavioral Treatment for Weight Management (CBT-WM) Overview

Secondary to social pressures and biases related to the perceived value of thinness, as well as common beliefs about health dangers of higher weight, individuals experience significant pressure to avoid having a higher-weight body and participate in weight loss interventions (Centers for Disease Control and Prevention, 2020; Jovanovski, 2017). Importantly, this pressure has existed for decades (Puhl & Brownell, 2003). Cognitive and behavioral interventions for weight management (components discussed below; Table 1) are considered the first-line, evidence-based treatment (Dalle Grave et al., 2020; Hampl et al., 2023). These interventions include a variety of cognitive-behavioral strategies collectively designed to induce changes in diet and physical activity to create a calorie deficit intended to produce weight loss (Dalle Grave et al.; Kelley et al., 2016). Many variants of CBT-WM are manualized psychological treatments and are delivered by trained professionals, paraprofessionals, smartphone apps (e.g.,

“Noom”), medical programming within large hospital systems, and self-help books.

CBT-WM Components

To achieve weight loss, CBT-WM emphasizes behavioral strategies, such as self-monitoring of dietary behaviors and physical activity, creation of SMART (specific, measurable, attainable, relevant, and timely) goals, stimulus control, and problem solving (Dalle Grave et al., 2011; Dalle Grave et al., 2013; Kelley et al., 2016; see Table 1). CBT-WM intervention developers are increasingly incorporating broader treatment targets that include stress management, sleep, internalized weight stigma, and cognitions about weight, eating, and exercise (Dalle Grave et al., 2020; Geiker et al., 2018; Pearl, Bach, et al., 2022; Xenaki et al., 2018). However, the primary focus of treatment remains weight loss, with the expectation that weight loss will improve health and quality of life. More intensive treatments also emphasize weight loss maintenance (e.g., Dalle Grave et al., 2020; also see below).

Dietary components of CBT-WM promote dietary restriction with the goal to create a 500–1,000 caloric deficit each day

that, theoretically, could cause weight loss of 1–2 pounds per week (Dalle Grave et al., 2013). Caloric intake goals typically range from 1,200–1,800 calories per day, and there is no consistent recommendation for how those calories should be distributed across macronutrients (e.g., fat, carbohydrates, protein). Many interventions also offer tools such as meal replacement products (e.g., prepackaged meals) and structured meal plans. Physical activity goals range from 150–250 minutes of moderate to vigorous physical activity per week.

Recently, a new variant of CBT-WM specifically targeting “obesity” (CBT-OB) was created by adding personalized cognitive strategies and procedures. CBT-OB targets adoption of a long-term lifestyle conducive to losing and then controlling weight, and a stable “weight-control mindset” (Dalle Grave et al., 2020). Targeting cognitions in CBT for weight loss is not new. In various forms of CBT-WM, clients evaluate whether their automatic thoughts are accurate or biased (Beck, 2007; Dalle Grave et al., 2013). Automatic thoughts may be about eating, weight, shape, control, and other related topics (e.g., interpersonal thoughts; Werrij et al., 2009). For instance, a client might be taught to challenge an all-or-nothing thought that “eating a whole bowl of food is inevitable if they take one bite” (Werrij et al., 2009). Importantly, we consider any weight loss/management protocol that includes CBT strategies as falling under the CBT-WM umbrella. A primary source for these protocols is large RCTs (discussed below) that are then implemented and modified in everyday clinical practice.

Outcome Data on CBT-WM

Does CBT-WM Lead to Weight Loss?

A comprehensive review of CBT-WM studies is beyond the scope of this paper. Readers are referred to other reviews for in-depth discussion (e.g., Comşa et al., 2020; Jacob et al., 2018; Mann et al., 2007; Nordmo et al., 2020). To briefly summarize, CBT-WM research generally supports the notion that many people attempting weight loss can “successfully” lose some weight short term (e.g., Nordmo et al.; short term defined as within 1 year; long term defined as more than 1 year). It is important to note that as little as 5% weight loss is typically viewed as success in CBT-WM trials, in part because some people experience some medical benefits at that level (Wing et al., 2011). More substantial weight loss also is harder for many to achieve; thus, 5% was adopted as a more

Table 1. Potential Harmful Effects of CBT-WM

Core Intervention	CBT Weight Management/Obesity Strategy	Potential Harmful Effects
Challenging Automatic Thoughts/Cognitions	Adapting weight-loss mindset vs. weight-gain mindset	Implies that an individual's weight gain is due to an individual's mindset and behaviors and ignores the multifactorial factors contributing to weight, including social determinants of health.
	The myth of Individualism in weight determination	Implies that if an individual only tries hard enough or ascribes to a certain set of behaviors, that weight loss is inevitable (bootstraps mentality; "If I can do it, you can too" "Think your way to successful weight management"-Laliberte al., 2009).
Goal Setting	Focus on weight loss as a goal	Although there is encouragement to think about potential outcomes in addition to weight loss, losing weight is still the primary goal. Recommending weight loss reinforces weight stigma, anti-fat bias, and fat phobia.
Stimulus Control	Increasing diet structure and limiting food choices	By encouraging significant restriction and limiting food choices, individuals may have difficulties incorporating these foods after treatment and/or may experience binge-eating in response to this restriction during or after treatment.
Skill building-Substitution	Encouraging individuals to ignore internal eating cues	This strategy is recommended to help individuals restrict their intake in the short-term, but can lead to further disconnection from valuable internal eating cues such as hunger, satisfaction, and enjoyment.
Goal Setting	Recommending specific diets	These specific diets (e.g., high protein) may be unrealistic to follow long-term and likely to lead to weight gain once stopped.
Goal Setting	Allowing individuals to choose a diet	Encouraging individuals to choose their own diet can also lead to dietary changes that are unrealistic for long-term maintenance and could lead to excessive restriction.
Self-Monitoring/Calorie Tracking	Focus on metrics	Tracking weight changes, calories or other dietary tracking, and specific numbers for exercise can increase risk of excessive focus on these areas and disordered eating behaviors.
Increasing Social Support	Involving significant others, friends, or co-workers	May lead to stressful dynamics in relationship for individual and/or increase the risk of disordered eating behaviors such as eating in secret.
Stimulus Control	Specifically encouraging eating disorder behaviors	Individuals are advised to complete the following daily: measure all food; weigh yourself; stay within allotted "units"; use distracting techniques when hungry; put utensils down between every bite and count to 10 before picking up again; take a sip of water "every minute

Table 1 continued on next page

Table 1 continued

Core Intervention	CBT Weight Management/Obesity Strategy	Potential Harmful Effects
Cognitive restructuring/ Contingency Management	Encouraging disordered eating cognitions	<p>or two”; “wrap up a small piece of “highly tempting foods” that you hadn’t planned to eat and take it home for the next day; of course, you’ll need to plan to eat less of some other food that day” (Beck, 2007).</p> <p>Beck (2007) provided the following phrases on alternative thought response cards, “Do it anyway; even if I don’t feel like using a diet skill, I Have to do it anyway. If I only do what I feel like doing I won’t be able to lose weight and keep it off.”; “Put dieting first – I have to plan my life around exercise and dieting activities, not vice versa.”; “Exercise no matter what. Say NO CHOICE”; “I’d rather be thinner; being thinner is SO much more important to me than eating this food”; “It’s NOT OKAY to eat this. I’m going to be very sorry if I do”; “CELEBRATE; I should celebrate each half pound loss!” (Beck, 2007).</p>

achievable “success” goal even though some researchers describe this goal as both “nonmedical” and “arbitrary” (Tomiya et al., 2013). Importantly, 5% weight loss has been shown to produce negative health impacts in those with atypical anorexia nervosa (A-AN; Forney et al., 2017), indicating that it is harmful for some. Even so, such modest weight loss is not experienced as success by many people in or outside of trials. Moreover, short-term weight loss is not the goal for those who provide or seek CBT-WM. Crucially, most of these limitations have been well known for over three decades (Wooley & Garner, 1991). With regards to longer-term weight loss, treatments can be divided into those that provide ongoing follow-up support and those that do not. Unsurprisingly, those that provide support throughout follow-up appear to produce more sustained results than those that do not (Nordmo et al.).

A critical question is whether high-quality research indicates that the average person who receives CBT-WM can accomplish stable, sustained, and substantial weight loss without ongoing treatment. Unfortunately, much of the relevant research is of poor methodological quality, limiting the conclusions that can be drawn (see Nordmo et al., 2020, for review of CBT-WM research limitations). However, a recent review of the few high-quality studies found that weight gain for most participants was inevitable (Nordmo et al.). Specifically, this review found a mean

weight loss of 7.4% at treatment end across the eight high-quality studies that met inclusion criteria. Participants then regained an average of 0.14% of body weight per month with full weight regain occurring at 4 years. In summary, the best evidence suggests that those who undergo CBT-WM without years of follow-up care can largely expect to regain all lost weight (i.e., failure of CBT-WM goals). This finding is consistent with results reported over 50 years ago (Swanson & Dinello, 1970) and more recent conclusions by Mann et al. (2007). Unfortunately for CBT-WM proponents, the magnitude of the more sustained outcomes that occur with years-long prolonged treatment also are fairly unimpressive, particularly given the fact that (a) most people cannot afford years of treatment (financially or in terms of time) and (b) only a minority of participants in trials actually complete these long-term treatments. For instance, while Lantz et al. (2003) reported that those who completed 4 years of treatment experienced an average of 7.0 kg of weight loss (+ 10.5 kg) and that 41% maintained at least 5% weight loss, that represented a mere 16.5% of the original sample.

Perhaps the most impressive results to date come from the Look AHEAD trial (Look AHEAD Research Group, 2014), which randomized participants to an intensive lifestyle intervention (ILI) and diabetes psychoeducation (i.e., control group). We think it is critical to examine

these results since this trial, which ultimately stopped early because it failed to meet clinical endpoints (i.e., no difference between ILI and control group on cardiovascular disease outcomes), is often described as a highly successful weight loss trial. ILI consisted of 1 year of intensive weight loss treatment followed by up to 8 years of maintenance treatment (Look AHEAD Research Group). At 8-year follow-up, participants ($n = 2,570$) lost an average $4.7\% \pm 0.2\%$ of initial body weight. Roughly 50% of ILI participants met the $\geq 5\%$ weight loss goal, although 26.4% weighed more than at baseline. We argue this outcome is the “best-case scenario” with respect to creating weight loss given the 8 years of treatment, and is not a scenario that can be expected to generalize to the average person seeking weight loss treatment. Of the eligible prescreen participants ($n = 15,561$), only 16.5% ($n = 2,570$) were randomized into ILI (Look AHEAD Research Group). Moreover, even in this trial, ILI participants regained some weight during maintenance. Regarding the benefit of losing approximately 5% body weight long term, the Look AHEAD researchers state that ILI yielded a mean 10-year medical cost reduction of \$5,280/pt relative to the control condition. However, the cost of running ILI per patient over 10 years was \$16,896. This “best-case” weight-loss scenario was both extremely costly and impractical for the average patient. Finally, this study had many limitations, including

researcher conflict of interests, lack of assessment of mental health concerns, participant bias, and high dropout. Overall, weight loss was modest, despite intensive, long-term treatment, and occurred in only half of ILI participants, although this met the standard definition of “success.” Many of the concerns listed below were not addressed/assessed in this trial.

CBT-WM Trials: Improvement in Health Indices Not Correlated With Weight Loss

It is important to acknowledge that CBT-WM trials have produced significant, if often modest, changes in health indices (Tomiya et al., 2013). For instance, although Look AHEAD was stopped early because of lack of group differences on primary cardiovascular outcomes, ILI was associated with improvement on some other health metrics. For example, exploratory analyses indicated that ILI increased probability of partial remission of Type 2 diabetes (Gregg et al., 2012). Other analyses also found ILI decreased use of medications for diabetes, hypertension, and elevated lipids (Espeland et al., 2014). This is not unprecedented. Tomiya et al. noted modest improvements in various health indices during weight loss trials, including blood pressure, fasting blood glucose, and lipids, and somewhat larger effects on hypertension and diabetes medication use. However, they also found that such changes were not correlated with weight loss. As such, these improvements do not support a focus on weight loss; instead, they add to an extant literature showing that health indices can be positively impacted by changes in diet and exercise. We do not deny that dietary or exercise interventions may impact health conditions for those who have resources to invest in such endeavors; indeed, we and others (e.g., Tomiya et al.; Tylka et al., 2014) contend that researchers and clinicians can design and implement interventions aimed at helping individuals manage or improve health conditions using a sustainable, weight-inclusive approach that reduces harms (discussed below). A weight-inclusive approach focuses on empirically supported strategies that enhance health in both patient care and public health settings irrespective of where an individual lies on the spectrum of weight (Tylka et al.). As noted by Tomiya et al., focusing on weight and weight loss is problematic because both are poor proxies for health and health improvement.

Potential Harms of CBT-WM

As noted above, under the “best-case scenario,” CBT-WM produces very modest weight loss on average in approximately 50% of participants, even with 8 years of costly support. These results might be tolerable if they came with minimal harms. However, there are many potential harms that are outlined below. Importantly, we are not the first to raise significant concerns about the harm of interventions that focus on weight loss (e.g., Burgard, 2010; Raffoul & Williams, 2021; Talumaa et al., 2022; Tomiya et al., 2018; Tylka et al., 2014); this literature goes back 30 years (e.g., Brownell & Rodin, 1994; Wooley & Garner, 1991). Moreover, in a scoping review of unintended harms of public health interventions, approximately one third of papers focused on potential harm caused by “obesity-related” interventions (Allen-Scott et al., 2014).

Eating Disorders

Eating disorders (EDs) are associated with major medical complications and carry the second highest mortality rate of any psychiatric illness (Gibson et al., 2019). In the past 2 years, ED-related hospitalizations doubled, and prevalence rates are growing (Asch et al., 2021; Devoe et al., 2023). Up to 17% of the population will meet ED criteria prior to age 30 (Silén & Keski-Rahkonen, 2022). Notably, rates are likely underestimates given the lack of proper assessment for other specified EDs and a lack of recognition in the following groups: historically minoritized, higher weight, older adult, and nonfemale (Becker et al., 2019; Silén & Keski-Rahkonen; Wilfred et al., 2021). EDs are common, deadly, and impairing, and exacerbated by lack of recognition, treatment, and allocated resources (Deloitte Access Economics, 2020).

