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ABCT MATTERS

Thank you, Mary Jane Eimer, for 45 Years of Service to ABCT

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

IN THIS ISSUE of *tBT* we celebrate Mary Jane Eimer's impressive 45 years of service as Executive Director of ABCT. Past presidents who worked with M.J. while on the Board and in other roles share their heartfelt tributes—their names alone mark the many points in the history of our field of cognitive behavioral therapy and the life of this association. As each president ended their term, M.J. remained a constant steadying hand for our organization for over more than four decades. Now, as she retires from ABCT, we honor her service, her persistence, and her dedication.

Forty-five presidents, 45 boards, 45 conventions (2 virtual!), dozens of strategic planning meetings, hundreds of board meetings, thousands of committee meetings, our 25th and 50th Anniversary celebrations, three essential journals, technological advances that have transformed our operations, our internal transformation from AABT to ABCT almost 20 years ago, and societal and economic highs and lows (one pandemic!). In all of it, we as a membership organization grew nationally and internationally and developed a solid financial portfolio that has protected us during tougher times. In 1993, ABCT strategically purchased a condominium office suite in NYC, an important and wise investment—and M.J. would be the first to invite you to come by and use the conference room if you needed some space while visiting NYC (and remind you that Macy's is nearby). If you have not visited our awards page in a while, I encourage you to look and appreciate the breadth of offerings and growth of our awards portfolio, many of which are endowed—a subset of our broader financial portfolio—while under M.J.'s consummate stewardship.

Importantly, Mary Jane Eimer is a Certified Association Executive and a recognized association expert within her own professional organizations. In 2013 she was recognized with the Diplomat Award by the New York Society of Association Executives, and just last year she was honored with the 2023 Synergy Awards Chief Executive of the Year!

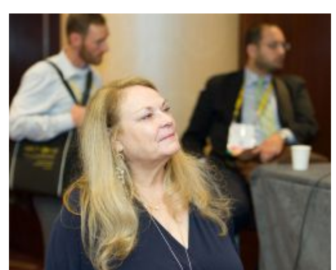
As much as we love data, M.J.'s service to AABT/ABCT is immeasurable. She will be the first to tell you it was all about the people in service of our mission. She has built and led a central office team, many of whom themselves have also served ABCT for decades, that has executed countless initiatives and innumerable daily operations (and that's approximately 17,000 days, for those counting).

Additionally, M.J. has been a steward of the histories of ABCT and the fields of behavior therapy and cognitive behavioral therapy. She can easily recount the original and ongoing professional contributions of early pioneers, not just due to her familiarity with their presentations and publications, but because of her personal and enduring relationships with them. And, M.J. can tell tales—the serious and the silly—of the countless and broad range of our members with whom she has worked over the decades, from our founders to the current trainees and future scientist-practitioners. M.J. has welcomed us all and always made special efforts to engage and support our student members and early career professionals in their entrée to ABCT. With her contagious enthusiasm for ABCT, M.J. thoughtfully encouraged service and eyed talent, sourcing so many of our committees, chairships, and coordinator roles. She advocated for fostering involvement from our students and young professionals, promoting their capacity for leadership in the organization even if they did not see it in themselves.

My own bit of heartfelt gratitude to M.J. illustrates her genuine interest in ABCT members. I started as an Associate Program Chair over 15 years ago. In large part due to M.J.'s encouragement and guidance, I continued my professional service to ABCT and took on increasing roles and responsibilities, even when I was unsure about being ready for a next step. (M.J.: *You should be a chair/coordinator/board member*. Sandy: *Who, me?* M.J.: *Yes, you!*). With great skill and a smile, she has masterfully accomplished the shaping and exposure to challenging situations for so many of us!

So many of us! One M.J.

On behalf of ABCT, thank you, Mary Jane, for your incredible service, expertise, kindness, and professionalism over these 45 years. ■



ABCT

Tributes

to Executive Director Mary Jane Eimer From Past Presidents of ABCT

Gratefully prepared by Gail Steketee, Toni Zeiss, and Anne Marie Albano on behalf of ABCT Past Presidents

The Past Presidents of ABCT are honored to pay tribute to you, Mary Jane Eimer, upon your retirement after many decades of outstanding service, for your incredibly productive, tireless, and inspired work for ABCT (formerly AABT). We salute you!

