

# the Behavior Therapist

## Contents

**Jill Ehrenreich-May**

Where Does CBT Go From Here? • 313

**Richard LeBeau**

Message From the Editor • 316

special issue

## Harms

Caused by the Misapplication  
of Cognitive Behavioral Therapies  
(Part 2)

**Guest Editors:** Alexandria Miller  
Ilana Seager van Dyk

**Alexandria Miller and Ilana Seager van Dyk**

Introduction to the Special Issue: Harms Caused by the Misapplication  
of CBT (Part 2) • 318

**Broderick Sawyer**

Liberated Cognitive Behavioral Therapy: Liberating CBT From the  
Cognitive Distortions of White Western European Culture • 320

**Emily B. H. Treichler and Nev Jones**

Harm in Psychological Interventions for People With Psychosis:  
The Twin Arms of Disempowerment and Discrimination • 327

**Ilana Seager van Dyk**

The "A" Is Not for Ally: The Continued Pathologization of Asexual  
People in Modern Mental Health Practice • 337

**Camila Tirado, Isis Garcia-Rodriguez, Geovani Munoz, Oswaldo Moreno**  
Cognitive Behavioral Therapy for Latine Immigrants: Implications for  
Reducing Harm and Promoting Change • 343

**Tori Moore and Madeline Brodt**

When Healers Have Harmed: Towards Culturally Responsive CBT  
With ME/CFS Patients • 347

**Natasha A. Tonge**

Rethinking Retractions: Towards a More Socially Responsible  
Clinical Science • 354

**Lorenzo Lorenzo-Luaces and Craig Rodriguez-Seijas**

The ABC(T)s of an Apology: When Allyship Breeds Animosity • 360

[Contents continued on p. 314]

## PRESIDENT'S MESSAGE



## Where Does CBT Go From Here?

Jill Ehrenreich-May,  
University of Miami

IN OCTOBER 2023, I was proud to represent ABCCT at the American Psychological Association's Population Health Science Summit. A central motivation behind this gathering of leaders across industry, research, clinical practice, public policy, and scientific funding is the ongoing mental health crisis among youth and adults, transposed against the significant shortage of therapy providers (e.g., there are only ~110,000 licensed psychologists in the United States). We know that an amazing array of high-quality evidence-based psychotherapies, including CBT and related behavior therapies, exist, but largely operate at the individual (and sometimes family) level, with relatively less research investigating opportunities for prevention, early intervention, or widespread implementation using these effective treatment tools. The APA Population Health Science Summit aimed to address these issues through collaborative thought and action. In this issue of *the Behavior Therapist*, Drs. Ilana Seager van Dyk and Alexandria Miller present the second part of a special issue on Harms Caused by the Misapplication of Cognitive Behavioral Therapies. The two issues on this topic stand as a call to action to reconsider the underlying assumptions and impacts of CBT as they relate to both minoritized persons and potentially oppressive systems.

So, if CBT and related interventions do not reach the vast majority of youth and adults in need, and can present some risk of harm to minoritized persons when not thoughtfully

[continued on p. 315]

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## Contents (continued)

### At ABCT

Fellows: Call for Applications • 367

### Awards and Recognition

Call for Award Nominations • 368

Award Recipients, 2023 • 372

### Convention 2024

Call for CE Ticketed Sessions • 375

## INSTRUCTIONS for AUTHORS

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

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

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

adapted, how do we move forward as a field of clinical scientists and providers that study CBT? How do we build on the dramatic potential for alleviation of suffering inherent in CBT and related approaches, while simultaneously minimizing potential for harm and realigning CBT-related research priorities to promote population-level impact? In my first presidential column in *the Behavior Therapist* (Ehrenreich-May, 2023), I remarked that failure to carefully attend to such flaws in our CBT-related models puts such work at risk of becoming less relevant over time. Thus, as I complete my term as ABCT President, I feel motivated to circle back to that concern and share five brief reflections on next steps that we may wish to consider as an organization and individuals, if we wish to see the positive impact of CBT expand.

### 1. Collaboration Is Key

Population-level or systemic applications of evidence-based change principles to larger groups of youth and adults must leverage collaborations with scientists in related domains, such as public health, business, nursing, computer science, and data science, among others. The field of psychology, in particular, tends to reify its own methods and focus on intrapersonal causes of psychopathology, rather than reconsider our approaches and add partnerships that might result in greater impact on a systemic level. To move forward quickly and fully address the barriers to implementation that CBT faces, we must partner with those that bring additional expertise to the table.

### 2. Cultural Competency Cannot Be an Afterthought in Training

If you are involved with training new clinicians, ask yourself how you are advancing their cultural competency in delivering CBT. Does your faculty or staff have this competency themselves? If they do not, what requirements are you holding forth to ensure that such training occurs appropriately? As described by Treichler and Jones (this issue; 2023), one potential source of the types of harm described in this issue is the historic lack of expertise in our field regarding how to train others to provide CBT in a culturally competent manner, along with the lack of diversity within training spaces to help ensure that expertise exists to understand how to adjust or change our CBT models to fit the needs of minoritized populations. This remains an elusive goal in many training environments and must be improved in

order to minimize future harms of CBT and related approaches.

### 3. Mechanisms Matter

As the author of the *Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents* (UP-C and UP-A; Ehrenreich-May, et al., 2017), it may seem rather rich of me to say that whole CBT packages are a barrier to dissemination. But, I am going to say it anyway. Whole CBT packages are a barrier to dissemination. Only a very slight percentage of the youth and adults lucky enough to receive face-to-face psychotherapy will receive a “whole manual” approach. We are fabulous as a field at writing these CBT-related manuals and workbooks, but what is actually disseminable on a broader, systemic level are the brief, mechanistic elements and single techniques within these CBT and related approaches, particularly when conveyed vividly, through a variety of delivery methods, and in a shorter amount of time.

### 4. People Drive Changes in Technology

An enormous healthcare sector has developed over the last several years to deliver CBT and related principles via technology, whether that be through apps, virtual reality, chats, the internet, artificial intelligence, or other software innovations. Many of our ABCT members have increasingly found a home in these industries and technology surely poses much promise for delivering CBT on that population level that eludes us as individual providers. However, those of us with expertise in CBT must continue to be part of the conversation in such industries to ensure that dose, content, and meaning of these approaches is accurately represented.

### 5. All Politics Are Local

Finally, I think many are daunted by translating our CBT expertise at the population level because it involves advocacy and policy-level changes to reduce practical and financial barriers at the provider, consumer, and government levels. This can feel hugely overwhelming when considering state or national or even larger levels of dissemination and implementation. I want to end here on a note of hope and encouragement. After years of working to establish the initial efficacy and effectiveness, as well as culturally responsive variations, of our own UP-C and UP-A, I was a bit bereft that the systemic barriers and limitations within the CBT model made future implementation efforts pointless. However,

during the pandemic, I started to just focus on ways to increase the availability of no-cost, culturally and linguistically appropriate CBT for youth and families in my local community. Partnering with children's services agencies, foundation sources, county-level resources, and local leaders, we have now achieved greatly increased availability of the UP-C and UP-A at no cost within Miami-Dade County, Florida. In other words, individual ABCT members, even those that study these more “traditional CBT” foci, can create positive population-level change, if we choose to. And, we may find that this change begins at home.

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## Message From the Editor

Richard LeBeau, *University of California, Los Angeles*



THIS ISSUE of the *Behavior Therapist* (Volume 46, Issue 8) marks the 32nd and final issue I will oversee as Editor-in-Chief. To mark this occasion, I want to share some words of gratitude and reflection, as well as some thoughts on the future.

It is striking to reflect on how much things have changed since I took over the reins of *tBT* from my illustrious colleague Dr. Kate Wolitzky-Taylor in Fall 2019. At that time, I had recently completed my postdoctoral fellowship at UCLA and was blissfully unaware of the pandemic that would soon transform our lives. Upon reflection, I realize that the timing of my transition into the role of *tBT* Editor had a profound impact on the nature and course of my Editorship. Taking over *tBT* during a year that saw the onset of COVID-19, the rise of the Black Lives Matter movement, and the contested presidential election helped me realize *tBT*'s often-underutilized capacity to be a change agent.

As I often mention to colleagues when extolling the virtues of the journal, *tBT* has two key aspects that set it apart from most other publications in our field. First, the relatively condensed peer review process and frequent publication intervals facilitate timely updates and important dialogue. Second, its flexible nature as a hybrid peer-reviewed academic journal and organizational newsletter allows us to publish important articles that would have difficulty finding an outlet in other publications (e.g., Op-Eds, calls to action, commentaries, narrative reviews). The result is that over the past 4 years, *tBT* has published 14 special issues about timely, important, and sometimes contentious topics like the mental health sequelae of the pandemic, the role of psychologists as advocates for minoritized people, Native American mental health, the mental health impacts of violence, the translation of neuroscience research into clinical practice, inequities in clinical training, resilience among sexual and gender minorities, and, now, harms that have resulted from the misapplication of CBT. I am proud of these special issues

and grateful that we were able to make room for them without having to limit more traditional *tBT* articles like original research articles, literature reviews, clinical commentaries, Op-Eds, obituaries, convention coverage, and ABCT news.

Even though my name was prominently featured on all 32 issues that were published between 2020 and 2023, I actually played a fairly small role in their development and execution. These issues could never have come to be without the hundreds who contributed content, the dozens who served on the *tBT* Associate Editorial Board and did the majority of peer reviews, the colleagues who stepped up to guest edit our many special issues, and the two exceptional Editorial Assistants I had the pleasure to work with (Resham Gellatly and Julia Yarrington). Additionally, I would like to thank ABCT Managing Editor Stephanie Schwartz, ABCT Director of Publications David Teisler, ABCT Publications Committee Coordinator Susan White, and ABCT Executive Director Mary Jane Eimer for their invaluable support during my Editorship. And, of course, *tBT* would cease to exist were it not for the engagement of its large and diverse readership.

Serving as the Editor of *tBT* was a profoundly positive experience for me. It allowed me to maintain connections with dozens of colleagues I might have otherwise lost touch with and make countless more connections. It helped me stay up-to-date regarding what is happening in our organization and field more broadly. It inspired in me a renewed passion for leadership. For those reasons, and many more, I am saddened that my time as Editor is coming to an end. At the same time, I could not be more optimistic that the future of *tBT* is in capable hands given that my successor, Dr. Gregory Chasson, has already proven to be brilliant, passionate, thoughtful, and innovative. Dr. Chasson will officially take over the reins of *tBT* with the January 2024 issue, which will also mark the first issue of *tBT* in its new fully online format. I cannot wait to see what exciting things *tBT* has in store for 2024 and beyond.

Perhaps fittingly for an editorial term that began during a year of great uncertainty and controversy, my last issue is likely to be one of the more challenging for some in our organization. The articles included in this issue directly and critically examine contentious issues in our field, some of which have long been debated without consensus and some that have long been ignored to the detriment of many. It is certainly not my expectation that everyone agree with the content of these articles, but it is my expectation—and hope—that their inclusion here will stimulate meaningful dialogue, ethical exploration, and future research. As always, *tBT* welcomes feedback regarding its content either in the form of informal communications to the Editor (I can be reached at [rlebeau@ucla.edu](mailto:rlebeau@ucla.edu) and incoming editor Dr. Gregory Chasson can be reached at [gchasson@uchicago.edu](mailto:gchasson@uchicago.edu)) or a formal submission to the journal (see the website for submission instructions).

Thank you for your readership and support over the past 4 years.

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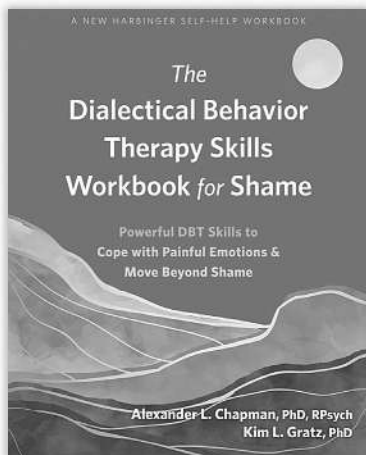
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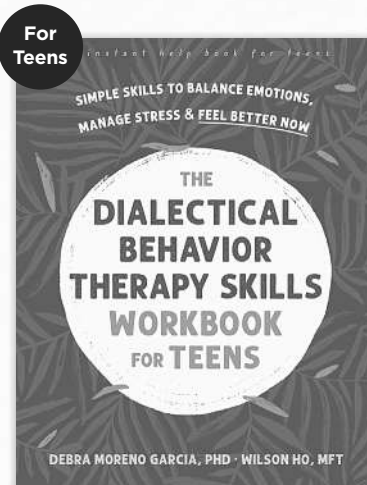


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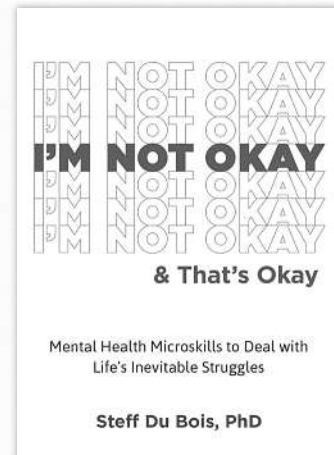
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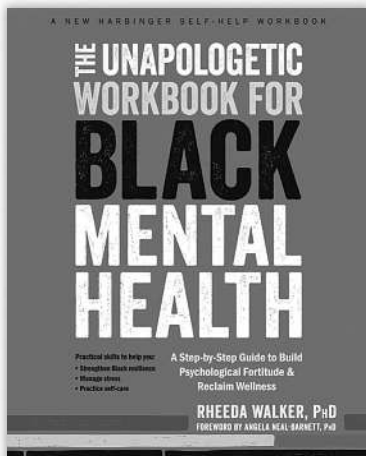
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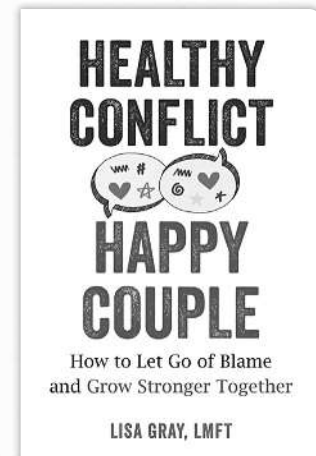
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## Introduction to the Special Issue:

# Harms Caused by the Misapplication of CBT (Part 2)

Alexandria Miller, VA Boston Healthcare System,  
National Center for PTSD

Ilana Seager van Dyk, Massey University

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. The goal of this special issue is to add to this literature and help readers understand how CBT can be misapplied and cause harm to clients. The authors in this special issue provide guidance for clinicians and researchers on how to adapt their CBT practice to remain effective while being affirming and culturally humble.

We were delighted to hear from so many ABCT members about how much they learned from the five articles published in Part 1, and their intentions to implement lessons learned in their clinical practice, research, and teaching. In this issue, we present seven articles that we hope will deepen readers' understanding of harms caused by the misapplication of CBT, in part by broadening the focus to more ethnic- (e.g., Black, Latine) and identity-based (e.g., asexual) communities, as well as people with stigmatized health presentations (e.g., people with psychosis, people with disabilities).

First, Sawyer (2023) presents a framework for Liberated-CBT, an adapted form of CBT drawing from Liberation Psychology, that challenges clinicians to avoid reinforcing White Western European cultural norms when applying CBT principles. Then, Treichler and Jones (2023) discuss ways in which people with psychosis are mistreated by psychological providers and interventions, and present a framework for empowering cognitive behavioral research, clinical practice, and training for people with psychosis. Next, Seager van Dyk (2023) argues that asexuality has been left behind in efforts to increase affirming practice with sexual minorities, and invites clinicians to implement clinical strategies that explicitly affirm asexual people. Tirado and colleagues (2023) then discuss the potential harms of applying traditional

CBT to Latine immigrant populations without engaging in cultural adaptation that considers the significant impact of racist, xenophobic, and oppressive environments on these communities. Next, Moore and Brodt (2023) discuss the potential harms CBT can cause for disabled clients, illustrated by a case example of a myalgic encephalomyelitis or chronic fatigue syndrome.

We also have two thought-provoking articles on professional issues, including the scientific community's approach to article retractions and institutional apologies. Tonge (2023) reviews the case for article retractions on the basis of moral or ethical concerns and proposes steps forward for a more socially responsible clinical science. Finally, Lorenzo-Luaces and Rodriguez-Seijas (2023) discuss institutional allyship towards harmed communities, using ABCT's apology for the field of behavior therapy's role in the development of so-called "conversion therapies" aimed at changing clients' nonheterosexual and/or noncisgender identities (ABCT, 2022) as a case example.

As editors, we placed particular importance on uplifting the voices of authors from communities that are often affected by the misapplication of CBT. We acknowledge that we also have 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 (Black, White, Māori), 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 (Oppression and Resilience: Minoritized Mental Health SIG; Sexual and Gender Minority SIG).

To understand better the authors' positionalities, we asked all authors to complete a brief demographic survey; 11 of the 13

authors responded. Authors were diverse in terms of sexual orientation (4 identified as heterosexual/straight, 2 as bisexual, 2 as pansexual, 1 as queer, and 1 as bisexual/queer); gender identity (4 identified as cisgender women, 4 as males, and 1 as each nonbinary, genderqueer, and cisgender); and race/ethnicity (3 identified as White, 3 as Hispanic/Latino, and 1 each as indigenous Latina, Peruvian American Mestizo, Black, African American/2nd generation Caribbean-American, and White/Māori). Five authors identified as disabled or a person with a disability, and 7 authors identified as fat or larger-bodied. The mean age of authors was 32.35 years ( $SD = 3.53$ ), and authors were early in their careers, with 4 current graduate students, 3 authors within 5 years of graduation, and 4 authors 6–10 years postgraduation. Importantly, at least 1 author of each article has lived experience of the issues described in their article (range: 1–3 authors). We acknowledge the courage, vulnerability, and increased emotional effort it takes to advocate for equitable access to treatment for your own communities. We are grateful to these authors for being willing to share this personal experience for our benefit and educate us, the readers, and the field.

It can be uncomfortable to acknowledge that CBT therapeutic techniques, the same ones that we may have spent entire careers studying and have seen help so many, can also cause harm. As you read through this special issue, you may notice this discomfort arising within yourself. Although it's understandable that you may want to turn away, we challenge you to use the discomfort to motivate behavioral change in line with the recommendations by these authors. As mental health professionals, we value alleviating suffering as much as we can for those we serve. Delivering CBT in a more culturally responsive, humble way is one tangible way we can act that aligns with that value.

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As our population ages, practitioners find themselves working with older adults more frequently. Alcohol use problems among older adults are often underdiagnosed and under-treated, and there are few treatments designed specifically for this client group. This practical guide provides practitioners with up-to-date information on assessing and treating unhealthy alcohol use among older adults. Focused on evidence-based treatments, it is highly relevant to practitioners working across a variety of settings. The author's expertise, highlights the prevalence of alcohol use among older adults, the models for understanding unhealthy use, and the different screening and assessment options as well as the treatment

possibilities relevant to health care and social service providers. Assessment and treatment options highlight the need to consider lifespan development when providing care as well as the relevance of common life transitions and generational differences. Clinical pearls and vignettes illuminate treatment approaches and further sections discuss pharmacological interventions and cultural considerations. Printable tools are available in an appendix. This book is a must for practitioners from diverse settings who work with older adults.

The materials for this book can be downloaded from the Hogrefe website after registration.



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When allyship breeds animosity. *the Behavior Therapist*, 46, 360-364.

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## Liberated Cognitive Behavioral Therapy: Liberating CBT From the Cognitive Distortions of White Western European Culture

Broderick Sawyer, *Liberation Psychology Trainer*  
*Brodericksawyer.com*

*It is no measure of health to be well  
adjusted to a profoundly sick society.*  
—Jiddu Krishnamurti, Indian Philosopher

COGNITIVE BEHAVIORAL THERAPY (CBT) is a set of mental health interventions centered in the philosophy that psychological stress is maintained by cognitive distortions that lead to emotional stress and maladaptive behaviors (Beck, 1970; Ellis, 1962). According to CBT's original model of distress, automatic thoughts are triggered across specific situations that prevent well-being. Importantly, change in psychotherapy is a matter of altering “distorted” cognitions, leading to decreases in emotional stress and decreases in maladaptive behavior. Patients receiving CBT collaborate with therapists to challenge maladaptive cognitions, beliefs, and schemas, to change behavioral patterns (Beck; Ellis). CBT has shown strong support for anxiety disorders (Kindred et al., 2022; Lewis et al., 2020; Öst et al., 2023; Van Dis et al., 2020), depression (Cuijpers et al., 2019; Oud et al., 2019), eating disorders (Linardon et al., 2017), and a wide range of other conditions (Hofmann et al., 2012).

Recently, along with providing critical commentary regarding the cultural blindspots of CBT research, diverse researchers have sought to increase the cultural competence of CBT clinicians (Naz et al., 2019) and create culturally sensitive treatment adaptations that still maintain CBT's core treatment philosophy (Hinton & Patel, 2017; Naeem, 2019). Targeting ways to increase the cultural sensitivity within CBT is undoubtedly helpful, and acknowledging *specific* anthropological mechanisms of white supremacy in Western culture is necessary to create *specific* clinical tools. This paper will explore the cultural location of white Western European (WWE) *cognitive norms* within the context of the U.S., and how this context permeates the attitudes of U.S.-based CBT practitioners. CBT is useful, *and* it can operate from a culturally universal frame if its Western cultural location is acknowledged and

compensated for with several easy-to-use treatment augmentations rooted in “cultural countertransference,” to be outlined later.

It has been the goal of many scholars to highlight how the inception of Western psychology/psychiatry was rooted in white supremacist ways of being that discredited other cultural worldviews. The work of Fanon (2016) sought to underpin the psychological contagion that is white supremacist cognition, and similarly, Burch (2021) unpacked how psychiatric institutions attempted to erase non-white cultural cognition. Further, the seminal works of Cokley et al. (2019), Myers et al. (2018), and Jamison (2017) all wisely identify the trends of white supremacist cognition, and discuss the need to decolonize psychiatric institutions from white supremacist thinking.

As evidenced by the work of these diverse scholars, acknowledging WWE culture as certainly not “unbiased” is a strong step in the right direction. However, to integrate this anthropological acknowledgment into CBT specifically, we must centralize and identify specific WWE cultural cognitive norms. Further, as a product of those WWE norms, we need specific CBT-based modifications that aim to target the anthropological root of what may cause cultural bias in CBT practitioners located in the Western world, specifically the U.S.

This paper will discuss and offer solutions regarding the notion that WWE culturally specific cognitive styles have been globally normalized and used as a frame of reference for *the way people should think, behave, feel, relate to their surroundings, conduct/interpret research, and achieve well-being*. A metaphor for culturally specific cognitive styles in this case is that of saltwater and freshwater. It's not that saltwater is supreme to freshwater, saltwater is merely different, and comprehending saltwater's molecular structure helps us to understand its effect on fish. Let us begin our assessment of WWE cultural cognitive



styles with an important anthropological exploration into WWE cognitive inception. Following this discussion, we will then explore several clinical modifications.

### *Western Cognition*

It is harmful to gauge health based on culturally biased lifestyle norms, deeming what is universally “adaptive” as opposed to “maladaptive.” CBT’s political place within psychology is part and parcel with the Western medical model, that is, seeking to identify disease within individuals, rather than identify the diseased environment in which so-called “individual” disease arises. Liberation Psychology’s creator, Martín-Baró (1994), outlined how individualism masks the operant conditioning that systems use to reinforce or punish culturally specific ideological reference points (e.g., capitalism, materialism, oppressive bias, etc.). More recently, Malherbe (2021) suggests that the role of psychotherapists is to assist clients in a process of *acultural* emotional integration that is beyond ideological reference points that systems cultivate.

Put plainly, without clinical tools filtering one’s cultural assumptions, the CBT practitioner situated in Western culture may see Western systems as “universally healthy and normal.” This translates into defining “mentally healthy individuals” as those who are best adapted to a system that is not “universally healthy.” To expand upon the above explanation of operant conditioning according to Martín-Baró, the U.S. capitalist system creates individual lifestyle stress, and then offers what I call “institutionalized sedatives” for citizens to cope with the stress that the lifestyle creates (e.g., alcohol, social media, entertainment, materialism, food, etc.). Thus, wealthy companies then profit off these “institutionalized sedatives” without offering changes to the environment which necessitate the sedatives in the first place. In essence, WWE lifestyles cultivate a level of “socially conditioned dissociation” that increases stress and competition, which likely drives oppressive attitudes, a lack of emotional awareness, limited interpersonal connection and compassion, and likely many other markers of individual health

that CBT practitioners seek to assist clients in achieving.