Dietary Restriction: Contributions to the Development of EDs

Like virtually all forms of psychopathology, EDs develop from an interaction of genetics and environment (Bulik et al., 2019; Reijonen et al., 2003). Significant data suggest that specific environmental risk factors trigger EDs; it is via these pathways that CBT-WM may increase risk for EDs. Notably, dietary restraint (purposefully attempting to limit caloric intake to lose weight; Fairburn, 2008)—often referred to as dieting—is a common risk factor for ED development (e.g., Bulik et al., 1997; Dakanalis et al., 2017; Fairburn; Hilbert et al., 2014). This extensive body of research

suggests that any person with a genetic vulnerability to an ED who engages in restriction (independently or through CBT-WM) is at increased risk for developing an ED.

While studies including individuals with clinical EDs have been excluded from recent meta-analyses of CBT-WM trials (Comşa et al., 2020; Jacob et al., 2018), eating behaviors have at times been assessed (Jacob et al.). When researchers assess ED behaviors within CBT-WM trials, they tend to focus on binge/emotional eating (Jacob et al.), even though (a) restricting EDs such as A-AN are common in people with higher-weight bodies (Harrop et al., 2021), and (b) restriction is present in most binge-spectrum EDs. The failure to assess restricting EDs is an oversight that may suggest CBT-WM implementers do not view restrictive behaviors as harmful, whereas in other settings (ED treatment) these are seen as very harmful. For instance, a recent CBT-WM meta-analysis found that cognitive restraint (i.e., dietary restraint) was assessed in 6 of 12 studies. Rather than viewing dietary restraint as an ED behavior that should be reduced, dietary restraint was instead viewed as a construct to increase (Jacob et al.). Trials also typically do not assess for compensatory behaviors or increases in overvaluation of weight/shape (Jacob et al.), even though overvaluation of weight/shape is commonly conceptualized as core ED pathology (Fairburn). In summary, we argue that the existing CBT-WM literature is so deeply flawed with regards to assessment of ED pathology that one cannot draw any empirical conclusions about the prevalence of EDs triggered/worsened by CBT-WM. For this reason, below we turn to reports of lived experiences that in other areas (e.g., so-called “conversion therapy”) have served as early and important red flags of harm.

What About the Use of CBT-WM to Treat BED in People Who Are Higher Weight?

Some research has investigated the use of CBT-WM to reduce binge eating and weight in higher-weight individuals who have binge eating disorder (BED; e.g., Grilo et al., 2011; Munsch et al., 2007), and some of these studies show overall reductions or no worsening of ED symptoms (including dietary restraint) during the assessment period, which has extended to 1 year in some studies. While on the surface this would seem to counter concerns about increasing ED symptoms, such studies are insufficient indicators of lack of harm for several reasons.

First, even relatively large trials exclude many people, which limits what such trials tell us to those who (a) undergo the extensive assessment battery and (b) choose to stay in the trial. For instance, only 18% of those screened and 48% of those evaluated were ultimately randomized into Grilo et al.'s (2011) trial of 125 participants; 30% of participants withdrew during the main phase of the trial. Second, temporary improvement in binge eating and other ED symptoms has been reported by individuals who participate in CBT-WM. Indeed, a recent study by Boutelle et al. (2023) showed significant decreases in ED symptoms during treatment, followed by significant increases when followed to one year. Kinavey and Sturtevant (2022), who write from the dual perspective of lived experience and clinicians and have treated many higher-weight individuals for EDs and weight stigma, discuss the temporary relief from symptoms (including binge eating) that often comes with starting a new weight loss plan in the short term (which can last many months) and the sense of success that comes with initial weight loss. They also discuss the intense disappointment when biology overrides the best of intentions and weight inevitably returns, as in most CBT-WM trials. Their discussion details what it is like to experience that cycle repeatedly over a lifetime and the long-term impact (e.g., shame) of repeated failures. This repetitive, but inevitable, cycle of failure also may engender learned helplessness (Tylka et al., 2014). If we listen to the lived experience of people who have been trying to lose weight for years, it becomes clear the BED CBT-WM studies are simply too short to tell us anything about the longer-term harms of CBT-WM. Finally, such trials do not typically assess internalized weight stigma or other potential harms (see below).

Weight stigma (WS). WS describes the negative attitudes, beliefs, stereotypes, and discrimination about and towards people in larger bodies that devalue this population (Pearl, Groshon, et al., 2022). Sources of WS include family, peers, educators, media, and healthcare providers (Puhl & Heuer, 2009). WS can be explicit (conscious and intentional) and implicit (unconscious). Medical education has been shown to increase WS, and medical students exhibit high rates of both implicit and explicit WS (Phelan et al., 2014). Research indicates that WS among healthcare providers is not limited to medical students (Palad et al., 2019). Importantly, providers who specialize in weight reduc-

tion also display anti-fat bias (Puhl & Brownell, 2003; Tylka et al., 2014). Research conducted from 2001–2012 indicates that explicit WS increased among “obesity” specialists during that period (Tomiya et al., 2015).

WS occurs at individual, interpersonal, and institutional levels. Individually, internalized WS refers to the process of higher-weight individuals applying stereotypes and negative attitudes about weight to themselves (Pearl & Puhl, 2018). At the interpersonal level, most people in Western society (including healthcare providers) hold biases about higher-weight individuals, which impacts how providers relate to such individuals (Puhl & Heuer, 2009). Research indicates that of those who report experiencing WS, up to two-thirds also report experiencing WS from physicians (Puhl et al., 2021). WS also occurs at the structural or institutional level, which may involve health insurance financial incentives for individuals with a lower body mass index (BMI; Cawley, 2014); denial of medical care (e.g., knee replacements) until a patient meets an arbitrary BMI threshold (Godziuk et al., 2021); inappropriately blaming all health concerns on BMI (Alberga et al., 2019); exclusionary-sized seating in public spaces (e.g., airplane; Pearl, Groshon, et al., 2022); and lack of appropriately sized clothing.

We understand that most weight loss researchers and practitioners very much want to help individuals living in higher-weight bodies. Some also, in fact, are aware of and want to reduce WS. Yet, we propose that it is likely impossible to design and run a weight-loss program and avoid colluding with the societal WS messaging that certain people can and must reduce the size of their bodies. By definition, if a provider offers an individual treatment for weight loss, they are agreeing to a weight-normative paradigm that (a) focuses on weight as a significant determinant of health/well-being and (b) identifies weight as something that is under a person's control (as opposed to recognizing that biology and environment play a far greater role in weight status; see Tylka et al., 2014, for discussion of a weight-normative paradigm). Moreover, the existence of programs developed and run by medical and mental health experts also conveys to the general public that we believe weight loss is both important and viable. Further, the emphasis on proper mindset and behavioral changes as key factors of successful weight loss perpetuates negative beliefs and stereotypes about higher-weight people that are endemic in

our society (e.g., the thought that higher-weight individuals lazy, lack self-control, simply need to try harder or better; Puhl & Brownell, 2003). Further, weight loss as the primary goal of CBT-WM reinforces the false notion that high weight should be avoided and is inherently “bad” and “unhealthy.”

WS and intersectionality. People simultaneously inhabit multiple identities (e.g., weight status, race, gender, etc.). WS does not affect all individuals in the same way, as weight is just one identity a person holds. For instance, White women experience WS more often and at lower weights compared to White men and Black men and women (Dutton et al., 2014). Higher-weight LGBTQ+ individuals are also at heightened risk of WS (Paine, 2021; Puhl et al., 2019). Higher-weight transgender and nonbinary individuals have identified WS as contributing to ED development, including pressures to reduce BMI in order to access gender-affirming surgeries (Harrop, Hecht, et al., 2023). Younger individuals, compared to older individuals, have also reported higher rates of WS (Puhl et al., 2008). Research further supports elevated WS in those living with more severe food insecurity (Becker et al., 2021). In addition to WS experiences potentially differing by demographic groups, some studies suggest that WS internalization and coping may differ by groups, such that some groups (e.g., Hispanic women, White women, Black men) may be at increased risk for negative consequences of WS (Himmelstein et al., 2017). Though this research suggests that some groups may face less risk (e.g., Black populations), we caution against such broad conclusions, as this line of inquiry is relatively nascent. Further, some researchers have argued that WS can be a proxy for other forms of prejudice that are less socially acceptable. For example, some racial groups are more likely to have higher BMIs (Heymsfield, et al., 2016); in this case, at times it may be more socially acceptable to comment on body size than race, thus obscuring these other forms of societal discrimination (Strings, 2019).

WS Contributes to Harm in CBT-WM

WS contributes to harm via several pathways. WS is a form of chronic stress (Tomiya, 2014), resulting in substantial physical harm for higher-weight individuals. Medical consequences include increased cortisol levels, chronic inflammation (Tomiya), diabetes (Wu & Berry, 2018), and increased rates of physiological dysregulation (i.e., a composite

index of system functioning, including blood pressure, cholesterol, triglyceride levels, and others; Daly et al., 2019). In two longitudinal studies ($N > 18,000$), WS increased risk of mortality by almost 60% (Sutin et al., 2015). Importantly, many of these health consequences are outcomes that CBT-WM seeks to minimize. Ironically, WS is also associated with weight gain (Tomiyama et al., 2018). Further, recent research with 13,996 adults participating in weight management found that internalized WS was associated with greater weight gain in the past year, poorer mental and physical health-related quality of life, decreased eating and physical activity self-efficacy, worsened body image, greater avoidance of going to the gym, and greater stress (Pearl et al., 2021). Finally, given the substantial evidence that WS contributes to the medical conditions used to justify CBT-WM, it is very problematic that WS can increase healthcare avoidance (Palad et al., 2019). Substantial mental health consequences occur among adults and youth who experience WS. Individuals who experience WS report higher levels of depression, anxiety, and substance use, lower levels of self-esteem, and increased rates of suicidality (Alberga et al., 2016; Brochu, 2020; Papadopoulos & Brennan, 2015; Puhl & Lessard, 2020).

WS and EDs. Experiences of WS are correlated with ED behaviors (Pearl & Puhl, 2018; Vartanian & Porter, 2016). One study indicated that 18% of patients receiving a high level of ED care attributed the onset of their ED to anti-obesity messaging. The majority of participants reported that this messaging came from educational settings and the media, though over 10% identified such messaging as coming from healthcare providers (Mensing et al., 2021). WS can lead to WS internalization (Romano et al., 2021), which is associated with body dissatisfaction, a primary ED risk factor. WS has a compounding effect on ED prevalence, in that WS among healthcare providers leads to an underdiagnosis of and delayed treatment for higher-weight individuals with EDs, specifically A-AN (Hughes et al., 2019). Early intervention for EDs is critical, as delayed treatment is associated with poorer outcomes (Austin et al., 2021). Recent research also has identified WS-related healthcare avoidance as a form of maladaptive vigilant coping that is associated with increased ED behaviors (Wetzel & Himmelstein, 2023).

Additional harms. Table 1 lists additional potential concerns with CBT-WM that should be considered by the field

broadly and the corresponding CBT-WM strategy. Overall, we contend that the focus on weight in CBT-WM perpetuates and maintains WS.

Lack of Evidence Is Not Evidence of Lack of Harm: A Request for Research Change

Above we identified significant limitations in the existing CBT-WM literature that constrain the data-based conclusions that can be drawn about the degree to which CBT-WM increases risk for EDs. When researchers fail to collect important quantitative data regarding harm, they must turn to reports of lived experience. Before addressing lived experience, we highlight a few additional problems with the existing CBT-WM research literature from a harm perspective, along with specific requests for change in how this research is conducted.

First, weight regain is a very common sequela of initial weight loss; yet most people will try repeatedly to lose weight—likely because transitory weight loss is highly reinforcing (to patients and providers). This sets the stage for weight cycling, which correlates with problematic outcomes, including mortality (Oh et al., 2019; Quinn et al., 2020; Rzehak et al., 2007), though notably more research and a better definition of weight cycling is needed (Rhee, 2017). Second, CBT-WM trials typically do not evaluate how internalized and externalized WS affect weight outcomes, health outcomes, and mental health outcomes (including ED) and how weight regain impacts WS. Research should also assess for experiences of WS within the trial (i.e., the degree to which participants feel stigmatized by study staff or procedures). Given that WS is associated with a host of negative outcomes (Daly et al., 2019)—including the very medical outcomes that are used to justify CBT-WM in the face of very mediocre results—WS should, at the very least, be rigorously assessed and included as a necessary covariate in all analyses.

In addition, we strongly encourage CBT-WM researchers to include psychometrically strong measurements of the full ED pathology. Even recent guidelines from the American Academy of Pediatrics recommend additional assessment of EDs when implementing CBT-WM (Hampl et al., 2023). This includes overvaluation of weight and shape, dietary restraint, restriction, compensatory behaviors, and A-AN. Researchers should also carefully assess for

medical indicators of EDs (see Academy for Eating Disorders Medical Guidelines for full list of indicators) throughout the trial, with a particular focus on early indicators. Some suggestions for assessments include the SCOFF (Morgan et al., 2000), Eating Disorder Examination Questionnaire (Fairburn & Beglin, 2008) and the Screen for Disordered Eating (Maguen et al., 2018). Such findings should also be reported in the literature, not just collected.

If such trials continue to occur (with our overall opinion that researchers conducting these trials should pivot to a weight-inclusive approach; see below and Tylka et al., 2014, for discussion), we encourage careful consideration of correlation/causation mistakes that may be influenced by WS. This issue is critical, given that we are all at least as subject to WS as other forms of bias, such as homophobia and anti-Muslim bias (Latner et al., 2008), and given that WS can intersect with other forms of bias. Weight change does not occur in CBT-WM unless behaviors change first. Despite this process, CBT-WM focuses on weight even though weight is not a behavior (rather it is a dependent variable sometimes attributed to behaviors but largely based on environment and genetics with estimates of heritability up to 80%; Bouchard, 2021). In other words, our opinion is that CBT-WM targets the wrong mechanism (weight is not a changeable mechanism, health behaviors are). Instead of trials focused on weight loss, trials should be focused on health behaviors, regardless of a person's size. We support and extend a previous call by Tylka et al. for researchers to pivot to a weight-inclusive approach that deemphasizes weight and instead focuses on behaviors (e.g., eating food variety, joyful movement) that impact health metrics such as blood pressure, HbA1c, etc. Importantly, the weight-inclusive approach also historically has better acknowledged the importance of environment and social determinants of health, which is critical given the association of income and race with higher-weight stigmatized bodies. We wish to amplify Tylka et al.'s argument that a weight-inclusive approach is not radical; instead, it is conservative because (a) it does not promote a treatment with documented harms; (b) concedes the fact that weight is far more determined by involuntary genetic and environmental factors (e.g., lack of resources to obtain nutrient-rich foods; lack of time to prepare meals) than individual behaviors; and (c) accepts the unpopular fact that despite millions (maybe bil-

lions) of dollars being invested in weight loss trials, long-term results remain poor (see Tylka et al. for further discussion).