... you have clearly left your mark not only on our association but on all of us

JON ABRAMOWITZ

Mary Jane, Wow—this is some news! I want to thank you for all of the blood, sweat, and tears you have shed for AABT/ABCT over the years. I am grateful to have had the opportunity to work closely with you and learn from you. Your contributions to the organization and to the field are incalculable. This truly marks the end of an era!

Sincerely,
Jon

ANNE MARIE ALBANO

Dear M.J.,
It will be impossible for many, many of us to ever think of ABCT without thinking "ABCTMJ" … as you are the heart and soul of this organization. Your smile, the twinkle in your eyes, and your graciousness has shepherded many of us from overly eager (and at times hungover) graduate student attendees to becoming committee members, SIG chairs, board members, and (Who'd a thunk it!), President! Without you, I don't know how I would have found that path from my first ABCT in Houston to that incredible convention in Orlando. You were there at each step and with invaluable guidance, calm reassurance, and words of wisdom. Mostly, I will never forget moving to NYC in 1998 and being completely overwhelmed with doing this on my own and not knowing how to hail a taxi, never mind fit all my belongings into 700 sq ft. But a knock on the door and there you were, with a young Nora in tow, carrying huge bags of groceries and staples to stock my kitchen and help me to unpack. Mary Ellen followed to do taxi and subway training. David was the arts and entertainment advisor. I settled quickly, knowing that I had a loving ABCT Godmother and her family nearby to answer any question and give me peace of mind that I wasn't alone in the city that never sleeps. That's you, M.J. Always there, always anticipating our needs, never asking for anything in return. We love you and I hope to see a TikTok or Instagram go up where we can follow your travels and celebrate your next chapter! Thank you, thank you, for all the energy, effort, sweat, and sacrifices that you made for ABCT and each of us.

XO *Anne Marie*

FRANK ANDRASIK

What more can I add to the long list of platitudes already bestowed upon you! I think the world of you and wish only the best for wherever life takes you. I truly enjoyed every moment I was able to spend with you over the years. You will be sorely missed, but you have clearly left your mark not only on our association but on all of us.

—*Frank*

MARTY ANTONY

Mary Jane— ABCT will not be the same without you. Most of our members (including me) have no firsthand knowledge of an ABCT without you at the helm. It's been an honour working with you all of these years, both during my two terms on the Board and in various other capacities. I look forward to seeing you during my future visits to the New York area!

—*Marty*

DAVID BARLOW

Dear M.J.,
It seems like only yesterday that, while delivering my presidential address in 1979, I said goodbye to the then Executive Director, Betsy Kovacs, wishing her well, before assuring everyone that we had already identified a very competent young woman on our administrative team to take over the role of ED. What I did not say was that there was considerable controversy on the Board at the time about hiring a very young and relatively inexperienced candidate compared to other people the Board was considering with substantially more leadership experience. Now, almost 45 years later it is very clear to those of us on the Board at the time and still on the right side of the grass, that not only did we make the right decision but that we hit a home run! In this day and age, over 45 years of dedicated service to one organization is essentially unheard of, and ABCT has been extraordinarily fortunate to enjoy the continuity of your strong and effective leadership during those decades. Godspeed on your next journey.

Best wishes,
Dave

GAYLE BECK

M.J.— You have been the heart and soul of AABT -> ABCT for many years. Your leadership and dedication have held the association together through a number of challenges: financial challenges, changes in membership, concerns over specific advertisers and vendors at convention, fussy Presidents, and much more. Throughout, you have been the ultimate professional and friend to many of us. Thank you for being such a great steward of the Association—and for taking such good care of all of us over the years. You will be missed by many, including me.

—Gayle Beck

KELLY BROWNELL

M.J., It is stunning to think of the association without you at the helm. This is huge news.

I loved working with you in various positions on the board. Through the hundreds of board members, dozens of presidents, tens of thousands of members, a new office, and much more, you have been highly professional, supportive, and a delight to work with. I offer my warmest personal thanks for all you have done.

Some people get a watch when they leave a job after many years. You deserve Big Ben!