By attempting to treat individual mental “illness” within a cultural system that causes illness, “health” means assisting clients in adapting to a system that is unhealthy. I identify this not to cause despair or hopelessness, but to highlight our cultural location as CBT practitioners in the U.S. and identify our need to acknowledge our cultural bias as those living a Western lifestyle, which is normalized in our national environment. To understand the implications of WWE cultural cognition in our understanding of applied CBT, anthropology can enlighten us to the fact that WWE thought is *not acultural or objective*. Anthropology is defined as “the science that deals with the origins, physical and cultural development, biological characteristics, and social customs and beliefs of humankind” (Dictionary.com). WWE cultural cognition began centuries ago, and the age of any culture may have us forget that culture shifts and changes over time—there are *no* universal styles of thinking or behaving.

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Outlined by African anthropologist Mariam Ani (1994), WWE culture holds a particular momentum, certain “cognitive assumptions about the nature of reality” or the term *Utamawazo* in Afrikan anthropological language. Ani outlines the primary *Utamawazo* of WWE culture as rooted in the assumption that WWE culture needs to be spread across the globe, as a “universally correct” style of thinking, behaving, and living. This particular WWE cognition, which we might identify as a cognitive distortion, developed into behavior that became intent on spreading its values, beliefs, and territories to other lands—often by brute force. Ani details the violent practice of conquering or colonization as culturally substantiated by the WWE cognitive distortion that others *should* adopt similar views, even by force. This cognition led to feelings of superiority, then leading to violent behavior that allowed the Roman State to spread not only its physical territories, but its *psychological territories*. By *forcing one’s cognitive styles* on cultures, WWE cultures identified their behavior as “civilizing” or “correcting” the irrational thoughts and behaviors of non-WWE cultural lifestyles.

Importantly, WWE goals of “civilizing” others was maintained by an additional culturally specific distortion: *the nonfalsifiable presence of what “reason” or “objective thinking” is, versus not*. We can start to see the parallel between WWE culture and the risk we run as Western CBT practitioners deeming certain thoughts as “realistic” or “unrealistic.” As Ani (1994) discusses, WWE culture aimed to physically and cognitively conquer territory, then coupled this aim with presenting its harmful actions as acultural, “logical,” “universally true,” or “virtuous.” In essence, this is the distortion that WWE cognition or thoughts are objective, untouched by cultural imprinting, context, history, or lifestyle. The distortion manifests such that: “Since I am objectively correct beyond reproach due to my WWE cognitive style, then I can force others to adopt what I want them to, and still see myself as a benevolent person.”

Centuries later, via ongoing physical and cognitive conquering, WWE cultural cognition and behavior has curated the surrounding environment in a way that supports WWE cognitive distortions—beyond falsifiability. Thus, reality now reflects what WWE says reality is when we look around, as WWE culture has forced others to adopt its own cognitive styles, and punished those who do not reflect its own distortions via operant conditioning. As mentioned,

Burch (2021) outlined this WWE phenomenon, identifying how WWE psychiatry attempted to erase non-WWE cultural cognition through the use of WWE institutions. Importantly, cultural norms are absolutely not inherently a negative or harmful thing, which is why CBT practiced with self-awareness of its own WWE cultural location is of utmost importance. Without cultivating self-awareness within the practice of CBT with specific alterations (to be detailed later), CBT practitioners run the risk of carrying out the WWE *Utamawazo* and potentially labeling *non-WWE thinking* as “maladaptive” or “unhealthy”—without acknowledging whether the environment itself is healthy. *The intention is not to overhaul CBT*, but to assist its ability to acknowledge cultural context of thoughts, emotions, and behaviors.

Not acknowledging the WWE cultural limitations within CBT may further promote hegemonic thinking, and grandiose attitudes. To make the case that CBT must include “cultural filtration” tools for WWE cultural distortions, acknowledging a definition of narcissistic thinking may help us see the issue with not utilizing clinical tools that operate as cultural bias “filters.” Briefly, narcissism is seeing one’s own reality as fundamentally correct without falsifiability, and then forcing others to adopt that reality with forceful physical and cognitive coercion, regardless of victim resistance (American Psychiatric Association, 2013; Skodol et al., 2014). While we as CBT practitioners are certainly not intent on victimizing those we serve, our WWE cultural location has a particular cognitive history that may cognitively coerce if we are not careful in acknowledging our Western *Utamawazo*.

Put simply, we don’t always acknowledge how the umbrella of the above anthropological details of WWE cognitive-cultural bias influences our lifestyles, treatments, research questions, or values within academic institutions. Concluding our exploration of WWE cognitive anthropology, we see that the psychology of WWE aimed to spread its cognitive style until the globe was no longer “distorted” in its thinking—according to its own culturally biased reasoning. While it is important to acknowledge the harm this global crusade has caused people and the earth itself (in the form of climate disaster), it is outside of the scope of our discussion. What is within scope is identifying the appropriate clinical tools we can use to assist CBT professionals to limit WWE cognitive distor-

tions negatively impacting clinical work. Prior to exploring clinical modifications, let us identify a primary WWE cognitive distortion and its operationalization, based on our anthropological discussion:

**WWE cognitive distortion:** WWE ways of life and beliefs are fundamentally objective, acultural, and beyond the need to gauge falsifiability.

**WWE cognitive operationalization:** Given WWE’s “objective” cognitive reasoning, anyone who cognizes differently must have their cognitions “corrected” by WWE norms, because they are unable to do so without WWE teaching them to.

I will now explore these cognitive mechanisms, which will then lead to the introduction of clinical modifications reflecting “Liberated Cognitive Behavioral Therapy” (CBT-L).

## Cultureblindness and Cultural Gaslighting

Readers may be familiar with the notion of *racial* colorblindness, described as the denial of racial difference altogether, to minimize and deny the harms of racism and white supremacy (Apfelbaum et al., 2012). Here I am using the term “cultureblindness” to extend this definition to include the distortion of “universality” of WWE cultural norms. This is an important distinction, intended to capture the anthropological essence of WWE momentum described above that exists *not only in white-identified individuals*, but also in people of color who have adopted WWE norms, and particularly, those trained in WWE psychology training institutions. I define *cultureblindness* as:

*The cognitive distortion that WWE cognition and behavior is acultural, universal, and not culturally unique, but a reference point for what are “normal” cognitions, behaviors, and lifestyles for all human beings.*

As outlined in our anthropological discussion with Ani (1994), this claimed “universality” of WWE culture has significant incentives driving its motivation, such as the expansion of land, expansion of preferred cognitive styles, and preferred style of intellectual analysis (detached reasoning which incorrectly side-steps cognitive-cultural imprinting and bias). One highly relevant example of cultureblindness in CBT

is the intellectual, detached “reasoning” prevalent in academic systems, treatment protocols, and academic journals that WWE systems self-select for.

As a Black-identified man (representing roughly 2% of clinical psychologists; Beasley et al., 2015), by wanting this paper to be accepted, I am forced to adopt a style of detached communication not native to my cultural identity. The words read on this page reflect the incorrectly assumed, acultural notion of “professionalism,” or “coherent” expression, devoid of curse words, Afrocentric slang, or other expressive styles that reflect emotionally integrated personality states, which convey completely valid information. The experience of having non-WWE cultural imprinting, yet the challenge of needing to adopt it to be seen as “normal,” is thoroughly outlined by W.E.B. DuBois as “double consciousness” (DuBois, 1903), sometimes known as “code switching.” Inasmuch, what is defined as “coherent” is within cognitive-cultural framing, and those who do not understand detached reasoning are not “unintelligent,” just perceptually different. If we were to unpack notions of neurodivergence (Sonuga-Barke & Thapar, 2021) and the WWE definition of what makes one “neurotypical,” we would stumble upon the same cognitive distortion of cultureblindness.

The embodiment of this cultureblindness distortion has significant cognitive implications. Specifically, acting as if WWE is not a *unique cultural perspective*, but instead a fundamentally correct perspective, any harm done on behalf of WWE behavior is rationalized as a normal or objective way to be. This side-steps any harm done to non-WWE cultures, and leaves no room to highlight its lack of falsifiability as a cultural philosophy. Cultureblindness then becomes operationalized in its assumed acultural, air-tight objectivity. Specifically, since one’s ideas are “objective” and not driven by one’s cultural imprinting, unconscious motivations, needs, or desired self-image, any harm caused is excused. The operationalization of cultureblindness is mechanistic, which I call “*cultural gaslighting*,” defined as:

*Ongoing rationalization of harm done to individuals or communities as “objectively correct,” functioning to gaslight victims into internalizing the cognitions that WWE culture defines for them. This forces victims of systemic harm to psychologically accept the cognitions of WWE*

*culture as the needs of oneself, one’s community, and the globe.*

Cultural gaslighting affords cognitive avoidance of shame or guilt related to one’s “correct thinking.” This leads to seeing oneself in the light of all-pervading-correctness, benevolence, and saviorism. The more harm that is done to others or the earth in this vein, may lead to further cognitive avoidance to compensate for the continued escalation of harm done. The parallels to narcissistic pathology (American Psychiatric Association, 2013; Skodol et al., 2014) here are striking, specifically related to an all-good and impossibly-never-wrong self-view. However, this pathology is being acted out on a collective psychological scale in WWE culture, and not specific to racial categories or individual actors, but to a culturally momentous, systemically celebrated cognitive frame, rooted in capital gain and hyper-individualism which masks systemic reinforcement. By framing WWE as a “normal” way to be, then avoiding one’s direct experience of negative affect related to harm done, WWE behavior cloaks its culturally biased roots. Therefore, it becomes difficult to identify its cognitive distortions.

Now understanding the primary WWE cognitive distortion and its operationalization, let us transition to an empowering, practical modification to traditional CBT that aims to “filter” these distortions from clinical work, protecting patients from harm. I call this modified version of CBT “Liberated Cognitive Behavioral Therapy” or “CBT-L.” CBT-L is a blend of traditional CBT and Liberation Psychology (Martín-Baró, 1994), with a focus on aligning CBT with its intentions to be collaborative, client-centered, and empowering. The following section will outline several modifications to help clinicians integrate CBT-L into their practice.

### **Liberated Cognitive Behavioral Therapy: Decolonizing CBT Application**

CBT-L aims to decolonize CBT by filtering cultural bias with the addition of simple tools, both assisting clinicians in their practice, and researchers seeking to retain measurability.

#### ***Working with Cultural Countertransference: Seeing “Subjectivity” Clearly***

WWE cultureblindness and cultural gaslighting combine to distort certain cognitions or behaviors as either “normal” or “disordered.” CBT-L includes the practice

of observing what I define as our “cultural countertransference.” While “countertransference” is related to our personal feelings and automatic thoughts about our clients (Prasko et al., 2023), “cultural countertransference” takes this a step further, by including our biases related to our WWE cultural lifestyle and framing. I define cultural countertransference as:

*Clinician assumptions of normality, pathology, and mental illness, located in systemically and culturally specific lifestyle contexts. These assumptions are projected onto clients not as a matter of health, but to align clients with culturally normative lifestyles which may or may not be helpful for client wellbeing or overall mental health.*

In Appendix A, I have included a “Cultural Countertransference Tracker” (CCT) sheet, intended to assist CBT-L practitioners in identifying WWE cognitive distortions in their work with clients. By honoring and reflecting on cultural countertransference, we develop a more self-reflective cognitive style that honors client and clinician perspectives. Not only is the CCT intended to “filter” our biases to move closer to objectivity as providers, but also to highlight our unique strengths, reactions, and perspectives of health as clinicians.

Rather than embody a generalized approach to CBT application, the CCT seeks to reveal what makes clinicians different in their cognitive styles; just as we want to remove our WWE bias from our approach with clients, we also want to address this bias in how we see ourselves as professionals. Learning more about our unique lens via CCT reflection can help us identify which client populations we work best with, what research inspires our curiosity most, and importantly, how we conceptualize mental illness. Considering the unique tapestry of thinkers, clinicians, and researchers in our field, embodying our creativity and personal flavor helps us to humanize and connect with our clinical work, ask innovative research questions, and propose creative frameworks for mental health and healing.

#### **Mirroring Cognitive Style, Rather than “Challenging” Cognition**

“Challenging” thoughts has been a staple of CBT interventions for decades as a part of the cognitive restructuring process (Beck, 1970; Ellis, 1962); however, when utilizing CBT-L, we are *more explicitly*



careful to acknowledge that our WWE-situated cognitions are *not objective*. Therefore, combined with our practice of reflecting on cultural countertransference, modifying thought “challenging” to what I call “*cognitive mirroring*” gives our clients the chance to hear themselves out loud, and importantly, allows clients to personally gauge the behavioral and goal-oriented impact of their own cognition. Here is a small example:

### Traditional CBT Thought Challenge:

BLACK-IDENTIFIED CLIENT: I can’t go the mall, or I’m going to have a panic attack because all white people follow me around in stores. I love shopping, but I’ll never be safe from racism.

WHITE-IDENTIFIED THERAPIST: I’m going to challenge that thought— all white people will follow you around in stores, and you’ll never be safe from racism?

### CBT-L Cognitive Mirroring:

BLACK-IDENTIFIED CLIENT: I can’t go the mall, or I’m going to have a panic attack because all white people follow me around in stores. I love shopping, but I’ll never be safe from racism.

WHITE-IDENTIFIED THERAPIST: You love shopping, you want to shop, and you fear that encounters with racism won’t allow you to feel safe enough to enjoy yourself. What can we do to help you feel a little safer to do what you love?

This slight shift is intended to empower clients to (a) recognize their own reasoning connected to a valued behavior, and (b) collaboratively choose strategies to overcome limiting behavior in service of lifestyle, but being more explicitly careful to not challenge assumptions of reality. As outlined above, the primary WWE cognitive distortion is cultureblindness, and when mirroring thoughts instead of challenging them, we allow clients to not become imprinted by WWE distortions, while still encouraging reflection on how cognitions are limiting client behavior. We will now explore two additional worksheet-based modifications.

### Tracking: Gathering Direct Perceptual Data and Empowering Client Lifestyles

CBT-L engages clients in gathering broader, direct perceptual data within their lived experience with the use of two additional worksheets, intended for use both

during treatment and long after treatment to prevent relapse. These modifications, like thought records, are designed to engage client reflection, but also motivate longer-term lifestyle changes. The first worksheet is called the “Energy Audit” (EA; Appendix B) and is intended for use (assuming weekly sessions) after Session 1, after Month 1 (after Session 4), and after Month 2 (after Session 8).

The EA assists clients in gathering data related to broader lifestyle habits, relationships, and behavioral patterns, helping them to connect their mental health status to everyday lifestyle decisions. As outlined in Appendix B, clients will broadly reflect on what behaviors they are choosing to engage in, the direct cognitive-emotional consequences of those behaviors, and encourage clients to self-identify changes to make based on an ongoing reflective process.

Considering assumed WWE “objectivity” of health practices and research institutions, the EA empowers clients to observe their own “feel good” perceptions, rather than being told what they “need to do” based on WWE research. Importantly, this is not designed to limit our clinical capacity to share helpful research findings. On the contrary, the EA is designed to help clients reflect on all behavior and its effects—including the behaviors we may suggest, client strengths, spiritual practices, musical tastes, food consumption, and much more. The EA is an expansion of tracking, both designed to reveal larger lifestyle patterns outside of the client’s awareness, and to expand the clinician’s ability to gather lifestyle data that transcends our need to ask all possible assessment (or research) questions.

The second worksheet is called the “Behavior Change Notebook Prompt” (BCNP; Appendix C), designed to help clients “tally” how many behaviors they engage in on a daily basis. While the EA is reflective and used across several time points, identifying which behaviors have a nourishing or depleting impact, the BCNP is intended to help clients begin and sustain the practice of increasing the behavioral repetition (or increasing “reps”) that improve overall well-being in expansive, daily, nonspecific fashion. Specifically, the BCNP is designed to engage clients in a direct analysis of the numerical relationship between their completed behaviors and mental health status. Also important is the assistance that the BCNP provides to clinicians and researchers in gathering numerical data, analyzing client strengths,

and in future research projects, broadly identifying behavior patterns that increase well-being. Outlined in Appendix C in further detail, the BCNP provides numerical data across 4 behavioral categories: Resisting behaviors they wish to extinguish, exposure-based behaviors they wish to increase, coping behaviors to practice regulation skills, and nourishing behaviors-intended to enhance joy, playfulness, and self-compassion.

The BCNP is intended to enhance the client perceptions of control over mental health status, increase empowerment, and increase chosen lifestyle habits that transcend diagnostic categories or preliminary treatment goals. While WWE culture has a habit of defining what is “normal” or “distorted,” the BCNP engages both client and clinician in a process of individualized self-discovery, encouraging the collection of behavioral data that not only tailors treatment to the individual, but also tailors individual practices for well-being to be utilized long after termination. The below case vignette highlights CBT-L application and utility:

*“Shuri” is a 32-year-old, Black-queer-identified woman, second-year graduate student experiencing anxiety, perfectionism, and hopelessness, seeing “Marsha” a white-queer-identified woman psychologist.*

*Shuri presented with symptoms of restlessness, racing thoughts, and panic that began following her first year of her psychology doctoral program. Shuri presented to Marsha, a therapist practicing CBT-L, hoping to decrease her symptoms while also being able to complete her doctoral degree.*

*After Session 1, Shuri completed an initial Energy Audit, recognizing that spending too much time around her white classmates left her feeling depleted, while spending time with Black-identified family, in addition to seeking queer community, nourished her. Prior to Session 2, Marsha recognized racial differences between herself and Shuri, and completed a Cultural Countertransference Tracker. In tracking, Marsha discovered that she felt uncomfortable when Shuri discussed racial microaggressions in her graduate program during Session 1, and felt that as a result of that discomfort, Marsha shifted the conversation quickly and didn’t give Shuri a chance to process racial harm. Recognizing her cultural countertransference, Marsha planned to use a deep breathing technique to calm discomfort whenever discussing race—to ensure plenty of open processing space.*



During Session 2, Shuri brought her Energy Audit into session to process her findings. Marsha used her deep breathing throughout the conversation to manage discomfort, and successfully mirrored Shuri's cognitions to highlight the cause and effect of her need to connect with Black individuals specifically:

SHURI: In the audit I was surprised how little I spend time with Black people, and how much it feeds my soul to talk to my father and sister (tearful)... spending so much time with white classmates makes me feel more nervous, making it harder to perform at school. I think white people really make me restless.

MARSHA [while breathing deeply, in soft, compassionate voice tones]: Not feeding your soul by talking to Black people more makes you restless in an already anxiety-producing, all-white environment (graduate school)... using what you found on your Energy Audit, what would it look like to increase the amount of time you spend with Black people, and decrease time spent with white people?

This question led to an empowering exchange, with Shuri reflecting on Black culture, connection, and ways she feels connected to her Black identity, in addition to merely speaking with Black people. Marsha and Shuri ended Session 2 by processing the Behavioral Change Notebook Prompt, and identified a few ways Shuri could begin to take control of her environment. Through continued use of her notebook, by Session 4 Shuri had reduced her symptoms, increased self-compassion, and:

- Increased her resistance to spending time with white classmates, choosing to set boundaries instead of attending all-white events from a place of guilt.
- Increased her exposure to exercise at the university gym, even though she was feeling guilty about going to the gym and not getting work done. Shuri also increased her time seeking queer community, even though feeling "out" sometimes caused her anxiety (as she came out as queer only 4 years ago, with no queer family members to help her make sense of the queer experience).
- Increased her use of spiritual coping skills, engaging more with her Tarot cards, astrology, and calling on the spiritual support of Black ancestors whenever stressed.

- Increased nourishment practices by watching more Black and queer aligned TV shows, reading empowering quotes from Black queer women freedom fighters, and spending much more time speaking and visiting with Black family. Additionally, after first challenging the anxiety of spending time in queer-centered spaces, Shuri began to spend time with a fellow Black-queer-identified woman she met.

Marsha and Shuri ended treatment after 8 total sessions, with Shuri expressing confidence that she would continue to reflect on ways to "feed her soul."

## Conclusion

With great enthusiasm I hope that CBT-L assists clinicians in uncovering their own WWE cognitive distortions, with the understanding that we are all being carried by generationally driven cultural momentum, rather than willfully choosing to embody harmful cognitive styles. Further, with the addition of the outlined modifications and clinical tools, CBT-L seeks to encourage clinicians and researchers to continue to enhance their sense of collaboration with clients and participants, leading to individualized and sustainable interventions that reflect the very best of us as CBT-practitioners, helpers, and human beings.

While certainly outside of the scope of this paper, it may also be helpful to consider the tools outlined by CBT-L not only for psychotherapeutic intervention but as a framework of empowered, self-determining public health practice (e.g., education systems, businesses, etc.). As we aim to increase accessibility to CBT interventions, CBT-L, specifically the EA and BCNP, were designed with those in mind who may not have access to empirically supported interventions delivered by mental health professionals in clinical settings. By engaging in a process of self-discovery, and receiving access to the tools to track those discoveries, CBT-L intends to liberate mental health from the shackles of treatment delivery systems, inaccessible clinical settings, and culturally biased WWE mental health perspectives that pervade our health and training institutions.

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## Appendix A. Cultural Countertransference Tracking

**Cultural Countertransference Tracking (CCT) Directions:** After sessions 1, 4, 8, 12, and 16, clinicians fill out this sheet (use another page if necessary) to reflect on the qualitative nature of clinical interaction. Clinicians may want to use the CCT more frequently for clients who feel especially challenging, or for clients who embody a different culture or lifestyle than the clinician (e.g., racial background, sexual orientation, non-monogamous relationship preferences, etc.). **Prompts:**

1. What do I think about this client's primary concern, and what is its root environmental (as opposed to individual) cause? Write as much as possible.
2. What makes me most uncomfortable about this client? What specific in-session client behaviors brings up this discomfort? Write as much as possible.
3. When I become uncomfortable in session when these client behaviors arise, how do I respond (or not)? Write as much as possible.
4. What behaviors does my client exhibit in response to my behavior when I become uncomfortable? Write as much as possible.

## Appendix B. Energy Audit

**Energy Audit instructions:** At the beginning of treatment, and again each month, reflect on all energy you consume on a daily basis. Here we are defining "energy" broadly, such as: The people you interact with, TV you watch, social media you engage in, physical activity, etc.

**Reflect:**

1. What energy is nourishing me, energizing me, bringing me joy, excitement, and inspired mood states? List as much as possible; use extra paper if needed.
2. What energy is depleting me, bringing me low energy, restlessness, agitation, low self-esteem, and low mood states? List as much as possible, use extra paper if needed.

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### Appendix C: Behavior Change Notebook Prompt

#### How to Start Your Daily Behavior Change Notebook

Urges travel through your brain like cars travel roads. Your brain is like a highway, and the smoothest roads are the ones MOST travelled. This means that the behaviors we want to stop are also the ones that are the EASIEST to give into.

But there is good news: You CAN change your brain, for GOOD!

Changing the brain is like creating new roads: You start walking into the wilderness, and if you keep walking the same path over and over, a road will begin to form. Even better, if you stop walking down certain roads, they disappear for good, making it harder to go back down the roads you don't want to travel. What does this metaphor have to do with your notebook?

Simple: The more you resist behaviors you want to stop, and the more you practice behaviors you want to continue = the more new "roads" you build in your brain, and the more old "roads" you stop using. Even better, new roads (behaviors) get easier to use the more you travel them!

This means that the more repetition or "reps" you practice resisting urges you want to stop, and the more "reps" you practice doing behaviors that you want to, your behavior changes over time.

Changing behavior is challenging, but with the help of this journal it becomes simple to change for good, track progress, and feel good about the hard work you put in! Here are the steps:

Step 1: Resist the urge to act on behaviors that you want to stop.

Step 2: Act on behaviors you want to start and keep doing.