Individuals With Lived Experience With AN and CBT-WM

Harms have been repeatedly voiced by those with lived experience. Unfortunately, such lived experiences and concerns are frequently dismissed as unscientific. Yet, early evidence of harms in other areas (e.g., so-called “conversion therapy”) first came from lived experience, not research. It is imperative that researchers listen to these voices to not replicate past mistakes.

We now briefly examine qualitative data from ED patients, reflecting on the role that dieting played in the development and maintenance of ED (published prior in Harrop, Hecht, et al., 2023; Harrop, Hutcherson, et al., 2023; Harrop, 2020). We selected only a few excerpts to illustrate how recommendations for weight loss and dieting approaches, such as those recommended in CBT-WM, can contribute to EDs. Another particularly compelling story (submitted for this commentary—not part of the qualitative study) of how CBT-WM specifically contributed to the development and maintenance of an ED is included in Figure 1.

When asked how their EDs developed, 77% ($n = 30$) of participants directly referenced dieting as a contributing factor. While this study did not explicitly focus only on CBT-WM, every participant who discussed dieting (including commercial diet programs, medically supervised dieting, and CBT-WM) viewed dieting as foundationally connected to their ED. No participants viewed dieting as neutral or helpful; however, several participants mentioned some benefits of dieting, including Ashley,¹ who highlighted that dieting helped her cope with trauma in the short term by increasing body disconnection, and Carrie-Ann, who highlighted the benefits of peer social supports in diet programs. Multiple participants reported starting their dieting journeys as children. Carly stated that she had been on a diet since she was an infant and referenced 12 separate diet programs, resulting in her losing over 100 pounds three times. Molly and Marie began dieting at age 9, Josephine at 11, and Carter in junior high. Many participants highlighted that well-meaning

“It is likely that a trained ED clinician would have diagnosed me with an ED at a very young age, but because I was a “heavy” child, I was sent to CBT-WM which effectively taught me how to better engage in restriction, which was a part of my ED.

I participated in three separate CBT-WM programs over the span of 20 years. I lost and regained the same 50-70 pounds repeatedly (weight cycling). After regaining the weight lost through CBT-WM a third time, I was depressed and in the throes of my ED. I chose what I believed was my last possible option: bariatric surgery. I went through an extensive CBT program in preparation for this surgery and was told my history of binge eating and restriction was not a problem since I had done so well with therapy. I chose lap band as I was terrified of permanently altering my body. After 8 years I had the band removed. At that time, my labs were indistinguishable from someone with severe AN and my primary care doctor was very concerned for my health. With the lap band in place, I experienced daily “manualized bulimia.” Any food that was not extremely soft and easily chewed led to vomiting, at times 3-4 times per day against my will. I was hungry and my overall health suffered. During this time, the therapist and dietitian at the bariatric program I attended reviewed CBT strategies that mimicked restriction with me and blamed the vomiting on not chewing the food enough despite my reporting extensive chewing.

The types of weight loss strategies I encountered in CBT-WM were exactly like those I used in my ED but were called CBT. I was always hungry and utilizing distraction, avoidance of any type of snacks and ate very small meals in order to keep to the number of calories I was assigned daily. I went through my day not able to concentrate and simultaneously working incredibly hard to keep my food diary, exercise and think about how great life will be when I finally lost my “excess” weight for good. I was a compliant patient because I wanted to please the healthcare providers in the programs I attended and, in the end, my restriction skills were improved. The only problem was the hunger that drove binge eating and ultimately more restriction, creating real issues for my physical and mental health.”

Figure 1. Lived experience of the harm of CBT-WM. *Note.* This is a verbatim story from a woman with lived experience; this person is not a participant in the qualitative study mentioned in text.

parents and medical professionals facilitated their first diets.

Participants reported that more ED behaviors and physical symptoms emerged after the initiation of restriction and dieting. Josephine described increased anxiety and negative self-talk. Grace discussed becoming increasingly obsessed with dieting, fearing even eating vegetables due to the carbohydrate content. In addition to physical symptoms due to food restriction (e.g., amenorrhea, weight loss, fatigue, dizziness), participants also mentioned engaging in other ED behaviors such as binge eating, purging, eating in secret, compulsive exercise, and obsessive food rules. However, the dieting also functioned to hide their EDs: “It wasn’t recognized as an ED! I was just a very good dieter” (Ashley). Dieting often triggered relapses for those who received treatment. Riley shared that receiving diet recommendations from her healthcare providers while

also recovering from her ED made her feel as if she had no “safe place” in healthcare “because I’m going to constantly be told to do the very behaviors [food restriction] that have hurt me.” The stories these ED patients told highlight a common narrative of (1) dieting and body dissatisfaction from young ages, (2) initiating dieting (often at the impetus of parents or providers, such as those who prescribe CBT-WM), (3) dieting developing into clinical EDs, (4) dieting masking the recognition of the ED, and (5) dieting serving as a risk factor for relapse.

Time for Change: Recommendations for Weight-Inclusive Clinical Practices

These recommendations come from the authors, who carry perspectives from ED, weight stigma, and former weight-management researchers, clinicians, and those with lived experience. CBT-WM is clini-

¹All names reported are pseudonyms.

cally used with many more patients than included in research trials. Given the potential harms of CBT-WM, we encourage all clinicians working in weight management settings to pivot to weight-inclusive practices that serve to increase health behaviors among individuals across the weight spectrum without adding to weight stigma and EDs (see Tylka et al., 2014). It is possible to increase health behaviors (e.g., joyful movement; regular/balanced eating) without focusing on weight (Bessey & Lordly, 2019). Weight-inclusive practices involve the clinician, the practice environment, and systemic changes (Mauldin et al., 2022).

The Clinician

It is important to examine internalized WS and body image concerns, as these will influence client interactions. If a clinician lives in a smaller body, they must be aware of thin privilege—social, financial, and practical benefits received if existing in a relatively smaller body—that can distort perceptions. Assessing explicit and implicit WS is also essential. One tool for learning more about implicit bias is to take the Harvard Weight Implicit Association Test on Project Implicit: <https://implicit.harvard.edu/implicit/Study?tid=-1>.

Check Flawed Weight-Related Assumptions

Examples of assumptions about those in larger bodies include: (a) assuming presenting issues are due to their weight and weight loss would help, (b) assuming fatness is always indicative of trauma and that a resolution or healing of that trauma will result in weight loss (Kinavey & Cool, 2019), (c) assuming all fat clients want to lose weight, and (d) assuming clients are not engaging in physical activity or are eating “too much” because of the size of their body. Participating in weight-control activities may be an expression of internalized WS, shame, and the desire to escape the stigma and oppression that clients face in their daily lives (Mauldin et al., 2022). Despite the futile weight cycling many people have experienced, clients may request support in ongoing weight loss efforts. Validate the desire to lose weight as understandable in a culture that idealizes thinness and demonizes fatness. However, given the ineffectiveness and potential harm, weight loss is not an appropriate therapeutic goal. As Kinavey and Cool state, “The work of therapy is not to help people adjust to oppression.” Instead, consider supporting healing their relationship

with their bodies by identifying weight-inclusive, health-enhancing goals as desired. This work may include addressing internalized WS, disengaging from diet culture and unrealistic cultural ideals, supporting body autonomy, finding communities and support systems accepting of fat bodies, and healing from the trauma of weight stigma and body-based oppression. For clients who are concerned about the health implications of their weight, providing information about the flawed assumptions surrounding weight/health may promote empowerment to identify weight-inclusive goals independent of weight changes (see <https://haeshealthsheets.com/resources/>).

The Practice Environment

A weight-inclusive practice strives to eliminate microaggressions: intentional or unintentional verbal, behavioral, or environmental indignities that communicate hostility or negativity toward people who hold less power in society. Proactive steps include providing safe, comfortable furniture and physical space that accommodate people of all sizes and abilities. Clarify that stereotypes about weight or weight/diet-related comments are not appropriate and adversely impact people. Demonstrate that your practice values diversity (e.g., via a Mission Statement, nonstereotypical images in magazines, pamphlets, and artwork).

Avoid Using Stigmatizing Language

“Ideal weight,” “normal weight,” and “overweight” imply that there is a “correct” weight everyone should be, ignoring natural human diversity. “Healthy weight” presumes that people are automatically healthy or unhealthy at a certain weight. “Obesity” and “morbid obesity” are medical terms that pathologize body size (Mauldin et al., 2022). When a descriptor is necessary, consider terms like “higher weight.” Some people may feel comfortable reclaiming the word “fat” as a form of liberation from weight stigma (Meadows & Danielsdóttir, 2016). If weighing clients is necessary for care, share decision-making with clients about whether, when, where, and how they will be weighed to minimize additional weight-based trauma. Scales should be in a private space, and personnel should refrain from commenting on someone’s weight, even “positively.” Clinicians who serve children and adolescents should be aware of the necessity of weight gain throughout puberty and into young adult-

hood and should avoid speaking casually about diet and weight in their presence.

Systemic Issues

It is our ethical duty to unpack and address prejudice (Kinavey & Cool, 2019). Where possible, work to increase health access, autonomy, and social justice for all individuals along the entire weight spectrum. Be aware of intersectionality; patients with multiple stigmatized identities may experience mutually reinforcing sources of oppression that negatively impact their well-being. Weight loss does not stop weight stigma. Stigma is a social justice issue. People deserve to live free of stigma and prejudice no matter what they weigh.

Summary and Overall

Recommendations

This commentary reviewed the literature on CBT-WM, including the outcomes and limitations of the data. We showcased how strategies included in CBT-WM can lead to the development/return of EDs and can lead to additional harms, such as medical complications, anxiety, depression, body dissatisfaction, weight stigma, weight cycling, and suicide. While limited data exist that quantifies harms within CBT-WM trials, we provided many excerpts from lived experience that demonstrate these harms are occurring. More research is needed to quantify these harms carefully. Finally, we provided a call to action to researchers and clinicians who currently offer CBT-WM by offering alternative concrete strategies that shift individualized weight-centric interventions to those that promote weight inclusivity and the dismantling of systemic issues. The authors highly encourage those who provide CBT-WM interventions to consider modifying their practices to reduce harm.

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Resisting the Misuse of Theories Foundational to Cognitive Behavioral Therapy in Anti-Trans Legislation

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AS OF JULY 28 2023, there are 533 anti-trans bills active in the United States (U.S.; Chapman et al., 2023), marking an unprecedented onslaught of legislation targeting the human rights of trans communities. We use the term trans to describe anyone who is not cisgender (i.e., identifies with the gender/sex they were assigned at birth). The rise in anti-trans legislation is likely to widen health disparities faced by trans populations (e.g., Horne et al., 2022; Pharr et al., 2022), through the impact of increased exposure to minority stress (Bränström & Pachankis, 2021; Flentje et al., 2020; Gleason et al., 2016; Puckett et al., 2022; Tebbe & Budge, 2022; Valentine & Shipherd, 2018) and increased burden of gender dysphoria (e.g., Brokjøb & Cornelissen, 2022; Chen et al., 2023). The rise in anti-trans legislation represents increasing efforts to regulate, surveil, and subjugate gender nonconformity and transness. In the context of sociopolitical power structures, these efforts necessitate differentiation of the trans and nonbinary “out-group” whose lives and existence are disadvantaged and disallowed for the benefit and livelihood of the general population, or the cisgender “in-group” (Foucault, 1998; Foucault et al., 2006; Neumann, 1999; Tajfel, 1974). By disallowing gender nonconformity, anti-trans legislation may be considered structural-level sexual orientation and gender identity change efforts (SOGICES).

SOGICES represent a group of scientifically discredited practices that seek to change or suppress transness and queerness (Kinitz et al., 2021). Formal, interpersonal-level SOGICES may operate under the guise of legitimate “therapy” (e.g., “conversion,” “reparative,” or “reorientation” therapies). SOGICES also include informal practices (e.g., providing

medication to suppress sex drive, sexual violence against queer and trans people, delaying gender affirming health care for trans people; Hipp et al., 2019; Kinitz et al., 2021; Przeworski et al., 2021). SOGICES also often occur at the community level in religious contexts through organizational condemnation of transness/queerness as sinful and immoral (Hipp et al., 2019; Plante, 2022). There is overwhelming evidence that interpersonal- and community-level SOGICES result in psychological harm (American Psychological Association, 2009, 2021; Campbell & Rodgers, 2023; Goodyear et al., 2022; Green et al., 2020; James et al., 2016; Jowett et al., 2021; Przeworski et al., 2021; Serovich et al., 2008; Turban et al., 2020a; Wang et al., 2023). Evidence of harm associated with structural-level SOGICES has also been documented. For example, in a recent study, greater psychological distress and suicidality were identified among trans adults in U.S. states with more anti-trans laws and attitudes (Price et al., 2023).

Operant conditioning (Skinner, 1963), social learning (Bandura, 1969), and cognitive (Beck, 1964) theories are foundational to and guide cognitive-behavioral therapy (CBT), and have been misused by SOGICES. When they misappropriate CBT’s guiding principles, SOGICES incorrectly assume that queer and trans identities can and should be altered because they are “maladaptive” behaviors based on “distorted” cognitions that develop in response to pathological, relational, or environmental childhood experiences (Last & Wuest, 2022; Przeworski et al., 2021). Misguided practitioners may directly use CBT techniques as SOGICES, like cognitive restructuring to challenge cognitive “barriers” to cisheteronormativity, or behavioral conditioning to associate aversive stimuli with sexual attraction,

arousal, or gender nonconformity (Morrow & Beckstead, 2004; Przeworski et al.; Wang et al., 2023). When appropriately applied, CBT is not inherently transphobic or homophobic. In fact, LGBTQ-affirmative CBT interventions demonstrate efficacy in supporting the psychological health of LGBTQ people (e.g., Austin et al., 2018; Pachankis et al., 2020).

Although anti-trans legislation precludes CBT and uses a variety of opportunistic arguments as justification¹ (e.g., Morrow & Beckstead, 2004; Przeworski et al., 2021), framing anti-trans legislation as a misapplication of theories foundational to CBT allows CBT practitioners and researchers to identify effective interventions. While efforts to document the misuse of CBT in individual- and community-level SOGICES are underway (i.e., publications by the ABCT Editorial Task Force on Addressing Published Articles on Sexual Orientation and Gender Identity Change Efforts), the misuse of CBT's guiding principles in structural-level SOGICES has received little attention. We aim to arm researchers and practitioners with a framework that leverages CBT *against* the codification of SOGICES into law by identifying, deconstructing, and providing evidence to refute their underlying faulty assumptions.