—Kelly

ED CRAIGHEAD

Dear M.J.,
The life journey of AABT/ABCT has been led for most of its expedition by you. Of course, you have had great colleagues including such wonderful people as Mary Ellen and Elsie, but the ultimate organization "buck stopped at your desk." What a leader you have been overseeing so many of us as Presidents who have depended on you to keep us on track as many others have noted. It has been a terrific journey, from almost "broke" financially when you began to having our own home and adequate resources—what a great testament to your leadership. You shall always remain a special person to Linda and me.

—Ed Craighead

GERALD DAVISON

It's hard to imagine ABCT without our M.J. She brought her support and good judgment to the many decisions that the Board had to make. Characters like us come and go, but the constant was M.J. The very best in your future ventures.

In this day and age, over 45 years of dedicated service to one organization is essentially unheard of . . .

You've made a profound difference in the world . . .

JILL EHRENREICH-MAY

Anytime I remind someone that you have been Executive Director of ABCT for 45 years, they are stunned. It is such a rarity in the organizational and nonprofit world to have such thoughtful guidance, such excellence, and such institutional knowledge available to one's membership over such a long period of time. You are such a kind and responsive person, on top of all your fantastic leadership skills. To say simply that you will be missed is a gross understatement of the truth. You leave an indelible legacy for future leaders to aspire to. Thank you!

—*Jill*

RAYMOND DIGIUSEPPE

M.J., thank you for your years of service to ABCT. You have made a difference, and all of us have experienced your dedication, perseverance, and creativity. Thank you for all you have done,

—*Ray*

STEVEN HAYES

You've made a profound difference in the world, M.J.
Thank you for all you've done and for just being you.
The association will miss you, as will I.

—*S.*

RICHARD HEIMBERG

M.J., it is a bit of a shock to hear that you are moving on. After all, you have been the executive director for virtually the entire time that I have been a member of ABCT. It is hard to think about ABCT without thinking about you at the same time! You have certainly been a part of every significant action that has taken place in the organization for decades.

I want to thank you for your service, I want to thank you for you counsel and guidance during my time as president, and I want to thank you for being a good friend over the years. I hope everything goes well for you in the next chapter of your life, whatever that may be.

Best regards always,
Rick Heimberg

MICHEL HERSEN

Congratulations, Mary Jane. You have done a marvelous job over the years. The ABCT will miss you very much. Many years ago when I was the 14th president you were hired. I had a feeling that you would be the right person for the job. Indeed, you were. May you find much happiness in your new endeavors.

My very best,
Michel

STEFAN HOFMANN

M.J. has been the heart and soul of ABCT. It is very difficult to imagine a future without her. I remember when she encouraged me as a young and ambitious, but also shy and insecure junior researcher to get actively involved with the board. Without this gentle nudge, I don't think I would have done it. I'm sure my story is not an exception. Thanks for all you have done, M.J. You have no idea how much of a positive influence you've had.

—*Stefan*

STEVE HOLLON

Best executive director ever. As far as I am concerned M.J. is ABCT.

—*Steve*

M.J. has been the heart and soul of ABCT. It is very difficult to imagine a future without her.

ALAN KAZDIN

It was an absolute privilege and joy to work with Mary Jane. Her commitment and contributions to the organization and the many ways she made life easier for colleagues, members, and staff are beyond words. I am almost sure there was a cloning clause in her contract: she cannot leave without an identical replacement.

PHIL KENDALL

Hey M.J.

Great news for you, not so good news for us.

You were vital to the growth and success of our organization. So glad for everything that the organization has done to make your time as pleasant as possible. Once your transition is complete, then you can tell the real stories behind the scene (Grin). Wishing you the very best.

—Phil k

ROBERT KLEPAC

From my own very selfish point of view, I'm very sad to learn of your decision to retire. You have done so much for ABCT, its members, and ME! It's hard to imagine what our lives will be like without you. You will be SO sorely missed! As a friend, however, I certainly understand your decision, and I'm excited and happy for you as you enter the next phase of your life. I wish you the very best!

Warmly,
Bob

BOB LEAHY

M.J. You will always be the heart and soul of ABCT, and it is difficult to find the words to express our gratitude.