Step 3: Every day, track the number of "reps" you do across four behavioral categories, and reflect on the relationship between the # of reps you did, and how you feel as a result. Here are the categories:

1. Resistance reps: Notice and describe urges, then resist them. Write down your favorite tools when resisting, and master the strongest tools! Count your reps.
  2. Exposure reps: Face your fears, but on purpose. What fears are getting in the way of your life? Challenge fear, do it anyway, take back your LIFE! Count your reps.
  3. Coping reps: Master your go-to emotion regulation and coping skills. Resistance and exposure will bring up discomfort. Which coping skills will you use? Count your reps.
  4. Nourishment reps: Building self-compassion skills increases the joy and inspiration you feel. What will you do to create joy in your life? Count your reps.
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## Harm in Psychological Interventions for People With Psychosis: The Twin Arms of Disempowerment and Discrimination

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THE INSTITUTIONS underpinning mental health research, clinical practice, and policy often structurally devalue people with psychosis, in some cases causing lasting harm. While examples of this harm are often relegated to the past (e.g., lobotomies; long-term institutionalization; George et al., 2023), negative impacts persist today, including socioeconomic marginalization undergirded by punitive social welfare and healthcare policies. For example, a recent meta-analysis of studies from 1957–2021 suggests that the 15- to 20-year "mortality gap" (i.e., 15- to 20-year shorter average lifespan) among people with schizophrenia is worse now than it was in the 1950s (Correll et al., 2022). The mortality gap among people with bipolar disorder is also growing (Staudt Hansen et al., 2019). While these shocking disparities are sometimes blamed on people with psychosis themselves (e.g., due to higher rates of smoking, poor eating habits, or sedentary behavior), strong evidence suggests that inequities in healthcare access and quality are a major contributor (see Roberts et al., 2022; Solmi et al., 2020, 2021). In spite of multiple major studies pointing to schizophrenia as one of the single largest predictors of COVID-related death and illness severity (e.g., Barcella et al., 2021; Lee et al., 2020; Hassan et al., 2022), few U.S. states prioritized access to COVID vaccinations for individuals with serious mental illness (Kumar et al., 2021). These inequities are generally even greater among people with psychosis with additional marginalized identities and experiences (Das-Munshi et al., 2017, 2021; Livingston, 2020).



Psychologists may argue that the primary responsibility for historical and contemporary harms that people with psychosis experience in the U.S. lies with mainstream psychiatrists, other physicians, governmental bodies, elected officials, or the general public (e.g., Correll et al., 2022; Kumar et al., 2021). Here we argue that we—psychologists—must shoulder our share. For example, one major cause of premature death among people with schizophrenia is suicide, with service users carrying a 970% higher chance of dying by suicide than the general population (Correll et al.). Despite this, 61.5% of clinical trials targeting suicide explicitly exclude people with psychosis as participants; of these, less than 10% provided a rationale for this exclusion (Villa et al., 2019). Studies that provided a rationale noted that psychotic symptoms prevent the ability to gain informed consent, a concept that has been disproven by decades of research (e.g., Carpenter et al., 2000). Similarly, research and clinical practice using therapies repeatedly found to reduce suicide risk, such as dialectical behavioral therapy (DBT), frequently exclude prospective clients or participants with psychosis (Phalen et al., 2022).

This commentary calls on the psychology community to acknowledge past and contemporary harms, work to end practices that further marginalize and disempower clients with psychosis, and commit to collaboration, equity, and progressive practices. We focus predominantly on the transdiagnostic psychosis population given that these issues tend to translate across psychotic-spectrum diagnoses. However, we mention specific diagnoses within this population and the concept of serious mental illness (SMI)<sup>1</sup> when relevant to the literature cited. Throughout, we argue that stigma and discrimination towards people with psychosis remains pervasive, and underlies each harm we describe; in particular, we emphasize deep-seated beliefs regarding clients' "lack of insight" and

inability to be trusted with treatment-related decision making. Ultimately, we hold that we will only move towards empowering and healing practices when psychology as a discipline, and psychologists as individuals, reckon with deep-seated prejudice.

### **Is Psychology Discriminatory Towards People With Psychosis?**

Psychologists and psychology trainees, like other mental health clinicians, endorse a range of stigmatizing beliefs and engage in discriminatory behavior towards people with psychosis (Henderson et al., 2014; Kopelovich et al., 2022b; O'Connor & Yanos, 2022). Recent work by O'Connor and Yanos (2022) shows that while increased training and knowledge of the recovery model improves attitudes of clinical psychology doctoral students towards people with SMI, presence of SMI-focused faculty and inpatient SMI rotations in clinical psychology training programs were associated with worse attitudes. Examining a 10-year period, O'Connor and Yanos (2021) also identified little to no growth in the number of SMI focused internships or training opportunities (O'Connor & Yanos, 2021, 2022). Only 58% of the clinical psychology doctoral programs the researchers surveyed had one or more faculty with SMI expertise, and only 6% offered a course on psychosocial treatment for people with SMI (O'Connor & Yanos, 2022). The authors suggest that one explanation for this discrepancy is clinical psychology's "turn" to neuroscience and more basic psychopathology research, translating into only a narrow range of SMI expertise, which does not necessarily lend itself to teaching or promoting recovery-oriented psychosocial intervention courses.<sup>2</sup>

Worse still, a third of psychology clinical training directors surveyed reported actively discouraging graduate students from specializing in SMI (O'Connor &

Yanos, 2022), supporting past work that clinical psychology faculty direct trainees away from people with psychosis due to stigma about low insight and lack of motivation (Mueser et al., 2013; Reddy et al., 2010; for a critique on insight as a concept, please see Forgione, 2019). Turning to the field's support for trainees and faculty with personal experience of psychosis, a recent large sample survey of psychology students and faculty found high rates of self-reported anxiety, depression, and trauma but extreme underrepresentation of students/faculty with experience of psychosis (Victor et al., 2022). Combined, this suggests that exclusionary practices are at play on multiple fronts: insufficient support for students, trainees, and faculty with psychosis on the one hand, and discouragement from working with or studying psychosocial intervention in SMI on the other, similar to how other marginalized groups experience complex exclusion in academic spaces (e.g., Settles et al., 2022).

### **Limited Access to Treatment and Clinical Support**

In the U.S., a further form of structural discrimination can be identified in the profound shortage of licensed clinicians, and particularly clinical psychologists, with competency in psychosis-focused therapies, including evidence-based cognitive behavioral therapy (CBT) interventions for psychosis (CBTp; Kimhy et al., 2013; Kopelovich et al., 2022a; Mueser & Noordsy, 2005). Indeed, recent work suggests that, despite long-standing evidence to the contrary, many psychologists continue to believe that people with psychosis will not benefit from therapy, including CBTp (Valery & Prouteau, 2020).

To be clear: CBTp is a strongly evidence-supported intervention (e.g., Burns et al., 2014; Naeem, 2016; Sitko et al., 2020). APA's Division 12 has determined that CBTp meets criteria for "strong research support" under the original criteria for empirically supported treatments (Chambers & Hollon, 1998), and leads to a range of benefits including symptom reduction and improved quality of life (e.g., Burns et al.; Naeem; Sitko et al.). Further, there is an array of other evidence-based second- and third-wave CBTs beyond CBTp. For example, Cognitive Behavioral Social Skills Training (CBSST; Granholm et al., 2014) integrates CBT with social skills training, and Individual Resiliency Training (IRT; Meyer et al., 2015) draws on CBTp techniques as well as best practices in self-man-

<sup>1</sup>Although "serious mental illness" has been defined myriad ways, in this paper we use SAMHSA's definition: "a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities" (SAMHSA, 2023).

<sup>2</sup>We struggle to identify clinical psychology faculty for students who are passionate about psychosis intervention or implementation science for this reason. The field is creating the gap: there are students who are invested in this work and faculty who want to provide the training, but there are few environments that facilitate this essential training and mentorship.



agement and coping. Outside the U.S., evidence-supported second- and third-wave CBTp interventions include narrative CBTp (Rhodes & Jakes, 2009), compassion-focused therapy for distressing voices (Heriot-Maitland et al., 2019), relating therapy (Hayward et al., 2017), Avatar Therapy (Ward et al., 2020), virtual reality-based CBTp (Monaghesh et al., 2022), and acceptance and commitment therapy for psychosis (Yildiz, 2020), among others (for an overview see Cupitt, 2018).

Unfortunately, despite the efforts of U.S.-based psychosis researchers, clinicians, advocates, and—most of all—people with lived experience of psychosis, these interventions are rarely available outside of a handful of psychosis specialty treatment settings (Burgess-Barr et al., 2023). Most psychologists working outside of these settings aren't trained to provide these therapies while in doctoral training, as described above (O'Connor et al., 2021, 2022). There are few opportunities for specialized postdoctoral training and supervision in psychosis therapies. With rare exceptions, there is essentially no access to training in the U.S. on specialized psychosis therapies being trialed in the U.K., the E.U. and Australia. With increasingly dire shortages of licensed providers willing to work in the public sector (Mongelli et al., 2020; Olfson, 2016), and specialty settings for people with long-term psychosis few and far between, too many people with psychosis are left to choose between no care or poor quality care (e.g., Bruns et al., 2016; Oluwoye et al., 2023).

Further, there are misperceptions that people with psychosis cannot participate in other types of therapies, including transdiagnostic therapies (e.g., Becker et al., 2004; Meyer et al., 2014). Clinicians themselves may also exclude people with psychosis from treatment due to stigma (Kopelovich et al., 2022b) or perceived risk (Villa et al., 2019). A common example is evidence-based cognitive behavioral trauma therapies like Cognitive Processing Therapy (Resnick et al., 2016); one of the most prevalent exclusion criteria from PTSD trials is psychosis (Ronconi et al., 2014). Beliefs that individuals with psychosis will not benefit from trauma-related therapies reduces access to needed care, especially given that people with psychosis are at substantially higher relative risk of abuse and other trauma exposure, and that psychotic symptoms are common in PTSD and trauma-related disorders (Kozarić-Kovačić & Boroveck, 2005; Shinn et al., 2020). And yet, empirically, multiple studies attest to

the benefits of trauma therapy for individuals with psychosis, including improvement of both trauma-related and psychosis-related symptoms (Adams et al., 2020; Sin & Spain, 2017; Swan et al., 2017).

### **Inequity in Treatment**

As noted above, people with psychosis are less likely to be offered evidence-based psychotherapies than virtually any other diagnostic group, lifespans are reduced by 15–20 years, and rates of negative outcomes such as incarceration and homelessness markedly elevated (Cloutier et al., 2016). These are major health and health-related disparities in their own right; however, it should come as no surprise that these disparities are even worse for multiply marginalized people with psychosis.

Black and Latinx Americans experience disparities in social determinants of health leading to psychosis that are fundamentally shaped by a history of structural racism in the U.S. (e.g., neighborhood instability; adverse childhood experiences; pregnancy and labor complications; Anglin et al., 2021), with parallels in Europe (e.g., Sellen et al., 2020). Despite higher prevalence of psychotic symptoms among Black and Latinx Americans (e.g., Cohen & Marino, 2013), there are marked disparities in access to care (Oluwoye et al., 2023) and quality of care (Maura & de Mamami, 2017). Ethnic minority groups with psychosis are also significantly less likely to be offered CBTp relative to White clients (Das-Munshi et al., 2018).

Beyond treatment access, contemporary Western psychotherapy approaches have been overwhelmingly developed by White clinicians, and grounded in Judeo-Christian cultural values (see Newnes, 2021). The disparities that define the Global North and the Global South (i.e., political, cultural, and economic marginalization of the Global South) permeate psychotherapy as well, and, as many critics have argued, continue to uphold the legacies of colonialism by applying White, Western conceptualizations of psychological processes to populations who already have their own processes for grieving and healing (Bulhan, 2015; Gone, 2021, 2022; Klein & Mills, 2017). Mainstream psychological research captures less than 5% of the global population (e.g., Arnett, 2008). In 2021, psychologists were predominantly White (81%), female (69%), and did not identify as disabled (94%; American Psychological Association, 2022). Participants in clinical trials of psychosis are predomi-

nantly White (Burkhard et al., 2021; Freudenthal et al., 2021). What little evidence we have to date from these trials suggests that different or adjunctive strategies are needed to align with the goals, values, and needs of clients from ethnoracially and/or culturally minoritized communities.

As a result of the pervasive Whiteness in the development, evaluation, and practice of CBT and other dominant Western therapies, many clinicians are unprepared to work with minoritized clients (Lowe, 2021). This has a range of harmful results, including misdiagnosis among both African Americans and White Americans (Garb, 2021). African Americans are more likely to be misdiagnosed with schizophrenia and their depressive symptoms overlooked especially if they are culturally specific expressions of depression (e.g., physical symptoms), while White Americans' psychosis is more likely to be missed or misattributed (Garb). Further, CBTp therapists are intended to accept, rather than hypothesis test, culturally or religiously aligned beliefs. However, misinterpretation of culturally grounded beliefs as "delusional" is common (cf. Jegarl et al., 2023). This may be because most incoming psychology interns and postdoctoral fellows have never engaged in training focused on non-Christian religions or minoritized racial/ethnic groups (Crawford et al., 2022). Incoming interns and postdoctoral fellows also report low levels of confidence working with a range of racial, ethnic, cultural, and religious groups, among others (e.g., Benuto et al., 2019; Crawford et al., 2022; Treichler et al., 2021). Coupling these data with the low rates of SMI training among current clinical psychology doctoral students, it seems reasonable to conjecture that few psychologists are truly competent in distinguishing between culturally aligned beliefs and delusions given low rates of training in either area, let alone both.

### **Treatment That Ignores Client Lived Experience and Meaning-Making**

We enthusiastically argue for broad training in CBTp and associated cognitive behavioral therapies and investment in implementation of these therapies across settings and populations. However, it is still essential to recognize how traditional conceptualizations of psychosis and psychosis treatment harm people with psychosis, whether directly (e.g., by treating rich, meaning-laded experiences reductively as

“mere psychopathology”; Jones et al., 2016a, 2016b) or by neglecting major social and structural determinants in favor of individual-level intervention (e.g., Ali & Sichel, 2014).

Early forms of CBTp focus predominantly on eliminating positive symptoms (Greenwood et al., 2010), whether or not this is the client's goal in therapy or would improve their quality of life (Brabban et al., 2017). However, many people with psychosis do not conceptualize their voice hearing or other unshared experiences as a “symptom” in need of a “cure,” but rather an innate and beautiful part of who they are:

What I love about [hearing voices] is I overcame my fear of being me, of being alive and in this big world, and I don't feel alone in it. I feel supported in it by the universe in some ways, as though there is a safety net around me. Knowing that, I feel indestructible. (participant quote from Jackson et al., 2011, p. 492)

As a result, traditional deficit-centered approaches harm people with psychosis, many of whom have advocated for acceptance-based or meaning-centered approaches to voice hearing and other “psychotic” experiences that honor their lived experiences rather than positioning them as necessarily pathological or harmful in nature (Corstens et al., 2014; Jones & Shattell, 2013; Jones et al., 2016c; Schrader et al., 2013).

Further, reductionistic deficit-centered approaches to therapy risk deemphasizing a broader range of client-identified goals, including social relationships, depression, and trauma. For example, service user co-researchers involved in a participatory CBTp outcome measure development study advocated for the inclusion not only of symptom severity items but also items focused on understanding oneself, feeling confident and empowered, and gaining personal meaning and relevant life skills (Greenwood et al., 2010). This aligns well with other studies that find that reducing symptom severity is only one of many common treatment goals among people with psychosis (e.g., Bridges et al., 2013; Kuhnigk et al., 2012; Yarborough et al., 2016), and may or may not be personally prioritized (Daley et al., 2020).

In keeping with the ethos of the recovery movement, even when psychological therapies are implemented, it remains critical to center individual clients' priorities and apply approaches that align with indi-

vidual values, goals, and cultural context, recognizing that the historical (and ongoing) exclusion of individuals with lived experience of psychosis from intervention development and testing have led to systematic biases in the extant clinical literature (cf. Greenhalgh et al., 2015). Ideally, evidence-based clinicians in Greenhalgh's (2014) sense would not be “algorithmic rule followers” but practitioners able to draw on a wide range of qualitative, quantitative, and service user-led research, and to match therapeutic support to the unique individual, social and cultural values and goals of a given client.

### The Privilege of Belief

CBT and allied evidence-supported therapies are intended to be egalitarian, with clients and therapists conceptualized as equals with separate areas of expertise: the therapist being an expert in therapeutic techniques, and the client being an expert in themselves and their life experiences (Okamoto et al., 2019). However, as the stigma literature attests, the experiences and beliefs of people with psychosis are rarely treated as epistemically equal, and this demonstrably extends to clinicians (Kurs & Grinshpoon, 2018; Sanati & Kyrat-sou, 2015; Scrutton, 2017). We use the concept of “privilege of belief” here — the privilege of knowing your own experience of the world, your beliefs, and your interpretations will be believed and accepted by others above another's — as shorthand for an assumed right that people with psychosis are often systematically denied (e.g., Mestdagh et al., 2014; Russinova et al., 2018). Indeed, more traditional iterations of CBT often require clients to tacitly, if not explicitly, agree that the therapist's experience of reality is the correct one, and that claims made by the therapist will be believed over the client's—for instance, allegations potentially leading to an involuntary hospitalization.

These epistemic inequalities help undergird paternalism and disempowerment, regardless of the way that psychotic symptoms are ultimately approached in care. While clinicians with psychosis expertise often caution against “reality testing” delusions that clients show firm and unwavering belief in, there is never a dispute about which version of reality is true (i.e., the clinician's). We argue that CBT may be helpful if used thoughtfully and collaboratively, but may instead harm clients if deployed in ways that explicitly or implicitly devalue their beliefs, interpreta-

tions, and self-understanding, and, by extension, reinforce a paternalistic hierarchy of power, knowledge, and truth (Brabban et al., 2017; Ritunnano et al., 2022). Approaches premised on the veridicality of the therapist may also engender further harm by teaching clients that the only way to be valued in the mental health system (or indeed, the world at large) is to deny their own experiences and align with, or parrot, the terminology and conceptualizations of providers. Given consistent evidence that in all therapies (and in CBTp in particular) a strong, collaborative therapeutic relationship imbued with trust is key (e.g., Brabban et al.; Wood et al., 2015), any approach that devalues the knowledge and truth claims of clients risks erosion of trust and heightens the risk of near-term or long-term disengagement (Shattock et al., 2018).

The privilege of belief additionally creates endless opportunities for “true” experiences of clients to be devalued and recast as psychotic, including experiences of bigotry, trauma, racism, and iatrogenic harm in the mental health system (Jones et al., 2023). We have many such examples: one common one is clinicians perceiving people with psychosis who discuss having money, high-ranking jobs, or being a graduate or professional degree as delusional (indeed, the latter happened to one of the co-authors while hospitalized for schizophrenia). In one situation, a patient's partner had to independently confirm the patient was a business owner and was rightfully concerned about their business interests while hospitalized. This example clearly demonstrates that stereotypes related to people with SMI being poor and uneducated persist and negatively impact care quality. After having an experience like this example, it is perhaps no surprise that trust between clients and health professionals may be eroded, perhaps permanently, damaging remaining opportunities for therapy benefit.

### “A Voice and a Choice”: The Road to an Empowering Cognitive Behavioral Practice

We have laid out a pattern of harms that negatively impact people with psychosis through stigma and discrimination; low availability of trained clinicians and low access to care; and poor quality, inequity, and iatrogenic harm in care that is available. These harms are all fundamentally intertwined with disempowerment, exclusion, and the decentering of people with psychosis from cognitive behavioral prac-

tice as a science and practical discipline. People with psychosis are too often excluded from essential decisions that impact their lives and well-being. As a result, people with psychosis have been banging the same drum for decades: nothing about us without us, nothing about me without me (Nelson et al., 1998). Fundamentally, this means that a decision to take an action in research, policy, training, or practice must meaningfully and powerfully include the individual or community that will be impacted by that decision. The time is now for the CBT field and research to listen to the call of that drum, and act.

True empowerment is the only real path forward: diverse groups of people with experience of psychosis must have a meaningful "seat at the table" regarding not only their own individual care, but the development, adaptation, evaluation, and implementation of therapeutic practices (Desai et al., 2019; Schoenfeld et al., 2019). Further, empowerment requires people with psychosis as a group be held up and supported as essential leaders. Leadership development, including access to higher education, and where desired, clinical training, must be supported (e.g., Jones et al., 2021). True empowerment can only be realized with actionable "control" over what does or does not happen; not tokenistic inclusion or lip service paid to self-determination, but *a vote that cannot be vetoed*. Empowerment of marginalized groups only occurs when members of that group can reliably show up to a space as their authentic selves; be fully transparent in their lived experiences, beliefs, opinions, and needs without having to bow to a respectability politic; and have sufficient power and influence over decision-making to fundamentally (re)shape what happens (e.g., Colder Carras et al., 2022; Haarmans et al., 2022). Finally, empowerment can only occur when transparency and authenticity is possible without risk of exclusion, minimization or harm if members of the majority disagree or find their comfortable status quo at risk; inviting only those who agree with the majority is not a true path forward (cf. Brown & Jones, 2021; Daya et al., 2020).

With these requirements for empowerment in mind, we make recommendations to support a future of empowering cognitive behavioral practice for people with psychosis. In this pursuit, our *overarching principles for empowering practice* are as follows:

**1. Empowering practice includes increasing the number of people with psychosis working as clinicians, clinical researchers, and clinical trainers.** As discussed, people with psychosis are severely underrepresented among psychologists (Victor et al., 2022). While representation and inclusion are not the only piece to the empowerment puzzle, it is a necessary one.

**2. The psychology field must disabuse itself of stigmatizing beliefs about people with psychosis.** Stigma persists, and with it, discrimination. Ableism and sanism negatively impact this field and the people psychologists seek to help (e.g., Jones et al., 2021; Kopelovich et al., 2022b). We encourage every psychologist to engage in deep reflection about their beliefs about psychosis and people with psychosis, and work to unpack the harmful beliefs embedded within our society and field. Training programs should actively counteract these beliefs.

**3. People with psychosis should have a seat at every table.** Access to and quality of care is often determined far before a client meets an individual clinician for therapy. Empowered cognitive behavioral practice means that people with psychosis have a "seat" at every important decision-making "table" (Nelson et al., 1998). Examples of "tables" include admissions and discharge criteria at the clinic level; which therapies are reimbursable and what research is prioritized and funded (Treichler et al., 2021).

**4. All roads lead back to social determinants of health, intersectionality, and culturally and structurally informed care.** Empowered and effective cognitive behavioral practice requires recognizing and addressing inequities among people with psychosis who hold other minoritized identities (cf. Anglin et al., 2021; Das-Munshi et al., 2018; Oluwoye et al., 2023). Addressing these inequities include, but are not limited to: investment in intersectional clinical training and advances in access to care among marginalized communities; increased clinical flexibility to allow for full understanding of each client's experience within their own sociocultural contexts and beliefs; and accepting that distrust, suspicion, and guardedness are sometimes evidence of an appropriate reaction to the world (Haarmans et al., 2018; Jegarl et al., 2023).

#### *Training Recommendations*

**5. Given that current numbers of people with psychosis in powerful positions in cognitive behavioral practice in the U.S.**

**are so limited, it is essential that clinical psychology training programs create sustainable and inclusive infrastructure to train people with psychosis as psychologists, cognitive behavioral clinicians, scientists, and trainers.** While exceptions exist (Frese et al., 2009; Varghese & Boyd, 2022), leaders with long-term psychosis remain a tiny minority. A thorough description of methods to create a pipeline to support these individuals in academia is available in our past work (Jones et al., 2021).

**6. All psychologists should receive broad cross-training in psychosis interventions, including innovative, culturally informed, and person-centered understandings of psychosis.** Psychologists have treated psychosis and SMI as a niche-only area of training for too long. People with psychosis exist everywhere. The first mental health access points for folks with psychosis are often places like college counseling centers, primary care programs, and general outpatient mental health programs (e.g., Bhui et al., 2014; Saavedra et al., 2023), especially for Asian and Black people (Coleman et al., 2019). All psychologists should receive appropriate training and supervision so they are confident implementing psychosis-specific and transdiagnostic interventions for people with psychosis.

#### *Research Recommendations*

**7. CBT research must invest in lived experience research and co-creation research practices.** It's not enough to collect data from people with psychosis; people with psychosis must be integrally involved in research at all stages, from design to dissemination (e.g., Haarmans et al., 2022; Nelson et al., 1998). People with psychosis must further hold important roles in this research up to and including "principal investigator," and be equitably paid and recognized for their labor (cf. Jones et al., 2021, 2023).

**8. All clinical research, including clinical trials, should include people with psychosis unless there is a clear scientific justification.** People with psychosis are capable of consenting to clinical research, although some participants may need additional time or explanation (e.g., Carpenter et al., 2000). In the authors' experience, spending a little more time on informed consent also helps build trust and troubleshoot areas of potential concern (e.g., how safe will my data be?) early on. Clinical researchers should provide this accommodation to all participants who require or



prefer it, regardless of diagnosis. Expanding study criteria to include people with psychosis expands our ability to impact populations in need of mental health intervention and improves generalizability of research findings.

### *Clinical Recommendations*

**9. As clinicians, we must engage in empowering practice by truly listening to our clients.** It's clear there is significant variation in how people experience psychosis and make meaning of those experiences (e.g., Jackson et al., 2011). We can serve our clients much more effectively by deeply understanding how they understand and make meaning out of their experiences. This supports the development of trust and a strong therapeutic relationship, and helps ensure that we jointly choose an appropriate treatment goal and intervention strategy for each client rather than assuming that all clients seek the same answer (e.g., Greenhalgh et al., 2014, 2015).

