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EDITOR'S MESSAGE

Extreme Makeover: *the Behavior Therapist* Edition

Gregory S. Chasson, *The University of Chicago*



PLEASE ALLOW ME to introduce myself. I am your new Editor of *the Behavior Therapist* (tBT), starting this issue. Many thanks to outgoing Editor, Richard LeBeau, and Editorial Assistant, Julia Yarrington. This dynamic duo has launched tBT to new heights through their vision and industriousness over the last several years—ABCT is better because of them. I so appreciate their hard work in helping me transition to this role.

I'm also so deeply intimidated by how much they have raised the bar for this publication. I'm going to offer my very best effort to meet and exceed that bar.

My editorship coincides with the launch of our new, all-digital format of tBT. As many of you know, tBT has been printed and "snail mailed" for decades as a membership benefit. A PDF of the issue was also made available online in recent years, but it had notable limitations (e.g., articles were not available individually, hyperlinks and other interactive elements were not integrated). A recent survey of membership, however, suggested that most of us would prefer electronic delivery of tBT as a way to save trees and money, among other reasons (e.g., increase accessibility for those with disabilities). See LeBeau et al. (2023) for detailed results of this membership survey. This transition will be sad for some of us who enjoyed receiving tBT in the mail, but membership has spoken and we have delivered (electronically). Again, thanks to Richard and Julia for spearheading this transition. And thank you to Susan White (Publications Committee Coordinator) for the assistance and ABCT's very own Stephanie Schwartz (Managing Editor) and David Teisler (Director of Publications and Deputy Director) for doing much of the work behind the scenes.

The new digital tBT format will offer searchable and reader-friendly HTML-based content with an easy one-button push for creating a handsome PDF. This versatility allows you to share tBT content with ease on social media, via email, or text messaging. For those that miss the physical copy of tBT, there is nothing stopping you from printing out the combined PDF issue and taking it on the go.

The format of tBT has always been unique. It offers high-quality empirical research and literature reviews but also humor, op-eds, forums (e.g., clinical, training), etc. It's also a platform for ABCT to communicate to the membership for housekeeping purposes.

Sometimes it's difficult to know which content is peer reviewed. We hope to facilitate this differentiation with the new digital format. We will bifurcate content into two sections. One section will encompass peer-reviewed (e.g., original research articles, review papers, clinical and scientific commentaries, op-eds) and editorial content (e.g., this editorial, President's Column). The other section will include ABCT official material for communication purposes (e.g., minutes from the annual meeting of members, information about local arrangements for the convention). Hopefully this helps with publication process transparency.

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The author has no conflicts of interest or funding to report.

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As another bit of exciting news, tBT will be transitioning to an electronic manuscript submission system, much like our siblings (i.e., *Cognitive and Behavioral Practice, Behavior Therapy*). Days of running tBT with Microsoft Excel and sticky notes are coming to an end. The timeline for this deployment isn't clear yet, but sometime in 2024 we hope to launch. Stay tuned for more.

My aim as Editoris to build on the heavy lifting of my predecessors to sustain high-quality and informative content. I have always loved tBT for its utility. It represents a powerful platform for communicating with membership. It's not as nimble as social media or discussion boards, but it has a much quicker turnaround than other journal outlets and boasts a wide reach. It does so without sacrificing peer review.

The look and feel of tBT may be receiving a major makeover, but its aims and quality content will continue. This includes disseminating important research findings, timely opinions and other food for thought, and even some humor and light reads. We will continue to promote diversity, equity, inclusion, access, and justice; inform the membership of critical developments in the field; and serve as a forum for difficult but respectful debate.

I have selected an impressive board of Associate Editors (please see the list below) for this coming year and have no doubt that content is in good hands with their expertise and keen eye. Many of them have been reviewing for tBT for several years and continue to show their commitment to this important outlet. If you have an interest in helping with tBT, don't hesitate to reach out to me (email below).

I hope you share in my excitement as we transition tBT to new leadership and the fresh digital format. Please consider submitting articles to tBT. If you have ideas for special issues, don't hesitate to reach out: gchasson@uchicago.edu. See, now you can even click on that email address for automation! These are exciting times for tBT!

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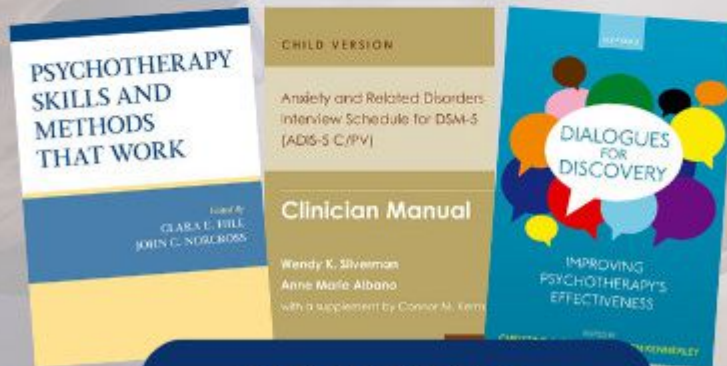
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Honoring Our History: A CBTer's Search for Mother

Sandra S. Pimentel, *Montefiore Medical Center/Albert Einstein College of Medicine*



DO YOU KNOW this pioneering woman? (see image to right).

Are you familiar with the names Skinner? Watson? ... Jones? For those who are not, I would like to introduce to you Dr. Mary Cover Jones—Mother of

Behavior Therapy.

The year 2024 marks the 100th anniversary of the publication of Dr. Mary Cover Jones's seminal publication, *The Laboratory Study of Fear: The Case of Peter*, wherein she established what would become a foundational model of our behavioral interventions still used today (Jones, 1924a). As a graduate student at Columbia University and then researcher at the Institute of Educational Research at Teacher's College in the early 1920's, she was struck by the work of John B. Watson (considered by many the "Father of Behaviorism"), who, along with Rosalie Rayner, demonstrated the conditioning of fears in a small child (Watson & Rayner, 1920). We all remember Little Albert? I must say for the record that I'm with Albert on this one and not a fan of white rats.

As Jones (1924b) herself wrote: "Dr. John B. Watson has analyzed the process by which fears are acquired in infancy, and has shown that the conditioned reflex formula may apply to the transfer of emotional reactions from original stimuli to various substitute fear-objects in the child's environment ... A study of how children's fears may be reduced or eradicated would seem to be the next point for an experimental attack" (p. 382). Dr. Jones introduced us to Little Peter and his laboratory peers, where via meticulous experimental small-*n* methodological design, she tested multiple methods for eliminating fears and found "unqualified success" for direct conditioning and social imitation. Ah, the power of a well-timed pleasant stimulus and social influence! She later expressed, "It has always been the greatest satisfaction to me that I could be associated with the removal of a fear when I came in contact with this three-year-old in whom a fear of animals was already well established" (Jones, 1974). And thus, Dr. Cover Jones laid the groundwork for operant conditioning, reciprocal inhibition, and modeling.

Yet, despite the burgeoning recognition of contingencies of reinforcement and mechanisms of behavioral intervention, it was not until five decades later, in 1974, that she would be designated "The Mother of Behavior Therapy" when she presented a keynote address aptly titled, "A 1924 Pioneer Looks at Behavior Therapy," at the 1st Temple University (Go Owls!) Conference in Behavior Therapy and Behavior Modification (see Jones, 1975). The conference title, "Behavior Therapy—50 Years of Progress," reminds us that as we enter 2024, it is no ordinary year. In celebrating Dr. Mary Cover Jones, we celebrate our own progress, those who made and continue to make ABCT's mission possible, and those yet to come who will continue her legacy.