Methods

We examined U.S. legislative maps and policy documents through a critical lens informed by the cognitive, social learning, and behavioral conditioning theories that guide CBT. Specifically, we leveraged a phenomenological analysis to derive and challenge a set of intermediary assumptions and foundational/core beliefs reflecting the misapplication of CBT's guiding principles across the larger phenomenon of anti-trans legislation (Levitt et al., 2018; Wertz, 2010). Authors include two graduate students and one clinical psychologist, trained in CBT and dedicated to the goals of trans and queer liberation, social justice, and antiracism. All authors are White and queer; two are trans and/or nonbinary.

To identify anti-trans legislation, we

used a legislative tracker created by Chapman et al. (2023). This tracker provides regularly updated summaries and links to policy documents organized by: legislative bill type, states in which specific types of bills are under consideration, status of the legislation, and level of risk. The landscape of anti-trans legislation is rapidly changing; as such, the current review is not exhaustive in its identification of this legislation. Anti-trans bill types (see Table 1) were selected by consensus based on their representation of a novel misapplication of cognitive, social learning, and/or behavioral conditioning theory or unique faulty assumption.²

To summarize policies included under each bill type, authors reviewed the most recent legislative policy documents linked by Chapman et al. (2023) for at least three of the states that have proposed or enacted a given type of legislation. If review of legislative text from additional states would be likely to contain novel content, authors reviewed additional states' legislation until no new policy details arose (i.e., thematic saturation). Legislative references are listed in the Appendix. To demonstrate the scope of these structural SOGICES, authors listed all states that had active legislation (i.e., proposed, moving through legislative processes, or passed) of a given bill type as of April 23, 2023. Authors then met to determine the logical fallacies of each bill type. Identification of these logical fallacies was informed by operant conditioning (Skinner, 1963), social learning (Bandura, 1969), and cognitive (Beck, 1964) theories. Any discrepancies or omissions of the logical fallacies reflected in these bills were resolved by consensus. Finally, authors generated challenges to faulty assumptions underlying each bill type by reviewing the research literature to identify theoretical or empirical evidence against each assumption.

Results

Faulty Assumptions Underlying Structural-Level SOGICES

Several underlying faulty assumptions were apparent from our analysis of anti-

trans legislation. As a whole, anti-trans legislation disregards trans or nonbinary gender as a "feeling," "belief," "psychological" experience, "ideology," or "delusion" (e.g., IA S.F. 129, 2023; IN H.B. 1346, 2023; Fairness in Women's Sports, 2023; MO S.B. 497, 2023; School Establishment Clause Act, 2023; WV S.B. 697, 2023). This legislation presumes that transness is learned through modeling of trans behavior in schools and other public spaces (e.g., Families' Rights and Responsibilities Act, 2023; School Establishment Clause Act, 2023), and that interpersonal recognition through use of chosen name/pronouns or gender affirming care positively "reinforce," "encourage," or result in "persistence" of trans or nonbinary gender identities (e.g., GA H.B. 653, 2023; IA S.F. 129, 2023; IN H.B. 1118, 2023; OK S.B. 937, 2023; Protecting Minors from Medical Malpractice Act, 2023; Saving Ohio Adolescents from Experimentation [SAFE] Act, 2023; TN H.B. 0001, 2023). As such, existing policies aim to remove models of transness and to punish its expression.

Some policies aim to prevent the development of trans identity by blocking access to examples or evidence of trans existence (e.g., banning drag shows, AL H.B. 401, 2023; TX H.B. 1266, 2023; censoring discussion of topics related to gender identity in schools, AL S.B. 294, 2023; FL H.B. 1069, 2023), while others use operant conditioning principles of negative punishment to block gender affirmation (e.g., restricting gender affirming care, OH H.B. 68, 2023; GA H.B. 653, 2023; banning use of bathrooms consistent with their gender identity, FL H.B. 1521, 2023; KY S.B. 150, 2023; limiting access to sport and drag performance, AL S.B. 211, 2023; AK S.B. 43, 2023). Gender affirming providers, teachers, or parents of trans children may also be negatively punished through operant conditioning for their support of trans people through loss of licensure or employment (e.g., IA S.F. 129, 2023; IN H.B. 1346, 2023; TX H.B. 1541, 2023) or parental custody (e.g., FL S.B. 254, 2023; TX S.B. 1690, 2023). Finally, a subset of anti-trans bills proposes the use of positive punishment (i.e., linking aversive consequences to the expression or affirmation of transness), including forced "outing" and misgendering for trans students (e.g., IA H.F. 180, 2023; IN H.B. 1346, 2023) or fines and imprisonment for trans and nonbinary individuals (e.g., MT H.B. 0359, 2023; OK H.B. 2186, 2023), trans and nonbinary organization

¹Anti-trans legislation is also heavily influenced by specific sociopolitical and religious contexts beyond the scope of the current report.

²Bill types identified by Chapman et al. (2023) not represented in Table 1 include legislation that: prohibits name or gender marker changes; legally defines gender as "biological" sex; bans use of public funding towards Environmental, Social, Governance or Diversity, Equity and Inclusion policies; and prohibits government contracts with companies that boycott businesses based on social, political, or ideological interests.

leaders (e.g., AK S.B. 43, 2023; IA S.F. 348, 2023; KS S.B. 149, 2023), gender affirming providers (e.g., WV S.B. 697, 2023) and gender affirming schools/teachers (e.g., AL H.B. 354, 2023; MO H.B. 634, 2023; OK S.B. 932, 2003; TX S.B. 393, 2023).

Challenging Specific Assumptions of Structural-Level SOGICES

Table 1 provides a summary of our analysis of specific types of anti-trans U.S. legislation to: (a) characterize their scope and consequences, (b) deconstruct logical fallacies specific to each type of anti-trans legislation, and (c) identify evidence challenging these faulty assumptions to disrupt this misapplication of cognitive, social learning, and behavioral conditioning theories.

“Drag Bans”

“Drag bans” force people to conform the expression of their gender to sex assigned at birth based on assumptions that witnessing queer and trans embodiment will cause children to express gender nonconformity. Policies that ban drag performances conflate transness, gender nonconformity, and drag under the assumption that these are fraudulent and deceitful behavioral attempts to impersonate a different gender (e.g., AL H.B. 401, 2023; KS S.B. 149, 2023; MO H.B. 498, 2023; MT H.B. 0359, 2023; NE L.B. 371, 2023; TN H.B. 0009, 2023; TX H.B. 1266, 2023), rather than authentic expressions of identity and gender exploration (Ashley, 2019; Bettcher, 2009). Laws from recent history that described straight, cisgender women who wore pants as impersonators (Sears, 2016) highlight the hypocrisy of policing gender expression.

“Drag bans” are also based on the assumption that trans embodiment (gender nonconformity) threatens cisgender embodiment (gender conformity; e.g., AK S.B. 43, 2023; KS S.B. 149, 2023; MT H.B. 0359, 2023; ND H.B. 1333, 2023; TN H.B. 0009, 2023). However, evidence that the rules of gender expression change according to cultural circumstances (Chenoune et al., 1993; Ford, 2021; Picken, 2013; Sears, 2016) undermine differentiation of gender conformity versus nonconformity. Moreover, gender exploration is healthy for trans, queer, cisgender, and straight people alike (Ashley, 2019), while policing gender expression of trans and queer people requires privacy violations against cisgender women too (Bagagli et al., 2021; Blumell et al., 2019).

“Drag bans” also conceptualize drag performances as sexually explicit and

harmful discriminative stimuli (i.e., Skinner, 1963) that encourage children to believe they are trans (e.g., AK S.B. 43, 2023; AL H.B. 498, 2023; KS S.B. 149, 2023; MO H.B. 498, 2023; MT H.B. 0359, 2023; ND H.B. 1333, 2023; OK H.B. 2186, 2023; TN H.B. 0009, 2023; TX H.B. 1266, 2023). However, gender dysphoria and euphoria (Badgley et al., 2022; Coleman et al., 2022) are characteristically distinct from DSM-5-defined paraphilic disorders (APA, 2013; Gijs & Carroll, 2011). Moreover, cis and trans youth seem to perpetrate sexual violence at equal rates (Ybarra et al., 2022). Conversely, trans people face increased risk of experiencing sexual violence relative to cisgender people (Coulter et al., 2017; Flores et al., 2020; James et al., 2016; Ybarra et al., 2022). Finally, healthy community and social life may be organized around drag performance. For example, the “kiki” scene supports youth involvement in Black and Latine cultural communities associated with “drag” and collaborates with community organizations to increase access to life-saving services (e.g., such as HIV testing; Matthes & Salzman, 2019; Smeyne, 2014), while providing physically and emotionally safe opportunities for youth to develop executive functioning and social-emotional skills (G. W. Harper et al., 2022).

Gender Affirming Care Bans

Gender affirming care bans that prohibit or restrict access to gender affirming medical interventions for trans youth and/or adults assume that access to gender affirmation causes trans identities, and that gender affirming medical interventions are new and experimental, risky, irreversible, and uniquely damaging (e.g., Protecting Minors from Medical Malpractice Act, 2023; SAFE Act, 2023; WV S.B. 697, 2023). These assumptions are not supported by the literature; youth social transition has been associated with improved mental health outcomes (Durwood et al., 2017; Olson et al., 2016), and similar mental health and quality-of-life benefits are seen for youth and adults who access puberty blockers (Rew et al., 2021; Turban et al., 2020b), gender affirming hormones (Nguyen et al., 2018; Turban et al., 2022), and gender affirming surgery (de Vries et al., 2014; Swan et al., 2023). Gender affirming medical interventions are not new (Bhinder & Upadhyaya, 2021) and are safe when provided under medical supervision (Coleman et al., 2022; Mahfouda et al., 2017; Olson-Kennedy et al., 2018; Safer & Tangpricha, 2019; Tangpricha & den

Heijer, 2017). Similar procedures are also regularly performed and accepted for cis youth, such as with the use of puberty blockers for precocious puberty (Rafferty et al., 2018) or nonconsensual genital surgery on intersex infants, simply because these procedures force conformity to cisheteronormative ideals (Reis, 2019).

These laws also call into question children’s competence to know their own gender identity and make medical decisions (e.g., GA H.B. 653, 2023; IA S.F. 129, 2023; TN H.B. 0001, 2023). They also assume that most trans youth eventually come to identify with their sex assigned at birth and that most people who transition later regret that decision or demonstrate poor mental health outcomes (e.g., Protecting Minors from Medical Malpractice Act, 2023; GA H.B. 653, 2023; IA S.F. 129, 2023; SAFE Act, OH H.B. 68, 2023). However, evidence supports trans adolescents’ capacity to consent to gender affirming health care (Clark & Virani, 2021; Vrouenraets et al., 2021), and the persistence of trans identity and gender transition for children (Olson et al., 2022; C. M. Roberts et al., 2022) and adults (Bustos et al., 2021; Jedrzejewski et al., 2023; Turban et al., 2021). Overall, trans identities are not pathological (Davies & Davies, 2020), and the distress experienced by trans people is primarily the result of social rejection and violence rather than the gender incongruence itself (Robles et al., 2016).

Laws to Legalize “Conversion” Therapy

Attempts to legalize gender identity-based “conversion” therapy by prohibiting conversion therapy bans or revising the legal definition of conversion therapy assume that cognitive behavioral techniques (e.g., aversive conditioning) can be used effectively to modify gender identity (e.g., UT H.B. 0228, 2023; WI S.B. 4, 2023), and that suppression of trans identities is not only innocuous, but actually serves to protect youth (e.g., TN H.B. 1378, 2023; WV S.B. 697, 2023). These assumptions are refuted by substantial evidence that efforts to conceal or suppress trans identity are actively harmful and predict increased risk of severe psychological distress, including increased suicidality (Brennan et al., 2021; Campbell & Rodgers, 2023; Goodyear et al., 2022; James et al., 2016; Testa et al., 2017; Turban et al., 2020a). Additionally, despite some evidence of minor and inconsistent modification of sexual behavior, so-called conversion therapy does not modify sexual orientation and

would likely produce similar results for gender identity (American Psychological Association, 2009; Jowett et al., 2021; Przeworski et al., 2021; Serovich et al., 2008). Therefore, parallels that have been drawn between gender dysphoria and eating disorder or body dysmorphic disorder treatment (e.g., SAFE Act, OH H.B. 68, 2023) are not supported by the evidence (Coleman et al., 2022; Murphy et al., 2010; Prazeres et al., 2013).

Forced “Outing” and Misgendering Policies

Bills that require educators to disclose information about students’ gender, pronouns, and sexuality to parents and prevent educators from using student names or pronouns different from those assigned at birth are based on assumptions that trans identities are harmful behaviors that educators encourage or coerce children to engage in (e.g., The Given Name Act, 2023; Education Matters, 2023; Vulnerable Child Compassion and Protection Act, 2023). Although transness is legitimate regardless of its basis in scientific study (Bettcher, 2009; Stone, 1993),³ biological evidence of transness (Clemens et al., 2021; Diamond, 2013; Fernández et al., 2018; Frigerio et al., 2021; S. C. Mueller et al., 2021) refutes the assumption that endorsement of trans identities is the result of behavioral learning or coercion. Rather than the result of coercion, increasing rates of LGBTQ identification among Generation Z are linked to increasing acceptance of LGBTQ people (J. M. Jones, 2022; McShane, 2022). Moreover, instead of causing harm, identity exploration is a key component of healthy development (Ashley, 2019; Marcia, 1966).

Policies that prescribe forced “outing” and misgendering also assume that parents’ beliefs override children’s rights to privacy and autonomy (e.g., Families’ Rights and Responsibilities Act, 2023; Parents and Children Protection Act, 2023; School Gender Identity Policies, 2023). However, children are active agents with moral agency, not passive objects owned by their parents (Bester & Kodish, 2017; Carnevale, 2012, 2016, 2020; Pugh, 2014). Finally, these bills assume that parents knowing about their child’s transness protects children from

harm (e.g., Vulnerable Child Compassion and Protection Act, 2023), when in fact, family members may enact violence or houselessness on children because of their gender identity (James et al., 2016).