**10. We must suspend our privilege of belief.** As CBT practitioners, we are well-equipped to help our clients reality test themselves. We must do the same within our own clinical practice. For example:

- Why do I believe this is a delusion? Is there clear and objective evidence that my client's perception of reality must be false?
- How does my client understand their symptoms? Do their symptoms fit into their cultural, religious, or spiritual values? Are they related to the client's personal history, including individual and generational trauma or grief?
- Why is it important to me for the client to recognize this belief as a delusion? What would they gain? What would I gain?

**11. Collaborative decision-making and person-directed care strategies support empowered practice.** Clients should be meaningful and powerful participants in each decision made about their care (Treichler et al., 2021). Past literature is clear that engagement in decision-making requires not only knowledge about the decision and alternate treatment options, but also true power in the process and trust in the clinical team (Joseph-Williams et al., 2014; Pérez Jolles et al., 2019).

### **Conclusion**

Pervasive stigma and discrimination against people with psychosis permeates

the discipline of psychology, spanning training, research, and practice, which negatively impacts our ability to provide truly patient-centered, collaborative, and effective therapeutic supports. At a structural level, lack of access to psychosis-focused clinical training, and the corresponding lack of psychosis-related competency and knowledge among psychologists, especially given the breadth and depth of evidence-supported interventions available, functions iatrogenically: clients are not provided access to best practices, and status quo practices too often reflect outmoded, stigma-laden interventions without appropriate tailoring to individual and cultural experiences and values. Investing in multi-level empowerment is the way forward, centrally including measures to ensure meaningful power and participation among people with psychosis as clients, clinicians, researchers, and decision makers. Current disparities and inequities are inevitable only if we take no action; we call on psychologists to acknowledge the past, embrace change, and act.

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# The “A” Is Not for Ally: The Continued Pathologization of Asexual People in Modern Mental Health Practice

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WHEN ASSESSING for depression during an intake session last year, a 20-year-old trans client told me that he has experienced low sexual interest for as long as he could remember, an experience about which he was not particularly distressed. When I asked whether the client had considered that he might be asexual, he exclaimed, “Thank you! My last therapist said that I was ‘just traumatized’ and that we would ‘fix’ that with the trauma treatment she had planned.” The client subsequently disclosed that they were exploring an asexual-spectrum identity.

Scholars have described asexuality as “one of the most under-researched, misunderstood, and under-represented sexual identities of the 21st century” (Pinto, 2014), and the former therapist’s statement demonstrates this misunderstanding. By framing the client’s lack of interest in sex as a symptom that could be cured, the therapist sent the message to this client that there was something wrong with him and that his low sexual interest can and should be changed. In so doing, the therapist (likely inadvertently) bought into discredited notions often peddled by so-called conversion therapists that nonheterosexual, “atypical” sexual orientations are wrong and should be a focus of intervention. The therapist reinforced stigmatizing views of asexuality as illegitimate, and problematized healthy sexuality by attributing it to psychopathology.

The mental health field, including cognitive behavior therapists, has a poor track record when it comes to serving people with nonheterosexual sexualities. As is documented extensively throughout this special issue and in the broader literature (Capriotti & Donaldson, 2022; Drescher, 2015), mental health providers have long stigmatized nonheterosexual sexual orientations by including same-gender attraction as a disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952, 1968, 1980; Drescher), minoritizing sexual minority professionals in the field (Drescher & Merlino, 2007, pp. xvii, 2), and, in the case of behavior therapists

specifically, developing cruel and inhumane so-called “treatments” to “cure” clients of their same-gender attraction (e.g., Barlow et al., 1972; Feldman & MacCulloch, 1971). Despite most reputable professional associations discrediting them (including the Association for Behavioral and Cognitive Therapies; ABCT, 2022), these sexual orientation change practices continue to torment sexual minorities across the world today (Adamson et al., 2020; Higbee et al., 2022).

Therefore, the goal of this article is to increase clinicians’ awareness of and competency in working with asexual clients by: (a) defining and demystifying asexuality; (b) highlighting ways in which the mental health field pathologizes asexual people and low sexual interest/attraction; and (c) providing concrete strategies for affirming asexual people in evidence-based clinical practice. In so doing, we can collectively reduce the number of asexual clients exposed to harmful sexual orientation change practices.

## Defining Asexuality

The Asexual Visibility & Education Network (AVEN)—which claims to be the world’s largest online community for asexual people—defines asexuality as “a person who does not experience sexual attraction” (AVEN, 2023; see Table 1 for a list of relevant terms and definitions). Asexuality can be thought of as the opposite of “allosexual”—a term referring to people who do experience sexual attraction. While researchers have historically viewed asexuality as negative (Prause & Graham, 2007), and as a symptom experienced by older people (Deacon et al., 1995), people with physical disabilities (Milligan & Neufeldt, 2001), and people with severe mental illness (Carmen & Brady, 1990), asexuality is now an identity label that people use to understand and communicate their own experience, and to find community. Estimates of the prevalence of asexuality range between 0.4% (Aicken et al., 2013; Greaves et al., 2017) and 1% (Bogaert, 2004; Ipsos, 2023), although studies in this area are limited by inconsistent operationalizations.

Asexuality is distinct from aromanticism (i.e., lack of romantic attraction) and from celibacy (i.e., refraining from sexual behaviors). Indeed, many asexual people form romantic attachments (including marriage) and masturbate or have sex with their partner/s (Aicken et al., 2013; Brotto et al., 2010; Foster & Scherrer, 2014; Kelleher et al., 2023; Rothblum et al., 2020). Some asexual people identify with another sexual orientation (in addition to asexuality) as a way to indicate their romantic orientation or other aspects of their identity (Foster & Scherrer). For example, a person might identify as an asexual gay man, indicating that they identify as a man, are interested in romantic relationships with other men, and are not interested in sex. In a survey of more than 7,500 asexual participants over the age of 18 living in the U.S., Canada, and the U.K., around 41% of respondents identified as biromantic or panromantic (i.e., romantically attracted to multiple genders), 18% as heteroromantic (i.e., romantically attracted to people of a different gender), 10% as homoromantic (i.e., romantically attracted to the same gender), and 32% as aromantic (Winer et al., 2022).

## Pathologization of Asexual People

Asexual people, like other sexual minorities, often experience sexual orientation-related marginalization and discrimination (APA, 2021; Chasin, 2015; MacNeela & Murphy, 2015; Prause & Graham, 2007), with some reports indicating more felt stigma and everyday discrimination among this group than other sexual minorities (Rothblum et al., 2020). Qualitative research reveals that asexual people are often met with a number of negative stereotypes about asexuality, including asexuality as a symptom of: trauma (particularly sexual trauma), immaturity (“late bloomers”), a lack of prior sexual experience, prudishness, anxiety (“just afraid of sex”), lacking humanity (“like a robot”), or a temporary affliction that will pass (Kelleher & Murphy, 2022). Experimental research suggests that asexual people, relative to heterosexuals and other sexual minorities, may be evaluated more negatively and viewed by others as less human, and are likely to be discriminated against by heterosexuals (MacInnis & Hodson, 2012).

At times, this harmful message that asexual people are defective has led to sexual violence in which others attempt to “fix” their lack of sexual attraction by

coercing them into sexual activity (Kelleher & Murphy). In line with minority stress theory (Brooks, 1981; Meyer, 2003), there is evidence that asexual people internalize these negative societal messages about asexuality, leading them to feeling socially isolated and “like an alien” (Kelleher & Murphy).

These stigmatizing messages about asexuality also exist among mental health providers (Herbitter et al., 2021). While training programs may have improved educational practices related to the care of other sexual minorities (e.g., gay, lesbian, and bisexual people), there remains a remarkable lack of education about asexual people (Abbott et al., 2021; Miller & Byers, 2010). Perhaps as a result, many asexual people choose not to share their identity with healthcare professionals due to expectations of being mistreated, pathologized, judged, or simply dismissed (Flanagan & Peters, 2020; Foster & Scherrer, 2014; Jones et al., 2017; Rothblum et al., 2020). Others feel forced to share their asexual identity to explain their sexual health decisions (e.g., not being on contraception), or to counter claims by providers that they are lying about their level of sexual activity (Flanagan & Peters). Even when asexual people do disclose their identities to health providers, many experience the pathologization of their asexuality by providers discussing and/or diagnosing them with a condition that might “explain” their lack of sexual desire or behaviors (Flanagan & Peters).<sup>1</sup>

The mistreatment of asexual people in clinical settings likely begins as early as the first encounter, when an initial case conceptualization is being formed. The collaborative development and refinement of an accurate case conceptualization that is guided by research-informed understandings of clinical symptoms and syndromes and the client’s expertise in their own culture and context is central to evidence-based mental health practice (Beck, 2021). To accurately co-conceptualize asexual clients, then, clinicians must recognize allonormative bias (that is, the default assumption that everyone experiences sexual attraction) in both our diagnostic

systems and in society. This is no mean task, given that allonormativity is built in to our mental health training programs—potentially a relic of Freud’s teachings that everyone is inherently sexual (Foster & Scherrer, 2014).

### *Asexuality in the DSM*

The clearest example of anti-asexual bias in clinical assessment can be found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; APA, 2022). Since DSM-III (APA, 1980), every DSM edition has included at least one diagnosis that is characterized by a lack of interest in sex (Hinderliter, 2015); in DSM-5-TR, there are two diagnoses: Male Hypoactive Sexual Desire Disorder (MHSDD) and Female Sexual Interest/ Arousal Disorder (FSIAD). In MHSDD, hypoactive sexual desire may manifest as absent or deficient sexual thoughts/fantasies, and as absent or deficient desire for sexual activity (APA, 2022). In FSIAD, lack of sexual interest may manifest as: absent/reduced interest in sexual activity and/or sexual materials, absent/reduced sexual thoughts/fantasies, absent/reduced sexual excitement/pleasure during sexual activity, and/or absent/reduced genital or nongenital sensations during sexual activity; no/reduced initiation of sexual activity; and/or being unresponsive to partner’s attempts to initiate sexual activity (APA, 2022).

Nowhere in the preamble to or the diagnostic criteria of the sexual dysfunction disorders is asexuality raised as an important possibility for clinicians to explore prior to diagnosis. Instead, brief statements about asexuality are buried in the extended explanations of these disorders. At the end of the MHSDD section under “other sexual dysfunctions,” the DSM-5-TR committee notes that “if the man’s low desire is explained by self-identification as an asexual, then a diagnosis of MHSDD is not made” (APA, 2022, p. 501). A similar statement with the word “asexual” in quotation marks is made in the FSIAD section under “diagnostic features” (APA, p. 478). (Of note, the word “gay” is included elsewhere in the FSIAD section without quotation marks.) Putting aside the fact that these considerations should be more prominent

and visible to providers (e.g., through inclusion in the diagnostic criteria), this statement perpetuates the message that low sexual desire/interest is pathological for those who do not specifically use the “asexual” label (including folks on the ace spectrum like demisexuals) (Margolin, 2023).

To meet diagnostic criteria for MHSDD or FSIAD, an individual must also experience clinically significant distress related to their low sexual interest/desire (APA, 2022). While this criterion may exclude asexual people who feel secure in their identity, it fails to acknowledge the stigma and minority stress that many asexual people experience that leads them to feel distressed about their asexual identity. Like the now-defunct DSM-II’s sexual orientation disturbance and the DSM-III’s ego dystonic homosexuality diagnoses, this distress criterion essentially allows asexuality to be considered pathological so long as the client is unhappy about it. Chasin (2015) criticizes this approach, noting that “allowing asexual people to be diagnosed with [the precursor to MHSDD and FSIAD] because they are distressed because they live in a world that is inhospitable to asexual people is not only complicit in the persecution of asexual people but actively reinforces it.”

The inclusion of low sexual interest disorders is fundamentally opposed to DSM-5-TR’s approach to same-gender attraction, a key feature of other sexual minority identities (e.g., gay, bisexual, pansexual). There is no diagnosis in DSM-5-TR that includes same-gender sexual desire or interest as a primary symptom because such desire/interest is considered a typical, nonpathological variation in human sexuality (APA, 2021). Why then does the DSM-5-TR include a central feature of asexuality as a primary characteristic of a disorder?

### *Depression and Trauma*

While low sexual interest/libido is not an official symptom of major depressive disorder or posttraumatic disorder (PTSD) in DSM-5-TR, clinicians like the one described at the beginning of this article may conceptualize low sexual interest as part of a broader depressive or trauma presentation.

Depression has long been associated with reduced sexual interest/libido (Michael & O’Keane, 2000), with 33–50% of clients reporting decreased sexual interest relative to before the onset of their depressive episode (Kennedy et al., 1999; Thakurta et al., 2012). Reduced sexual

<sup>1</sup>Importantly, there is mixed evidence for an increased mental health burden among asexual people relative to their heterosexual peers. While some studies have found evidence for more mood concerns, anxiety, psychotic symptoms, suicidality, and personality disturbance among asexual people relative to heterosexuals (Brotto et al., 2010; Yule et al., 2013), others have found no difference in mental health symptoms across the two groups (Brotto et al.; Greaves et al., 2017).

interest in this case may be considered a symptom of anhedonia, or a loss of enjoyment in pleasurable activities. The key to differentiating asexuality from depression-related reduced sexual interest is chronicity. While sexualities are fluid (Diamond, 2016), they are more stable than mood episodes (which may last only a few weeks); thus, if a client's low sexual interest and attraction precedes mood symptoms, an exploration of the client's potential asexuality might be warranted.

Asexual people report higher rates of PTSD and past 12-month sexual assault victimization relative to allosexuals (Parent & Ferriter, 2018). Scholars have previously speculated that childhood trauma or sexual abuse might be the reason behind asexual people's lack of sexual attraction (Brotto et al., 2010; Yule et al., 2015). However, recent work on a validated measure of asexual identity found that scores on this measure were not correlated with scores on a common childhood trauma measure (Yule et al., 2015), suggesting that asexuality and childhood trauma are distinct constructs. Thus, contrary to the statement by the clinician at the beginning of this article, it is not possible to definitively conclude that a lack of sexual attraction in a person who has experienced trauma is due to the trauma—

it could also be related to a healthy variation in human sexuality (e.g., asexuality).

### A Call to Action

The APA *Guidelines for Psychological Practice with Sexual Minority Persons* state that “psychologists understand that sexual minority orientations are not mental illnesses, and that efforts to change sexual orientations cause harm” (APA, 2021). To fully enact this guideline with asexual people, clinicians must challenge personal, professional, and societal assumptions that sexual attraction is universally experienced. Clinicians can prevent the continued pathologization (and attempted “conversion”) of asexual people by adjusting their clinical practice to affirm asexual identities and experiences in the following ways.

#### Inclusive Demographic Forms and Intake Questions

Asexual people are more likely to disclose their asexuality to a health practitioner when asked a direct question about their sexual identity (Flanagan & Peters, 2020). Therefore, consider asking clients directly about their sexual orientation and/or including “asexual” and other ace-spectrum identities like demisexual and

gray-A (see Table 1 for definitions) on demographic forms in clinical and research settings to provide individuals the opportunity to share this information. Providing this visible indicator of your understanding of asexuality sends the signal to the individual that your setting is safe for asexual people.

Similarly, when asking clients about their romantic and sexual lives, do not assume that they are allosexual (Flanagan & Peters, 2020). Instead, ask questions like, “Are you interested in having romantic relationships?” and “Is sex an important part of your life/relationship?” Showing an awareness of and openness to the broader LGBTQIA+ community (e.g., including visible indicators of support like pride flags in your clinic space) can signal to asexual people that you might be a safe health professional with whom to share their identity (Foster & Scherrer, 2014; Zullo et al., 2021).

#### Respecting Self-Determination

Given asexuals' poor treatment by the mental health field both historically and at present (e.g., Capriotti & Donaldson, 2022; Hinderliter, 2015), it is critical that clinicians and researchers respect individuals' right to self-determination. As in our work with gender diverse individuals and other

**Table 1.** Definitions of Common Terms Relevant to People Under the Asexual Umbrella

Term	Definition
Asexual	A person who does not experience sexual attraction. Sometimes referred to as “ace”
Allosexual	A person who experiences sexual attraction. Sometimes referred to simply as “sexual”
Allonormativity	The assumption that all people experience sexual attraction
Demisexual	A person who does not experience sexual attraction until they develop a close emotional bond with a partner/s
Gray-asexual (gray-a)/Gray-sexual	A person who experiences sexual attraction infrequently
Aromantic	A person who does not experience romantic attraction or desire romantic relationships
Grayromantic	A person who feels romantic attraction rarely or very weakly
Heteroromantic	A person who is romantically attracted to people of a different gender
Homoromantic	A person who is romantically attracted to people of the same gender
Biromantic / Panromantic	A person who is romantically attracted to people of multiple genders
Sex-favorable	An attitude describing a positive willingness to engage with a sexual partner and find ways to enjoy sexual activity in a physical or emotional way
Sex-indifferent	An attitude describing a possible willingness to engage with a sexual partner, while not enjoying sex much, but doesn't feel distressed thinking about it
Sex-repulsed	An attitude describing a distressed, often visceral reaction to the thought of having sex; not willing to engage in sex
Anti-sexual	A belief that sexuality in society is wrong or should be avoided <sup>1</sup>
Queerplatonic relationship	A committed non-romantic, non-sexual relationship often between aromantic and/or asexual people who experience a deep emotional bond that is more than friendship

*Note.* This table was compiled from the Asexual Visibility & Education Network's (AVEN) website and forums and is nonexhaustive. For additional definitions, see <http://wiki.asexuality.org/Asexuality>. <sup>1</sup>According to AVEN, most asexual people do not hold this view.



sexual minorities, it is not the job of a provider to “figure out” whether someone is asexual (unless the client wants to explore this topic) or what might have “caused” their lack of interest in sex. If someone says that they are asexual, believe them.

### *Affirming Disclosures of Asexuality*

When a client discloses their asexual identity, convey your support and acceptance verbally and nonverbally (Flanagan & Peters, 2020), both towards your client specifically, as well as towards the notion that asexuality is a normal and healthy identity. Rather than dismissing a client’s lack of sexual interest or attraction as a symptom of a disorder, thank the client for trusting you with that information and listen to what they wish to share (Flanagan & Peters). Given the broad diversity of experiences under the asexual umbrella, consider asking further questions such as, “I’ve had a number of asexual clients in the past, all of whom describe their sexuality slightly differently. What does being asexual mean to you?” If terms arise that are less familiar, spend time before the next clinical session reading up on the topic to reduce the educational burden on the client (Flanagan & Peters). Remember that the client’s sexuality may be unrelated to the presenting problem; do not assume that the client’s identity is inherently linked to their mental health concerns (Foster & Scherrer, 2014; Zullo et al., 2021).

### *Differential Diagnosis*

If a client has raised low/no sexual attraction/interest as an important part of their presentation, it is wise to include this in their collaborative case conceptualization. However, carefully consider whether a diagnosis is appropriate. Establish a timeline of the client’s other presenting problems (e.g., low mood, trauma exposure) as well as their sexual interest/attraction. If the low sexual interest appears to be temporarily confined to a mood episode or had a sudden onset after trauma exposure, consider the appropriate mental health diagnosis. If the low sexual interest/attraction seems tied to medications, or hormonal or developmental changes, consider consulting the appropriate medical professional. If, however, the low sexual interest/attraction is lifelong or longstanding, consider exploring the client’s sexual orientation.

Regardless of the diagnostic outcome, it is important to embody an affirming stance towards folks who do not experience sexual attraction, and avoid labeling low sexual

interest/attraction as a problem or symptom. Diagnosing clients with MHSDD or FSIAD is antithetical to this affirming stance; however, acknowledging and normalizing the very real distress that clients may be experiencing is well within an affirming framework and good clinical practice. You might say to the client something like, “Human sexuality is super complex and can take a wide range of forms—from feeling a lot of sexual attraction to feeling none at all. All of these variations are normal, natural, and healthy, and don’t need to be changed or treated.” Even if low sexual interest appears to be related to depression or trauma, focus on managing the client’s other symptoms using an evidence-based approach, rather than attempting to directly change the client’s sexuality. Future DSM workgroups should carefully consider the removal of MHSDD and FSIAD as mental health diagnoses, in consultation with asexual stakeholders.

### *Exploring Asexuality*

Because of society’s denigration of people who experience low sexual interest or attraction, as well as misunderstandings of what asexuality is, some clients may be unaware of asexuality as a label that might apply to them. If the client expresses interest in exploring this possibility, consider using evidence-based tools like the Asexuality Identification Scale (AIS; Yule et al., 2015), or introducing the client to online asexual community resources like AVEN ([www.asexuality.org](http://www.asexuality.org)) so that they can learn about a diversity of asexual experiences and begin to determine if this label fits themselves (Foster & Scherrer, 2014; Jones et al., 2017). The role of online communities cannot be understated; given the lack of asexual representation in popular media, many individuals only find language to describe their experiences, as well as support of those experiences, through these online forums (Fox & Ralston, 2016; Jones et al., 2017). Discussing these resources and asexuality in general during therapy sessions may also help clients clarify their identity (Foster & Scherrer, 2014). It is important to express throughout this work that asexuality is healthy and normal and that this label does not signal something wrong or deficient in the client (Foster & Scherrer).

### *Sexuality-Related Distress*

Living with a lack of sexual interest in a culture that values sexuality may be an isolating and distressing experience for asexual people (Chasin, 2015). Thus, it is possi-

ble that when conducting an initial assessment, some asexual people might describe distress related to their disinterest in sex. As when working with other sexual minorities, clinicians should carefully assess the source of the client’s distress with attention to these societal and cultural factors (e.g., discrimination) that may make identity development, sexual orientation disclosure, and social and romantic relationships challenging for asexual people. For example, clinicians might ask, “What messages have you received about asexuality, or about what it means to not be interested in sex, from those around you?” Consider adapting and using evidence-based treatment protocols that directly address minority stress for use with asexual clients (e.g., Pachankis et al., 2022). Regardless of whether a client’s lack of sexual interest is related to asexuality or not, using cognitive strategies to explore the impact of negative societal and cultural views of sexuality on the client will likely challenge any erroneous beliefs that the client is somehow wrong or deficient for having low sexual attraction/interest and in so doing, decrease their distress.

### *Navigating Relationships*

The literature highlights navigating romantic and sexual relationships as a potential stressor for asexual people (Kelleher & Murphy, 2022). Due to the internalization of negative messages about asexuality as bad, prudishness, or otherwise illegitimate, some clients might avoid relationships altogether in order to avoid “burdening” potential partners (Kelleher & Murphy). In line with models of affirming therapy for LGBTQ+ people (Pachankis et al., 2022), clinicians can use standard cognitive and behavioral techniques to challenge clients’ negative beliefs about their identity and to explore what the client’s romantic relationships might look like (if the client is interested).

Other clients may enter into relationships but be unsure about whether or how to share their asexual identity with their partner(s) (Kelleher & Murphy, 2022). If the client does decide to share their identity with loved ones, consider supporting this disclosure (e.g., in a joint session) and providing psychoeducation to the partner(s) about asexuality. It may be useful to discuss communication strategies with the client and their partner(s), particularly around sex, to prevent the client feeling pressured to engage in sex that they do not feel comfortable with.

## Conclusion

Asexuality is poorly understood by mental health providers, and asexual people are at high risk for inadvertent (but still unethical) sexual orientation change practices (also called "conversion therapy"). Providers must intentionally challenge their own allonormative biases to provide asexual people with the affirming care that they deserve.

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# Cognitive Behavioral Therapy for Latine Immigrants: Implications for Reducing Harm and Promoting Change

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IT IS ESTIMATED that 44% of U.S. immigrants (19.8 million people) are from Latine<sup>1</sup> ethnic origins (Esterline & Batalova, 2022), and 13% (8 million people) of the 62 million Latine individuals in the U.S. are undocumented (Department of Homeland Security, 2022). The Latine immigrant community is growing, and public health inequalities and disparities for these communities are also rising, especially as they relate to increasing individual stress and community/systemic discrimination (Cariello et al., 2022; Morey, 2018). This is especially true for immigrants with interacting minoritized identities (e.g., Black, Latine, undocumented status, nonheterosexual orientation, and noncisgender; e.g., Cadenas et al., 2022; Torres et al., 2022). Many Latine immigrants who choose to immigrate may have faced trauma in their country of origin and/or experienced traumatic-stress migration (Fortuna et al., 2023). Experience of traumatic stress can be compounded upon arrival in the U.S., especially those with undocumented legal status, who face xenophobic, anti-immigrant, and racist policies and sentiments (Alang et al., 2017; Arbona et al., 2010; Garcini et al., 2017; Moreno et al., 2021). The challenging social, economic, and public health issues affecting the well-being of undocumented Latine communities require immediate action to address their complex needs, protect their human rights, and reduce public mental health risks.