Meanwhile, in 1927, Dr. Jones moved from New York to the University of California, Berkeley, with her husband Dr. Harold Ellis Jones, who was to start as the Director of



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Research at its Institute for Child Welfare (later the Institute of Human Development), and their two young daughters, Barbara and Lesley (Alexander, 2018; Logan, 1980; Rutherford, 2010; see also Reiss, 1990). Dr. Cover Jones also worked at the Institute as a research associate and joined the impressive Oakland Growth Study (OGS; originally referred to as the Adolescent Growth Study), a longitudinal study that launched in 1932. It tracked fifth and sixth graders through adolescence and was at the forefront of understanding child development and the behavioral correlates of puberty and early and late maturing youth. Dr. Cover Jones published extensively on the OGS (e.g., Jones, 1957; Jones & Bayley, 1950; Jones & Mussen, 1958; Mussen & Jones, 1957). More impressive still, albeit unsurprising, was that even when hours and staff salaries at the Institute had to be cut during the depression, Jones and her collaborators reported that most continued to work full-time to meet the needs of the OGS (Rossiter, 1982).

The longevity of the OGS, which continued as subjects moved well into later adulthood, has been largely attributed to Jones with her warmth and having formed meaningful connections with the participants (Logan, 1980; Rutherford, 2010). Throughout her career, pioneering contributions were generated by Dr. Jones, first as a behaviorist and then as a developmental scientist, and most especially as a humanist—and always, as a lifelong “kid person.” Her published scientific work delivered important data; much like the copious observations in her laboratory notebooks, Dr. Cover Jones accompanied her academic corpus with elegantly detailed case studies to contribute more qualitative knowledge, understanding, and to elucidate the deeper implications of the study findings. Additional ongoing follow-up studies further revealed her unyielding commitment to generating meaningful knowledge about the long-term course of development (e.g., Jones, 1965, 1967, 1968). Dr. Cover Jones was known for not simply having “subjects” in her longitudinal study—she fostered decades-long relationships with the participants, invested in their shared community, and in her words, considered them “partners in the studies of human lives” (as seen in Almy et al., 1993, p. 81). In fact, over 150 of her “subjects” attended her memorial service in 1987—over 50 years after having started the longitudinal study (Krasner, 1988).

An important and illustrative side note: Due to existing antinepotism rules, given her husband’s position in the psychology department, Dr. Cover Jones was not appointed to the faculty for many years. She became Assistant Professor (of Education) in 1952 and then Full Professor in 1959, one year prior to her retirement (see Rutherford, 2010).

Despite the primacy, longevity, and significance of Dr. Cover Jones’ seminal work in developing an applied therapeutic technique fundamental to behaviorism, and the recognition conveyed by the Temple conference, 100 years later, many within ABCT and elsewhere are not familiar with Dr. Mary Cover Jones, the range of her brilliance, or her lasting impact. If not for one of my mentors, Dr. Anne Marie Albano, who made it a point to share with her interns her own encyclopedic knowledge and spotlight Dr. Cover Jones’s essential contributions to our science, I may not know about her fully today. And it of course begs a bigger question: Who else in our historically minoritized and marginalized communities has history dimmed, diminished, or deleted?

The “Mother of Behavior Therapy” was also a beloved mother of two daughters, Barbara and Lesley, and grandmother of six grandchildren. We will spend the year ahead honoring Dr. Cover Jones and getting to know her through her foundational science to our field and our organization and through the eyes of some of those who loved her up close through her foundational love and nurturing.

In preparing to honor and celebrate this LEGEND, I have been so fortunate to be

able to engage her family—including her oldest daughter, Barbara, who just celebrated her 101st birthday and Barbara’s son, Jim Coates, as well as her late daughter Lesley’s daughter, Jane Alexander. They have generously shared time, stories, and photographs, and readily shared the late Lesley’s incredible historical chronicling of their family’s history in a book entitled *Coming and Going: One Family’s Tale* (Alexander, 2018). They have warmly accepted my admiration (complete with fan-girling!) and professional mission to make others more aware of this innovative and devoted foremother (please feel free to ask Montefiore Psychology about their limited-edition Mary Cover Jones laminated trading cards!). They have inspired kindred admiration for this beloved and devoted mother and grandmother.

In the year ahead and with the proper magnitude of centennial celebrations and with the help of Dr. Jones’ family, we will hope to pay proper tribute and commemorate the incredible life and work of Dr. Mary Cover Jones.

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Experiences of Physically Disabled and Blind People in Psychotherapy: Lessons for CBT Therapists

Rhoda Olkin and Marco Gomez, *California School of Professional Psychology at Alliant International University*

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DUE TO THE FREQUENCY of disability (26% of the adult U.S. population; Centers for Disease Control & Prevention, 2022), it is highly likely that most psychotherapists will see clients with lived experience of disability in themselves or their families. However, barriers for mental health trainees with disabilities (Joshi, 2006; Lund et al., 2014) means that the mental health field has a paucity of therapists with disabilities. Therefore, disabled clients¹ are most likely to be in cross-cultural therapy with a nondisabled therapist. Disabled clients experience mental health disparities compared to nondisabled clients yet are more likely to receive mental health treatment (Connor et al., 2023). Therapists are unlikely to have received any training in working with disabled clients (Berrin et al., 2012; Lund et al.; Olkin & Pledger, 2003; Tervo & Palmer, 2004). Thus, they may have difficulties “knowing how to modify the diagnosis, case formulation and treatment to integrate the disability” (Olkin, 1999, p. 155). Without relevant training, therapy can lead to negative mental health outcomes (Conover & Israel, 2019; Mazur, 2008).

Disabled people are at higher risk for mental health issues (Emerson et al. 2008; Honey et al., 2010; Miauton et al., 2003) due to higher rates of physical and sexual abuse (Nosek et al., 2001; Nosek et al., 2006; Olkin, 2006), substance use disorders (Brooks et al., 2014; Koch et al., 2002; Tate et al., 2004), and minority stress (Meyer, 2003) from the experiences of microaggressions, discrimination, and stigma (Keller & Galgay, 2010; Olkin et al., 2019; Smart & Smart, 2006). Additionally, coexisting mental health disorders, notably depression (Olkin, 2004), anxiety, and/or PTSD, may be present (Evans et al., 2007; Hermans et al., 2014; Jones et al., 2012; Kinne et al., 2004; Okoro et al., 2014; Robinson-Whelen, et al., 2013). These disorders may be directly related to the disability (e.g., higher rates of depression in people with MS; Hanna & Strober, 2020; Henry et al., 2019; Scott et al, 2017), a response to minority stress (Meyer, 2003), or mostly unrelated to the disability. Last, previous negative medical experiences may lead to distrust of health professionals, including mental health clinicians. These risk factors suggest that mental health professionals must be adept at assessing and carefully parsing out these factors in deriving a case formulation. Disability-affirmative therapy (Olkin, 2017) was designed to help clinicians develop a case formulation that keeps the disability in proper perspective. Disability-affirmative therapy is defined as a template of nine areas to explore with a disabled client so as to properly center the disability in the presenting problem(s) without over- or underestimating the relevance and role of the disability. It is not known whether this approach is widely known, taught, or utilized by mental health professionals.

¹ We prefer to use identity-first language as discussed in Dunn and Andrews (2015).