—Bob

DEAN McKAY

Mary Jane, leaders of ABCT come and go, but you have been a steady hand on the ship for decades. The availability of sound evidence-based CBT interventions is in large measure due to the impact of ABCT, an effect only possible by the consistency you brought to the organization. It was an honor to have the opportunity to work with you. You have richly earned the accolades of the organization. Congratulations on a beautiful career, and best wishes in your retirement.

ROSEMERY NELSON-GRAY

Best wishes for an enjoyable retirement, M.J.! We were both embarking on our respective careers in 1980: You were starting your position as Executive Director of AABT, and I was beginning my year as AABT President-Elect. I fondly recall our mutually supportive conversations in the New York AABT office which continued over decades at Past-Presidents dinners or in hotel convention offices in various cities. A sincere thank you for all your professional and personal contributions to AABT-ABCT over more than 40 years.

All best wishes,
Rosemery Nelson-Gray

DAN O'LEARY

Dear Mary Jane,

It has been years since I was president in 1982–1983, and I see I was preceded by Rosemery Nelson-Gray, a former Stony Brooker, and followed by Alan Ross, who hired me to come to Stony Brook. Betsy Kovacs was executive director of AABT in 1982–1983 and I just missed serving with you, but I have been very glad that you have been at the helm all these forty years. Gordon Paul was a young faculty member at Illinois when AABT was formed in 1966

You always made me feel welcome and you helped guide the organization to be a major force in health care delivery.

and Gordy suggested that I not join AABT as it would become a cult. I did not join as a grad student or as a newly minted Ph.D. in 1967, but under the guidance of Len Krasner who was the DCT at Stony Brook I decided to join AABT around 1968 or 1969. AABT/ABCT has been my professional home for over fifty years, my favorite place to meet and greet, and the best place to learn about new psychological interventions. You always made me feel so welcome and you helped guide the organization to be a major force in health care delivery. Many thanks for your great service!

Best,
Dan O'Leary

THOMAS OLLENDICK

M.J., thanks for this message and for informing us personally at the meeting yesterday. As mentioned then, this is sad news but yet good news for you and the future that lies ahead for you. You have truly been a force that has held us together over the many years of your service and leadership. I remember learning much from you during my active membership and very specifically during my presidency in 1995, now a mere 28 years ago. You have been with us a very good amount of time. Thanks again, and the very best of wishes — enjoy your retirement years!

—*Tom*

MICHAEL OTTO

Dear M.J.,
I want to personally mark and thank you for all your years of service to ABCT. I greatly enjoyed my time with you during my Board service. I love how you valued our organization and I greatly appreciate how well we collaborated together. My best wishes for you as you step forward into your post-ABCT life.

—*Michael*

PATRICIA RESICK

Dear M.J., I am writing a personal note. We are both retiring at the same time and I want to take this opportunity to thank you for the huge role you have played in my career. I was the second chair of the Women's SIG after Marsha Linehan and you recommended me to become the Coordinator of the SIGs. That brought me into the board meetings where I learned so much about AABT as an organization and made conference friends that have lasted for decades. You were one of them and I always remember your face lighting up in a smile when we first saw each other. I served on the board for nine years and appreciated your attention to small details and the overall health of the organization. I have such fond memories of some of our midyear board meetings. I also appreciate our work together when I was President in bringing some of the items from our strategic plan to fruition. As the last President of AABT and the first of ABCT (it officially changed names during the convention), I got to play a role in rebranding that included a new logo. Your input in this process was invaluable. We no longer have to advance behavior therapy, everyone knows what CBT is, and you played no small role in its growth. Happy retirement.

Love,
Patti

LINDA SOBELL

When I started to look back on my time and memories with M.J., I recalled some things that I think other past presidents might not. The first thing I realized is that my recall spans 40 years.

One of my most fun and earliest memories was from one of ABCT's board meetings at Hilton Head Island (SC). M.J. and I went bike riding and halfway around the island, we came to a river inlet where we had to tip-toe through the inlet to get to the other side. We also had to carry our bikes over our heads to get across. Guess what, I quickly realized M.J. was not 5'10' (like me) as I ran across the river to the other side with my bike extended 8" above my head.

Leaders of ABCT come and go, but you have been a steady hand on the ship for decades.

M.J. tried to convince me that I was trying to drown her— I got to the other side and then had to go back to get her bike while she tiptoed across the inlet.