Cognitive behavioral therapy (CBT) is considered the “gold standard” of psychological treatments (David et al., 2018; Huey Jr et al., 2023), and it could play a key role in addressing the public and mental health needs for Latine immigrants; however, therapists are cautioned to engage critically in helping and not further harming these communities when applying CBT with

racially and ethnically diverse clients (Naeem et al., 2019). Given that the theory and practice of cognitive and behavioral interventions were historically founded and rooted in the global north (i.e., Western or Euro-American) and not based on the lived experiences of Latin Americans (i.e., ancestry or origin from Central and South America and the Caribbean), psychologists run the risk of further marginalizing Latine immigrants when applying interventions like CBT without cultural humility. Thus, this article will (a) describe the potential harms of applying CBT without an emphasis on Liberation Psychology with Latine immigrants, (b) discuss current efforts to culturally adapt CBT with Latine immigrants, and (c) provide further recommendations for enhancing the cultural responsiveness of cognitive behavioral therapies with Latine immigrants.

## CBT Through the Lens of Liberation Psychology

The theoretical underpinnings of CBT interventions are based on cognitive and behavioral models that help explain how negative thoughts and behaviors can lead to mental health problems (Thoma et al., 2015). Cognitive models suggest that individuals' interpretations of situations can influence their reactions more than the situations themselves (e.g., cognitive triad; David et al., 2018; Thoma et al.). On the other hand, behavioral models suggest that our environment and the reinforcement of our actions can shape our behaviors (David et al., 2018; Hayes & Hofmann, 2018). As a result of these theories, CBT interventions are designed to modify negative thoughts and behaviors through cognitive restructuring (i.e., identifying and challenging negative thoughts and beliefs and replacing

them with more realistic and positive ones; Hayes & Hofmann).

Contrary to CBT, which psychologists in North America primarily developed, the Liberation Psychology movement grew out of postcolonial struggles in Latin America and Africa, where psychologists like Ignacio Martín-Baró questioned the universality of psychology research and sought to apply psychological principles in the service of the oppressed (Burton & Guzzo, 2020). Through the lens of Liberation Psychology, Martín-Baró argued modern psychology, including cognitive theory and behaviorism, fails to be relevant to Latine people due to their rooting in individualism compared to the collectivist nature of Latin American culture. He also challenged the assumption that psychology findings are universal because they neglect historical and political factors, including oppression and their influence on human behavior (Martín-Baró, 1994). The critiques of psychology offered by Liberation Psychology have direct relevance to applying CBT with Latine immigrants. When psychologists solely focus on the individual level (e.g., cognitive distortions), they ignore the root causes of the problem, such as the broader racist and oppressive environments that impact clients' well-being (Chavez-Dueñas et al., 2019). Neglecting the sociopolitical context during heightened nativism and racism towards Latine individuals could lead to significant harm in therapy.

## CBT for Latine Immigrants: A Potential Harm?

Psychologists utilizing CBT with Latine immigrants could harm clients if they fail to conceptualize the client's behaviors and mental health challenges regarding their social and cultural contexts. This could result in a misdiagnosis, unhelpful treatment plans, and microaggressions, defined as subtle discriminatory comments or actions that cause offense and invalidate the lived experiences of members of minoritized groups (Owen et al., 2014). The occurrence of microaggressions is associated with greater psychological distress for Latine individuals (Moreno et al., 2023), and microaggressions that occur in therapy have been shown to harm the therapeutic alliance, which is a central factor of therapeutic success across treatments (Owen et al.). Microaggressions towards Latine immigrants in therapy may also perpetuate societal anti-immigrant bias and reaffirm specific fears and mistrust some

<sup>1</sup>Latine aims to define the diverse communities in the Americas and the Caribbean, including Latino/a, Latinx, Hispanic, and Spanish-speaking individuals. It's important to note that some Latine communities also include indigenous people with non-Spanish languages. It is important to note that self-identification is a personal choice, and “Latine” may not fully represent everyone's experiences, especially among indigenous individuals.

Latine immigrants may have towards U.S. institutions.

While microaggressions can occur regardless of the therapeutic modality used, CBT practitioners must recognize the risks of harm when rigidly adhering to CBT interventions and techniques. CBT's emphasis on individuality, rationality, and assertiveness may contradict Latine immigrants' specific values when prioritizing family, spirituality, and emotional expression (Huey Jr et al., 2023; Moreno et al., 2023; Sue et al., 2022). Additionally, CBT practitioners' focus on treating intrapsychic factors could lead to neglecting the realities of environmental oppression.

For example, a non-Latine White CBT practitioner working with a Latine immigrant client with anxiety may identify a client's belief that "I am never safe" as a cognitive distortion to dispute. While a psychologist may look at this as an example of "all-or-nothing thinking," directly disputing this thought may minimize a client's rational fears stemming from acculturative stress (Moreno et al., 2022), fear of deportation (Moreno et al., 2021), individual- and systemic-level discrimination (Meca et al., 2022), and other immigrant-related stressors (Moreno et al., 2023). In this example, a culturally responsive CBT practitioner may instead validate the realities of the client's fears stemming from social-political factors and work with the client on identifying culturally significant coping strategies and finding sources of support.

### **Cultural Adaptation of Cognitive Behavioral Therapy for Latine Immigrants**

The effectiveness of CBT with racial and ethnically diverse clients has been questioned in recent years, with researchers highlighting the need to make cultural adaptations for racially and ethnically diverse clients (Huey Jr et al., 2023; Naeem, 2019). While researchers have generally shown that CBT effectively treats a wide array of mental health disorders with racially and ethnically diverse clients, Huey Jr and colleagues found in a recent review that the CBT effect sizes were consistently greater for White participants than ethnic minority clients. In a review of treatments for depression among Latines, CBT was found to be better than usual care but not when compared to an active matched control condition (Collado et al., 2016). In a review of CBT for Latine clients with anxiety, Casas and colleagues (2020) found sup-

port for using CBT in reducing anxiety symptom severity in several studies. Additionally, they found that cultural adaptations may reduce external barriers to treatment (e.g., offering bilingual services). The authors also suggested cultural adaptations may be especially critical for Latine immigrants (Casas et al.).

Examples of culturally adapted CBT for Latine immigrants include the work of Fortuna and colleagues (2020), who developed an integrated CBT and mindfulness intervention for Latine immigrants with co-occurring substance use and mental health disorders. Their intervention included training in mindfulness skills, cognitive restructuring, motivational interviewing, and relapse prevention skills culturally adapted through the use of culturally relevant metaphors, proverbs, values, and increased use of visual aids. In their mixed-method study, participants were positive about the therapeutic alliance and intervention. They reported improved illness self-management and recovery skills and greater use of mindfulness and cognitive skills, which they reported to help manage anxiety and depression. In a subsequent study, Fortuna and colleagues (2023) integrated mindfulness, CBT, and spiritual and religious beliefs with Latine unaccompanied immigrant children. In this intervention, the authors incorporated a cultural humility framework to explore the participants' experiences with religion and spirituality and integrated them as a form of adaptive coping when appropriate. The authors also discussed exploring participants' migration-related factors and attending to their family relationships. In their case study, Fortuna and colleagues (2023) observed reductions in post-traumatic stress disorder (PTSD) symptoms among participants.

Chavez-Dueñas and colleagues (2019) suggested a model for Healing Ethno-Racial Trauma (HEART) among Latine immigrant communities that integrated Liberation Psychology and Trauma-Focused CBT (TF-CBT). In the HEART model, the authors proposed psychologists can foster individual and communal healing by offering sanctuary spaces for Latine immigrant clients. The authors discussed integrating cognitive restructuring skills with the process of *concientización*, which refers to critical consciousness-raising (i.e., developing awareness of how historical and contextual factors led to the systemic oppression of marginalized groups). The authors highlight how this can help clients externalize their trauma symptoms from

self-blame to recognizing how they are influenced by environmental and political factors (Chavez-Dueñas et al.).

### **Recommendations for CBT With Latine Immigrants**

Psychologists utilizing cognitive and behavioral theories can potentially harm Latine immigrant clients if they fail to recognize their historical and cultural backgrounds. However, culturally adapting CBT in such a way that promotes ancestral, collectivistic, and cultural values that support well-being may facilitate healing in Latine immigrant communities (Chavez-Dueñas et al., 2019; Comas-Díaz, 2015; Hernandez-Wolfe, 2022; Fortuna et al., 2020; 2023). In the following section, we offer recommendations drawing on prior literature for how psychologists can better serve Latine immigrant communities.

#### ***Reflections of Privilege and Deconstructing Power Hierarchies in CBT***

Psychologists who fail to recognize the cultural background of Latine immigrants or who neglect the historical and contextual factors contributing to oppression may be more likely to commit microaggressions, which can harm the therapeutic relationship and mental health of clients (Owen et al., 2014; Sue et al., 2022). Thus, clinicians who work with Latine immigrant communities must become aware of the relative privilege they hold through their professional roles and intersecting identities and find ways to limit power hierarchies with their clients who may hold less privilege. Clinicians can do this by adopting a standpoint of cultural humility, which is displaying openness and curiosity about the relevance of their client's cultural background (Hook et al., 2016). Using cultural humility may limit the likelihood of microaggressions (Hook et al., 2016) and assist therapists in providing CBT to Latine immigrant clients in a collaborative and empowering way.

Additionally, it is essential to understand that marginalized groups, such as Latine individuals, are not a monolithic entity (Huey et al., 2023). Latine immigrants specifically may hold shared experiences, but they represent diverse subpopulations with varying beliefs and values that can influence their mental health and engagement in therapy (Maura & Kopelovich, 2020). Therefore, when applying CBT to Latine immigrants, it is crucial to recognize the heterogeneity within this population and adopt a culturally situated

approach to assessment and intervention (Huey et al., 2022; Maura & Kopelovich). Clinicians who utilize cultural humility can acknowledge and respect their clients' unique backgrounds, experiences, and identities and not make assumptions or pool all Latine individuals together, which could lead to essentializing or stereotyping (Held et al.; Huey et al.).

For example, a White female therapist working with a male Latine immigrant client from El Salvador could display cultural humility by inquiring about their experiences of immigration-relation stressors, discussing their client's cultural and familial background, and demonstrating openness to incorporating Latine cultural and spiritual values into therapy. When providing CBT, the therapist could inquire if certain cognitions have a basis in Latine culture and engage in cognitive reframing collaboratively. The therapist could also integrate mindfulness interventions by exploring the importance of the mind-body connection and discussing mindfulness to engage one's spirituality (Fortuna et al., 2020; 2023). For further guidance on adopting a culturally humble approach, the authors recommend Davis and colleagues (2019) mindfulness-based practices in therapy.

### *Decenter Away From Western Views of CBTs*

Feminist and multicultural scholars have argued that the push towards evidence-based practices like CBT in psychology has led to the marginalization of non-Western healing practices and social justice approaches, often rendered invisible in the literature (Hernandez-Wolfe, 2022; Rogers-Sirin, 2017). However, the Western framework of CBT may clash with the values and epistemological frameworks of Latine immigrant communities (Martín-Baró, 1996). Recently, psychologists have highlighted the importance of uplifting ancestral wisdom and indigenous and Latine cultural teachings as important funds of knowledge that continue to be ignored and devalued to the disservice of Latine communities (Comas-Díaz, 2015; Hernandez-Wolfe). There are many examples of practices psychologists can integrate, ranging from incorporating storytelling into therapy and integrating religion and spirituality.

According to Comas-Díaz (2015), empowering clients to develop personal narratives or testimonials is an approach consistent with Latine cultural and indigenous worldviews, which can empower

clients to heal from trauma. Assisting clients in developing personal narratives, which may be written or oral, and then sharing in therapy and within their community is also consistent with TF-CBT trauma narrative exposure (Chavez-Dueñas et al., 2019). Many non-Western communities, including Latine ones, may believe that mental health symptoms have a spiritual or religious basis (Naeem et al., 2019). Failing to assess the spiritual and cultural significance of mental health and incorporating a client's values and cultural beliefs (e.g., spiritual background) into clinical practice harms the counseling relationship and leads to premature dropout from therapy (Hernández Dubon et al., 2022).

That said, CBT therapists utilizing a cultural humility framework can help clients differentiate thoughts that contribute to distress (e.g., beliefs that they are guilty or being punished) from healthy thoughts (e.g., believing God is on their side; Comas-Díaz, 2015). While not all psychologists will be experts in Latine spiritual and cultural traditions, exploring and being curious about healing practices and rituals ranging from prayers, cleansing ceremonies, and enlisting curanderos (i.e., traditional healers or Shamans) may be helpful for clients who are religious or spiritual (Hernandez-Wolfe, 2022; Comas-Díaz).

### *Engaging in Liberation Praxis for Latine Immigrant Clients*

Additionally, traditional CBT fails to account for how psychological manifestations of distress, such as anger, depression, paranoia, and fear, are not always symptoms of maladaptive thoughts but natural reactions to injustice (Sue et al., 2022). Challenging cognitive distortions to help a client more accurately perceive reality does nothing to change the material conditions of a client experiencing marginalization or adverse social determinants of health. Feminist and multicultural theorists have long critiqued theories that ignore the injustice clients face rather than encouraging the client to recognize social realities, including oppression, and empower clients to become active agents of change (Rogers-Sirin, 2017; Sue et al., 2022).

Cognitive and behavioral therapists may consider integrating components of Liberation Psychology with CBT to promote challenging the oppressive systems and policies that place Latine immigrants at risk for diminished mental health. This can incorporate cognitive restructuring with critical consciousness-raising on how

oppression may contribute to stress and life problems to reduce self-blame (Chavez-Dueñas et al., 2019). Psychologists may also work with clients to find ways to act according to their values to self-advocate for social justice. This valued focused action approach aligns with Liberation Psychology (Comas-Díaz, 2015; Hayes & Hoffman, 2018). For example, a therapist working with a Latine immigrant with symptoms of depression due to microaggressions they experienced at work could validate them and help them contextualize their experience within the broader socio-political context to reduce feelings of alienation and engender greater self-compassion. This can be followed by the therapist working with the client on taking valued actions to self-advocate at their workplace, only if doing so would not threaten their livelihood. If that is not the case, the therapist could focus on taking other value-consistent action that empowers them to have greater agency, such as fostering community with others who can offer support in and outside the workplace. In all, therapists can also actively combat social injustices against Latine immigrant communities through advocacy and community outreach. For example, psychologists utilized research findings to advocate against the forcible separation of immigrant families, citing the harm and traumatic stress it creates (Stringer, 2018).

### **Conclusion**

Cognitive and behavioral interventions are derived from Western-centric cultural interpretations and observations, which may limit the relevance to Latine immigrant communities. Clinicians can utilize cultural humility and cultural adaptations when applying CBT with Latine immigrants to avoid harmful microaggressions. For example, therapists can incorporate a client's spiritual and religious values by exploring traditional healing practices. Last, psychologists can integrate tenets of Liberation Psychology with CBT to empower them to recognize social injustices and self-advocate for social change.

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## When Healers Have Harmed: Towards Culturally Responsive CBT With ME/CFS Patients

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MYALGIC ENCEPHALOMYELITIS, or chronic fatigue syndrome (ME/CFS), is a chronic condition with primary symptoms of debilitating fatigue that increases with activity, post-exertional malaise following activity, and unrefreshing sleep (National Institute for Healthcare Excellence [NICE], 2021a). The disease was first observed in outbreaks of viral illnesses in the mid-1900s (Hunt, 2022). As most patients were women and initial test results were normal, the illness was conceptualized as psychosomatic, and its symptoms were attributed to mass hysteria (McEvedy & Beard, 1970; Weir & Speight, 2021). Later studies found physiological abnormalities in ME/CFS patients; however, the previous psychogenic conceptualization of the disease continued to be perpetuated by physicians, resulting in misdiagnosis of psychiatric disorders rather than a diagnosis of ME/CFS (Geraghty & Blease, 2018; Morris et al., 2014; Nacul et al., 2019; Shan et al., 2020). In addition to facing misdiagnosis, ME/CFS patients are viewed more negatively than patients with other diseases by physicians, and many physicians do not believe the diagnosis is real (Pheby et al., 2020; Scoles & Nicodemo, 2022). Though ME/CFS affects an estimated 836,000 to 2.5 million people in the United States, physicians report a lack of confidence in diagnosing and treating ME/CFS, which may be a result of the disease not being covered in many medical schools and a lack of research funding (Pheby et al.; Scoles & Nicodemo).

Given physicians' lack of knowledge about ME/CFS and the pervasiveness of the psychogenic conceptualization of the disease, patients were commonly treated with a combination of graded exercise therapy (GET) and cognitive behavioral therapy (CBT). GET engages patients in increasing levels of physical activity with the goal of eliminating physical deconditioning thought to cause fatigue (Núñez et al., 2011). The combination of CBT and GET is intended to cure ME/CFS (Geraghty, 2020). This treatment conceptualizes that

patients' symptoms are supported and maintained by "maladaptive" thoughts (Geraghty, 2020). CBT/GET can worsen ME/CFS symptoms, which prompted health organizations to recommend against using GET in updated treatment guidelines for ME/CFS (NICE, 2021a; Twisk & Maes, 2009).

### Healthcare Provider Attitudes Toward ME/CFS

Healthcare providers have significant biases about patients with chronic conditions or disabilities, likely due to assumptions about their etiologies (Geraghty, 2020; Geraghty & Blease, 2018). Individual physician bias about disabilities and lack of knowledge about the Americans with Disabilities Act reinforces and perpetuates healthcare disparities for disabled people (Lagu et al., 2022). Physicians feel "overwhelmed" by treating disabled clients (Lagu et al.). Specific to ME/CFS, more than half of patients were dismissed or told that symptoms were due to depression, anxiety, or another psychological issue (McManimen et al., 2019). Healthcare providers demonstrated a lack of knowledge about ME/CFS; accordingly, more than 50% of participants reported being disbelieved when sharing their symptoms (McManimen et al.). This is especially concerning given the intersection with gender, as women are more likely to receive this negative treatment (Hintz, 2022; McManimen et al.). Physicians discuss ME/CFS significantly more negatively than other conditions, with "over four times more negative words than the results for depression" (Scoles & Nicodemo, 2022, p. 182). These studies demonstrate how many providers may not be supportive, culturally competent, and effectively provide appropriate supports and treatments.

### Issues with CBT and ME/CFS

Due to the prevalence of the psychogenic view of ME/CFS, therapists who lack disability cultural competency may incorrectly view ME/CFS symptoms as

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mental health symptoms (Geraghty, 2020; Geraghty & Blease, 2018). This belief may have motivated researchers to explore how CBT could “cure” ME/CFS patients by challenging their thought patterns (Knoop et al., 2007). Patient activists and academics have pushed back against these claims, resulting in updated guidelines for treating ME/CFS (NICE, 2021b; Twisk & Maes, 2009).

Although research on the harmfulness of CBT/GET exists, there is less data on the use of CBT itself; however, studies indicate that CBT frequently resulted in no change or worsening of symptoms (67% and 44% of participants in two studies; NICE, 2021b; Twisk & Maes, 2009). The use of CBT specifically risks delegitimizing the physical nature of ME/CFS and Long COVID by targeting “illness beliefs,” or, in the words of Jennifer Brea, a ME/CFS patient, being told, “your symptoms are being caused by false beliefs you have about your illness” (Brea, 2017, 0:53:44). In addition, use of behavioral activation may be infeasible due to clients’ reduced capabilities for activity without causing post-exertional malaise, and clinicians may interpret pushback against these suggestions as resistance (Geraghty, 2020; Geraghty & Blease, 2018).

### *The Medical Industrial Complex*

For decades, doctors have voiced concerns about the role of for-profit companies’ involvement in medicine (Relman, 1980). The transition of medicine from a scientific practice to a corporate endeavor was “virtually complete” by 1984 (Wohl, 1984, p. 2). Their concerns about the medical industrial complex have become reality, increasing healthcare disparities across economic and racial lines, financial conflicts of interest driving healthcare policy, and other manifestations of a profit over people leadership (Cook et al., 2019; Cosgrove et al., 2006; Cosgrove & Krinsky, 2012; Wasserman et al., 2019). America spends the most per person on healthcare (Centers for Medicare & Medicaid Services, 2021), while receiving lower-quality treatment (Fullman et al., 2018; Haakenstad et al., 2022). In psychotherapy, the medical industrial complex has influenced how we practice and orient ourselves to the client’s problem; we only receive payment from insurance companies for specific treatments for disorders (Barlow, 2004). Others have voiced concerns about how the medical industrial complex has resulted in medicalization and pathologization of

normative human experience (Ussher, 2010).

The medical industrial complex enforces norms of oppressive systems (Broderick & Roscigno, 2021; Jain, 2022; Mingus, 2018). Ableism is the system of oppression that oppresses disabled people; it creates standards for what is considered normal and healthy and views violators of those standards as aberrant, inferior, or lesser than others (Nario-Redmond, 2021). Ableism can be internalized by individuals, communicated via interpersonal interactions, and influences the way we create systems in our society, also known as systemic ableism.

### *The Present Study*

Multicultural therapy, in short, is the tailoring of treatments to the unique identities and intersections of the client (Hays, 2009; Iwamasa & Hays, 2019). This fourth force has compelled psychotherapy to reckon with its history, as “research has historically focused almost exclusively on European Americans, with little to no attention given to cultural influences related to ethnicity, religion, sexual orientation, disability, or social class” (Iwamasa & Hays, 2019, p. 5). Thus, using CBT without integrating relevant multicultural issues can result in less efficacious treatment. The importance of multicultural factors in therapy is so great that it has been memorialized within the APA Task Force on Evidence Based Practice Guidelines (2006). Meta-analyses indicate that cultural adaptations to CBT are efficacious (Benish et al., 2011; Chu & Leino, 2017; Huey et al., 2014; Soto et al., 2018).

There are not enough disabled therapists to be able to treat those with disabilities (approximately 3% of psychologists have a disability; Andrews & Lund, 2015). Accordingly, most CBT for chronic conditions is cross-cultural, “which carries higher risk of misdiagnosis and incorrect case formulation and, hence, treatment” (Olkin, 2017, p. 2). Every disabled client deserves culturally sensitive and effective care that supports their well-being. CBT used to “cure” ME/CFS may represent the most extreme case of culturally insensitive and harmful treatment. We could not identify any literature that uses a critical lens to explore how CBT is used with ME/CFS patients. Thus, this study focuses on how ME/CFS patients experience CBT.

## **Methods**

This study qualitatively analyzed Reddit posts and comments on a subreddit devoted to ME/CFS. Reddit was selected as a data source due to challenges with obtaining information from clients who have had negative experiences with healthcare providers; there would be significant challenges to recruiting and conducting interviews with this population. Following examination of the subreddit, we have a unique view into how ME/CFS patients discussed interactions with mental health providers and CBT with each other, rather than how they presented it to providers. These postings articulated complexities of engaging with CBT as a ME/CFS patient: the good, the bad, and everything in between. Not all content on the subreddit was analyzed, as it contains information not germane to this research (e.g., political advocacy), so we extracted relevant data.

### *Data Extraction*

MB reviewed a month of recent postings to identify relevant Reddit posts and identified potentially relevant postings through a full read of original posts. Postings were screened as relevant when they discussed experiences of therapy, CBT, interactions with mental health care providers, or discussed psychological issues related to ME/CFS. These screened postings were then reviewed to develop a set of appropriate terms to search the complete history of the subreddit for relevant posts. A sampling of keywords utilized for the search are: mental health, therapist, CBT, and depressed. A search of the subreddit identified nearly 500 relevant original posts based on reading the title and first few sentences. These posts were then screened in their entirety for relevance by MB. If MB was unsure about a posting’s relevance, TM also reviewed the posting and had final say in its inclusion. This resulted in 100 original posts that met criteria. MB then copied the text of the original post and any relevant comments, using the same criteria, into a file for coding. The average number of comments excerpted per original post was 7, ranging from 0 to 23 comments. In total, 709 relevant comments were analyzed.

### *Data Analysis*

A thematic analysis consistent with Braun and Clarke’s (2006; Clarke et al., 2015) methodology was used to analyze the data. Thematic analysis was chosen given the relative lack of data on this phenomenon and the initial exploratory nature of



our study. Within the Reddit-based research literature, thematic analysis was the most commonly employed methodology (Proferes et al., 2021). Braun and Clarke's method is broken down into six steps. First, the researcher familiarizes themselves with the data through reading and rereading, while taking note of any ideas during this process. Researchers then generate initial codes across the data set, then collect codes into relevant themes. Researchers review these themes with the coded excerpts and the broader data set. This process often involves mapping and identifying how themes may be related. Themes are then defined and named for clarity. Finally, researchers create a report that includes relevant quotes to illustrate themes (Braun & Clarke; Clarke et al., 2015).