“Don’t Say Gay” Laws

“Don’t Say Gay” laws restrict and regulate K-12 students’ access to information about LGBTQ topics, at times entirely prohibiting discussion of sexual orientation and gender identity in the classroom. These laws are based on assumptions that contact with concepts of queerness or transness in schools is an inappropriate or harmful discriminative stimulus (i.e., Skinner, 1963) or behavioral model that coerces children to believe that they are queer and/or trans (e.g., FL H.B. 1069, 2023; MO H.B., 634, 2023; OK S.B. 30, 2023; Parents and Children Protection Act, 2023; TX S.B. 1155, 2023). The substantial empirical literature on comprehensive sexuality education suggests that curriculums that center empowerment and social justice for women and LGBTQ people support positive health outcomes and reduce risk of child abuse or dating and intimate partner violence (Goldfarb & Lieberman, 2021; Haberland & Rogow, 2015). Moreover, evidence that conversion therapy may modify behaviors but not sexual orientation (American Psychological Association, 2009; Jowett et al., 2021; Serovich et al., 2008) suggests that learning about sexuality and gender different from one’s own is unlikely to change internally experienced sexuality or gender.

“Bathroom Bills”

“Bathroom bills” intended to prohibit trans people from using multiple-occupancy restrooms or public changing facilities not designated for the sex they were assigned at birth are based on the assumption that transness is a dangerous and maladaptive behavior that cis people must be protected from. Specifically, these laws assume that trans people will sexually assault cis people in these spaces or that witnessing trans bodies is inherently an invasion of privacy involving non-consensual sexual behavior (e.g., FL H.B. 1521, 2023; KY S.B. 150, 2023; Protecting the Privacy and Safety of Students in Public Schools, 2023; Safety in

Private Spaces Act, 2023; To Amend the Criminal Offense of Sexual Indecency with a Child, 2023). However, trans people are extremely unlikely to commit sexual offenses in restrooms (Barnett et al., 2018; Hasenbush et al., 2019), and are no more likely than cis people to perpetrate sexual violence in general (Ybarra et al., 2022). In contrast, trans people are much more likely than cis people to report being harassed or assaulted in public restrooms, and to experience sexual violence victimization overall (Coulter et al., 2017; James et al., 2016; Murchison et al., 2019; Ybarra et al.). Additionally, these laws increase privacy violations for both trans and cis women, because they rely on biological essentialist understandings of gender and sex and reinforce sexist conceptions of women as vulnerable (Bagagli et al., 2021; Blumell et al., 2019).

Trans Sports Bans

Bans that prohibit trans youth from participating in sports not designated for the sex they were assigned at birth and create guidelines for “proving” one’s biological sex in order to participate in sports assume that trans women have inherent physiological advantages and pose a threat to women’s sports and sex equality (e.g., Fairness in Women’s Sports, 2023; Save Women’s Sports Act, MO H.B. 183, 2023; Save Women’s Sports Act, OH S.B. 68, 2023). The bans and underlying assumptions have roots in historical “femininity tests” that punished deviations from feminine ideals in sports and define women as physically inferior to men (Karkazis & Jordan-Young, 2018; Sullivan, 2011; Vilain et al., 2017). Contradicting the validity of such tests, humans are not sexually dimorphic and show substantial overlap in all possible criteria (Pape, 2017). Moreover, there is no evidence that the effects of testosterone-driven puberty predict athletic performance or that trans women show any athletic advantage after testosterone suppression (CCES, 2022; Defreyne et al., 2019; J. Harper, 2015; B. A. Jones et al., 2017; Klaver et al., 2018; Lapauw et al., 2008; A. Mueller et al., 2011; T. A. Roberts et al., 2021; Scharff et al., 2019; Tack et al., 2018; Van Caenegem et al., 2015; Vita et al., 2018; Wierckx et al., 2014; Wiik et al., 2020). Additionally, trans women are significantly underrepresented in elite sports and as winners of sporting competitions, with no trans woman having ever won an Olympic medal (CCES, 2022; Ivy & Friedlaender, 2020; B. A. Jones et al., 2017).

³Although beyond the scope of the current article, attempts to essentialize transness as a biological phenomenon are problematic because they imply that biological or medical evidence is necessary to legitimize trans and nonbinary identities (Bettcher, 2009; Stone, 1993). We include evidence of the biological markers of transness and queerness as a surface-level challenge to claims that transness is learned behavior.

Table 1. Characterizing the Scope of Anti-Trans Legislation and Challenging its Faulty Assumptions

Legislative Category	Description	At-Risk States	Faulty Assumptions of Legislation	Evidence Against Faulty Assumptions
Drag Bans	Prohibit performances by people expressing a gender different from SAAB in a location where it may be viewed by someone under 18 years old.	AK, AZ, IA, KS, MN, MO, MT, NE, ND, OK, SC, TN, TX	Trans people are impersonators, they are not who they say they are.	Transness and gender nonconformity are authentic expressions of identity and gender exploration. ^{3, 8}
	Prohibit funding, minor attendance at performances by people expressing gender different from SAAB.		Trans and nonbinary embodiment is a threat to cisgender embodiment.	Biological evidence of trans identity and gender dysphoria. ^{24, 30, 33, 36, 60, a}
	Criminalize engaging in performances as a person expressing a gender different from SAAB where it may be viewed by minor.		Being trans, queer, and/or gender nonconforming is inherently sexual.	History demonstrates socially constructed nature of gender conforming expression. ^{22, 35, 70, 82}
	Prohibit people expressing gender different from SAAB from reading aloud during story time in schools.		Gender expression is non-consensual sexual behavior.	Gender exploration is healthy and benefits everyone, including cisgender straight people. ³
	Prohibit trans/nonbinary performances within certain distance (e.g., 2500 feet) of schools.		Children need to be protected from trans and queer people.	Surveillance and regulation of trans and nonbinary embodiment require privacy violations that result in increased surveillance and control of cis women too. ^{5, 10}
			Seeing trans people accepting themselves and being accepted by others will coerce children into identifying as trans.	Trans identity and experiences of gender dysphoria and euphoria ^{4, 27} are categorically distinct from definition of paraphilic disorders in the DSM-5 including so-called “transvestic disorder”. ^{1, 38}
				Equal rates of sexual violence perpetration among cis and trans youth, ¹⁰⁴ and higher risk of experiencing sexual victimization among trans populations. ^{26, 34, 47, 104}
				Majority of child sexual abuse is connected with the church and other systems of power (e.g., politicians, police officers), not drag performances. ¹⁵
				“Kiki” scene created by and for young people in the House and Ball Community ^b as a space for young people of color to socialize, practice, perform, and receive services (e.g., HIV

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(Table 1 continued)

Laws to Legalize Conversion Therapy	TN, TX, UT, WA, WV	Most people who transition later regret that decision.	
	US	Trans people are too healthy to deserve medical intervention (i.e., no disease or damage to gendered body parts), but also not healthy enough to consent to this intervention (i.e., trans identity as delusional, psychiatric comorbidities).	
Laws to Legalize Conversion Therapy	IA, IN, NH, OH, TN, UT, WI	Conversion therapy protects youth from harm by suppressing their expression of trans identities.	Suppression of trans identity and exposure to gender identity conversion efforts predict increased risk of severe psychological distress, including increased suicidality. ^{13, 17, 40, 51, 91, 92}
		Suppressing the expression of trans identities is not harmful.	“Conversion therapy” may marginally and inconsistently change behavior, but not identity. ^{2, 51, 72, 83}
		Conversion therapy is effective for changing trans identities and preventing their persistence.	Substantial differences between effective treatments for body dysmorphia in eating disorders vs. gender dysphoria. ^{25, 62, 71}
		Conversion therapy for trans youth is comparable to treatment for eating disorders or body dysmorphic disorder.	
Forced Outing and Misgendering Policies	AK, AR, AZ, CT, GA, HI, IA, IN, KS,	Queerness or transness is caused by educators coercing students to identify as such; queerness or transness is caused by schools allowing students to use chosen name/pronouns.	Transness and gender nonconformity are authentic expressions of identity and gender exploration. ^{3, 8}
		Require K-12 educators in public, private, and/or charter schools to report information about students’ gender, gender pronouns, or sexuality to students’ parents.	Biological evidence of queerness ^{11, 37, 63} and transness. ^{24, 30, 33, 36, 60, a}
		Prohibit educators from addressing/referring to a student with pronouns that differ from	Increasing rates of LGBTQ identification among Generation Z linked to increasing rates of acceptance. ^{50, 58}

(Table 1 continued)

those associated with SAAB or name other than their name of record without parental consent and/or change of school record or birth certificate.	KY, LA, ME, MO, MT, NH, NC, ND, OH, OK, OR, SC, TN, TX, UT	parents/guardians. Child autonomy and privacy, especially related to gender and sexuality, is irresponsible/inappropriate.	Violence and loss of housing reported as response to family member knowledge of trans identity. ⁴⁷
Prevent schools from encouraging or allows refusal from students or school employees to use a name, pronoun, or title different from the student's name on birth certificate or those associated with a student's SAAB.	US	Parental beliefs/rights are more important than the beliefs/rights of their child.	Children are not the property of their parents. ⁷ Children are active agents with moral agency, not passive objects or property. ^{19, 20, 21, 73}
Prohibit federal funding for schools that do not require written parental consent prior to changing child's gender marker, pronouns, or name of school forms.		Parental consent concerning their child's schooling/health is more important than a child's consent to release information.	Healthy development involves identity and belief exploration in childhood. ³⁶
Prohibit or retract funding from public school educators assisting student with social transition.		Parents knowing about their child's gender and sexuality protects children from harm.	Child rights to privacy and confidentiality in medical settings. ^{65, 69}
Often included in conjunction with "Don't Say Gay" bills.			
"Don't Say Gay" Laws	AZ, AK, FL, GA, HI, IA, IN, KS, MO, MT, NH, NJ,	Children can be "turned" queer or trans by learning about LGBTQ topics at school.	Low likelihood that learning about LGBTQ topics will influence internally experienced identity, based on lack of identity change associated with "conversion therapy" ^{2, 51, 83}
Restrict or prohibit discussion of LGBTQ topics in public, private, and/or charter school classrooms, up to specific grade or K-12.		Queerness or transness is caused by educators coercing students to identify as such.	Biological evidence of queerness ^{10, 37, 63} and transness. ^{24, 30, 33, 36, 60, a}
Ban or require parental permission prior to instruction in topics about sexual orientation, gender identity, and/or other sexual health education.		Learning about gender and sexuality is inappropriate for children.	Increasing rates of LGBTQ identification among Generation Z linked to increasing rates of acceptance. ^{50, 58}
Remove books from school district			Sexuality and gender education for children involves socioemotional diversity, acceptance and sexual harm

(Table 1 continued)

	libraries, conducts monthly checks for books to remove.	NM, NC, ND, NH, NJ, NM, OH, OK, OR, SC, TN, TX	prevention, not exposure to explicit sexual material. ^{42, 41}
	Prohibit federal funding schools that do not require parental consent prior to instruction related to LGBTQ topics.	NH, NM, OH, OK, OR, SC, TN, TX	Reduced rates of STIs/STDs and unintended pregnancy associated with comprehensive sexuality education that centers women and LGBTQ people. ⁴¹
	Often included in conjunction with Forced Outing/ Misgendering bills.	OR, SC, TN, TX	Dating and intimate partner violence prevention, development of healthy relationships, prevention of child sex abuse, improved social/emotional learning, and increased media literacy supported by comprehensive sexuality education that centers women and LGBTQ people. ³⁹
		US	Long-term reductions in violence perpetration and reduced risk of childhood sexual abuse associated with earlier introduction to sexuality education. ^{39, 101}
"Bathroom Bills"	Prohibit people from using multiple-occupancy restrooms or public changing facilities designated for the "opposite" biological sex.	AZ, AR, CT, FL, ID, IL, IA, KY, MI, MN, NE, NH, ND, OK, RI, TX, KS	Extremely low likelihood of trans people committing sexual offenses in public restrooms/changing rooms. ^{6, 45}
	Require public schools to designate multiple-occupancy facilities by biological sex.	FL, ID, IL, IA, KY, MI, MN, NE, NH, ND, OK, RI, TX, KS	Relatively high likelihood of trans people experiencing sexual violence. ^{26, 47, 61, 104}
	Allow businesses to designate restrooms based on biological sex.	MI, MN, NE, NH, ND, OK, RI, TX, KS	Privacy violations against cis and trans women associated with surveillance/restriction of trans people using public restrooms/changing rooms, based on biological essentialist and sexist conceptions of womanhood. ^{5, 9}
	State that "reasonable accommodations" cannot involve allowing use of multiple-occupancy facilities designated for the "opposite" sex, and/or cannot place an "undue burden" on cis people.	RI, TX, KS	
	Define use of "opposite-sex" facilities as a crime (sex offense,		

(Table 1 continued)

second-degree misdemeanor).				
Trans Sports Bans	Require schools to designate all sports as female, male, or coed. Prohibit students from participating in sports designated for the “opposite” biological sex, with a focus on barring those assigned male at birth from sports designated female. Require some or all students to prove their biological sex with their original birth certificate, a physical examination, or a written statement signed by a parent/guardian.	AK, AL, CT, HI, IL, KS, KY, MN, MO, NC, NE, NH, NJ, NM, ND, NV, OH, OK, OR, RI, TN, TX, WY US	Trans people, particularly trans women, have physiological, “biological” advantages in athletics. Trans people, particularly trans women, pose a threat to women’s sports and sex equality. Trans people are easily identified and excluded from athletics. Biological sex is determined at birth and is based on reproductive anatomy, genetic makeup, and/or naturally occurring testosterone levels.	No evidence to indicate that trans women show any athletic advantage after testosterone suppression. ^{18, 28, 44, 49, 52, 54, 59, 78, 81, 89, 96, 99, 102, 103} Trans women do not dominate women’s sports; they are underrepresented. ^{18, 46, 49} Excluding trans women from women’s sports requires policing femininity and defining women as physically inferior to men, just as historical “femininity tests” punished women who did not conform to traditional feminine ideals. ^{87, 98}
Revocation of Parental Care	Prohibit conservatorship of a child by a parent who: furnishes medical gender affirmation treatment; or removes the child from this state for certain purposes relating to gender reassignment. Legalizes abduction of trans kids.	TX, FL	Providing access to gender affirming care is tantamount to child abuse The state is more competent to care for trans youth than parents	Safety, mental health, and quality of life benefits of gender affirming care. ^{29, 32, 64, 66, 68, 76, 93} Withholding access to gender affirming medical care from transgender and nonbinary youth is associated with significantly elevated risk for suicide. ⁸⁸ Existence of state sanctioned child abuse (e.g., forced childbirth considered a war crime by international standards). ¹²

(Table 1 continued)

Detainment/ Incarceration Based on SAAB	Prohibit correctional facilities from housing inmates in rooms, cell blocks, facilities etc. with those of the "opposite" biological sex. May involve "Bathroom Bills" for correctional facilities Prohibit the use of state or federal funding for gender affirming health care for incarcerated individuals.	IN, KS, NH, ND, TX, WA	Trans people are rapists. Protecting cis women from physical and sexual violence while incarcerated requires the exclusion of trans women from women's spaces. Gender affirming health care is not medically necessary for incarcerated trans people.	Incarcerated trans people are at substantially increased risk for harassment and physical and sexual violence by both correctional officers and other inmates, compared to the general prison population ^{14, 47, 86, 97} Common to placing trans inmates in solitary confinement to remove them from gendered spaces is cruel and inhumane, and has well-established negative psychological effects. ^{42, 53, 97} Elevated risk for mental health problems like self-harm and suicide among formerly incarcerated trans people, especially if they were denied gender affirming health care or exposed to gender-based victimization while incarcerated. ^{31, 97}
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Notes. LGBTQ, lesbian, gay, bisexual, trans, and queer; SAAB, sex assigned at birth. Reference numbers are indicated by subscript in the Reference List. Exemplar legislation appears in the Appendix.