Despite the higher risk of mental health issues, disabled people experience several disadvantages in the ability to access psychotherapy. These include lack of physical accessibility in the spaces where services are provided (Drainoni et al, 2006; Leigh et al., 2004; Olkin, 1999), attitudinal barriers (Cornish et al, 2008), inadequate transportation, a high rate of poverty (Mitra & Sambamoorthi, 2014; Pinilla-Roncancio & Alkire, 2021), and the greater likelihood of having government insurance with restricted lists of providers (Lauer & Houtenville, 2018; Parish et al., 2016; Rotarou et al, 2021). Additionally, clinicians often lack disability-specific knowledge and disability-affirmative training (Lund et al., 2014; Olkin, 2017; Olkin & Pledger, 2003).

In addition to the American Psychological Association (APA) guidelines on assessment and treatment with persons with disabilities (APA, 2012), there is growing literature on culturally informed therapy with disabled clients (Artman & Daniels, 2010; Cornish et al, 2008; Mpofu & Conyers, 2004; Olkin, 2017; Parsloe, 2022), particularly within cognitive behavioral therapy (CBT; Elliott et al, 1991; Galvin & Godfrey, 2001; Gerry & Crabtree, 2013; Guest et al., 2015; Hassiotis et al., 2013; Mehta et al., 2011; Mona et al., 2006; Radnitz, 2000). Nonetheless, there is still much to be learned about what constitutes culturally informed CBT with disabled people (Mona, 2019).

Hearing directly from psychotherapy clients with a variety of disabilities, in treatment with therapists who do not specialize in disability, can be useful in providing more guidance to clinicians (Drainoni et al., 2006). A recent study on the experiences of adults with physical disabilities in therapy examined positive and negative therapeutic interactions and accessibility of services (Connor et al., 2023). Themes in negative interactions were avoidance of disability topics (almost all 24 respondents), invalidation of disability experiences (more than half), responding inappropriately (more than half), and attributing physical disability to psychopathology (one third). Of concern was that



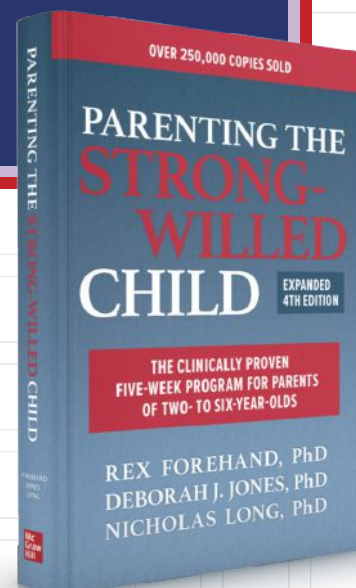
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one third reported that negative experiences led to exacerbations of physical or psychological symptoms. Further, there were numerous inaccessibility features of therapy, including costs, physical setting, transportation or parking, and finding a therapist with openings for new clients.

Purpose

The purpose of this study was to conduct a phenomenological investigation of the experiences of disabled people in psychotherapy. Despite myriad similarities in experiences across people with a variety of disabilities, there are important distinctions among disabilities, such as visibility of the disability, effects on activities of daily living, and types of accommodations. Therefore, we elected to focus on those with physical disabilities and/or blindness. Both of these types of disabilities are generally visible to the clinician, and as such there may be more countertransference reactions to the disability (cf. Corbett, 2014; Freedman et al, 2020; Tervo & Palmer, 2004).

We were interested in two research questions:

1. What were the issues that led clients to seek therapy and were disability issues one of the main purposes?
2. What barriers to psychotherapy did disabled clients cite (e.g., physical barriers, training barriers, and prejudice or microaggressions)?

Both authors have physical disabilities, are cisgender female and male, and one is an ethnic minority.

Methods

Participants

Inclusion criteria were as follows: (a) identifying as having either a physical disability (either visible or invisible), low vision, blindness, or a combination of these; (b) age over 18 at the time of data collection; and (c) having participated in psychotherapy at least once since the age of 18 and/or currently seeing a licensed mental health professional for therapy; (d) living in the U.S.

After IRB approval, participants were recruited from July 2019 through February 2020 from major disability organizations and websites such as The National Multiple Sclerosis Society, The National Federation of the Blind, Post-Polio Health International, and local college disability offices in the San Francisco Bay Area via monthly newsletters, email listservs, and research discussion board posts as well as social media (e.g., Facebook). Flyers were posted in person locally and sent online to disability organizations nationally.

A total of 62 persons were included in the data analysis. Everyone had the option of completing the survey online or by phone. Two blind respondents elected for the phone. Those who completed the survey online spent an average of 76 minutes, and completion of the phone survey ($n = 2$) took roughly 120 minutes. The mean age of participants was 48.37. Most (82%) identified as White. Regarding education, 50% held an associate or bachelor's degree, with 29% holding a master's or doctorate degree (see Table 1). The majority (at least 66%) used a mobility device, 23% used a screen reader, and 10% used voice input on computers. (Due to oversight, data on gender was not collected.)

Measures

The measure was a survey on Qualtrics organized into four parts. Part One contained the 11 screening questions used to determine participants' eligibility using the inclusion criteria, followed by questions about the participants' disability. Part Two comprised 23 questions on the therapists' characteristics (e.g., the most recent therapist, if there was more than one), the presenting problem in therapy, and the perceptions of the therapy experience. A six-point scale was used for any scaled questions in the survey. The area of "therapist knowledge about disabilities" was constructed by asking a variety of questions designed to assess the degree to which participants felt their therapist had at minimum a basic foundation of information needed to work with people living with physical or visual disabilities.

Part Three comprised a list of 14 items about perceived barriers to treatment. Eleven of these 14 were on physical accessibility and 3 were on systemic accessibility. Part Four contained eight questions regarding participant demographics, including age, state of residence, ethnicity, highest level of education, source of income, relationship status, and insurance status.

To assess the worst experiences in therapy, we asked, "Have you had a negative experience in therapy?" and "Please describe your worst psychotherapy experience." To assess knowledge, we provided seven areas to be rated on a scale of 0 to 5 (knowledge about your disability, disability in general, models of disability, disability culture, and methods of pain, fatigue, and stress management). Regarding the presenting problem, we asked two questions: "In your opinion, how much is your disability a part of the main reason you are coming/came to therapy?" and "How relevant was your disability to the issues you wanted to discuss in therapy?" (both rated 0 = *not at all* to 5 = *completely*).

Table 1. Demographic Characteristics of Sample Participants ($N = 62$)

| Demographics | N^* | % | Mean | SD | Range |
|------------------------------------|-------|------|-------|-------|-------|
| Age | 62 | 100 | 48.37 | 14.22 | 22–73 |
| Ethnicity of Participant (>1 OK) | | | | | |
| Caucasian/White | 51 | 82.3 | | | |
| Black/African American | 6 | 9.7 | | | |
| Latina/o/ Hispanic | 3 | 4.8 | | | |
| Native American | 2 | 3.2 | | | |
| Middle Eastern | 2 | 3.2 | | | |
| Highest Level of Education | | | | | |
| High School (partial or completed) | 12 | 19.7 | | | |
| Associate/Bachelors | 31 | 50.0 | | | |
| Masters/Doctorate | 18 | 29.1 | | | |
| Sources of Income ** | | | | | |
| Government Assistance | 31 | 50.0 | | | |
| Familial | 17 | 27.4 | | | |
| Self-employment | 7 | 11.3 | | | |
| Student Loans | 1 | 1.6 | | | |
| Disability *** | | | | | |
| Multiple Sclerosis | 48 | 62.9 | | | |
| Other Physical Disability (not MS) | 39 | 14.5 | | | |
| Blindness | 9 | 24.9 | | | |
| Mental Health Disorder **** | 15 | 17.7 | | | |

Notes. $*N < 62$ in some cases due to missing data. ** Adds to more than 100% due to multiple sources of income. *** Adds to more than 100% due to multiple disabilities. **** Depression, Anxiety, or PTSD

Design and Procedures

Participants who elected the online option were directed to a URL with the survey usable on a tablet, computer, or cellphone. If they agreed to the initial page of informed consent, they were directed to the set of 11 eligibility screening questions. Telephone participants called the generated Google Voice number provided on the flyer and left a voicemail and call-back number. The lead researcher called them back to arrange a time to go over consent and eligibility, and to take the survey.