My second short memory also involved fun. M.J. asked me to go jogging with her. However, I told her later you must keep your eyes on the road to avoid falling. The end of this story I think will be obvious to most. I could go on, but my recall is as a good friend of M.J.'s and knowing how hard she worked as ABCT's CEO for four decades.

M.J., enjoy your retirement and spend quality time with your family and friends, you earned it.

—Linda

GAIL STEKETEE

M.J., this is truly the end of an era. I so enjoyed working with you over the years. You have given boundlessly to the organization. Congratulations on your many accomplishments. I look forward to celebrating your 45 years of service and truly hope the coming years offer much enjoyment of family, friends, gardening, and whatever next pursuits you undertake!

—Gail

RICHARD STUART

Having watched ABCT evolve for more than half a century, it is clear that you are an Executive Director who has a profoundly positive effect on the organization. Your departure is a major loss for us, but I hope a new beginning on a happy and fruitful next phase of your life. I wish you all the best and hope that let us know from time-to-time what new successes you achieve.

With warm farewell hugs, *Dick*

DAVID TOLIN

Mary Jane, I joined ABCT somewhere in the early 90s and since then, you have been synonymous with ABCT in my mind. It's hard to imagine the organization without you. And I am always going to be grateful for your willingness to shepherd me through the presidency. I wish you the very best with the next chapter in your life.

Best,
David

SABINE WILHELM

Dear Mary Jane:
It's been an honor to work with you. Thank you for your thoughtfulness, kindness, and major contributions over so many years. You've had such a big impact on ABCT that we'll feel long after you leave. We will miss you!

Wishing you all the best,
Sabine

ANTONETTE ZEISS

M.J., it is wonderful reading the messages for you, which are so richly deserved. All of the ways you have influenced ABCT positively and constructively are deeply important to the organization and to me personally. So hard to see you leave, but I am so happy for you as you move forward. I love retirement, and I hope and expect you will, too. You approach everything with zest and positive energy, and that will be true with your new life. All I ask is that you stay in touch and please, please come visit in Santa Cruz!

Love,
Toni

A Basketful of M.J. Memories

Lata K. McGinn, *Yeshiva University; President, World Confederation of Cognitive and Behavioural Therapies*

As a longstanding ABCT member, a former board member, and the current chair of the International Associates Committee, as well as the current president of the World Confederation of Cognitive and Behavioural Therapies (WCCBT), I am delighted to share my memories of Mary Jane Eimer.

I have never known ABCT without M.J., so it is hard for me to contemplate ABCT without M.J. Mary Jane has provided exceptional service to ABCT over the last 40 years as its Executive Director. She has skillfully led the central office and has worked with innumerable boards, 45 presidents, 15 secretary-treasurers, and countless other chairs and other governance members to lead the organization efficiently and skillfully while maintaining a deep, unwavering commitment to its mission combined with a steadfast respect for its members, staff, and vendors.

Based on strategic growth initiatives and her leadership, ABCT is extremely well-managed and is one of the most stable nonprofits in our field. It has grown from a North American Association to an internationally organization with members across the globe. M.J. has consistently promoted ABCT's presence in international organizations and encouraged their participation in ours, which has led to a deep loyalty and gratitude to ABCT among our international colleagues.

ABCT is one of six founding CBT membership organizations of the World Confederation of CBT (WCCBT) that represent the continents of North America, Europe, Asia, Central and South America, and Oceania. Broadly, the mission of the WCCBT is to promote and advocate for global mental health and to facilitate the development and dissemination of evidence-based science and practice through the formation, collaborations, and partnerships with bodies such as World Health Organization, regional CBT organizations, and governments. When the WCCBT was looking for an organization to support its administration and offer guidance, ABCT was our first choice based on the stability and generosity of ABCT members, the quality of work of the ABCT staff, and M.J.'s deep commitment to thinking globally as well as her value of diverse cultures around the world. She has done an excellent job working with her staff and the ABCT and WCCBT boards to provide the WCCBT with advice and support. On behalf of myself and the rest of the current WCCBT board, I want to extend my heartfelt thanks to M.J.