^aWe include evidence of the biological markers of transness and queerness as a surface-level challenge to claims that transness is learned behavior, despite the problematic nature of attempts to essentialize transness as a biological phenomenon.^{8, 85}

^bBlack and Latine queer cultural community involving performance, dance, lip-syncing, and modeling.

Revocation of Parental Care

Laws intended to remove children from homes in which caregivers furnish gender affirming medical care are tantamount to legalized abduction of transgender and nonbinary children by the state. These laws assume that affirmation of trans identity and expression is a form of child abuse (e.g., FL S.B. 254, 2023; TX S.B. 1690, 2023). The assumption that the furnishing of transition-related medical care is harmful, abusive, or negligent to a child's safety, is not supported by the literature. Research demonstrates the safety, mental health, and quality-of-life benefits of social and medical transition (e.g., de Vries et al., 2014; Durwood et al., 2017; Nguyen et al., 2018; Olson et al., 2016; Rew et al., 2021; Turban et al., 2020b). Withholding access to gender affirming medical care from trans and nonbinary youth is associated with significantly elevated risk for suicide (Swan et al., 2023).

Detainment/Incarceration Based on Assigned Sex

These bills primarily prohibit correctional facilities from housing inmates in rooms, cell blocks, or other accommodations with those who were not assigned the same sex at birth. Some also ban the use of state or federal funding for gender affirming health care for incarcerated trans people. These provisions assume that trans people, particularly trans women, are a danger to other inmates (e.g., Female Prisoner Protection Act, 2023; KS S.B. 228, 2023; Preventing Pregnancy in Prison, 2023). However, research suggests that trans inmates are at drastically increased risk of harassment and physical and sexual assault, both by correctional officers and other inmates (Brömdal et al., 2019; James et al., 2016; Stotzer, 2014; Van Hout et al., 2020). Correctional staff often respond to this problem by placing trans inmates in solitary confinement (Lamble, 2012; Van Hout et al., 2020), despite the well-established negative effects of this practice (Haney, 2018). Laws that prohibit gender affirming health care for incarcerated trans people additionally assume that this health care is not medically necessary or required under the Eighth Amendment (Van Hout et al., 2020). Poor mental health outcomes among incarcerated trans people, including suicide attempt rates over 50% (Drakeford, 2018), are especially elevated following periods of solitary confinement (Van Hout et al.) and among those who were unable to access gender affirming care or experienced gender-based victimization while incarcerated (Drakeford).

Discussion

The present analysis leveraged cognitive behavioral principles to examine the foundations of current anti-trans U.S. legislation as structural-level SOGICEs. We found a network of faulty assumptions that underpin structural-level SOGICEs and reflect the misapplication of cognitive behavioral theory. By conceptualizing transness as "maladaptive" behaviors or "distorted" cognitions, the assumptions underlying anti-trans legislation imply that trans identity is not a "real" or valid embodied experience. However, if trans identities were not "real," there would be no threat to protect against and no need for these policies; thus, the existence of anti-trans legislation itself legitimizes transness.

The evidence supplied to counter the faulty assumptions of anti-trans legislation (rightmost column of Table 1) may be leveraged by CBT researchers and practitioners to combat SOGICEs at individual levels (e.g., supporting a trans or nonbinary client in identifying and challenging internalized transphobic cognitions), interpersonal levels (e.g., identifying and challenging transphobic assumptions in interactions with colleagues, supporting a trans or nonbinary client in identifying and responding to transphobic comments from family or peers), community levels (e.g., researching and disseminating evidence against transphobic assumptions), and structural levels (e.g., advising legal professionals defending the rights of trans and nonbinary individuals, providing expert testimony that undermine pseudoscientific claims that SOGICEs are evidence based, consulting on policy development that protects the rights of trans and nonbinary people).

Although these examples are a good place to start, attempts to resist anti-trans legislation that rely solely upon reacting to strategies used by proponents of SOGICEs are not sufficient, because they promote further differentiation between trans and cis people and reinforce damaging power structures. To resist anti-trans legislation, we call on CBT researchers and practitioners to reimagine how CBT may be leveraged for non-oppressive means. For example, we may reimagine opposite action strategies (Linehan) at a structural and community level to destabilize power structures maintained by social differentiation. Opposite action typically refers to behavioral responses to urges on an individual level (e.g., a person feels the urge to self-harm and instead engages in

self-care; Linehan, 2014). Instead of focusing on behaviors on an individual level, acting opposite to social differentiation may involve identifying shared needs for liberation from structural oppression, and coalition-building between trans and cis people to resist legislation that imposes surveillance and regulation.

Our analysis of the faulty assumptions underlying recent anti-trans legislation elucidates the objective of structural-level SOGICEs: to position trans people in opposition to cis people. Because differentiation occurs across social positions, implications of intersections between race and gender on the processes detailed here are significant. The expression of femininity, masculinity, and androgyny are racialized such that people of color (especially Black women) are perceived as inherently violating hegemonic gender ideals (Goff et al., 2008; Slatton & Spates, 2014). As a result, Black women (trans and cis) are at greater risk of punishment by anti-trans legislation than are White women—for example, trans sports bans may be used to punish any woman who is deemed "too masculine" or "too athletic," but these accusations are most often targeted at Black women (Karkazis & Jordan-Young, 2018). Further, Black and Brown trans women are disproportionately incarcerated and are at higher risk of victimization while incarcerated relative to non-Hispanic, White trans women (Reisner et al., 2014). As such, they are at a higher risk of harm and death as a result of laws requiring detainment based on the sex they were assigned at birth. Because Black and Brown people are at greatest risk of harm by anti-trans legislation, efforts to resist structural-level SOGICEs represent and need to center efforts to resist White supremacy.

Overall, the anti-trans legislation reviewed here is intended to consolidate power by structuring trans and queer people in opposition to cisgender, heterosexual people. The faulty assumptions underlying these laws are based on the social construction of hegemonic gender and sexuality through the vilification, surveillance, and attempted elimination of trans people. By framing transness as a maladaptive learned behavior that can and should be unlearned, the anti-trans political movement is able to enforce gender conformity and compulsory heterosexuality on all people. In this way, these laws not only harm trans people, but also serve to create restrictions on free sexual

and gender expression for cis people as well.

Addressing the harmful consequences of anti-trans legislation requires resistance to the misapplication of CBT's guiding theories and the regulation of intimacy and identity. Confronting the misapplication of these theories that underlies structural-level SOGICEs will allow researchers and practitioners to delegitimize the social differentiation these laws attempt to impose and advocate for trans and queer clients, community members, and colleagues. For trans and queer people ourselves, the faulty assumption that maintaining power requires the legislation of intimacy suggests that trans and queer embodiment, existence, and autonomy in creative gender expression is an essential weapon against tyranny and expression of freedom.

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Positionality statement: Authors include two graduate students and one clinical psychologist, trained in CBT and dedicated to the goals of trans and queer liberation, social justice, and antiracism. All authors are White and queer; two are trans and/or nonbinary.

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Webinar

OCTOBER 19

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DBT for Suicidal Adolescents: With an Emphasis on Mindfulness and Validation

— Dr. Alec L. Miller

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

Today's youth are faced with a multitude of stressors that have been exacerbated by the pandemic. The social, emotional, behavioral and academic functioning of young people have been dramatically impacted. Dr. Alec Miller and his colleagues' adaptation of Dialectical Behavior Therapy has become the only well-established evidence-based treatment for adolescents presenting with suicidal behavior along with a variety of emotional and behavioral challenges. DBT teaches youth and their caregivers a variety of acceptance-based and change-based skills to use to cope more effectively in their lives. This webinar will provide participants with an overview on DBT with adolescents as well as a deeper dive into two critical acceptance-based skills used with teens: Mindfulness skills and validation skills. Validation skills might be the most effective tool you will learn to help regulate your client's emotions (and your own).

1.5 CE credits

2023 Graduate Student Research Grant Winner and Honorable Mention

EVERY YEAR, ABCT's Research Facilitation Committee awards a Graduate Student Research Grant (GSRG) to provide financial support for a student whose research shows great innovation, creativity, and broader significance. Our 2023 Winner is Alexa Raudales, a doctoral student in the STRESS Lab at the University of Rhode Island, for her dissertation project entitled "Opioid Use and Acute Suicide Risk: The Real-Time Influence of Trauma Context." Our 2023 Honorable Mention is Mallory Cannon, a graduate student in the BRAINS lab at Auburn University for her master's thesis project entitled "Examination of Fear Extinction in Chronic Cannabis Use, Anxiety Disorders, and their Co-occurrence." We sat down with our awardees to learn more about their projects.



2023 GSRG Winner:
Alexa Raudales

Tell us about the project the GSRG is funding:

Every day, over 200 people in the United States die from opioid overdose. Opioid use co-occurs with suicide at an alarmingly high rate. The co-occurrence of opioid use and suicide is associated with a wide array of deleterious outcomes, most notably premature death. However, empirical examinations in this area continue to lag behind, with no studies explicating the longitudinal association between opioid use and acute suicide risk in real time; this information is needed to inform targeted intervention and policy. Furthermore, it remains unknown how an individualized trauma context—notably, proximal posttraumatic stress symptoms (PTSS)—may serve as a trigger for co-occurring opioid use and acute suicide risk.

The present study examines the real-time associations among opioid use, suicide risk, and PTSS among individuals in the community. Specifically, this study will use a multiphase design among trauma-exposed adults who currently use opioids and experience suicidal thoughts and behaviors. Participants will take part in 30 days of ecological momentary assessment, a method which involves repeated sam-

pling of behavior in real time as it unfolds in natural settings. Information from this study could be mobilized via novel treatments for comorbid opioid use and suicide risk (e.g., just-in-time interventions) that provide evidence-based support at the right time (e.g., trauma context).

What does getting this award mean to you?

To me, this award marks a critical next step for understanding and intervening on opioid use, suicide, and trauma. I see this project as compassion and hope for those directly impacted by this research, including those from marginalized communities. Funding for this project affirms the importance of the work towards refining understanding, assessment, prevention, and intervention efforts for co-occurring opioid use and suicidality following the experience of trauma. I am grateful for the opportunity that this award provides for me to pursue my long-standing research interests and further hone my research and clinical skills.

How has ABCT contributed to your development as a researcher and clinician?

I have attended ABCT conferences as a member every year since 2018, which was prior to my acceptance into a doctoral program. In fact, ABCT was one of the first conferences that I attended. These early experiences opened the door for me to connect with a larger scientific community, helped me to develop foundational skills presenting my research, and fostered a sense of my own belonging in the field. Throughout the years, I have benefited from ABCT's commitment to evidence-based treatment; rigorous and cutting-edge research; justice, equity, diversity, and inclusivity; and mentorship. I have gained exposure to innovative research methodologies, received feedback on my own project ideas, formed collaborations with other ABCT members, kept up to date with clinical best practices and policies, gained exposure to diverse perspectives in the field, and so on. Funding from this award allows me the training and experiences to further develop my own line of research and inform my clinical work. I am so grate-

ful for the continued positive impact of ABCT on my own development as a researcher and clinician.

How did you first become involved in research? What was this first research experience like?

I became involved in research as an undergraduate at Case Western Reserve University with Dr. Norah Feeny and a summer intern at the University of South Florida. These experiences provided me with a rigorous foundation in scientific methodology and helped me to pursue my interests in understanding mechanisms underlying mental health. I connected with excellent mentors and accumulated a wide range of research skills in areas such as data entry, clinical interviewing, participant recruitment, and data analysis. From early on, research has been an exciting opportunity for me to explore my scientific interests and contribute to a field aimed at enhancing individuals' mental well-being.

What does an average day or week look like for you?

One of my favorite aspects of my day-to-day work in this field is that it is very dynamic. Being a clinical psychology doctoral student has entailed a shifting balance of coursework; clinical work across a variety of settings; contributing to research projects such as within my lab or collaborations; and pursuing my own research interests such as leading a manuscript, teaching, mentorship, and activism. Some days I am in the lab running analyses, attending to emails, and mentoring undergraduates. Other days I am commuting to teach or attend classes, participate in or lead meetings or clinical supervision, or conduct one-on-one or group therapy sessions with individuals of diverse backgrounds. I also work from home or cafés when possible. The hours shift as well, sometimes beginning at 8 a.m., whereas other days I have commitments for the afternoon and evening. Regardless, the start of each workday begins with me checking my Google calendar and prioritizing my tasks.

What drew you to this particular research question?

Large-scale efforts have been made to decrease the high prevalence and substantial impact of both opioid use and suicide. Yet, it has been clear to me that considerable work is still urgently needed, and that I could contribute in this regard. Building on my prior work examining trauma-related outcomes, I became interested in

the frequent co-occurrence that I was observing between posttraumatic stress symptoms and both opioid use and suicidality. This population also appeared to be particularly high risk, evidenced by associations with worse outcomes including more severe opioid use and psychosocial problems. Given the gap of research in this area, I was passionate about shedding light on opioid use and suicide risk that may occur following the experience of trauma. I became motivated in understanding how opioid use and suicidality may directly impact each other, or if this comorbidity could be better explained by shared underlying factors. Moreover, I wanted to better understand the impact of fluctuations in posttraumatic stress symptoms on this relationship, particularly in individuals' daily lived experiences.