In our analysis process, MB and TM read the extracted postings and coded these individually. During this process, the authors met to discuss emergent themes and to process any reactions to data. Once the individual researchers coded all data, they organized the initial codes by theme. The researchers met multiple times to discuss the development of themes across the set. Any discrepancies in the coding were addressed by examination of the specific data and both researchers' codes, which were discussed until a consensus was reached. MB then created an initial map of larger themes with more minor themes underneath. TM reviewed the map and provided feedback. This process was iterative across the analysis.

### Positionality

The second alphabetical author, TM, is a queer, disabled, White gender minority with educational, economic, and citizenship privileges. TM's experience of the medical industrial complex as a person with ME/CFS and involvement in the disability community informs and inspires their work to reduce harm done to disabled people by doctors. TM is also motivated by the lack of research on ME/CFS and is concerned with how people with Long COVID may be harmed similarly to those with ME/CFS. In addition, as a disabled doctoral student in counseling psychology, TM has felt isolated due to psychology's lack of attention to disability. This has inspired TM to emphasize an integrated conceptualization of mental and chronic illness to help therapists work with disabled people without pathologizing their experiences as wholly psychosomatic.

The first alphabetical author, MB, is a cisgender, queer, disabled and chronically ill, White woman with educational, economic, and citizenship privilege. MB uses the framework of disability justice (Sins Invalid, 2015) to guide her research processes and uses a critical social constructivist lens in her qualitative work (Prilleltensky et al., 2013). Her experiences with the medical industrial complex and growing up in a fatphobic culture as a disabled, tall, fat woman shaped her meaning-making process. Notable for this research and disability justice's focus on the expertise of lived experience, MB wishes to disclose her diagnosis of Systemic Lupus Erythematosus. Though lupus is a different experience than ME/CFS, lupus is a multi-systemic disease that is invisible and has dynamic impacts on her ability. When reviewing data for this study, there were aspects of the participants' experience that resonated with her. She discussed these with TM, in her personal therapy, and wrote memos about these similarities.

### Ethical Considerations

Reddit is an open forum where many members use anonymous accounts to engage in dialogues, meaning comments are publicly available. This study was exempt from IRB review because it used publicly available data. Redditors have not explicitly opted into a research process through informed consent or other mechanisms. To the best of our ability, we have made methodological considerations to maintain the anonymity of commenters. Consistent with recommendations from other Reddit researchers, we have also disguised quotes without altering their meaning to prevent identification by searching direct quotations (Proferes et al., 2021; Reagle, 2022; Reagle & Gaur, 2022).

## Results

The analysis revealed three major themes with various subthemes. These three major themes were (a) harmful interventions and their correlates and (b) aspirational therapy for ME/CFS clients. Our results illuminated that participants have had various experiences within therapy and remind us that our work is not always helpful; it can harm (Klatte et al., 2023).

### Harmful Interventions

This theme comprised three subthemes: (a) harmful advice and harmful treatment, (b) harmful therapy, and (c) results of harmful interventions. Due to the nature of ME/CFS patients' condition, they inter-

acted with multiple kinds of healthcare providers, so we separated harmful advice and treatment received from healthcare providers (including therapists) and harmful therapy they had received.

- *Harmful advice and treatment.* Participants described a variety of harmful advice given by healthcare providers, which focused on wellness being the sole result of individual neoliberal actions (Cosgrove & Karter, 2018). Examples of harmful advice included increasing exercise, increasing the number of activities one engages in daily, ignoring one's body, and other contraindicated behaviors for those with ME/CFS. Harmful treatment for ME/CFS patients by healthcare providers followed along similar lines. This theme was differentiated by how much power the healthcare provider wielded with more restrictive treatments being prescribed.

- *Harmful therapy.* Harmful therapy practices were prevalent in the sample. This subtheme had two themes: harmful therapy and the harms of CBT. Harmful therapy consisted of examples in which therapists did not have appropriate competency in ME/CFS and treated it as a psychosomatic condition or did not appropriately tailor therapy to the unique needs of ME/CFS patients. For example, participants described being told by therapists that talking about their symptoms (e.g., fatigue, post-exertional malaise, brain fog) would perpetuate them. Thus, clients could not discuss basic realities of their everyday experiences with their therapists. Other therapists went further than this, stating that the client should stop acting like a victim of their body, and blaming ME/CFS clients for not meeting the intense demands of treatment, with increased symptoms framed as punishment. Discursively, these comments positioned the ME/CFS client similarly to how sexual violence victims are blamed for their assault (Gravelin et al., 2019).

*Harmful CBT:* CBT was viewed as neither helpful nor harmful for a variety of different ME/CFS issues. Participants described CBT as unhelpful because it is mentally and physically taxing, does not change ME/CFS symptoms, and is predisposed to minimize a patient's symptoms. Participants stressed clarifying with one's therapist the focus of treatment as they noted that CBT for mental health problems can be helpful. Participants described CBT as harmful when used to directly treat or minimize ME/CFS symptoms. Participants stated that CBT taught them to ignore their bodies, to endure their current circum-

stances, and to blame clients for their symptoms.

Particularly harmful CBT occurred when it was operating akin to sexual orientation conversion therapy by denying clients' inherent limits and encouraging clients to think them away. One Redditor sought support after a challenging interaction with a therapist:

My therapist frequently made statements undermining my experience, such as "why do you pay so much attention to CFS?" or insinuating that I have control over my energy levels. Telling me to take back my control from CFS. While this notion may seem valid and appealing, her approach can be considered manipulative.

On their face, these questions appeared to be searching for evidence, a classic CBT technique. However, these questions denied clients' very real physical symptoms of ME/CFS. CBT should not be used to invalidate. The Redditor went on to share more about their interaction:

Initially, I believed that engaging her would assist me in gaining clarity and perhaps uncover a path for navigating this seemingly insurmountable existence. I cooperated, but her barrage of attacks appears to be unending, leaving me exhausted from repeatedly explaining my pain. Her approach lacks supportiveness, as she completely disregards the suffering experienced by her clients. Merely the thought of her words fills me with anger.

Multiple participants shared that they had to work to undo the self-blame and desensitization to their own experiences they had developed from harmful therapy in future therapy sessions and healing work. A participant posted about the impact that multiple rounds of CBT treatment had:

All of these therapies share a common theme: they focus on avoiding relying on emotions to guide behavior, highlight that feelings don't always reflect reality accurately, view distressing bodily sensations as non-harmful, and view stress as benign. The underlying message is to take action despite fear or stress and not let them hinder one's capacity to live a fulfilling life. By embracing this mindset, I developed the habit of ignoring and suppressing my body's messages. I believed everything was purely psychological until it reached a critical stage, severely affecting my physical

well-being and ultimately resulting in my present state of disability.

This quote extended our understanding of the harms of CBT on people with ME/CFS, from a time-limited interaction with a therapist being harmful to creating an inner distrust of self.

- *Results of harmful interventions.* The impacts of harmful CBT were a significant focus of data analyzed. These included negative emotions, negative mental and physical health outcomes, internalizations of negative experiences, and other adverse outcomes. Participants described feeling angry, hopeless, and lonely, which led to increased stress, physical symptoms, feelings of disconnection, and medical trauma. As a result of negative experiences, participants avoided healthcare provider-based treatments altogether by doing "DIY therapy" and engaging in harmful treatments out of desperation (e.g., GET or pseudoscientific treatments).

Afterwards, participants doubted their lived experience or felt like a failure because treatments that they were told would work, did not. Participants experienced hopelessness and ceased engaging in self-advocacy with healthcare providers. These negative experiences led to greater mistrust of healthcare providers:

When I disclosed the details of my living situation to my therapist, their reply was that they would also feel fatigued if they were in a comparable scenario. My therapist holds the viewpoint that I am suppressing negative emotions, which subsequently materialize as physical symptoms. Consequently, I have essentially lost trust in providers.

Many participants described having to figure ME/CFS out independently and only trusting fellow community members' advice due to harm they experienced from healthcare providers.

### *Aspirational Therapy With ME/CFS Clients*

From the previously overviewed data, current CBT practices have failed or caused harm to ME/CFS clients. Within the framework of disability justice, the principle of leadership of the most impacted requires that therapists listen to the ME/CFS community regarding effective therapy practices. As such, we identified a variety of subthemes in this theme, including (a) accommodations to therapy, (b) description of the ideal therapist, (c) help-

ful interventions, and (d) positive aspects of CBT.

- *Accommodations to therapy.* Current psychotherapy practice focuses on the preferences and needs of nondisabled clients. As such, therapy has often been inaccessible for disabled clients, and scholars have published about the need to create a practice that centers the needs of disabled people (Artman & Daniels, 2010; Olkin, 1999; 2017). A key component of creating a disability-competent therapeutic relationship is accommodating the client's unique needs. Our data illuminated what types of accommodations may most support clients with ME/CFS. Most accommodations focused on assisting clients in pacing to minimize risk of post-exertional malaise. Accommodations included teletherapy, phone sessions, shorter duration sessions, and flexible cancellation/rescheduling policies. Other suggestions focused on adaptations to commonly used therapeutic techniques, such as engaging in meditation lying down, using ambient soundscapes when the client is too fatigued for meditation, and shorter intervals of mindfulness practices. Participants stressed the need for ongoing communication about accommodations because of the dynamic nature of ME/CFS.

- *Describing the ideal therapist.* Participants also described a variety of attributes their ideal therapist would have. The vast majority of comments within this sub-theme focused on therapists being culturally (in)sensitive to the needs of disabled and chronically ill people. They described the most harmful experiences of therapy being with therapists who did not recognize the limits of their competence when working with clients who are disabled and chronically ill. In multicultural therapy, the Dunning-Krueger effect (Kruger & Dunning, 1999) is commonplace, where the less knowledge we have on a subject, the more likely we are to overestimate our competence on that topic (Hook et al., 2017). One commenter described the benefits of having a culturally sensitive therapist:

In my opinion, having a therapist competent in treating disabled people can be beneficial. They can aid you in identifying your boundaries, easing the distress of your reduced capabilities through instruction in acceptance and emotional management methods, and assisting you in exploring adaptive approaches that can enrich your life quality or facilitate the attainment of specific goals. Nevertheless, if their primary emphasis lies in convinc-

ing you to perceive a medical condition as psychosomatic, they might not be able to offer the right support. It might be more advantageous to seek a therapist who specializes in assisting individuals with disabilities, as they may possess a greater comprehension of your needs.

It may be that many therapists discussed in the data overestimated their disability competence. Specific to multicultural disability competence, participants desired a therapist who would help them grieve their loss of abilities, adjust to a new identity, develop self-compassion, and build coping skills. These are all common foci of therapy for disabled and chronically ill clients (Olkin, 2017). The remaining coded themes within this subtheme focused on therapists being competent in the basics of the therapeutic relationship, also known as the common factors model (Wampold & Imel, 2015). Participants articulated wanting a therapist who meets you where you are, listens and validates experiences, tailors treatment to your needs, and makes you feel encouraged, not pushed.

- *Helpful interventions.* A variety of therapeutic interventions were found helpful by ME/CFS clients, with a few specific theoretical orientations explicitly named, including somatic approaches (including EMDR), ACT, and DBT. The benefit of these approaches was a focus on accepting reality and developing relevant coping skills. Somatic approaches were also positively discussed because of how low effort they can be, reducing risk of triggering post-exertional malaise. Participants specified various foci within therapy that were supportive and positive. These included setting boundaries, learning to ask for assistance, processing medical trauma, creating a flare-up plan, and various mindfulness and meditation techniques. A common factor was a focus on coping with, rather than fighting against. One commenter summarized it nicely: "although mindfulness can assist in managing and adapting to challenges, it is important to acknowledge that it does not function as a remedy or cure." Effective therapy with ME/CFS clients can best be described as "striving to lead a fulfilling life despite chronic illness."

- *Positive aspects of CBT.* Finally, CBT was discussed as positive and helpful when it targeted comorbid mental health problems rather than ME/CFS. Redditors shared how helpful CBT skills were for coping with chronic illness, improving

mental health symptoms, understanding feelings, reducing stress, and addressing microaggressions related to ME/CFS. Most interestingly, reframing and challenging thoughts helped manage ME/CFS-related thoughts, such as feeling negatively about needing to cancel plans, reducing levels of self-isolation, and seeing themselves as more than just a person with ME/CFS. Participants also discussed how CBT can assist in developing pacing skills, the most effective strategy to manage post-exertional malaise and other symptoms.

A set of comments explored the value of a group CBT intervention, which further illuminated how CBT can help or harm ME/CFS clients. Participants articulated that the connection with other patients in the group was invaluable, a common benefit that group members articulate (Corey et al., 2018). Participants shared that the group was a uniquely helpful venue for CBT because the modality allowed them to obtain the benefits of peer support, such as developing better language for what their illness has taken, sharing resources, and feeling seen by others who have similar experiences, while also being able to take pieces of CBT that worked for them.

## Discussion

This study explored the impact of therapy and CBT for ME/CFS clients with a particular focus on harm through data collected from Reddit. Redditors identified various sources of harm, how CBT helped or harmed them, and what they wished therapy would look like for someone with ME/CFS. Results indicate that harm occurs to ME/CFS patients through the medical industrial complex that is similar and different to the experiences of other disabled clients.

Our results indicated that curative CBT for ME/CFS patients can do harm. Redditors clearly articulated these harms. Some of the most significant harm to clients is through internalizing ableist norms and turning clients away from any interactions with healthcare providers. Scott and colleagues (2022) articulated the recursive vicious blaming cycle that many were stuck in: "Rather than question the legitimacy of CBT and the treatment model, clinicians can attribute the failure of CBT to patients' unwillingness to change their beliefs and behaviors" (p. 4). Practitioners should reflect on how they may be creating this cycle with patients. An alternative to this cycle is to focus treatment goals on coping with a chronic health condition rather than

curing. Participants discussed benefits of CBT when it was directed towards associated mental health impacts of having a chronic health condition in our ableist world.

Our findings also illustrate systemic practice issues that must be addressed in therapist education. Many harmful experiences of therapy occurred because the therapy was inaccessible. Scholars have discussed challenges to and necessity of incorporating disability competent care in training (Andrews & Lund, 2015; Hunt, 2022, Lund et al., 2023)—namely, developing a holistic and anti-ableist lens that recognizes the limits that systems place on the therapeutic dyad (Hunt, 2022). Therapists inaccurately assess their cultural competence and humility (Placeres et al., 2022). Thus, we encourage therapists who want to work with chronically ill and disabled clients to seek substantive training and supervised experience with this population before treating clients with these presenting problems. Participants had positive therapeutic experiences with nondisabled therapists who were open and willing to learn about their client's condition. Although research indicates that there is less risk of harm in therapy when clients and therapists have shared identities and experiences, participants pointed out that a "good enough" therapist does not have to share their disabled identity to be effective so long as they practice disability-affirming therapy (Olkin, 2017). Participants noted that therapists who strived to learn about their condition and adapt therapy to their needs also delivered beneficial treatment. Participants also indicated that therapists experienced in working with neurodivergence, grief, end-of-life care, and trauma have skills that transfer to the therapeutic needs of people with ME/CFS.

Participants noted that CBT can help cope with the stress of ME/CFS. Further, increased ability to manage mental distress due to CBT skills resulted in better ability to judiciously spend their energy. Helpful CBT was distinguished by the overall goal of therapy, where CBT focused on supporting clients in coping with chronic illness or managing comorbid mental health conditions was useful, while CBT focused on treating symptoms of ME/CFS themselves or curing was harmful.

### *Affirming CBT With ME/CFS Clients*

Our results highlight that the majority of CBT for ME/CFS clients was practiced in a way that diverged from good CBT practices. Based on the results of this study, the



authors suggest the following practices when using CBT with ME/CFS patients. Therapists should not use CBT in an attempt to cure ME/CFS, as treating physical illness is outside of the scope of mental healthcare. In addition, functional labels (e.g., mild, moderate, severe) should be limited as they often invalidate clients' physical illness and contribute to a lack of nuance in understanding the condition as dynamic. Additionally, practitioners should use a disability-competent, anti-ableist approach when working with clients with ME/CFS (Hunt, 2022). Finally, although people with Long COVID have been taken more seriously and stigmatized less than those with ME/CFS, there is risk of the condition being treated similarly to how ME/CFS has been treated. To prevent repeating the harm experienced by people with ME/CFS, practitioners should also apply these recommendations when working with clients diagnosed with Long COVID.

### Limitations and Strengths

A strength of this study was that client perspectives on CBT were gathered from Reddit, a forum in which participants freely share their experiences among their community without complications imposed by sharing experiences with a person in a position of power, such as an interviewer. This allowed responses to take on their form rather than being prompted by predetermined interview questions, which may have yielded more comprehensive accounts. However, the data may represent a subset of ME/CFS patients who had greater energy to engage in dialogue on Reddit.

Not all data were specific to CBT or mental healthcare, as participants shared experiences with various physicians and mental health interventions. Although participants did not always share experiences explicitly related to CBT, this broadness was a strength in helping inform about common issues ME/CFS patients have in healthcare and therapy that can be applied to CBT. A limitation of this study is the focus on negative aspects of psychotherapy, though data about affirming practices in therapy was collected. Qualitative research highlights the nuances of lived experiences and is not generalizable. However, results of our study could potentially transfer to future psychotherapy with ME/CFS clients.

Another strength of this study was the authors' shared experience of disability and chronic illness. Disabled academics have highlighted how cross-cultural research is

often influenced by ableism and assumptions that disabled people are inferior, leading to a negative feedback spiral (Milton, 2014). Meaningful participation by community members is necessary to produce ethical and culturally sensitive research (Gillespie-Lynch, 2017; Milton & Bracher, 2013).

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- The authors have no conflicts of interest or funding to report.
- Positionality statement:** TM is a queer, disabled, White gender minority with educational, economic, and citizenship privileges. TM's experience of the medical industrial complex as a person with ME/CFS and involvement in the disability community is relevant to this article. MB is a cisgender, queer, disabled and chronically ill, White woman with educational, economic, and citizenship privilege. Though Systemic Lupus Erythematosus is a different experience than ME/CFS, it is a multisystemic disease that is invisible and has dynamic impacts on her ability and there were aspects of the participants' experience that resonated with her.
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## Rethinking Retractions: Towards a More Socially Responsible Clinical Science

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SCIENTIFIC PUBLISHING practices do not align with typical casual behavior when it comes to righting a wrong. In our private lives, when we make a mistake, we might choose to apologize, publicly or privately, seek to make amends, or revise an incorrect statement. Within the sciences, however, the most common practice is to allow science to self-correct and only if absolutely necessary will a retraction be issued. Additionally, retractions are usually only issued in a few instances: if the results or methods have been shown to be fabricated (data misconduct), if plagiarism or duplicate publication is detected, or an error in the manuscript was found (Fang et al., 2012).

Retractions on these grounds seem to be increasing over time (Steen et al., 2013); however, the overall number of retractions remains relatively low, with the upper tail of estimates suggesting that although an estimated 2% of researchers admit to academic misconduct, only 0.04% of published papers are retracted (Fanelli, 2009; Oransky et al., 2012). Retraction because a study has been found to promote unethical, amoral, or harmful practice seems to be the rarest of the rare among retractions of published scientific literature.

### *Ethics, Harm, Morals, and the APA Ethics Code*

Retractions are commonly seen as a means of upholding scientific ethical standards. For psychologists (and potentially researchers in related fields), understanding the interconnection between ethics and morals is necessary and justifies the need for "moral retractions." The American Psychological Association (APA) ethics code, established in 2002, sets clear standards for research integrity (APA, 2017). Psychologists are encouraged to avoid causing harm in various aspects of their work through General Principle A. Standard 3.04 further specifies that psychologists should take "reasonable steps" to prevent harm to their clients, students, research participants, and others they work with. In cases where harm has occurred, psychologists have a duty to minimize it, as stated in Standard 8.08, which details the debriefing process. Specific guidelines for repairing harm caused



by research are lacking and how to establish if harm was caused is unclear.

It is important to consider the overlaps and distinctions between ethics and morals in the context of research and professional psychology. Whereas ethics refers to the professional rules that guide behavior and conduct, morals are societal guidelines that may not be explicitly codified. For instance, data fabrication is a clear ethical violation and also goes against moral proscriptions against lying and cheating. As a result, most retractions in the scientific literature that are of this type would violate APA's ethical standards due to scientific misconduct. Research that is poorly conducted and promotes harm through its conclusions presents a more complex situation. The APA ethics code integrates societal responsibility into the role of psychologists, which means that research promoting practices that are considered amoral by broader societal standards may also be considered unethical. Because of this link, moral retractions are a method of addressing harm done by research that stays in line with our professional obligations.

### ***Moral Retractions—A Reasonable Step?***

Considering the ethical obligations of psychologists in general, and clinical psychologists specifically, it seems appropriate to revise the scientific record when harmful practices are identified. Research in our field is embedded in a rapidly evolving social and cultural milieu and needs to support safe and effective practice. Therefore, clinical psychology and other patient-oriented disciplines arguably have a greater responsibility to monitor amoral research because of their potential for harm, particularly to marginalized and underrepresented groups. Revisiting studies that have methods or conclusions that go against consensus for current moral and ethical practice is simply a way of ensuring that scientific progress is not impeded and that the public record reflects the most accurate and ethical findings that minimize likelihood of harm to patients. Despite these arguments, retractions on moral grounds appear to be the rarest of the rare in the literature.

There are several potential reasons for their rarity. First, the Committee of Publication Ethics (COPE; Retraction Guidelines, 2019) issues guidelines for circumstances under which retractions happen for the scientific literature at large, and these guidelines are least ambiguous in the cases of plagiarism and data fabrication, which represent the bulk of documented retrac-

tions. All scientific disciplines likely agree on these forms of misconduct as being incongruent with ethical scientific practice and this is reflected by COPE guidelines. The conditions under which retractions on moral grounds are issued are more ambiguous. The COPE guidelines state that one of the reasons an editor may retract an article is if "It reports unethical research" (Retraction Guidelines, 2019); however, unethical research is unclear here. Does this refer only to research that was, for example, conducted without an Institutional Review Board (IRB) in place? Or, given the fuzzy boundary between morals and ethics for psychologists, can the research be judged to be unethical retrospectively based on the moral principles of a society after the article was published? What about research that violated research ethics before the publication of the Belmont Report, which set guidelines for ethical human subjects research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979)? Research on "conversion therapy" (also known as "reparative" therapy, or Sexual Orientation Change Efforts [SOCE])<sup>1</sup>, whether patients sought treatment or were coerced, comes immediately to mind with regard to these questions.

The second reason is what I will refer to as the "changing times" argument. It has been argued that if at the time of publication, the research was not unethical or amoral, then retraction is not appropriate. This line of argument can be seen in a recent editorial accompanying an Expression of Concern, in which the editor declined to issue a retraction because the study was supposedly not unethical by the standards of its day (The Society for Experimental Analysis of Behavior, 2020). Instead of retraction, some encourage waiting for the scientific record to self-correct through the process of replication and later publication (Alberts et al., 2015). A potential issue with this reasoning is that in the absence of retraction, the act of correcting the scientific record might encourage conducting replications of studies or covertly support continued examination of treatment practices that have already been shown to be ineffective and harmful.

For example, although there are extremely clear prohibitions against current research and practice of SOCE (American Psychological Association, 2015), researchers continue to explore their putative benefits and are even published in APA journals. Although such articles are accompanied by formal criticism (see the 26 commentaries on Spitzer [2003] in Bancroft [2003] or Berhanu [2007]'s critique of the book *IQ and the Wealth of Nations* for examples), the absence of retractions of past unethical research sets the foundation for current studies looking to revisit those practices. The typical method of self-correction then becomes a tool for re-harming often vulnerable communities and likely contributes to the defense of ongoing unethical and amoral practices (Carey, 2012).

The third potential reason that retraction on moral grounds may be rarer than other types of retraction is a lack of awareness of other articles retracted on moral grounds among journal editors or authors who might consider retracting these types of studies. Colleen Flaherty (2022) wrote a news report covering the Association for Behavioral and Cognitive Therapy's formal apology for "conversion therapy" and subsequent reactions. Notably, two prominent psychologists were quoted in the piece expressing regret for publishing research on "conversion therapy" and also reservations about retraction.