One of the things I appreciate most about M.J. is that she has worked hard to maintain the spirit of ABCT as a professional home and family for its members while firmly expanding its reach nationally and globally. Thanks to her efforts, our national and international members all view ABCT as their professional home. For example, M.J. introduced the SIG Expo at the conference, which is wildly popular and enables newcomers an easy way to network and meet new colleagues. The International Associates meetings and dinners held at each ABCT conference are eagerly anticipated by all our colleagues around the world who have appreciated ABCT's generosity in inviting them each year.

ABCT has also been my professional home for many years, which is in no small part due to the warm, hospitable, and stable environment M.J. has created. Over the years, she has become a close colleague and friend. I offer her my deepest gratitude for her exceptional service to ABCT and the WCCBT. I am going to miss her, and I am excited for her that she is starting a new, exciting chapter in her life. ■

Farewell

Mary Jane Eimer, *ABCT's Executive Director*

My farewell is bittersweet.

I've had the pleasure, mostly, of working with 48 presidents. Few people on earth have had more professional partnerships than I. There have been 15 secretary-treasurers, one of the most important and least heralded position in the Association. Members have become committee members, then chairs, then coordinators, reps, and, ultimately, presidents. I cherish the time helping them grow, reach the pinnacle here, then take those skills to leadership roles to other organizations like APA, CPA, or the Veteran's Administration, to name a few.

My staff know my frugality on little things; big things too. You now have reserves that both fund an impressive awards program and protect you from economic downturns that have come so perilously close in recent times. Our doors remained opened with no layoffs. Staff continued to work and enhance our offerings. Pivoting is one of our best skill sets during times of adversity.

I say good-bye to staff, a third of whom I've known for more than a quarter century and two of whom have left only to return, for which I'm quite grateful. Some have left to pursue other interests but most stay in touch. All staff past and present have helped build a financially stable organization and one that is often viewed by our members on other boards as a shining example of expertise and dedication. I will miss my daytime family.

I leave behind honors the association has won, including the New York Society of Association Executives' Cyber Award for best website. We have a good working relationship with the executives of allied organizations. We are renowned for the quality of our journals and training through our monthly webinars and Annual Convention. I write my farewell notes to you from an office that you own and that I, in concert with Phil Kendall, purchased so that you'd have a permanent home and never waste time or money searching for a space or renovating or moving. No diaspora here.

I have a few "pearls of wisdom" to share with you:

- *Get involved*: serve on a committee, join a SIG, attend a convention—you'll connect with your colleagues, develop a broad network of support, and make lasting friendships, plus a ribbon to wear at the Annual Convention.
- *Get to know your staff*: They are dedicated to your success and the field. They are seasoned professionals and will help you achieve your goals within ABCT.
- *Be kind to my successor*: S/he will need your generosity of spirit, patience, and guidance to learn all the ins and outs of ABCT. It will take some time. Keep in mind, I grew up in ABCT. My successor is taking over a complicated organization with high expectations.

It has been a very satisfying career and I thank all of you whom I had the good fortune of getting to know and work with. You took a risk on a very young and enthusiastic MJE. I hope you are proud of your membership in ABCT and all we accomplish annually. After Philadelphia, the next hotel I set foot in will be as a vacationer and I won't know any of the 5,000 people there. ■

ACADEMIC FORUM

A Psychotherapeutic Maverick: A Celebration of the Career of Dr. Marvin Goldfried

Alex Broekhuijse, *Roosevelt University*

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On April 16, 2024, the Philadelphia Behavior Therapy Association presented its Lifetime Achievement Award to Dr. Marvin Goldfried. This honor, first awarded to Dr. Aaron Beck in 2008, recognizes "profound, sustained, and influential contributions to the field of cognitive and behavioral therapy" (Philadelphia Behavior Therapy Association, 2014). While surrounded by colleagues, mentees, and friends, Goldfried used his platform to address the division within the psychotherapy community and overcome theoretical tribalism for the sake of the patient. Dr. Corey Newman, Goldfried's former mentee and Professor of Psychology in Psychiatry at the University of Pennsylvania, noted that this approach is not new to Goldfried, who spent his career campaigning for clinical advancement even when it was not politically popular.