Data Analysis

We used a phenomenological theory approach (Creswell, 2013) for open-ended responses for the worst experiences. There were 17 responses about the worst experiences, each only one to two sentences. We used inductive methods to derive themes, using as few themes as possible, and consensus for any discrepancies. We had three themes: feeling misunderstood (e.g., the therapist did not know about disability or its symptoms), being prejudiced or inappropriate, and encountering a barrier. The two authors did the coding, and had 100% agreement about which comments were related to disability, and which theme was exemplified in the responses.

Results

Question 1: What were the issues that led clients to seek therapy and were disability issues one of the main purposes?

The majority (82.3%) indicated that disability was one of the main reasons for seeking therapy (defined by participants responding “moderately,” “very much,” or “completely”). When asked about other reasons for seeking the most recent treatment, the highest responses were depression (61.3%) and anxiety (53.2%). Just under 13% indicated trauma resolution, and only one individual indicated substance use.

Question 2: What barriers to psychotherapy did disabled clients cite (physical barriers, training barriers, and prejudice or microaggressions)?

Participants were given a list of 14 accessibility barriers and asked if any were a perceived barrier to treatment. There were 11 physical barriers listed (i.e., access to curb cuts for wheelchairs, access to an elevator, accessible bathrooms and stalls) and 3 questions that asked about systemic barriers (i.e., offering pro bono sessions, accepting Medicare, offering a sliding scale fee). Although 55% of offices had a parking lot, only 45% of the total had a handicapped parking space. Blind respondents indicated the lowest levels of accommodation, with only 25% of therapists accommodating vision needs. Wider doors and lighting issues were written in by a few respondents as we had not included those on our list of potential barriers (see Table 2).

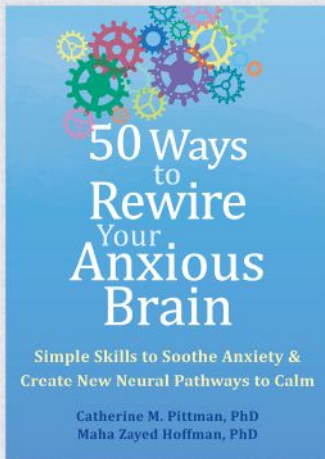
Knowledge about disability was defined as knowing about the social model of disability (disability as a social construct), disability culture, and pain, fatigue, and stress management. For each of these we report the percentage of those answering “Not at All,” “Mostly Not,” or “Slightly” (group A) versus those answering “At Least Moderately,” “Very,” or “Completely” (group B) respectively (Table 3). The greatest percentage of perceived knowledge was about stress management (77%), and the least was about fatigue management. Perceived knowledge about pain management was also relatively low (40%). We also inquired about who brought up the disability first, the client or therapist. Of the 57 people who answered this question, most (56.5%) indicated that they brought it up first and only 11% said the therapist brought it up first (9% said no one brought it up, and 19% could not remember).

Table 2. Responses to Open-Ended Question About Worst Experiences That Were About Disability

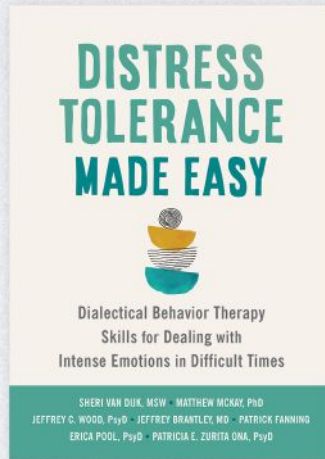
| Theme | Statements from Participants |
|---|---|
| Feeling misunderstood / therapist did not know about disability or its symptoms | <ul style="list-style-type: none"> • “Several (many) time in treatment (inpatient or otherwise) providers have NO understanding of the physical limitations and impacts of multiple sclerosis—most importantly, how those limitations and symptoms can and frequently do change.” • “The therapist not getting the complexity of having a disability and how it affects your life in every aspect.” • “The reason I went to see a therapist is because I was depressed about losing my sight. I wasn’t sure what I would be able to do now that I lost my sight and felt like my life was over. I was looking for hope, guidance, direction, and the therapist provided none of that. I was basically left on my own to figure things out and thank God I did.” • “Complete failure of empathy and inability to understand my disability.” • “The worst experience I had within therapy was when they completely disregarded my disability and told me to try things (like going to community clubs, i.e., books). They gave me ‘advice’ to go do things that my disability disallows me.” • “She missed the boat on my entire disability and external factors entirely.” • “She was unable to understand how going from an incredibly independent person to someone that had to rely on others for basic things was an issue for me.” • “Had mental health crisis in (year); intensive outpatient psychotherapy. Most of the staff there were clueless about blind people. I found the staff policy of ‘hands off’ triggering because the rule didn’t apply to blind people. My doctor there thought my blindness was part of my mental health issues. That that was the cause of my being so depressed and not myself.” |
| Prejudice or being inappropriate | <ul style="list-style-type: none"> • “The therapist asked a bunch of questions about my blindness, and it came off as that of pity and curiosity and not of a therapist.” • “Therapist seemed to center her focus on my child’s father rather than me giving him more credit for being the non-disabled parent.” • “A counselor at the student counseling center at my school told me that I was a burden to those around me and needed to learn to accept help graciously.” • “I went to see the therapist because I was depressed about my blindness. She advised me to find something meaningful to do. Then she wanted to know how I was able to cook since I was blind. I left feeling even more depressed.” • “Another female counselor...was trying to say how my symptoms at that time were the reasons partners sometimes looked for different partners than their spouse. Did not go back for second appointment.” • “He wouldn’t let me finish my sentences, and I felt like he didn’t know how to treat someone who is blind.” |
| Encountering a barrier | <ul style="list-style-type: none"> • “My psychologist just recently retired, and I found that it upset me more than I expected. No other local psychologists accepting Medicare so I will have to switch to an MSW.” • “I was resisting going to therapy but recognized I was very depressed and anxious and knew I needed to go I scheduled an intake and showed up via paratransit. The driver walked me into the therapist’s office within a big building and she came out and told me she couldn’t see me after all because she had dog allergies, and I had my guide dog with me. I’m not sure if that counts as it wasn’t an official session after all, but it was a scheduled appointment and it is the first thing I think about regarding negative therapy experiences.” • “Where do I begin? She was more interested in following the prescribed questions and typing the answers that she wasn’t listening to the answers. She incorrectly recorded the answers which caused issues with my SSDI.” |
| Other | <ul style="list-style-type: none"> • Not being able to get the medication I need for pain! |

Note. One response was broken into two responses as it had two different thoughts in it.)