Steven Hayes apologized for his involvement in a 1983 paper supporting "conversion therapy" because the case was "morally wrong" and also stated that there was no precedent for moral retraction. Hayes also recorded a personal apology and released it on YouTube (Hayes, 2022). In the comments section, he states that he requested a retraction from the then editor-in-chief Michelle Craske, but again states there was no precedent for a moral retraction and that more research on the topic was needed. In the same article by Flaherty (2022), David Barlow was quoted expressing regret for his own involvement in research on "conversion therapy" but noting that retraction "because times have changed or have a different view of it now and you don't like the conclusion" was not possible (Flaherty, 2022). These prominent

<sup>1</sup>GLAAD media guidelines emphasize the importance of placing "conversion therapy" or "reparative therapy" in quotation marks in order to highlight the misnomer: it is not therapeutic, a "conversion," nor is it a "repair," since these assumptions draw on misrepresentations of data and often used to insinuate that LGBTQ identities are not real (GLAAD, 2022).

psychologists and others may continue to shift their viewpoints around the potential for retracting past harmful work; however, at the times they were quoted, they seemed unaware of even the possibility of retraction on moral grounds.

Because of these and other reasons that moral retractions remain a rarity, it is important to assess the published record of retractions that were issued on moral grounds in psychology and related disciplines to inform future discussion on the role moral retractions might have in preventing or repairing harm.

## Method

I used the search terms "harm," "unethical," and "patient harm" on the Retraction Watch blog; and the filter "bias issues or lack of balance" and the keywords "psych,\*" "neuro,\*" "treat,\*" "therap,\*" or "clinical" on the Retraction Watch Database to identify all articles that were potentially retracted on moral grounds from psychiatry, medical, or psychology journals, and that were related to therapy or treatment. I also used "related articles" recommendations through the Retraction Watch blog to expand the search and refine search terms in the Retraction Watch Database. If there was an editor's note attached to the original article, it is summarized here. Otherwise, the original article was read to identify possible reasons for the retraction.

Due to the significant potential overlap between moral and ethical retractions (e.g., use of fabricated data to promote racist ideology), but given the need to identify cases where societal standards or prohibitions are at the forefront of retraction, I defined a moral retraction on the following grounds:

1. The retraction notice explicitly stated that the study was amoral, or it was clearly described as unethical due to societal standards or the study's potential for social harm, or
2. The retraction notice followed from a public conversation or call for retraction based on societal standards or the study's potential for social harm, or
3. Expression of concern or other mechanism fitting the criteria above.

Studies were excluded if the paper concerned a topic that is societally prohibited, for example, encouraging racist practices, but the retraction notice cited data fabrication as the reason for retraction with no mention of the study's subject matter and if no evidence that the amoral nature of the

study was a reason for retraction could be found. Whenever possible, citations are provided for the retraction notice or a related internet post, rather than the retracted article itself, to prevent recirculation of the retracted articles.

## Results

I found only one clear retraction within clinical psychology and psychiatry, in which the retracting editor stated that it was primarily on moral grounds. In 2020, John Talbott, the editor of the *Journal of Nervous and Mental Disease*, retracted a 1951 manuscript that supported the use of "conversion therapy," largely based on the author's own flagrantly prejudicial beliefs. In his editor's note attached to the article, Talbott wrote:

...journals like this one published papers in the past reflecting many other beliefs we find abhorrent today, such as those on eugenics, the disabled, women, Blacks, sexual problems, and yes, sexuality... The editor would like to express his gratitude for Dr. LeVay's perception, precision, and service to science. The 1951 Glover article is but one that deserves a relook, reappraisal, and perhaps retraction. (Talbott, 2020)

Not only was the 1951 article retracted, but the editor also invited a commentary from LeVay accompanying the retraction that added additional context about the time period in which the author of the original publication was publishing, LeVay's decision to petition retraction, and a discussion of the role of retraction in general (LeVay, 2020).

Outside of clinical psychology and psychiatry, five papers by J. Philippe Rushton have been retracted by *Psychological Reports*. All were flagged as having bias issues of lack of balance in the Retraction Watch database. The retractions were accompanied by a note in the journal stating that the work was "unethical, scientifically flawed, and based on racist ideas and agenda" (Retraction Notice, 2020, 2021) implying that the research was socially irresponsible. An additional paper by this author and co-author was retracted by the editors of *Personality and Individual Differences*. The editors discussed the methodological, moral, and ethical problems with the paper at length, including the need to practice beneficence, nonmaleficence, and compliance with the Universal Declaration of Human Rights as additional considera-

tions in the decision to retract (Rushton & Templer, 2021).

A more recent publication in the *Archives of Sexual Behavior* on a purported 1,655 cases of "rapid-onset gender dysphoria" (ROGD) was retracted in 2023. Researchers proposed ROGD as an explanation for increases in the numbers of adolescents and children that identify as a gender other than what they were thought to be at birth. Rather than being seen as an increase in identified cases, so-called ROGD proponents explain the population increases as an emergent gender dysphoria syndrome that is culture-bound and socially influenced. Thus far, research has only been based on parent report of their children without any attempt to survey the children about their own experience. The research has been used to reject the notion of gender-affirming care models and the now-retracted 2023 paper is cited by at least one parent group that advocates for the ROGD diagnosis to be assessed by community practitioners. The publisher and editor-in-chief cited noncompliance with research policies around consent as the reason for retraction (Diaz & Bailey, 2023). Thus, the public notice of retraction does not appear to be on moral grounds; however, the article faced notable public criticism, with many on social media suggesting a moral (or political/ideological) reason for the retraction (International Academy of Sex Research [TheIASR], 2023; Kincaid, 2023).

Notably, the first author published under a pseudonym and is a member of the aforementioned ROGD parent group. In the published manuscript, the authors explained that the second author's IRB was consulted and did not certify the study but given that the survey data was collected by the first author who was not affiliated with an institution, both the Editor and IRB thought it to be ethically appropriate at the time of publication.

The article that initially coined the term ROGD was initially published in PLOS ONE in 2018 and then was republished in 2023 following a postpublication review (Littman, 2019). Formally, no retraction by the journal was issued and it was listed in the Retraction Watch database as a "retract and replace." The materials and methods sections were expanded to provide details on data collection and the results remained unchanged, but all other sections were revised to provide clarification and context. The original study that implied evidence of cases of "ROGD" remains available as a supplement and the correction emphasizes

that parent perception of the proposed phenomenon cannot be taken as sole evidence for existence of a phenomenon in their children/adolescents.

Both the stated and circumstantial reasons for these ROGD retractions raises concerns about whether the whole line of research is socially irresponsible, given that the use cases for the studies (e.g., denying efforts to provide gender-affirming care to children and adolescents) are in contrast with both medical and psychological association practice guidelines (American Psychological Association, 2015; Hembree et al., 2017).

An article in *Psychological Science* was retracted by the authors after readers raised concerns with the validity of the data source and the article. The study utilized data that had been previously contested for “racist, sexist, and antihuman nature of the research tradition in which the authors anchored their studies and the deep methodological flaws” (Berhanu, 2007) to imply that among countries with lower IQs, declines in religiosity were linked to higher violent crime rates. A separate editorial by the Editor-in-Chief, Patricia Bauer, defends the peer-review process and the need for editorial consideration of the sociocultural implications of research in the social sciences (Bauer, 2020).

The search uncovered two “expression of concern” cases. In the first case, an “expression of concern” was issued over a 1974 publication in the *Journal of Applied Behavior Analysis* that endorsed using behavioral reinforcement and punishment, including tokens, time-outs, and spanking, to alter the behavior of a 5-year-old child to be gender-conforming. Initial concerns about the ethics of the treatment approach described were submitted as early as 1975 (Nordyke et al., 1977; Winkler, 1977), and the study continues to spark debate (Capriotti & Donaldson, 2022). The editorial report notes direct, lasting harm to the child, their family, and the continued use of the study to promote “conversion therapy.” Nevertheless, the editors reviewed COPE guidelines for both retractions and expressions of concern and decided that the latter was the more appropriate avenue for flagging the article given the perceived lack of methodological or ethical flaws (The Society for the Experimental Analysis of Behavior, 2020).

In the second case, an expression of concern was issued by *Depression Research and Treatment* regarding the use of a 2016 article to support protests against marriage equality (Depression Research and Treat-

ment, 2017). The article claimed to provide evidence of higher depression and obesity rates among adults with same-sex parents. It was criticized for methodological limitations such as a small sample size and for ignoring confounding factors. A neo-Nazi group used statistics from the article on a poster, and the expression of concern condemned the citation of the article in support of hate speech (Minneapolis, MN: Community Mobilizes After Neo-Nazis Put Up Anti-Queer Posters, 2017). Despite this, the handling editor declined to retract the article and instead invited commentary to be attached to the article.

The final article was found through a search on the Retraction Watch blog but did not appear in the database because the journal declined to retract it. Robert Spitzer conducted interviews with 200 participants who reported a change in their sexual orientation following therapy in a 2003 study published in *The Archives of Sexual Behavior*. Interestingly, Spitzer played a key role in the effort to change how variance in sexual orientation was classified in the *Diagnostic and Statistical Manual* in the 1974, 1980, and 1984 editions. He later expressed regret over the study and pursued retraction. Commentaries on the paper noted many methodological and inference issues (Bancroft et al., 2003); nevertheless, the journal's editor at the time disagreed that these issues rose to the level of a formal retraction (Dreger, 2012). Instead, Spitzer formally documented his apology in the form of a Letter to the Editor along with his agreement with critiques of his study and regret for the harm to the gay community stemming from the publication (Spitzer, 2012).

### A Socially Responsible Clinical Science?

This article demonstrates that full retractions of articles on moral grounds are possible, though they are exceedingly rare in treatment-relevant research. It should also be noted that a shift in cultural norms was never the sole reason for a retraction, even when moral elements were an acknowledged component of the retraction. The vast majority of the flagged articles concerned the treatment of sexual and gender minorities. Racial/ethnic minorities were the second largest category due to several retracted publications written by the same author.

Typically, bias was a component in the Retraction Watch database, but issues with the data source or methodological flaws were prominent. Editorial decisions following the discovery of articles with the

potential for negative social impact were highly dissimilar. For example, Talbott (2020) and Bauer (2020) used their capacities as Editors to discuss the justification for retraction and that larger social context scientific research must operate in. The Editors of *Personality and Individual Differences* used the retraction notice itself as the mechanism to explain the methodological problems with the retracted paper and interestingly cite both the Declaration of Human Rights and compliance with COPE guidelines (Rushton & Templar, 2021). The editorial note from the Society for Experimental Behavior Analysis, on the other hand, acknowledged that harm was done and provided substantial discussion of issues with the target article, yet declined to issue a retraction because of COPE guidelines (The Society for the Experimental Analysis of Behavior, 2020).

Overall, retraction with acknowledgment of moral underpinnings as a reason for retraction was almost nonexistent. Most other editorial notes were accompanied by caveats, calls for the scientific record to be allowed to correct itself in the form of commentaries or additional publications, and several mentioned or alluded to COPE guidelines as a reason why a retraction could not take place.

This begs the question: If there is an acknowledgment that the research has ethical problems and negative societal ramifications, but retraction is deemed inappropriate, is there an alternative and more appropriate avenue to acknowledge and confront the public or private harm the publication might cause?

Disclaimers, similar to the expressions of concern mechanism, are one proposed alternative (Flaherty, 2022). There are advantages to this, such as being a workaround for major publication houses that refuse to allow journals to retract articles on the basis of COPE guidelines, even if the author, editor, or journal requests one. The disadvantage is that disclaimers are not, at this time, indexed in a way that makes those papers easily identifiable. Another possible approach is to nominate specific articles for rereview, but finding reviewers willing to take on this task may be challenging, given the long wait times even for new research. The nomination process might also be subject to criticism if it is perceived to be initiated on ideological grounds.

Until more journals and publishers enact consistent policies, it is hard to speculate what practice of revision to the scientific record will be more effective. Regard-



less of the form it takes, that effectiveness should be measured on how often articles that promote socially irresponsible research continue to be cited or have their findings promoted within the public sphere. Retractions, for example, have been estimated to reduce citations by 65% (Furman et al., 2012) and a comparable statistic for other types of revisions to the scientific record should be generated. Furthermore, it is essential that the solution implemented is search engine-friendly and able to keep up with the constantly evolving search engine algorithms. Large language models (LLMs) will likely see increased use and often rely on publicly available information.<sup>2</sup> Publication practices have changed dramatically since the first retractions (Oransky, 2012): in the era of AI and data scraping, we have to consider what a naive reader may directly or with the aid of LLM search engine might uncover or advance.

Retractions have a significant impact and are already integrated into scientific practices, so expanding them would be feasible. If retractions are more readily recognized by LLMs as problematic research when search results are returned, then expanding the use of retractions might be more pragmatic compared to disclaimers or expressions of concern.

The issue at hand is the frequent use of COPE guidelines to avoid retraction. The small number of articles that have been retracted is unlikely to represent all articles that promote harmful practices. Given the ambiguity surrounding what constitutes "unethical" practice, the guidelines appear to be necessary but not sufficient for preventing or managing research that promotes harmful treatment practices. A further complicating but important issue to resolve is the conflict between the ethical principles of the author's field or discipline and those of the editor or home journal. For example, some journals concerned therapy or mental health but were not psychology journals (e.g., *Archives of Sexual Behavior*). Spitzer (2012) represents a very public version of this conflict between

author and editor/journal's wishes and, very recently, the Association for Behavioral and Cognitive Therapies (ABCT) sought to pursue retractions for "conversion therapy" papers but were denied by the publisher, Elsevier (Lamb, 2022). Psychologists wishing to retract amoral work may need to assertively cite our professional ethical responsibility to correct harm due to research when it is recognized. COPE guidelines should also be expanded to allow for this.

Based on this review of the literature in this article, I suggest that the following provisional guidelines for articles that should be eligible for retraction:

- Research that the publisher, authors, journal editors, reviewers, or ethics committees deem to be socially irresponsible or amoral;
- Research that promotes, endorses, or is used as support for harmful or discriminatory practices, particularly towards marginalized or vulnerable groups; and
- Research that was once considered morally acceptable at the time of publication but is later widely recognized as morally objectionable based on contemporary ethical principles or societal values.

## Conclusion

Many scientific disciplines are grappling with the idea that published research does not exist in a vacuum (Zivony et al., 2023); clinical science must be among them in the call for socially responsible as well as rigorous work. We must ensure that our scientific record reflects the most accurate and ethical findings and prioritize the well-being and safety of all individuals impacted by our research. Though use of retractions has been historically circumscribed, in the future they may serve as a crucial step in acknowledging mistakes and promoting social responsibility within clinical science. As with apologies in our personal lives, the best ones are followed up by taking active

steps to ensure the same mistakes are not repeated.

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<sup>2</sup> I asked an AI language model how it dealt with the issue of retractions, and it returned the following:

As an AI language model, I do not have access to real-time information about the status of scientific articles. However, I can be programmed to search for information about retractions by using specific search terms and databases. For example, I can search for retractions in the Retraction Watch database or use keywords such as "retracted," "withdrawn," or "correction" to find information about articles that have been retracted. However, it is important to note that my results may not be comprehensive or up-to-date, and it is always best to consult the original source or contact the journal directly for the most accurate information.

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- ...
- The author declares no conflicts of interest or relevant funding.
- Positionality statement:** I would like to acknowledge my standpoint as a Black American of Caribbean descent who is a cis-gender, heterosexual woman, and a parent. I acknowledge that my positionality influenced this investigation to some extent; particularly as the articles I cited and examined threatened the human rights and dignity of identities I hold and strive to be supportive of in both my personal and professional life.
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# The ABC(T)s of an Apology: When Allyship Breeds Animosity

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Cis heteronormativity finds a way of creeping in when the interests of straight allies supersede those of their LGBTQ and trans counterparts. (Grzanka, 2022, p. 769)

IN JUNE 2022, just in time for pride month, the Association for Behavioral and Cognitive Therapies (ABCT) Board of Directors and past leadership released an apology for the role of behavior therapy in the development and practice of “conversion therapy,” a practice now known to be both ineffective and harmful (ABCT, 2022). The ABCT Apology was paired with efforts to give awards to members who were important in the organization’s history with LGBTQ+ rights. In other words, ABCT was being an ally. The term “ally” is used to denote an individual who supports a minoritized group. It is often used as a label (e.g., “I am an ally”) but may better be thought of as a process (Grzanka, 2022). The apology, as is a convention in some academic articles, refers to sexual orientation or gender identity change efforts (SOGICES). We use the term “conversion therapy,” which avoids euphemisms and appropriately conveys the historical weight and emotional significance associated with the “change efforts” being described.

The ABCT apology was criticized by some members, including the authors of this piece, for its failure to name the specific ABCT members who contributed to “conversion therapy” research and its focus on the more positive aspects of ABCT’s history. The criticism followed the revelation that past ABCT presidents threatened to withhold their signatures from the apology unless an award was given to Dr. Gerald Davison to honor his allyship to the LGBTQ+ community. Dr. Davison is a past president of ABCT, winner of the ABCT Lifetime Achievement Award, and a former “conversion therapist” who later advocated against the practice. ABCT members debated among themselves, advocated for a different approach to ABCT’s history with LGBTQ+ rights, and

struggled with the definition and practice of allyship.

The current paper has several aims. First, we document the events of the ABCT apology, not to relive past grievances without purpose, but rather to call attention to the construct of effective apologies and LGBTQ+ allyship. We further contribute to the apology’s mission to understand sexual and gender minority (SGM) history by providing context regarding the history of “conversion therapy” by ABCT members. Finally, we use the series of events surrounding the apology and its criticisms to illustrate the complexities of allyship, including how structures within our field maintain systems of power and aggression and harm as they purport to fight it.

## Effective Apologies and the ABCT Apology

Researchers have tried to isolate components of successful apologies (Lewicki & Brinsfield, 2017). According to this research, effective components of an apology are: (a) acknowledging responsibility (“I was wrong and I accept responsibility for what I did”), (b) offering repair (e.g., “to make it up to you, I will...”), (c) promising not to repeat the offense (e.g., “I promise not to do it again”), (d) expressing regret (e.g., “I am sorry for what I did”), (e) explaining (e.g., “at the time, I was thinking...”), and (f) requesting forgiveness (e.g., “I hope you can forgive me”). Lewicki and Brinsfield reported that offering repairs, acknowledging responsibility, and promising not to repeat the offense are among the apology elements that make it more likely an apology will be well-received; direct requests for forgiveness are the least effective. The authors also report that apologies

work best the more elements they have. Apologies tend to be less effective for violations of integrity vs. violations of competence and work best when they are perceived as sincere.

The ABCT apology spans about 1,500 words and does a lot of things effectively. First, it expresses regret. The apology also has something of a promise not to repeat the offense in that it decries the practice of so-called “conversion therapies” because they are ineffective, harmful, and imply LGBTQ+ identity is something to be treated. The first 330 words or so of the apology appear to convey an understanding of the harm done through “conversion therapy” and include some of the effective components of an apology. The apology also explains some historical context relevant for individuals with little knowledge on the topic. It describes that “conversion therapy” was legal in all 50 states years ago. Halfway through, the tone of the apology shifts to highlight “the courageous and historic role that [ABCT] members have played in advancing SGM rights and mental health” (ABCT, 2022, p. 2), using the names of Drs. Gerald Davison and Charles Silverstein. The content centered in the remainder of the apology is the subject of the documentary *Conversion* (Caruso, 2021): Drs. Davison and Silverstein became unlikely friends and fought against the practice of “conversion therapy.” Dr. Silverstein was instrumental in the removal of the diagnosis of homosexuality from the DSM in 1973.<sup>1</sup> For example, he was recognized for this advocacy in another documentary, *Cured* (Sammon & Singer, 2020).

## Erased: Omissions From the Apology and the History of ABCT

Though the ABCT apology references Drs. Silverstein and Davison extensively, it does not name the ABCT members who contributed to “conversion therapy” research, only referencing that “members in prominent leadership roles” practiced “conversion therapy” (p. 1). At least 8 of ABCT’s 55 past presidents have been identified as having conducted “conversion therapy” research: Drs. Joseph Wolpe, Joseph Cautela, Gerald C. Davison, David H. Barlow, Alan S. Bellack, W. Stewart

<sup>1</sup>For historical purposes, it may be worth noting that homosexuality per se was removed as a diagnosis from DSM in 1973 but it was replaced by sexual orientation disturbance and later “ego-dystonic homosexuality” in DSM III (1980), and sexual disorder NOS in DSM-III-R (1987), DSM-IV (1994), and DSM-IV-TR (2000).



Agras, Kelly D. Brownell, and Steven C. Hayes. Two of these men, Drs. Wolpe and Cautela, were founding members of the organization in 1966, which was first called the Association for Advancement of Behavioral Therapies (AABT). All of the mentioned researchers signed the apology, with the exceptions of Drs. Wolpe and Cautela, who are deceased.

The nature of past ABCT presidents' contributions to "conversion therapy" research varied substantially. We focus on two individuals who were, in our review of the literature, among the most prolific "conversion therapy" researchers: Drs. Steven C. Hayes and David Barlow. Dr. Hayes studied the efficacy of "conversion therapy" (Brownell et al., 1977; Hayes et al., 1983). He also had research on "sex roles" (Hayes & Leonard, 1983; Hayes et al., 1984). While this work appeared neutral at a surface level, it was described as formative research for "conversion therapy," intended to inform behavioral theories of the mutability of sexual orientation and gender identity:

an effeminate boy is likely to be teased about his sexual orientation (e.g., called a fag) and may subsequently adopt this as his own self-identity (Green, 1974, 1979). This may, in turn, lead to homosexual experiences and the development of homosexual arousal ... *There are many applied areas that require treatment of sex-related motor behavior, such as training of transsexuals ... [and] children showing cross-sex mannerisms.*" (Hayes & Leonard, 1983, p. 425, emphasis added)

Dr. David H. Barlow published extensively on the topic of "conversion therapy"—around 19 papers between 1969 and 1985 (e.g., Barlow et al., 1969, 1973, 1975, 1977, 1979; Brownell et al., 1977; Hayes et al., 1983). Indeed, Dr. Barlow had so many papers on this topic that we cannot directly cite all of them as it takes around 3 pages of references that we use for text instead. Interested readers can find the references in our OSF page (Lorenzo-Luaces & Rodriguez-Seijas, 2023). According to Scopus, Dr. Barlow had published around 93 papers by 1985. This means that 1 out of every 5 papers authored or co-authored by him related to "conversion therapy." The research ranges from systematic desensitization (Barlow et al., 1969; 1973) to covert sensitization/modeling (Brownell et al., 1977; Hayes et al., 1983) to the use of biofeedback (Barlow et al., 1975), all in aid of decreasing (homo)sexual arousal and

demonstrations of gender atypical behavior. One paper, for example, is a case study on the "successful" psychosocial treatment of a transgender individual. The treatment in question? An exorcism (Barlow et al., 1977). Lest a reader assumes we are judging this work devoid of historical context, most of this research (72% or 14/19 papers) followed the removal of homosexuality as a category from DSM-II in 1973.

One shocking aspect of this "conversion therapy" research is that it reports largely positive results supporting the "therapy," usually based on single-case designs. Survey data from behaviorists who practiced "conversion therapy" at the time—including members of AABT/ABCT—suggested behaviorists believed they had good success rates in reducing homosexual attraction (60%) and increasing heterosexual attraction (46%; Davison & Wilson, 1973). More contemporary and rigorous research on "conversion therapy" survivors suggests that as little as 4% of people perceived a change in their orientation with 10% or so perceiving the "conversion therapy" did "help" them learn to be celibate (Shidlo & Schroeder, 2002). Even the most contemporary research published by proponents of "conversion therapy" suggests very low rates of "conversion" (the retracted Rosik et al., 2023). Reviews also suggest harm to those who undergo "conversion therapy" vs. those who do not in term of "serious psychological distress (47% vs 34%), depression (65% vs 27%), problematic substance use (67% vs 50%), and attempted suicide (58% vs 39%)" (Forsythe et al., 2022). Contrary to what the papers describe, "conversion therapy" is ineffective and likely iatrogenic.