If you weren't pursuing a career in psychology, what would you be doing?

While I am certainly not qualified to do so presently, in another lifetime, I might have become a musician if I did not pursue a career in psychology. I really enjoy listening to music, playing the acoustic guitar, and creative writing. I could see myself enjoying studying music, learning how to play and master various instruments, and working with wonderful musicians. Perhaps there are key parallels between music and psychology, such as exploring the human condition and advocating for improved mental health. I think both fields are admirable and make a positive impact on the lives of others.



**2023 GSRG
Honorable Mention:
Mallory Cannon**

Tell us about the project the GSRG is honoring:

The project GSRG is honoring is an experimental study looking at the relationship between chronic cannabis use, anxiety, and fear extinction. Rates of regular cannabis use have increased in the United States over the past two decades and as rates increase, more individuals are using cannabis to improve mental health-related symptoms, including anxiety. Little is known about the relationship between anxiety and cannabis use. However, cannabis use has been linked to worse mental health outcomes and reduced therapy effectiveness. Exposure therapy, a

front-line treatment for anxiety disorders, works in part through fear extinction (i.e., the lessening of a conditioned fear response through repeated exposure to the conditioned stimuli in absence of the unconditioned aversive stimuli). The main active ingredient of cannabis is Δ^9 -tetrahydrocannabinol (Δ^9 -THC). Acute THC intoxication has been shown to improve between- and within-fear extinction, while chronic THC intoxication has been found to impair fear extinction and discrimination. As such, the current project aims to determine if chronic cannabis use (i.e., chronic THC intoxication) has a negative impact on fear discrimination, extinction learning, and extinction retention in the anxiety disorder population. Eighty participants will be recruited from a southeastern university and the surrounding community. Participants will be from one of four groups (i.e., clinically significant anxiety with chronic cannabis use, clinically significant anxiety and cannabis-naïve, chronic cannabis users without clinically significant anxiety, or cannabis-naïve healthy controls) and will complete a 2-day fear differential conditioning paradigm. To our knowledge, this is the first experimental study to look at the relationship between anxiety disorders, chronic cannabis use, and fear discrimination/extinction.

What does getting this honorable mention mean to you?

I am honored to have been selected as an honorable mention for the Graduate Student Research Grant. It means a lot to me to be recognized for my research and to have the opportunity to share my work on a larger platform.

How has ABCT contributed to your development as a researcher and clinician?

ABCT has inspired me to be a better researcher and clinician by showcasing the best of psychological research and clinical practice. At every conference, I walk away with a new appreciation for clinical work and a breadth of new research ideas. ABCT has also helped foster my professional development by providing educational workshops where I have been able to hone my skills and interact with other young professionals in the field. The experiences I have had are invaluable and I cannot wait to continue to learn through ABCT.

Please join us in congratulating these fabulous graduate student researchers! ■

Visit ABCT's Featured Labs



[https://www.abct.org/
featured-labs/](https://www.abct.org/featured-labs/)

- Schiller Lab for Women's Affective Neuroscience
- Sexuality, Health, and Gender Lab
- EMPOWER Lab (Engaging Minorities in Prevention, Outreach, Wellness, Education, & Research)
- Knouse Lab
- Research Enhancing Access to Culturally Informed Mental Health Services Laboratory
- The Child and Adolescent Research in Emotion Lab
- ADDRESS Mental Health Laboratory
- Advancing Care through Community Engagement, Services, and Outcome Research Laboratory
- The Mindful Way to Well-Being Lab
- The Anxiety and Stress Lab
- The Global Mental Health and Addiction Program
- Culture, Affect, Relationships Lab
- Anxiety, Cognition, and Emotion Lab
- Suicide Prevention and Risk Behaviors Lab
- HIV Prevention Lab
- Mood and Personality Studies Lab

... and many more!

*Explore ABCT's Featured Labs
and learn more about their
specific and varied investigations,
trainees' research interests, and
how ABCT helps through
networking and mentorship
opportunities.*



Getting to Know Seattle

Tammy Schuler and Jamie Keyes, *Local Arrangements Committee*

THE LOCAL ARRANGEMENTS Committee for ABCT is thrilled to welcome you to the Hyatt Regency Seattle for the 57th Annual Convention this November. Seattle is a vibrant and picturesque city with stunning natural surroundings and a bustling urban atmosphere. Known as the "Emerald City," Seattle boasts lush greenery, sparkling waters, and a backdrop of majestic mountains, creating a unique and breathtaking landscape. A strong sense of community and social consciousness is evident in Seattle's progressive and inclusive atmosphere and residents take pride in their commitment to environmental sustainability and eco-friendly initiatives. Overall, Seattle offers an unparalleled experience for residents and visitors alike.

Although most of your time may be spent attending sessions at the convention, we hope you will carve out time to experience some of Seattle's landscape, attractions, and restaurants. The convention itself takes place in downtown Seattle, and while many of our suggestions will be for this general area, we will also make some suggestions for attractions in surrounding areas, provided below.

Statement Regarding Indigenous Land

ABCT acknowledges the Coast Salish peoples of the land on which the conference will take place, the land which touches the shared waters of all tribes and bands within the Duwamish, Puyallup, Suquamish, Tulalip and Muckleshoot nations.

COVID-19

Please practice COVID-19 precautions to allow the ABCT convention to be as inclusive of an experience for everyone, including those who are immunocompromised or otherwise at high risk of adverse outcomes from COVID-19. If you need a COVID-19 test for any reason, please visit: <https://kingcounty.gov/depts/health/covid-19/testing.aspx#sites> to locate testing sites in King County. Many Seattleites still mask, and it is unusual to be criticized for masking in this general area.

Kids

If you are planning on bringing your kids to Seattle this year, check out the "Kid-Friendly" section (under Attractions). We're also including links to two websites that offer lots of suggestions as well, though not all are November-weather-friendly: <https://sugarspiceandglitter.com/101-things-to-do-in-seattle-with-kids/> and <https://secretseattle.co/things-to-do-kids-seattle/>.

ABCT is offering childcare during the convention as well (free of charge)! Details are available at: <https://www.abct.org/2023-convention/child-care/>.

Attractions

Outdoors

Seattle's residents are known for their love of the outdoors. With a moderate climate, they embrace outdoor activities year-round. From hiking in the nearby Cascade and Olympic Mountain ranges to sailing on Puget Sound or kayaking on Lake Union, there are endless opportunities to enjoy nature in and around the city. It may have cooled down by November (highs and lows in the 40s), but there are still plenty of outdoor options to choose from, weather permitting. Remember to dress in layers and be prepared for potential rain during your outdoor adventures in November. Embrace the cozy Pacific Northwest vibe and enjoy the beauty of Seattle's outdoors, even in the transition to the rainy season.

Fall Foliage Walks: November brings beautiful autumn colors to the city's parks and surrounding areas. Take a leisurely stroll through Discovery Park, Green Lake Park, or the Washington Park Arboretum to enjoy the vibrant hues of red, orange, and yellow leaves.

Hiking: While some higher-elevation trails may have snow, many lower-elevation hiking trails remain accessible in November. Popular options include Bridle Trails and Volunteer Park, St. Edward State Park, and Tiger Mountain State Forest. Just be sure to check weather conditions and trail status before heading out.

Wine Tasting: The nearby Woodinville Wine Country is a great place to enjoy wine

tasting, especially if the weather gets a bit chilly. Explore the wineries and tasting rooms and savor some local wines with friends or loved ones.

Whale Watching: November is an excellent time for whale watching in the waters surrounding Seattle. Gray whales and transient orca whales can often be spotted during their migration. There are various whale-watching tours available from Seattle and nearby areas.

Urban Parks: Seattle is home to many beautiful urban parks, and they can be enjoyable even in November. Pack a picnic, visit Gas Works Park, or take a relaxing stroll through Volunteer Park, which features the iconic Volunteer Park Conservatory (or its Lakeview Cemetery where Seattle's founders and Bruce Lee are buried).

Waterfront Walks: Enjoy a stroll along Seattle's waterfront, where you can take in the fresh sea breeze and scenic views of Puget Sound. Alki Beach and Golden Gardens Park are excellent choices for beachfront walks.

Seattle Japanese Garden: Located in the Washington Park Arboretum, the Japanese Garden offers a tranquil and serene experience with its stunning autumn foliage and calming landscapes.

Bike Riding: If the weather permits, renting a bike and exploring the Burke-Gilman Trail or the Sammamish River Trail can be a fun and active way to experience the city and its surroundings.

Beaches: If you're not deterred by the cooler weather, consider Alki Beach or Discovery Park. Beachcombing can also be rewarding during low tide at places like Carkeek Park or Lincoln Park.

Eco-Friendly

Seattle is known for its eco-friendly and environmentally conscious culture, and there are plenty of eco-friendly activities you can enjoy in November. Here are some options to consider:

Urban Farm Visits: Several urban farms and community gardens in Seattle are still active in November. You can visit places like Tilth Alliance's Rainier Beach Urban Farm & Wetlands, Marra Farm, or Alleycat Acres to learn about sustainable farming practices and even volunteer to help with seasonal tasks.

Beach Cleanups: Participate in beach cleanups organized by local environmental groups. Help keep Seattle's shorelines clean and protect marine life from pollution. Organizations like Puget Soundkeeper Alliance often host regular cleanup events.

Sustainable Shopping: Explore local markets and shops that focus on sustainability and eco-friendly products. Visit farmers' markets, co-ops, or stores specializing in eco-friendly goods and support businesses that prioritize environmentally responsible practices. Some sustainable businesses in the Seattle area are listed here: https://seattlegood.org/shop-sustainably/?gclid=EAIaIQobChMIj8Guq_nAgAMVYCKtBh2qQQI5EAAYAiAAEgIX0vD_BwE.

Don't forget to purchase an "Orca Pass" before you leave home to ride all the bus and light rail options that reduce our carbon footprint.

Kid-Friendly

Visit Museums: Seattle has numerous family-friendly museums, such as the Pacific Science Center, Seattle Children's Museum, and the Museum of Pop Culture (MoPOP). These museums offer interactive exhibits and activities that will keep kids entertained and educated.

Seattle Aquarium: Spend a day exploring the underwater world at the Seattle Aquarium. Kids can observe marine creatures, learn about ocean conservation, and even touch some marine animals in the tide pools.

Woodland Park Zoo: Despite the cooler weather, the Woodland Park Zoo remains open in November. Kids can see a wide range of animals and learn about wildlife conservation efforts.

Explore Pike Place Market: Take a stroll through Pike Place Market, where kids can enjoy watching fish being thrown at the fish market, sample local treats, and experience the vibrant atmosphere.

Seattle Public Library: Visit one of Seattle's many public libraries for story times, craft activities, and a wide selection of children's books. Check the library's event calendar for special activities.

Indoor Play Spaces: Seattle has several indoor play spaces and trampoline parks where kids can burn off energy and have fun, even on rainy days.

Seattle Center: Head to the Seattle Center, where kids can enjoy the Children's Museum, ride the historic Monorail, and have a blast at the Artists at Play playground.

Outdoor Adventures: If the weather permits, take advantage of the scenic outdoors by going for a family hike in local parks or exploring nearby beaches. Just be sure to dress warmly and bring rain gear. Don't forget the iconic ferry boats which can take you places in under an hour.

Family-Friendly Events: Keep an eye out for family-oriented events and festivals happening in the city during November. These can include holiday-themed events, cultural celebrations, and more.

Another idea is the **Seattle City Pass**, which provides discount entry to many of these locations, including the Space Needle; Aquarium; Zoo; Chihuly garden and glass and Argosy Cruises. (<https://www.citypass.com/seattle#buy>)

For our "young at heart" group, do check out the entertainment in Seattle, origins of Jimmy Hendrix; Nirvana; and many more. One current entertainment guide is "What to Do in Seattle" (<https://do206.com/>)

Students

For students, we recommend visiting <https://theticket.seattletimes.com/neighborhoods/where-to-get-student-discounts-in-seattle/> to find attractions with student discounts. It's also on the Link Light Rail to stop at University of Washington and tour the campus, seeing where some of our history makers (e.g., Marsha Linehan) wrote their research papers.

Black-Owned Businesses, Restaurants, and More

On this page you'll find an array of ways you can join in supporting Black-Owned businesses and community members. This page is updated regularly, so please check back before November: <https://seattlegood.org/support-black-communities/>.

Another amazing place to see that is near the convention hotel, owned by the Black Farmers Collective, is **Yes Farm**. At Yes Farm, the Collective is "developing out 1.5 acres of space along I-5 at Yesler Terrace for community building, educational programming, and growing our farm co-op." <https://www.blackfarmerscollective.com/yes-farm>

LGBTQIA+ Owned Businesses, Restaurants, and More

This page lists LGBTQIA+-owned business and restaurants in the Seattle area. As the page says, it is more crucial than ever to support the LGBTQ+ community, and here are a few ways to do so: <https://www.seattlemet.com/style-and-shopping/lgbtq-owned-businesses>.

Restaurants

A full listing of some of local favorite restaurants, including names, brief descriptions, and locations is available at:

<https://www.seattlemet.com/eat-and-drink/seattle-s-100-best-restaurants-right-now>

Microbreweries and Distilleries

Also, don't forget that Seattle has been named one of the best sources of microbrew pubs in the United States. Check out local offerings: www.travelandleisure.com/food-drink/beer/best-breweries-in-seattle-and <https://wanderlog.com/list/geoCategory/127012/best-distilleries-in-seattle>

Transportation to and From the Conference and in and Around Seattle

SeaTac to Downtown Seattle

Seattle's transportation infrastructure includes an extensive bus system, light rail, and the famous Washington State Ferries, connecting the city to nearby islands and the mainland.

Getting from SeaTac (Seattle-Tacoma International Airport) to the conference hotel in downtown Seattle is relatively straightforward, with several public transportation options available to suit different preferences and budgets. Here are the main options:

Link Light Rail: The Link Light Rail is a popular and convenient mode of transportation connecting SeaTac Airport to downtown Seattle. The airport station is located directly above the airport's parking garage. Trains run frequently, and the journey to downtown takes approximately 30 minutes. The Link Light Rail stops at several key downtown locations, including Westlake Station and University Street Station, making it easy to access various attractions and hotels.

Sound Transit Express Bus: Sound Transit operates express buses that connect SeaTac Airport to various parts of downtown Seattle and nearby cities (Everett & Tacoma). The bus stops are located on the lower drive outside the baggage claim area. While the travel time may vary depending on traffic, these buses are another reliable option for reaching downtown.