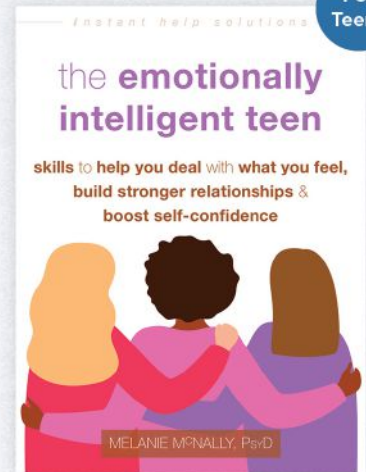
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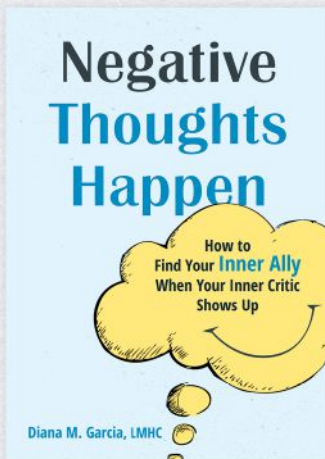
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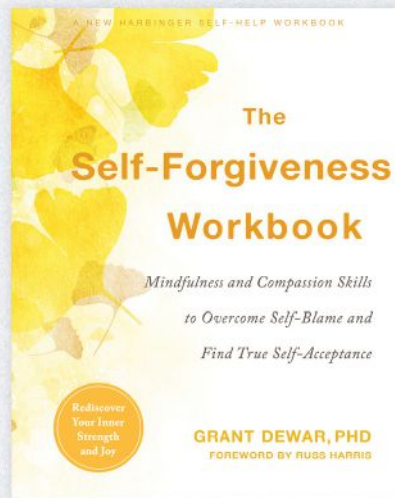
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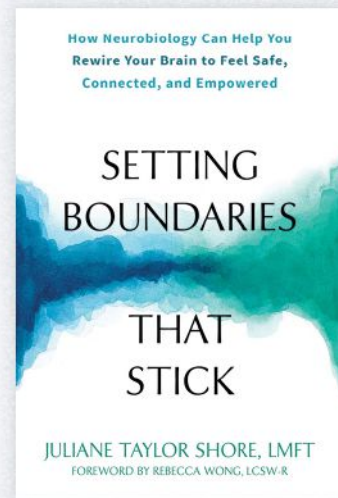
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There were 41 responses to an open-ended question about the worst experiences in psychotherapy, of which 44% ($n = 18$) were directly related to disability. (See Table 4 for the responses about worst experiences.) There were 8 responses about feeling misunderstood, that the therapist did not know about disability or its symptoms (e.g., “She missed the boat on my entire disability and external factors entirely”). There were 6 responses about a therapist being prejudiced or inappropriate about the disability (e.g., “The therapist asked a bunch of questions about my blindness and it came off as that of pity and curiosity and not of a therapist”). Three responses were about encountering a barrier (e.g., payment issues), and 1 about not getting medications for pain.

Discussion

This study explored the experiences of physically and visually disabled persons in mental health treatment. Of note is that the majority of respondents indicated that their disabilities were one of the main reasons for seeking therapy. This should not be surprising, as living with a disability exposes one to multiple microaggressions and minority stress. Furthermore, the disability is not separate from the person—that is, if a person goes to therapy for depression or anxiety, their demographic characteristics, including disability, are a part of the total picture.

Consistent with previous literature, there were significant barriers to treatment. These included physical inaccessibility, accommodations for blind persons, lack of knowledge about pain and fatigue management, and prejudicial comments from therapists. Mostly it was the clients who raised the issue of disability.

We note several limitations of the present study. It was a relatively small sample size, with very few persons with low vision or blindness. The majority had MS, which is generally a later-onset disability, a factor that might be quite relevant in their psychotherapy experiences. The sample skewed towards older age, and only 18% were people of color. Due to an error in the survey, we did not have data on gender, thus omitting a key variable of intersectionality (cf. Banks & Kaschak, 2003; Marshall et al., 2009; Nosek et al., 2001; Olkin, 2003; Sasseville et al., 2022). The worst experiences were single write-in items and garnered few responses. The data relied on memory and perceptions of treatment, without knowing how long ago that treatment took place or how accurate the perceptions were. We also did not collect information about the educational preparation of the therapists, as we did not expect clients to know this information.

Training and Clinical Implications

Given the high proportion of disability in individuals and families, and the salience of disability as an impetus for therapy, it is incumbent on clinicians to have some training and supervised experience in treating disabled clients and to be familiar with vari-

Table 3. Perceptions of Therapists’ Knowledge Regarding Disability

| Knowledge | Group A ¹ | Group B ² | Missing |
|----------------------|----------------------|----------------------|---------|
| Stress management | 16% | 77% | 7% |
| Models of disability | 34% | 66% | |
| Disability culture | 43% | 58% | |
| Pain management | 56% | 40% | 4% |
| Fatigue management | 48% | 32% | 20% |

¹ Group A: Little to no knowledge (i.e., those answering *Not at All* or *Mostly Not* or *Slightly*);

² Group B: Adequate or significant knowledge (i.e., those answering *At Least Moderately*, *Very*, or *Completely*)

Table 4. Perceived Percentages of Therapists With Physical and Systemic Accommodations to Treatment (*n* = 62)

| Barrier | % |
|---|------|
| Physical Barriers: | |
| Parking lot | 54.8 |
| Bathroom stall | 53.2 |
| No stairs | 51.6 |
| Bus stop | 50.0 |
| Elevator | 50.0 |
| Handicapped parking space | 45.2 |
| Wheelchair ramps | 45.2 |
| Ability to accommodate assistive device | 38.7 |
| Handrails | 38.7 |
| Curb cuts | 37.1 |
| Accommodates vision needs | 24.8 |
| Systemic Barriers: | |
| Does not accept Medicare/MediCal | 45.2 |
| No sliding fee scale option | 38.7 |
| Does not offer pro bono sessions | 17.7 |

ous models of disability (e.g., Olkin, 2017; Petasis, 2019; Retief & Letšosa, 2018, Smart & Smart, 2006; Smith & Bundon, 2018; Waldschmidt, 2018). Yet studies verify that most clinical psychology training programs lack education about working with disabled clients (Berrin et al., 2012; Lund et al., 2014; Olkin & Pledger, 2003; Tervo & Palmer, 2004). Of note, disability issues were cited as the main reasons for seeking therapy by most respondents, along with depression and anxiety (which may have been related to disability issues). Thus, it seems incumbent on therapists to be knowledgeable about factors involved in living with a physical or visual disability, and to be able to take a disability-affirming stance (Connor et al., 2023; Olkin).

Specific knowledge about disability sequelae also is important. Although over three-quarters of participants believed their therapists to be knowledgeable about stress management, far fewer perceived their therapists to be proficient in fatigue and pain management. Over 20% of Americans live with chronic pain, and chronic pain is one of the most common reasons for seeking medical care (Dahlhamer et al., 2018). Training should include the management of pain and fatigue, two of the most prominent disability sequelae. Pain and fatigue have direct effects on activities of daily living (ADL) and socialization; reductions in ADL and socializing are risk factors for depression. Therefore, the management of pain and developing a lifestyle that accounts for disability-related fatigue can be core components of therapy for disabled clients.

We acknowledge the difficulty of shoehorning more material into APA-accredited curricula; however, there are places in existing courses where pain management could be included (e.g., cognitive behavior therapy; psychopharmacology; integrated health). Fatigue management is unique to disability and chronic health conditions. (Two activities for students to learn about fatigue management are in Olkin, 2021.) At the very least, clinicians should be familiar with the APA Guidelines for Assessment of and Intervention with Persons with Disabilities. And both training programs and placements/internships should include disability in their diversity training (Olkin). We encourage more continuing education opportunities specific to this population, including disability-affirmative therapy. Training has to include attention to countertransference and ableist assumptions by therapists.