It is difficult to know why the apology names Drs. Silverstein and Davison but does not name Drs. Barlow, Hayes, Bellack, Agras, Brownell, Wolpe, and Cautela. A clue is found in communications regarding the ABCT Apology. In an email sent on behalf of the ABCT Board of Directors to the various Special Interest Group (SIG) leaders on 06/02/2022, it appears that the decision to forego specific names was deliberate. The email states:

If the focus of the public discussion were to become our history (*who did what*, *who deserves credit* and *who deserves blame*) versus our acknowledgement of our wrongdoing and our commitment to doing better going forward, *there is great risk to the reputation of the field*. Although our members may disagree on some issues or who should get an award and why, we

*believe we all agree that it would be a great disservice to the association and the public if we were to go back to the days when behavior therapy became fused with images of thought control and manipulation.* (emphasis added)

It appears then that the image of the organization and field were considered when drafting the apology. This in effect limited the apology's acknowledgment of its own responsibility in the legitimization of a baseless and harmful practice. Finally, although the apology referenced the potential for disclaimers to the "conversion therapy" articles, it lacked a concrete offer of repair. Members pointed out that retracting "conversion therapy" articles would be a concrete behavior the organization could engage in, especially because some of the articles were published in the ABCT organization's journals like *Behavior Therapy* or are in journals in which ABCT members have influence (e.g., *Behaviour Research and Therapy*).

In summary, the apology sidestepped some of the organization's harmful past, focusing heavily on the friendship and activism of Drs. Davison and Silverstein. It preserves the identities of senior ABCT leaders involved in "conversion therapy." Finally, the apology also lacks an effective offer of repair. These factors make the apology run an insincere tone, making it less likely to be well-received (Lewicki & Brinsfield, 2017). Information that was later revealed would suggest even more violations of integrity on the part of the organization.

### The Closet: The Apology Behind Closed Doors

Following the release of the apology, the leaders of the ABCT SGM SIG sent an email on 6/9/22 to the SIG membership explaining the events that led up to the ABCT Apology. First, the SIG was contacted to provide support for the documentary *Conversion*. The SIG leaders expressed some concerns about elevating Dr. Davison and proposed a recognition or award for Dr. Silverstein given his advocacy, especially as an SGM graduate student. The SIG proposed that ABCT could offer an apology from the organization for its role in propagating "conversion therapy." The 6/9/22 email also states that the SIG leadership was aware "that a vocal minority [of past ABCT presidents] threatened to remove their names from [the ABCT] apology if Dr. Davison was not given an award

for being an ally to the SGM community” (emphasis added).

It was alleged on social media that these past presidents and members of the ABCT Board of Directors—Drs. David H. Barlow, Linda Sobell, Anne Marie Albano, Patricia Resick, Gayle Beck, and Michelle Craske<sup>2</sup>—were so adamant that Dr. Davison be the recipient and have an award named in his honor, over or with Dr. Silverstein, that the apology was ultimately released devoid of any reference to awards. As more information became public, there was outcry on the social media channel Twitter, some of it fueled by us, emails across the SGM SIG listserv, and a flurry of emails and discussions among stakeholders.

### Privilege-Preservation: In Defence of “Conversion Therapy” Research

Privilege-preserving epistemic pushback is a variety of willful ignorance that dominant groups habitually deploy during conversations that are trying to make social injustices visible. (Bailey, 2017, p. 877)

By and large, most of the reactions to our social media posts about the roles of ABCT members in “conversion therapy” research were reactions of shock. Many individuals who were consumers of the works of these ABCT presidents, especially Drs. Barlow and Hayes, were not aware of their involvement in “conversion therapy” research. The second author (CR-S) too was unfamiliar with this research. Arguably the most shocking response to our criticisms came from the “conversion therapy” researchers themselves. Dr. Barlow claimed that he had published “maybe eight” papers on “conversion therapy” (Flaherty, 2022). Similarly, in a video apology Dr. Hayes (2022) described how his work in this area is limited to “one case.” The reader is referred to the papers we found for both above and in our OSF page (see Lorenzo-Luaces & Rodriguez-Seijas, 2023). We understand a desire to minimize involvement in harm. However, neither the goals of apologizing nor the goals of allyship are served by rewriting his-

tory rather than acknowledging responsibility for past harms that continue to this day. There was also refusal at the suggestions for retractions. According to Dr. Barlow, as quoted by Flaherty (2022), “the only reason you can really retract a journal article, based on my understanding, and I’ve been an editor myself, is if you have some evidence that the data was manipulated or fabricated or false, and the science is wrong.” The veracity of this statement is somewhat questionable as research may be retracted when deemed unethical, for example, when consent is not obtained (Wager et al., 2009). The most startling aspect of Dr. Barlow’s reaction came when he added:

I don’t think you can retract an article because times have changed, or *have a different view of it now and you don’t like the conclusion*. But you can put a disclaimer on it. And that disclaimer is that we know a lot more about this now. *It’s not that the science then was faulty*. It’s that we have additional science that now shows that engaging in this type of conversion activity does more harm than good. (Barlow as quoted in Flaherty, 2022, emphasis added)

One interpretation of this statement is that he believes the work is scientifically sound in the conclusions that LGBTQ+ individuals can change their orientation and identity. We refer readers to the research on “conversion therapy” survivors (Shidlo & Schroeder, 2002). Dr. Barlow eventually changed his position, noting that he “will support whatever reparative actions regarding these articles that are decided upon by Editors, Associations, and publishing companies.” Dr. Hayes was more supportive of retractions initially. The articles have not been retracted, and will not be, although ABCT appointed a task force to review them (Lorenzo-Luaces & Rodriguez-Seijas, 2023). ABCT stated it “may not take actions on articles inconsistent with Elsevier policy. Elsevier strictly adheres to COPE guidelines, and articles

on SOGICEs do not qualify for retraction consideration per Elsevier policy.”

Responses to critiques also invoked the idea that denouncing “conversion therapy” research refers to judging past behaviors by current standards. For example, Dr. Barlow said, “the social and scientific context in which this issue has played out has radically changed over the last 50 years.” Dr. Hayes added in his personal apology, “I am also 74 freaking years old, you’d do gay jokes and nobody would think about it.” Both referenced the idea that homosexuality was a DSM category until 1973. We are sympathetic to some aspects of the defenses by Drs. Barlow and Hayes (e.g., homosexuality was in the DSM). That said, most of the work we described was published after the DSM’s removal of homosexuality, which was a rather publicized affair. Even assuming a 3-year publication lag, all of Dr. Hayes’s articles were published on or after 1976 and most of Dr. Barlow’s were too. Of note, one can find writings suggesting homosexuality is a normal variation in human functioning as early as 1896 in the writings of Magnus Hirschfeld. The Kinsey studies were published in the late 1940s–early 1950s (e.g., Kinsey et al., 1948). Dr. Silverstein published *A Family Matter: A Parent’s Guide to Homosexuality* in 1977. Indeed, although the survey by Davison and Wilson (1973) reported more negative attitudes towards homosexuality than heterosexuality, most therapists did not consider homosexuality per se (86%) as a mental illness and many had personal experiences with gay individuals (e.g., attending a gay bar).

Thus, the “contexts” to which Drs. Barlow and Hayes refer are the contexts in which they existed and which they attended to. Scholars and LGBTQ+ individuals have long decried arguments about the mutability of sexual orientation and gender identity. “Conversion therapy” researchers have simply never been engaged with this sort of scholarship and context. Indeed, in his 2022 interview (Flaherty, 2022), Dr. Barlow admitted that he had not kept abreast of the impact of his “conversion therapy” research since its publication, even though this was a substantial part of his research program until the mid-80s. There is a lot of privilege inherent in being a contributor to harmful research and simply having no need to ever consider the implications of this harm. It is an affront to then attempt to define who is and who is not an appropriate ally to that community (i.e., Dr. Davison more than Dr. Silverstein).

<sup>2</sup>Craske published an apology for her role in the ABCT apology with various effective components: (1) acknowledgement of responsibility (“I apologize for my role in it”), (2) offers of repair (e.g., “I am committed to engaging in further dialogue on this issue”), (3) a promise not to repeat the offense (e.g., “I commit to centering the experiences of the harmed and marginalized in my future research and clinical endeavors”), (4) expressions of regret (e.g., “this entire situation unfolded is deeply regrettable and I apologize”), and (5) explanation (e.g., “At first, I was overly focused on seeing additional recognition go to Jerry Davison ...”).

The discourse in response to the ABCT Apology circumvents the harm done to instead bolster a desire for innocence among purported allies (i.e., privilege preservation). Indeed, some of the responses were even light in apology content. For example, in his video-taped apology (a 9 minute and 21 second video), Dr. Hayes makes one indirect statement of apology around 7:30, 80% into the video: “it’s important to apologize and I do.” Until that point, he discusses the history of behavior therapy, how ACT has contributed to more affirmative LGBTQ+ approaches, recommends that we read Dr. Hayes’s research, and discusses his history of grant funding.

Some individuals decried the use of social media rather than other purportedly more “proper” channels like the ABCT in-person conference. Existing research suggests individuals from minoritized groups use social media differently than members of majority groups, usually with the purpose of broadening their social connections (Gonzales, 2017). Others decried the specific naming of Dr. Barlow, Dr. Hayes, and the past presidents who threatened to withhold their signature. For the sake of contextualizing this debate, the co-leaders of the SGM SIG, and the co-authors of this paper, at this time were early career psychologists. While it might be enticing to assert that past presidents hold little institutional power, the collective leveraging of their signatures by a subset of ABCT past presidents was itself a display of power. It resulted in hours of work from junior ABCT members, including the amount of time and energy it took to write and revise this manuscript. Some senior scientists saw fit to write to the institutional superiors of the SGM SIG co-leaders criticizing them for expressing their opinions on the controversy on social media in what was interpreted by the co-leaders as an attempt to silence dissent. In summary, the apology gave the impression of being in service of privilege preservation of ABCT and its past presidents. Some ABCT past presidents then leveraged their collective weight to determine the parameters of allyship and former “conversion therapy” proponents downplayed their responsibility in the propagation of a harmful and baseless practice. Whatever this is, it is not allyship.

### **The Ally Paradox and Recommendations for the Future**

In *The Ally Paradox*, Grzanka (2022) outlines the complexity of allyship, with

several relevant points. First, allyship is often seen as a necessary evil. Self-appointed allies reap the benefits of hetero/cisnormativity without the risk of harm faced by LGBTQ+ individuals. Indeed, as the SGM SIG pointed out, despite the extremely laudable and tireless work by Dr. Davison, it was the bravery of Dr. Silverstein’s 1972 speech—a gay man and a student at the time—that undergirded Dr. Davison’s subsequent impact. Second, straight allies are often preoccupied with their own interests and reputation. Allyship becomes conditional on their terms rather than SGM individuals deciding who is acting like an ally. This centering of straight allies is seen at several points throughout the ABCT apology, most notably when past presidents advocated for an award to Dr. Davison over Dr. Silverstein and also when there was a heavy focus on the optics of the apology. We argue that the process of allyship works best when it centers the needs of minoritized individuals over the optics for organizations or individuals in power.

To be extremely clear, we believe the ABCT apology was well-intentioned. We also believe it has some positive aspects, as we have mentioned. But, there are important lessons for other organizations and individuals to learn. Organizations faced with the need to apologize are recommended to use effective apology components (see Lewicki & Brinsfield, 2017). Before promising or denying complex actions like retractions, organizations and individuals may need to inform themselves, sometimes substantially. One of the issues with allyship is that it presents individuals with a power inversion. On the one hand, a prospective ally may be in a position of power by not being from a minoritized group. On the other hand, they are not experts on the subject matter, nor do they have expertise by virtue of lived experience. For many academics, this kind of allyship, which requires being in a position of low expertise, is an uncomfortable place.

The focus for future apologies should be on members of the community themselves, especially those that experienced harm. Moreover, no community, including the SGM community, is a monolith and there will be individual differences in how something like an apology is received. It is also important to reflect on how lived experiences confer unique insights. For example, we already know Dr. Silverstein was a key figure in the depathologization of SGM identities. Consider the optics and reaction had ABCT given an award for social justice,

on pride month, for a purported ally and a former “conversion therapist” and not Dr. Silverstein. Ultimately, the organization did what we think is the right thing in creating the “Charles Silverstein Lifetime Achievement Award in Social Justice.” Another example of centering the cis-heteronormative perspective, in our read of the “conversion therapy” research by ABCT members, we could not find a single article in which harm coming from the interventions was referenced. It is possible that centering the voices of the individuals being subjected to “conversion therapy” may have revealed the harm being done rather early on as harm appears commonplace with “conversion therapy” (Forsythe et al., 2022).

### **A Concluding Thought**

Ultimately, we do not wish to call for the “cancellation” of the ABCT past presidents who conducted “conversion therapy” research, nor the ones who threatened to withhold their signatures from the ABCT Apology. We also do not wish to place blame on Dr. Davison, who had no responsibility for the behavior of his colleagues. We have criticized the ABCT Apology and described its fallout to illustrate how processes within academia often do not align with the needs of minoritized populations. It behooves those within scientific organizations to understand and accept responsibility when privilege-preserving behaviors are enacted to the detriment of populations we intend to serve. As highlighted by apology research, acknowledgment of responsibility is one of the key ingredients in an effective apology. Obscuring details for the preservation of an individual or organization’s stature serves neither the goals of an effective apology nor those of allyship. We also hope for individuals to learn about the specific harms that can come from behavioral therapies. One concrete action that we have advocated is retraction of articles supporting “conversion therapy” on the grounds that they report unethical research. Retraction is important because articles supporting “conversion therapy” are being published to this day (e.g., Rosik et al., 2023). Retraction would have little-to-no impact on the CVs of Drs. Barlow, Hayes, or others. Finally, we want individuals and organizations to know that allyship does not come for free. One cannot have the benefits of being seen as an ally without the potential for risk of reputation nor can there be effective apologies without sincere acknowledg-



## Find a CBT Therapist



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

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

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For further questions, contact the ABCT central office at 212-647-1890 or [membership@abct.org](mailto:membership@abct.org)

ment of harm. Recognizing the great allyship of someone like Dr. Davison, for example, involves understanding the harm of his prior actions. It is time for our field to truly recognize the harm we can do, not in the form of symptom scores going up on some summary statistics, but in the lives of people that were lost or traumatized in the name of research.

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*ABCT Congratulates Its Executive Director, Mary Jane Eimer, CAE*

## Mary Jane Eimer, CAE, ABCT's Executive Director, Receives Prestigious Chief Executive of the Year from New York Society of Association Executives

Mary Jane, who has spent virtually her entire professional career at ABCT and who prides herself in her association pedigree and acumen, was recognized by the New York Society of Association Executives as its **CEO of the Year**. The Award "recognizes an executive who has contributed significantly to the advancement of association management professions as a key leader and has demonstrated outstanding achievement in advancing the mission of their organization." In effect, Mary Jane was honored for both her association management bona fides and her work at ABCT.

Several staff were in attendance as were her daughter, Nora, and her son-in-law. In her acceptance speech, she noted she has been lucky to be "surrounded by people who want you to succeed," adding "I've been very fortunate to have coworkers who have been a tremendous asset and have become valued friends."

She noted the tradeoffs that come with dedication to a job, remembering that "Nora learned how to cook dinner at an early age due to my late nights."

She thanked the NYSAE Board and its Awards Committee, as well as Betsy Totten, Marriott's Global Account Executive, for nominating her, noting that the relationships one develops with industry partners makes for very good business and successful conventions.

## ***ABCT Fellows Application for the Class of 2024***

The ABCT Fellows committee is pleased to announce that 5 new Fellows were inducted this past year and were acknowledged at the awards ceremony on November 17, 2023. **For a complete list of all Fellows, please see <https://www.abct.org/membership/fellow-members/>.** ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role.

The Fellows Committee encourages qualified and diverse applicants to apply. We seek diversity in professional background and pathway, as well as in other areas of diversity. It is important that ABCT members have multiple routes to Fellow status, and six areas of consideration for fellowship have been identified: (a) clinical practice; (b) education and training; (c) advocacy, policy, public education; (d) dissemination, implementation; (e) research; and (f) diversity, equity and inclusion. Applicants for fellowship will be asked to endorse in which area(s) they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow; demonstrating outstanding, sustained effort in one area is all that is required and has been the most effective route in successful applications.

Fellow applicants must have full membership in ABCT for at least 10 years (not necessarily continuous), and they must have a terminal graduate degree in behavioral and cognitive therapies or a related area(s); whatever degree allows licensure and practice for a profession qualifies as “terminal”. Obtaining at least 15 years of professional experience following graduation with the terminal degree establishes eligibility to apply for Fellowship. Two letters of reference are required, one of which should be from an existing ABCT Fellow. If the latter requirement is a barrier to applying, please contact the Chair of the Fellows committee at [fellows@abct.org](mailto:fellows@abct.org), who will assist in determining how best to handle this requirement.

Letter writers should include detailed, specific descriptions of contributions that are outstanding and sustained. Potential applicants can detail their contributions for letter writers who have agreed to provide a reference. Don't hesitate to sell yourself! The Fellows Committee provides a list of potential activities that would be considered outstanding and sustained contributions; it can be viewed at <https://www.abct.org/membership/fellow-members/>. These are only a sample, offered to provide information regarding what the Fellows committee has considered outstanding, sustained contributions, but it is far from exhaustive. If potential applicants believe they have made enduring contributions that are not listed exemplars, please do not let that be a barrier to applying. Members' career paths come with unique opportunities, so the committee will be sensitive to the environment in which the prospective applicant is functioning and will weigh the contributions against the scope of the current/primary career.



## Call for Applications

# FELLOWS

*Fellows Application, Class of 2024*

ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role. Because members' career paths come with unique opportunities, the committee is sensitive to the environment in which the applicant has functioned, and we weigh the contributions against the scope of the applicant's current or primary career.

### Multiple Routes to ABCT Fellow Status

ABCT offers 6 areas of consideration for Fellowship status, with only one area necessary for selection: (a) clinical practice; (b) education and training; (c) advocacy/policy/public education; (d) dissemination/implementation; (e) research; and (f) diversity, equity, and inclusion. Applicants for fellowship will be asked to endorse the area(s) in which they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow, and focusing on one area of outstanding and sustained effort is an effective strategy for the required self-statement and emphases by letter writers. What guides the committee's decision making is determining if an applicant has made outstanding, sustained contributions that go beyond their work role expectations.

### Who Is Eligible to Apply for Fellow Status?

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

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

### ABCT Fellows Committee

*Antonette Zeiss, Ph.D., Chair*  
*Christopher Martell, Ph.D., ABPP,*  
*Vice Chair*  
*Brian Chu, Ph.D.*  
*Deborah Dobson, Ph.D.*  
*Debra Hope, Ph.D.*  
*Simon Rego, Ph.D.*  
*Gail Steketee, Ph.D.*

### Deadline for Fellow Status Applications: July 1, 2024

This is the deadline for both applicants and letter writers to submit their materials.

Applicants will be notified of the decision on their application by mid-October 2024.

For more information, visit the Fellowship application page: <https://www.abct.org/membership/fellow-members/>

2024



# Call *for* Award Nominations

*to be presented at the 58th Annual Convention in Philadelphia*

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*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](http://www.abct.org/awards)) and e-mail nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](http://www.abct.org/awards)) and e-mail nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](http://www.abct.org/awards)) and e-mail nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](http://www.abct.org/awards)) and e-mail nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](http://www.abct.org/awards)) and e-mail nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](http://www.abct.org/awards)) and e-mail nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](http://www.abct.org/awards)) and email nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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)<<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](http://www.abct.org/awards)). Email all nomination materials as one pdf document to [ABCTAwards@abct.org](mailto: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](mailto: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](http://www.abct.org/awards)). Email the completed form and any supporting materials as one pdf document to [ABCTAwards@abct.org](mailto:ABCTAwards@abct.org). Include "Outstanding Service" in the subject line.

► *Nomination deadline:* March 1, 2024

**NOW ACCEPTING  
APPLICATIONS**

# **GRADUATE STUDENT RESEARCH GRANT**

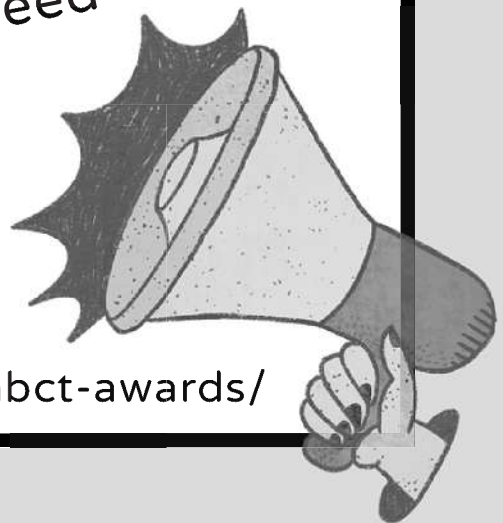
ABCT's Research Facilitation Committee is sponsoring a grant of up to \$1,000 (plus one honorable mention) to support graduate student's master's thesis or dissertation research with a clear financial need

**APPLICATIONS DUE 3/1/24 TO:**

RJJACOBY@MGH.HARVARD.EDU

For detailed instructions see:

[www.abct.org/membership/abct-awards/](http://www.abct.org/membership/abct-awards/)



# Congratulations, ABCT Award Recipients

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## ***Career/Lifetime Achievement***

Stefan Hofmann, Ph.D., *Alexander von Humboldt Professor, LOEWE Spitzenprofessur for Translational Clinical Psychology, Philipps-University Marburg, Germany*

## ***Outstanding Clinician***

Robert Leahy, Ph.D., *Founder and Director, American Institute for Cognitive Therapy and Center for Cognitive Therapy, NYC*

## ***Outstanding Training Program***

Torrey A. Creed, Ph.D., *Founder and Director, Penn Collaborative for CBT and Implementation Science, University of Pennsylvania, Perelman School of Medicine*

## ***The Francis C. Sumner Excellence Award***

Sierra E. Carter, Ph.D., *Georgia State University*

## ***Anne Marie Albano Early Career Award***

Lauren Quetsch, Ph.D., *University of Arkansas*

## ***The President's New Researcher Award***

(awarded by the President's New Researcher Committee)

Jessica Hamilton, Ph.D., *Rutgers University*

## ***Outstanding Service to ABCT***

Members of the Task Force for Equity, Inclusion, and Access:

RaeAnn Anderson, Ph.D., *University of North Dakota*

Anu Asnaani, Ph.D., *University of Utah*

Sierra Carter, Ph.D., *Georgia State University*

Christina Cho, Psy.D., *Rutgers University*

Ryan DeLapp, Ph.D., *The Ross Center*

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

Christina Lopez, Ph.D., *Medical University of South Carolina*

Jae Puckett, Ph.D., *Michigan State University*

## ***Charles Silverstein Lifetime Achievement Award in Social Justice***

Thema S. Bryant, Ph.D., *Pepperdine University and President of the American Psychological Association*

## ***Distinguished Friend to Behavior Therapy***

Connie and Steve Ballmer and the Ballmer Institute



*Awardees were honored at the ABCT Annual Convention, November 17, 2023*

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***Virginia Roswell Student Dissertation Award***

Emily Presseller, M.S., *Drexel University*

***Leonard Krasner Student Dissertation Award***

Mackenzie Zisser, M.A., *University of Texas at Austin*

***Student Research Grant***

Alexa Raudales, M.A., *University of Rhode Island*

***Student Research Grant — Honorable Mention***

Mallory Cannon, B.A., *Auburn University*

***Champions***

Ayada Bonilla, M.Ed., *Hawaii State Department of Education*

Lucene Wisniewski, Ph.D., FAED, *Center for Evidence Based Treatment Ohio*

Elizabeth Koschmann, Ph.D., *University of Michigan*

Regine Galanti, Ph.D., *Long Island Behavioral Psychology*

Vanessa Ramirez, Psy.D., *Kristi House Child Advocacy Center*

***Elsie Ramos Memorial Student Poster Winners***

Xinyi Deng, M.A., *Southwest University, China/Cornell University*

Melissa-Ann Lagunas, Ph.D., *Seattle Pacific University*

Mikela D. Ritter, AA, *Children's Hospital Los Angeles/University of Southern California*

***Student Travel Award***

Min Eun Jeon, M.A., M.S. *Florida State University*

Hila Sorka, Ph.D., *The Hebrew University of Jerusalem*

***Spotlight on Mentors***

Anu Asnaani, Ph.D., *University of Utah*

Kelsie Okamura, Ph.D., *Baker Center for Children and Families/Harvard Medical School*

Michael Twohig, Ph.D., *Utah State University*

***Fellows***

Ray Christner, Psy.D., NCSP, *Cognitive Health Solutions, LLC*

Muniya Khanna, Ph.D., *OCD & Anxiety Institute; Lumate Health*

Carmen McLean, Ph.D., *VA Palo Alto Health Care System*

Russell Morfitt, Ph.D., LP, *National Center for PTSD*

Nicholas Salsman, Ph.D., ABPP, *Xavier University*

# 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

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**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](mailto: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](mailto: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](mailto: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](mailto: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](http://www.abct.org) and click on "Convention and Continuing Education."*



*the Behavior Therapist*

Association for Behavioral  
and Cognitive Therapies

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Log in at [www.abct.org](http://www.abct.org) & click*

**RENEW**