Shuttle Services: Several shuttle companies provide transportation between SeaTac Airport and downtown Seattle hotels. Shuttle services offer door-to-door service and can be a convenient option for travelers with heavy luggage or those seeking direct transportation to their accommodations. www.shuttleexpress.com/seattle-seatac-airport-transportation

Taxis and Rideshare Services: Taxis and rideshare services like Uber and Lyft are readily available at SeaTac Airport. You can find designated pick-up areas on the third floor of the parking garage outside of baggage claim. The travel time to downtown Seattle depends on traffic conditions, but it typically takes around 20 to 30 minutes.

Rental Cars: If you prefer the flexibility of driving yourself, various car rental agencies have counters at SeaTac Airport. Renting a car allows you to explore not only downtown Seattle but also the surrounding areas at your own pace.

The iconic Monorail built during the Seattle World's Fair (1962) runs between Westlake Center and the Seattle Center (Orca Pass doesn't cover this). In its 2½ mile run, you can see vistas of the city and sound and get to the Seattle Center where many interesting events and restaurants are located.

Overall, the Link Light Rail is often the most popular and efficient choice for getting from SeaTac Airport to downtown Seattle due to its frequency, speed, and cost-effectiveness. However, all of these public transportation options offer viable ways to reach the heart of the city, allowing you to start your Seattle adventure with ease.

Portland to Seattle Public Transportation Options

Traveling from Portland to Seattle, both cities with well-established transportation systems, provides several public transportation options for a convenient and comfortable journey. Here are the main choices:

Amtrak Cascades: Amtrak operates the Cascades train service, which connects Portland's Union Station to Seattle's King Street Station. The Amtrak Cascades offers a scenic ride through the Pacific Northwest, passing by lush landscapes, rivers, and beautiful vistas. The journey takes approximately 3.5 to 4 hours, depending on the train schedule and stops.

There are multiple options for buses, including: (a) *FlixBus*: FlixBus is a budget-friendly bus with a couple of options daily between Portland and Seattle (University of Washington and the downtown Seattle area); (b) *Greyhound*: Greyhound, a well-known long-distance bus company, also provides service between Portland and Seattle. Similar to FlixBus, Greyhound offers several daily departures and takes around 3 to 4 hours to complete the journey, depending on the route and traffic

conditions; (c) *Megabus*: Megabus is another budget-friendly option for traveling between Portland and Seattle. Their coaches offer amenities like Wi-Fi and power outlets, and the travel time is similar to that of other bus services, averaging around 3 to 3.5 hours.

Vancouver, BC, to Seattle Public Transportation Options

Traveling from Vancouver, BC, to Seattle offers several public transportation options, making it convenient for visitors to explore both cities. Be sure to double-check availability far in advance as some transportation options were closed/discontinued during parts of the COVID-19 pandemic. Here are the main choices:

Amtrak Cascades: Amtrak Cascades operates a train service that connects Vancouver, BC, and Seattle. The train departs from Vancouver's Pacific Central Station and arrives at Seattle's King Street Station. The Amtrak Cascades route provides passengers with scenic views of the Pacific Northwest, passing through lush forests and alongside the coastline. The journey takes approximately 4.5 to 5 hours, depending on border crossing and train schedules.

There are multiple options for buses, including: (a) *FlixBus*: FlixBus is a budget-friendly bus with a couple of options daily between Vancouver and Seattle (University of Washington and the downtown Seattle area); (b) *Greyhound*: Greyhound operates buses between Vancouver, BC, and Seattle, providing another option for intercity travel. The buses depart from Pacific Central Station in Vancouver and arrive at King Street Station in Seattle. Greyhound's travel time is similar to FlixBus, ranging from 4.5 to 5.5 hours, depending on traffic and customs procedures; (c) *Quick Shuttle*: Quick Shuttle is a private shuttle service that offers direct transportation between Vancouver, BC, and downtown Seattle. The shuttle departs from various locations in Vancouver, including downtown and the airport, and drops off passengers in Seattle's downtown area. The travel time is typically around 4 to 4.5 hours, depending on traffic and border crossing.

Water Transportation

Getting to areas outside of Seattle, including the surrounding Puget Sound area, may require different transportation options. Here are some common ways to access nearby islands and other destinations:

Washington State Ferries: The Washington State Ferries operate a comprehensive ferry system connecting Seattle to several islands and peninsulas in the Puget Sound region. The ferries depart from various terminals in Seattle, including the Colman Dock (downtown) and the Fauntleroy Terminal (West Seattle). Popular island destinations accessible by ferry include Bainbridge Island, Vashon Island, and the San Juan Islands.

King County Water Taxis: King County Water Taxis offer a quick and scenic way to reach some nearby destinations. The West Seattle Water Taxi operates between downtown Seattle (Pier 50) and Seacrest Park in West Seattle. There's also a water taxi service between downtown Seattle and Vashon Island.

Public Transit: Some islands can be accessed via public transit, including buses and light rail. For example, you can take a combination of buses and the Kitsap Fast Ferry to reach the Bainbridge Island ferry terminal. However, check the schedules; these options do not run as frequently as city buses.

Seaplane Services: Seaplane companies in Seattle offer scenic flights and transportation to some remote islands in the Puget Sound region. This option provides a unique experience and allows you to see the stunning landscapes from the air.

Before planning your trip, check the ferry schedules, availability, and other transportation options for the specific destination you want to visit. Some islands have limited services, especially during the off-season, so it's a good idea to plan ahead and make reservations if needed. Keep in mind that transportation schedules may be subject to change (and some routes were closed during parts of the COVID-19 pandemic), be sure to verify the latest information before your trip.

Conclusion

Overall, Seattle is a city that effortlessly blends natural beauty, technology, culture, and a love for the outdoors. Whether you're strolling along the waterfront, enjoying a cup of coffee in one of its many coffee shops, feeding the seagulls at a downtown dock, or immersing yourself in its lively cultural scene, this enchanting city is sure to leave a lasting impression on you. ■



Call *for* Award Nominations

to be presented at the 58th Annual Convention in Philadelphia

The ABCT Awards and Recognition Committee is pleased to announce the 2024 awards program. Nominations are requested in all categories listed below, including those that might appeal to clinicians, researchers, trainers, and students. Our ABCT community is doing meaningful work, and we encourage you to consider yourself and to nominate a student or a colleague for an award. ABCT values and has committed to supporting individuals from a diverse range of backgrounds with these awards. The Committee also encourages those who have submitted in a prior year and not yet received an award to reapply. If you decide to reapply, please let the Committee Chair know whether you'd like to use your prior submission, or make updates. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Stefan G. Hofmann was our most recent recipient. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line.

► *Nomination deadline:* March 1, 2024

Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Researcher" in the subject line.

► *Nomination deadline:* March 1, 2024.

Outstanding Mentor

Eligible candidates for this award are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Mentor" in your subject heading.

► *Nomination deadline:* March 1, 2024

Sobell Innovative Addictions Research Award

The award is given to an individual who, through the performance of one or more research studies, has developed a novel and very innovative (1) program of research or (2) assessment or analytic tool or method that advances the understanding and/or treatment of addictions. The emphasis is on behavioral and/or cognitive research or research methods that have yielded exceptional breakthroughs in knowledge. The recipient receives \$1500 and a plaque. Candidates must be current members of ABCT and are eligible for the award regardless of career stage. Candidates may self-nominate or be nominated by others who need not be members of ABCT. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Sobell Research Award" in the subject line.

► *Nomination deadline:* March 1, 2024

The Francis C. Sumner Excellence Award

The Francis Cecil Sumner Excellence Award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the “Father of Black Psychology,” he is recognized as an American leader in education reform. This award can be given on an annual basis, awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree. Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and professional members of ABCT at the time of the nomination. The award is intended to acknowledge and promote the excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional within 10 years of award of the PhD/PsyD/EdD/ScD/MD who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. The recipient will receive \$1,000 and a certificate. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include “Francis C. Sumner Award” in the subject line.

► *Nomination deadline:* March 1, 2024

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

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT’s mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano’s core commitments. This award includes a cash prize of \$1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 10 years of receiving his/her the doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and “Albano Award” in the subject line.

► *Nomination deadline:* March 1, 2024

Charles Silverstein Lifetime Achievement Award in Social Justice

Members of the Association are encouraged to nominate individuals who have made significant and sustained lifetime contributions to advancing social justice initiatives over many years. This award is given at the discretion of the Board of Directors and is primarily designed to recognize the critical, and often underrecognized, contributions from cognitive and/or behavior therapy (CBT) grassroots activists who are from and primarily work with minoritized and oppressed communities. In very rare instances, the award may be given to allies from the CBT field if nominations arise from minoritized members and their perspective is centered. A key element of this award is recognition that grassroots CBT activists typically have less access to power to directly change systems secondary to structural injustice and oppression. Thus, contributions to advancing social justice by grassroots CBT activists may look different than those of allies, even though grassroots activist contributions are no less important and typically confer increased risk for the individual. Eligible candidates for this award do not need to be a current ABCT member but must have a strong historic connection to the CBT field. ABCT membership at some point in the candidate’s career is desirable. Please use the nomination form (available at www.abct.org/awards) and email nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and “Silverstein Award” in the subject line.

► *Nomination deadline:* March 1, 2024

President’s New Researcher Award

ABCT’s 2023-24 President, Sandra Pimentel, Ph.D., invites submissions for the 46th Annual President’s New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent, innovative work published in high-impact journals; and promise of contributing to cognitive and behavioral theory to advance the field. Scholars who trained in smaller labs or who work in less research-intensive environments are also encouraged to apply, as the quality and potential impact of one’s work, not the number of publications, will be the focus. Requirements: must have had terminal degree (Ph.D., Psy.D., M.D., etc.) for at least 1

year but no longer than 5 years; must submit a recent peer-reviewed, empirical article for which they are the first author; 2 letters of recommendation must be included; the author's CV, letters of support, and paper must be submitted in electronic form. Self-nominations are accepted and applicants from traditionally underrepresented backgrounds, or whose work emphasizes community engagement or advances our understanding of behavioral health disparities, are particularly encouraged to apply. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org <<mailto:PNRAward@abct.org>>. Include candidate's last name and "President's New Researcher" in the subject line.

► *Nomination deadline:* March 1, 2024

Student Dissertation Awards

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

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

► *Nomination deadline:* March 1, 2024

Distinguished Friend to Behavior Therapy

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

► *Nomination deadline:* March 1, 2024

Outstanding Service to ABCT

This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form (available at www.abct.org/awards). Email the completed form and any supporting materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Service" in the subject line.

► *Nomination deadline:* March 1, 2024

ABCT FORUMS

Connect with like-minded professionals around the globe

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

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

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

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

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

ABCT's 58th Annual Convention | Philadelphia | November 14–17, 2024

Opening Our Doors: Inspiring Community Engagement, Advocacy, and Innovation to Advance CBT

PROGRAM CHAIR: Muniya Khanna, Ph.D.

ASSOCIATE PROGRAM CHAIRS: Abby Bailin, Ph.D.; Maria Alba, Ph.D.

ABCT PRESIDENT: Sandra S. Pimentel, Ph.D.

The 2024 Annual Convention theme will showcase the latest efforts in community engagement, advocacy, and innovation designed to advance CBT and prepare us to meet the demands of the future. Like our host city of Philadelphia, ABCT is steeped in a rich history. Our history is of advancing cognitive and behavioral science—it too a revolution of its time. We work to honor this history, acknowledging its difficult lessons, and striving to do better today and in the days ahead. We aim to open our doors for individuals (you!) to join us more readily, and so that we may step out into the communities we serve with science and humility. You are cordially invited to present, connect, reconnect, learn, relearn, contribute, inspire, challenge, eat, dance, and even run the iconic Rocky Steps! While all fabulous submissions will be considered, we are particularly excited by those featuring:

Community Engagement

We all are part of varied personal, professional, and intersecting communities. How does community involvement inform your CBT work? How are you bringing our best science, clinical care, and teaching into the community and how are community partnership efforts bettering our science, clinical care, and teaching? Tell us about:

- Research incorporating community members as equal partners to facilitate sustainable change.
- Clinician efforts to serve the needs of the communities in which you practice.
- Interventions for advancing behavioral health, community resilience, and public health.

Advocacy

Mental health is a human right. We stand on the shoulders of so many who have advanced our science and our reach. Scientists. Practitioners. Educators. Advocates. Tell us about your advocacy work, specifically, efforts towards:

- Utilizing and expanding CBT to advocate for individuals facing oppression, including methods that integrate social, political, and economic factors into CBT to pursue social justice.
- Promoting equity and diversity in CBT practice and research, including ways to surmount barriers to treatment and educational access.
- Addressing the unique experiences of our most vulnerable and historically marginalized.
- Improving policies that promote mental health and dismantling those that harm it.

Innovation

As the philosopher and Yankee legend, Yogi Berra, said: “The future ain’t what it used to be.” With so many technological advances (e.g., Virtual/Augmented Reality, Artificial Intelligence, digital platforms), we want to hear about how you are investigating these vast possibilities as well as the work of those taking a critical look at ethical, legal, and clinical considerations. As the next sentence written by ChatGPT notes: “AI has the potential to revolutionize mental health care by providing innovative tools and insights, but it must be implemented with care to prioritize patient privacy, human connection, and avoid exacerbating existing disparities in access and treatment.” Yes, that! We are especially interested in:

- Scientific advances and innovative delivery models to increase scale and sustainability of CBT interventions, particularly in underresourced and historically excluded communities.
- Strategies to promote population understanding and awareness of CBT to wider audiences.
- Creative ways to teach and train future generations of scientist-practitioners.

Speaking of future generations, students, and people doing cool things—this message is for YOU: We need your vitality and perspective. This conference—this organization—is for you! We are open to novel submission formats or events to enhance the experience of community at the conference. We would love suggestions for ways to give back to the Philadelphia community hosting us.

We hope to see you in Philly. We hope to hear from you anytime. Our doors are open.

—Sandy, Muniya, Abby, and Maria

*Opening Our Doors: Inspiring Community
Engagement, Advocacy, and Innovation to
Advance CBT*

Call for Continuing Education Ticketed Sessions

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

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

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

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

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

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

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

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

Submission deadline: February 7, 2024 3:00 a.m. EST

Submissions will be accepted through the online submission portal, which will open after January 1, 2024. Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on “Convention and Continuing Education.”

the Behavior Therapist
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FACT SHEETS

Treating Race-Based Traumatic Stress

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

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