Therapists also could inquire at intake about whether any accommodations are needed. For example, one could say that “I offer a variety of different forms and brochures that are available to clients, such as large-print, or electronic copies; just let me know if I can provide them for you.” Information about accessibility should be on therapists’ websites (e.g., closest bus stop, whether the office has stairs with no alternative route, alternatives to online forms).

Our participants provided many examples of therapists’ pathologizing statements. Olkin’s “ten general rules” of etiquette with clients with disabilities (Olkin, 1999, pp. 190–194) provide conventional guidelines for interactions between therapists and clients with disabilities. We suggest neutral, person-first language initially (e.g., “What is the nature of your disability?”), letting the client be the expert on the effects and relevance of their disability.

Consistent with the findings of Connor et al. (2023) that therapists avoided talking about disability, our respondents said that they were the ones who brought up their disability first in therapy, with only 11% remembering that the therapist raised it first. Although this may suggest that clients took control of the narrative, this may also mean that there was reluctance by therapists to ask about clients’ disabilities, further perpetuating stigma about disability being a taboo topic, even within therapy. To break this taboo, therapists must ask about it. It can be routine on intake forms and in initial sessions; the more it becomes routine, the more it is normalized. Suggested language might be, “What is the nature of your disability?” (Olkin, 1999, p. 167). Another important question is, “How do you think your disability is related to the presenting problem?” The important thing is to ask, without making assumptions.

Research Implications

These clients reported numerous barriers. Over half of the therapists did not have handicapped parking spaces, wheelchair ramps, or curb cuts. Three-quarters were perceived not to be able to accommodate vision needs. Throughout responses it seemed that blind respondents were the most unhappy with their experiences in psychotherapy. This is in accordance with an earlier finding from a survey of psychologists who cited those with visual impairments difficult to serve (Leigh et al., 2004). In that same survey, psychologists stated that their state or local psychological association either did not offer training on serving clients with disabilities (33%) or did not know if it was offered (49%). One research implication is to conduct an update to this survey.

Forty-four percent of responses to an open-ended question about worst experiences in therapy were related to disability. Of the 18 written responses, 44% were about feeling misunderstood or invalidated regarding the realities of living with a disability. This compares to the more than half of the respondents in Conner et al. (2023) who reported invalidating experiences. Another six were about inappropriate behaviors by the therapist, such as asking questions out of curiosity or pity, or calling someone’s disability a “burden” to others. (This compares to more than half in Conner et al.) The responses in this category were somewhat shocking, as they were openly prejudicial and anathema to a trusting therapeutic relationship. It could be useful to examine positive experiences in therapy, as this might help create useful guidelines for therapists—what to do, not just what not to do.

Despite three decades since the passage of the Americans with Disabilities Act (1990), implicit bias towards disability has not appreciably changed (Charlesworth & Banaji, 2019; Davidio et al., 2011). This is a fruitful area for future research—to assess various methods of teaching trainees and clinicians about disability so as to reduce

implicit bias.

Disabled clients are likely to bring disability issues into the therapy, such as minority stress and experiences of microaggressions. Therapy has to be disability affirmative and avoid ableist assumptions and microaggression. As yet there is no empirically validated best psychotherapy for disabled clients. There is, however, a growing body of calls for disability-affirmative therapy, which is an area ripe for research. We strongly encourage more research on experiences of disabled clients in general psychotherapy with mental health practitioners not specializing in disability. There are still many unanswered questions: Are there regional differences in physical accessibility? Do clients and psychotherapists agree about who raised the issue of disability? When therapeutic ruptures related to disability arose, how were these handled? How can disabled people best access therapists knowledgeable about disability? How might we improve training so that there are more therapists with core knowledge of pain and fatigue management, disability culture, and disability-affirmative therapy? The field has a way to go to address these questions, because most of them haven't even been asked yet.

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CBT in Greenland

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NESTLED IN THE CRADLE of the Arctic circle is the world's largest island where a significant number of mental health professionals are treating their patients with cognitive behavior therapy (CBT). I was pleasantly surprised to learn this information during a recent visit to this sparsely inhabited nation, roughly three times the size of the state of Texas, with the lowest population density in the world. With less than 57,000 people, most of whom are a mixture of Danes and native Greenlanders, many are comprised of descendants of the Inuit origin, a culturally unique indigenous people of the Arctic, who resemble their kin, the Eskimo.

Culture and Language

While the country of Greenland officially remains part of the Kingdom of Denmark, the island's home rule government is responsible for most domestic affairs and they function independently in many ways. They proudly refer to their homeland as "Kalaallit Nunaat" (Country of the Greenlanders). The Greenlandic language is very unique, not typically spoken anywhere outside of the country. It is also not listed as one of the languages available through Google translate, nor any other formal language training program. It is primarily spoken among the population along with Danish. On many occasions, the two languages are often mixed; however, Greenlandic remains the predominant language. There are no mental health journals and few professional newsletters published in the Greenlandic language. The professional textbooks are mostly published in Danish with some in English. Many students at the University of Greenland, including those majoring in psychology and nursing, are permitted to write their thesis or dissertations in their native language, if they choose. Most mental health professionals are able to read English and have a fairly good command of the spoken word, particularly the younger population, who acquire their English-speaking skills primarily from music, movies, or television.

I had an opportunity to sample the national dish of Greenland, known as "suaasat," a traditional soup often made from seal or whale meat, which has a very unusual taste. They also serve reindeer and trout, which is prepared in a very unique way. Fishing and farming are the primary industries along with some mining in the northern regions.

In the colder regions, the Inuit enjoy the primitive excitement of hunting dangerous animals and driving dog teams on the sea ice in the Arctic night, where the sun is seen for the last time in October. The middle of the island consists of an enormous ice cap, which does not support life of any kind.

The crime rate is very low in Greenland, although many folks still carry guns for protection against the polar bears, particularly in the outlying areas.

A favorite pastime of Greenlanders involves folk arts such as soapstone carving and drum dancing along with kayak building and sailing. They produce some very impressive artwork.

Native Greenlanders are a very kind, good-hearted, but a protective race of people who pride themselves on being self-sufficient. They are extremely family oriented and

tight knit. Consequently, this makes it challenging for couple and family therapy interventions, particularly where child physical and sexual abuse is a major problem, especially in the ice zones. The population in these zones sometimes dips as low as 150 people.

Mental Health Problems

This intriguing country, as is the case with many other nations, has its share of emotional and behavioral disorders that range from anxiety and depression to a host of major mental illnesses. The suicide rate is 6 to 7 times that of any other Nordic country and is the highest in the world (Thorslund & Misfeldt, 1989; World Health Organization, 2012). The more serious of the mental illnesses includes schizophrenia, the prevalence rate of which is approximately 1.0%, commensurate with international statistics (Van Os & Kapur, 2009). For reasons that are unclear, a slightly higher occurrence of schizophrenia is found among younger men in Greenland (Jakobsen & Pedersen, 2021). Alcohol and cannabis abuse/dependence is also quite prevalent and is often used to temper the sting of loneliness as well as the frigid weather. In fact, the nation established a program known as “ikioqatigiit” (those helping together) for improving outreach for the treatment of alcoholism (Aage, 2012). The more severe cases are treated at a psychiatric hospital in the capital city of Nuuk (pronounced “Nuke”), known as Queen Ingrid Health Centre, which has both an inpatient and outpatient mental health clinic. This facility also serves as the central hospital for the entire country. Long-term psychiatric patients are usually referred to hospitals in Denmark, although there are other very small facilities that exist throughout the country’s smaller regions, many of which are spread out along the coastline. While there are a number of outreach clinics sparsely dispersed throughout the nation, the majority of mental health cases are usually treated in the capital city where there is a sizable staff of psychiatrists, psychologists, and social work therapists.