A panel of six of Goldfried's former colleagues and students described him as "creative," "an intellectual leader," "a maverick," "dogged," and "a visionary with an activist's spirit." Together, they highlighted his ingenuity as a clinician, dedication as a mentor, and persistent efforts to develop psychotherapy. Dr. Louis Georges Castonguay, Liberal Arts Professor of Psychology at Penn State, claimed that Goldfried changed the field "at least 6 times," driven by Goldfried's "constant awareness of psychotherapy's limitation." This praise is well earned, as Goldfried was responsible for linking cognitive and behavior therapies, establishing the integrative psychotherapy movement, and expanding psychotherapeutic care to sexually and gender-diverse clients. Dr. Adelle Hayes spoke to Goldfried's commitment to mentorship, recalling how he attended her hooding ceremony when her assigned mentor was unavailable. Goldfried beamed watching his former students speak, proudly noting, "Look at how well you all turned out."

As a boy growing up in Brooklyn, New York, Goldfried aspired to ride off the hopper of garbage trucks, a desire he later "sublimated while riding cable cars in San Francisco" (Goldfried, 2024, p. 94). After abandoning his dreams in the sanitation industry, Goldfried studied psychology at Brooklyn College and completed his doctorate at the University of Buffalo. There he witnessed the widening gap between clinical practice and research, a gap he again encountered during his first faculty position at the University of Rochester. While speaking with colleagues and mentors, Goldfried was astounded by the lack of empiricism in clinical practice. He attempted to remedy this disconnect by studying novel behavioral interventions like systematic desensitization, despite behavior therapy's status as a "bad word" amongst his peers. These efforts brought Goldfried to a new faculty position at Stony Brook University, where he played a pivotal role in establishing the first clinical program rooted in behavior therapy.

While directing the Psychology Clinic at Stony Brook, Goldfried found purely behavioral interventions insufficient for some patients (Goldfried, 2024). Through his work with chronically anxious students, he noticed that it was their reflections on a life experience that drove their worry. In pursuit of greater clinical effectiveness, Goldfried outlined the integration of cognitive interventions in his 1976 text *Clinical Behavior Therapy,* co-written with Dr. Gerald Davison (Goldfried & Davison, 1976). In his remarks at the

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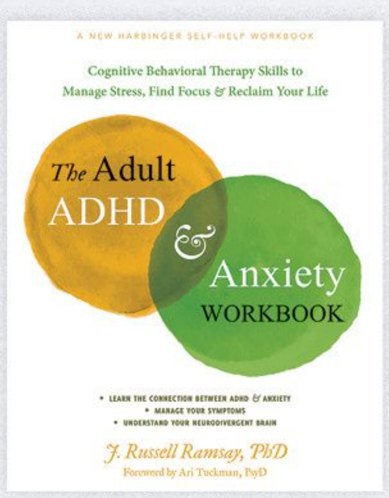

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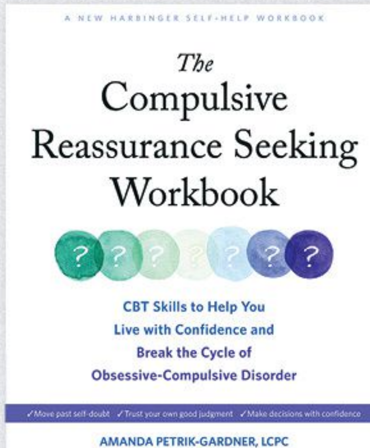

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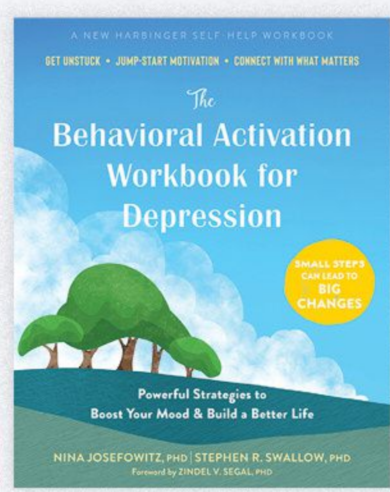

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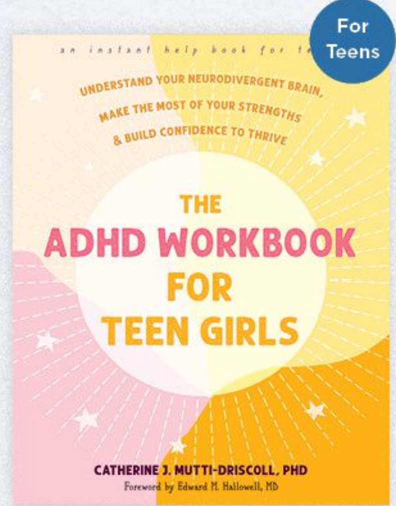