The Prominence of CBT in Greenland

My contact in Nuuk, a psychologist named Ruth Blytman Nielsen, Ph.D., who is a native Greenlander, informed me during an extensive interview that clinicians espouse a variety of different psychotherapeutic modalities that include psychodynamic, dialectical behavior therapy, systems theory, and an eclectic mix of interventions, including CBT.

Psychopharmacology is still predominant among treating psychiatrists. But CBT has become quite popular in recent decades among all mental health professionals as a result of the training that they received in Denmark and other parts of Europe. CBT is vastly becoming one of the methods of mental health treatment due to its utility. Courses are also now taught regularly at the hospital. CBT’s use is encouraged among clinicians and is taught at several facilities. The CBT approach is particularly apropos for cases involving anxiety and depression, especially in the remote outlying regions where people are very isolated. Due to the fact that the country is so large and the small cities are spread out, some paraprofessionals are even employed in the remote regions. There are approximately 60 psychologists, 25 of whom are native Greenlanders, and the majority are located on the coastal regions (Ruth Blytman Nielsen, personal communication, 6/27/23).

I found the native Greenlanders to be delightful people who appear to be doing good work with their small yet demanding population. I donated a copy of the 4th edition of my CBT book on crisis intervention (Dattilio et al., 2023) to the hospital in Nuuk along

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with my presentation on self-care of the mental health professionals, from which they no doubt can benefit, particularly in some of the remote areas where there is a lack of collegial exchange due to the geographical isolation. As a result, camaraderie is rare. This usually raises the likelihood of added stress among mental health professionals as is noted in the professional literature (Dattilio, 2015 & 2023; Gilroy et al, 2002; Pope & Tabachnick, 1994).

As with many small countries that I have visited over the 40-plus years of my career, Greenland faces an arduous population to treat. They are credited with handling a more challenging society because of the many isolated parts of the territory, a land noted for its tundra and immense glaciers where the moon sometimes goes blue from the cold.¹

Since the recent pandemic, many individuals throughout the world know all too well the profound effect that being isolated can have on the human condition, especially with those who already suffer from mental health problems. In addition, the solar changes are significant, involving extended periods of light in summertime and darkness during the winter months. Depending on the location, one may experience 24 hours of complete darkness, or enjoy only 4 hours of daylight. This poses an additional stressor, especially the effect that it has on mood. CBT is also particularly beneficial to individuals who are used to functioning independently since it can be adapted in a style that complements self-reliance, providing individuals with skills that can be employed as opposed to a more traditional type of therapeutic relationship, which, for some, may be too threatening. The late Aaron T. Beck always expressed his belief that CBT is an integrative therapeutic modality (Alford & Beck, 1997). This often dovetails beautifully with some of the cultures that may view the didactic approach as too intrusive, in which clients feel they are being told what to do, as opposed to providing them with an array of tools that they can use independently to help themselves. This is an area that mental health professionals have been addressing in Greenland, particularly those who are Native Inuit and can relate effectively with the population. Some of the barriers that still exist involve the lack of access to remote areas with populations between 200 to 1,000, such as Qaanaag and Paamiut, where I also visited. These regions can only be accessed by boat. Some of these residents are also avoidant of any type of mental health intervention, preferring instead to deal with mental health issues on their own. Adapting CBT to these cultural characteristics is a challenge and is being addressed by building personal relations and using group interventions in order to garner support and encour-

¹A blue moon sometimes appears during the month of January when the atmosphere is frigid and contains a larger amount of dust particles.

agement from their cohorts (Ruth Blytmann Nielsen, personal communication, 6/27/23).

It is very likely that, with time, CBT—owing to its short-term, pragmatic approach and scientific efficacy—will continue to grow in popularity with Greenlanders. While data is not available as of this writing, hopefully with time, the onset of scientific investigation may spawn innovative research involving the indigenous population of Greenland and the manner in which people may best be served.

Until then, in the language of the Inuit, we wish them “Ajunngikkisi” (all the best).

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Reflections on the Benefit of Psychodynamic Training on Behavioral Work

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I WILL ADMIT IT—I have always loved a smorgasbord lifestyle. I suppose it is unsurprising then that I filled my early clinical training years with a variety of cognitive-behavioral and evidence-based experiences. Though as a psychology intern, I recognized that for me something was still missing, and thus as a postdoctoral fellow, I was happy to join a program that emphasized psychodynamic training. As a person, this varied lifestyle is a preference. As a clinician, I would argue that it is a strength. Though in an age in which our field sometimes parallels our nation's own political dichotomy (i.e., cognitive-behavioral therapy vs. psychodynamic psychotherapy), many avoid or criticize this approach to training and clinical practice, harboring fears of the “other” and voicing dislike for the “enemy.” It is a tendency that many on both sides have demonstrated, and it is one that I too have been guilty of at times.

My intent in writing this opinion and reflection piece is not to argue which school of thought has a stronger theoretical foundation or utilizes more efficacious interventions. And I certainly do not aspire to articulate an all-encompassing clinical and training approach for a field that at its core is too innately complex to be solved in a few brief paragraphs. To put it simply, within this article, I wish to find that space in between, to reach across the aisle and share some of the ways in which dynamic training benefited me, someone predominantly steeped in behavioral training and practice. Perhaps I can inspire other cognitive-behaviorists to accept and maybe even embrace some of the positive attributes of the psychodynamic school of thought. With that said, below are a few of the ways in which I believe that I benefitted from adding dynamic training to my behavioral background. This is not to say that these attributes are unique to psychodynamic training, though in my experience they are more readily emphasized in that theoretical orientation.

1. I Am Human—Emotions Are Too

As stated before, our field is such a complex field—some of the situations we find ourselves in are so uniquely human and so uniquely different from those of our friends and family members in other disciplines. At times it is laughable. At others it is heart-wrenching. Psychodynamic supervision encouraged me to be more unapologetically honest about how I feel. At one point or another, we are all going to feel powerless in helping specific patients, to despise aspects of our patients, and to like or identify with our patients to such an extent that we fear pushing them to better reach their full potential. As trainees, sentiments such as these can be challenging to understand and navigate, at the expense of both the patient and the self. Unnurtured, these experiences can lead to frustration, self-judgment, and lack of confidence. Dynamic training offered me the opportunity to identify and verbalize these feelings, receive related validation and compassion, and eventually navigate them in a clinically useful way. Through these mechanisms, I developed greater self-insight, self-acceptance, and problem-solving abilities, which has enabled me to feel better in my work and improve the help that I

Psychodynamic training helped me improve my therapeutic relationships and emboldened me to more confidently engage in dialogue with my patients about the relationship, both with respect to general interpersonal dynamics and treatment interfering behaviors.

provide to my patients. Whether or not we rely on these emotions to inform our assessments of patient functioning, approaching these emotions head-on with ourselves, our colleagues, and our supervisors encourages the processing of all our internal data, which opens doors for catharsis, self-compassion, self-care, and, of course, the modification of our interventions and communications with patients.

2. Nurture the Relationship

Psychodynamic supervision enabled me to better understand the therapeutic relationship and the unique characteristics that my patients and I bring to the table. In this way, I became more mindful of my patient interactions and more flexible in the way in which I approached patients who are diverse in symptoms, symptom severity, and backgrounds. Across orientations, it is commonly said that the relationship is the most important part of clinical practice. Psychodynamic training helped me improve my therapeutic relationships and emboldened me to more confidently engage in dialogue with my patients about the relationship, both with respect to general interpersonal dynamics and treatment-interfering behaviors. It has been my experience that many in the CBT field recognize the importance of the relationship; however, at times it has appeared to me as though it was assumed that good clinicians could seamlessly develop strong patient relationships automatically, without necessarily engaging in thought or conversation on how to build those relationships. Once again, this is not to say that many cognitive-behavioral therapists do not excel at forming extraordinarily positive therapeutic alliances, but I do believe the psychodynamic world at times places a greater focus on the relationship and offers unique ideas about the skills that can be implemented to understand and foster the relationship.

3. Keep Learning, Keep Improving

We make mistakes. Every single session. We miss cues, use the wrong word, and go in one direction when we should have gone in another. We push forward, when instead we should follow closely behind. And we hold back, when instead we should state, ask, urge, and wonder aloud. And sometimes, even when we “get it right,” there is something to learn. We all succumb to imperfection and ambiguity in our clinical work. During my fellowship, I encountered an institution that heavily emphasized the use of process notes, video recordings, verbal reviews of interactions, and role-plays. In doing so, the program reinforced self-reflection on the back-and-forth between patient and clinician moment-by-moment and offered trainees the opportunity to identify mistakes, consider how to address them in later sessions, and learn how to better navigate similar situations with future patients. By so readily acknowledging the imperfections of clinicians within each interaction, we ourselves are offered the opportunity to reach for (but

We can all learn from the humility in that overt practice of “life-long learning.” DBT’s consultation groups certainly serve as a nice model for the application of ongoing supervision within the behavioral world. Perhaps there is room for us to do a better job of pursuing continued supervision as well as openly talking about our own participation in it, both with colleagues and with trainees.

never meet) clinical perfection within almost all facets of our clinical work. This sentiment can apply to clinicians of all theoretical orientations and at all stages of our careers. Perhaps one way in which this can be achieved is by embracing the concept that supervision does not have to end following internship or fellowship. Before my fellowship year, I had never heard so many senior clinicians speak openly about participating in routine supervision of their own work, even in areas in which they themselves were adept. We can all learn from the humility in that overt practice of “life-long learning.” DBT’s consultation groups certainly serve as a nice model for the application of ongoing supervision within the behavioral world. Perhaps there is room for us to do a better job of pursuing continued supervision as well as openly talking about our own participation in it, both with colleagues and with trainees.

In conclusion, these are some of the lessons I learned from a year of more psychodynamically oriented training. I still love practicing exposure and response prevention and remain an advocate for effective goal setting. But I also believe that I am a more well-rounded clinician due to these experiences and that I have found greater confidence, happiness, and meaning in my work because of them. These developments are not unique to psychodynamic training, but that said, psychodynamic training may serve as an effective adjunctive training experience for other cognitive-behavioral clinicians—during and/or after completing their degrees. I do not believe that psychodynamic training is all good, nor do I believe that it is all bad. For me, it has fit in quite nicely with my desire for a smorgasbord lifestyle. Perhaps more important, though, it has helped teach me some meaningful lessons and has highlighted the positives that can come from reaching across the aisle. It is not so scary after all. ■



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Nomination deadline: March 1, 2024.

Outstanding Mentor Eligible candidates for this award are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Mentor" in your subject heading. | **Nomination deadline: March 1, 2024**

Sobell Innovative Addictions Research Award The award is given to an individual who, through the performance of one or more research studies, has developed a novel and very innovative (1) program of research or (2) assessment or analytic tool or method that advances the understanding and/or treatment of addictions. The emphasis is on behavioral and/or cognitive research or research methods that have yielded exceptional breakthroughs in knowledge. The recipient receives \$1500 and a plaque. Candidates must be current members of ABCT and are eligible for the award regardless of career stage. Candidates may self-nominate or be nominated by others who need not be members of ABCT. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Sobell Research Award" in the subject line.
Nomination deadline: March 1, 2024

The Francis C. Sumner Excellence Award The Francis Cecil

Sumner Excellence Award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the “Father of Black Psychology,” he is recognized as an American leader in education reform. This award can be given on an annual basis, awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree. Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and professional members of ABCT at the time of the nomination. The award is intended to acknowledge and promote the excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional within 10 years of award of the PhD/PsyD/EdD/ScD/MD who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. The recipient will receive \$1,000 and a certificate. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include “Francis C. Sumner Award” in the subject line. **Nomination deadline: March 1, 2024**

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

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT’s mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano’s core commitments. This award includes a cash prize of \$1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 10 years of receiving his/her the doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and “Albano Award” in the subject line. | **Nomination deadline: March 1, 2024**

Charles Silverstein Lifetime Achievement Award in Social Justice

Members of the Association are encouraged to nominate individuals who have made significant and sustained lifetime contributions to advancing social justice initiatives over many years. This award is given at the discretion of the Board of Directors and is primarily designed to recognize the critical, and often underrecognized, contributions from cognitive and/or behavior therapy (CBT) grassroots activists who are from and primarily work with minoritized and oppressed communities. In very rare instances, the award may be given to allies from the CBT field if nominations arise from minoritized members and their perspective is centered. A key element of this award is recognition that grassroots CBT activists typically have less access to power to directly change systems secondary to structural injustice and oppression. Thus, contributions to advancing social justice by grassroots CBT activists may look different than those of allies, even though grassroots activist contributions are no less important and typically confer increased risk for the individual. Eligible candidates for this award do not need to be a current ABCT member but must have a strong historic connection to the CBT field. ABCT membership at some point in the candidate’s career is desirable. Please use the nomination form (available at www.abct.org/awards) and email nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and “Silverstein Award” in the subject line. | **Nomination deadline: March 1, 2024**

President’s New Researcher Award

ABCT’s 2023-24 President, Sandra Pimentel, Ph.D., invites submissions for the 46th Annual President’s New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early career 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. Include candidate's last name and "President's New Researcher" in the subject line. | **Nomination deadline: March 1, 2024**

Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2023. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted, or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form (available at www.abct.org/awards). Email all nomination materials as one pdf document to ABCTAwards@abct.org, and include candidate's last name and "Student Dissertation Award" in the subject line. | **Nomination deadline: March 1, 2024**

Distinguished Friend to Behavior Therapy This award is given annually to an individual or organization that supports the aims of ABCT in providing awareness, advocacy, or evidence-based behavioral health services in the field of cognitive and behavioral therapies. Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Recent recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, Vikram Patel, Benedict Carey, and Bivian "Sonny" Lee III. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line. | **Nomination deadline: March 1, 2024**

Outstanding Service to ABCT This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form (available at www.abct.org/awards). Email the completed form and any supporting materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Service" in the subject line. | **Nomination deadline: March 1, 2024**

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

Call for Continuing Education Ticketed Sessions

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

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

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

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

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

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

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

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

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

The online submission portal opens after January 1, 2024.

> *Preparing to Submit an Abstract*

> *CE sessions*

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

*Don't forget to refresh
your membership for 2024
Log in at www.abct.org & click*

RENEW