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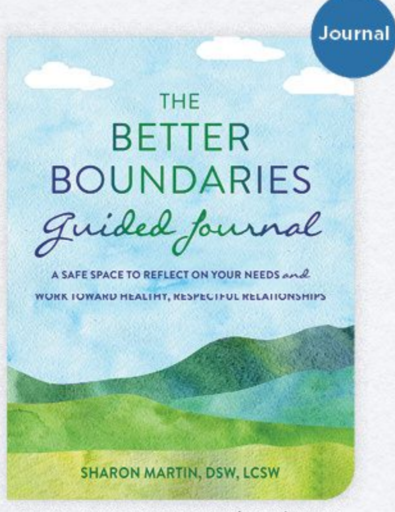

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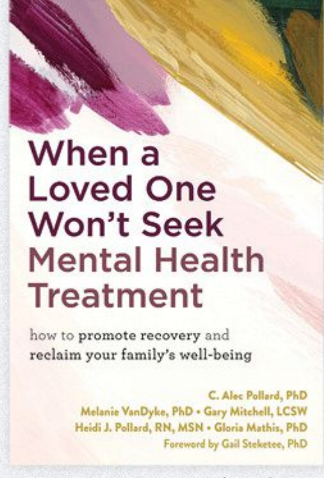

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Goldfried continued to challenge the theoretical rigidity that limited the advancement of psychotherapy. He viewed the division between psychoanalytic and behavioral schools as preventing psychotherapy from reaching the shared understanding needed to mature as a science.

ceremony, Davison recalled that this text made Goldfried the "Rodney Dangerfield of clinical psychology"—unpopular for his efforts to challenge the status quo and drive practice forward. While many consider Goldfried the father of Cognitive Behavioral Therapy (CBT), he insisted that CBT was "developed … by an extended family" (Goldfried, 2024, p. 98). Goldfried's contributions did not end with integrating cognitive interventions. Indeed, Dr. Castonguay noted that he was "not just responsible for the C, but also the E"; that is, he recharacterized emotion as a stimulus to be aroused rather than a symptom to be reduced in behavior therapy.

As his career progressed, Goldfried continued to challenge the theoretical rigidity that limited the advancement of psychotherapy. He viewed the division between psychoanalytic and behavioral schools as preventing psychotherapy from reaching the shared understanding needed to mature as a science. Dr. Allen Frances, Goldfried's cohost on *Talking Therapy* and Professor at Duke University, suggested that this conflict between schools left psychotherapy a "silly conglomerate of alphabet soup," and turned therapists into "hammers searching for nails." To resolve this conflict, Goldfried began researching principles of change effective across theoretical orientations. These findings informed his 1982 text, *Converging Themes in Psychotherapy* (Goldfried, 1982), alongside the *Handbook of Psychotherapy Integration*, co-written with Dr. Jon Norcross, Distinguished Professor of Psychology at the University of Scranton (Goldfried & Norcross, 1992).

Goldfried dedicated equal effort to extending psychotherapy's reach to underserved communities. In the early 2000s, Goldfried noticed that many clinicians were unprepared to work with issues related to sexuality, and research in this area was stigmatized and siloed as "gay issues" (Goldfried, 2024, p. 116). In 2001, Goldfried authored an article in the *American Psychologist* urging for greater clinical and empirical attention to the needs of sexual and gender minority communities (Goldfried, 2001). Later, inspired by his relationship with his son, Goldfried founded Psychologists Affirming their Lesbian, Gay, Bisexual and Transgender Family (AFFIRM), an organization committed to allying with the LGBTQ community and condemning the use of psychotherapy to cause harm.

In his acceptance speech, Goldfried outlined the changes needed to advance psychotherapy. He presented techniques with proven effectiveness that transcend theoretical orientation, including building motivation, establishing the therapeutic alliance, developing self-awareness, engaging in corrective experiences, and cultivating reality-testing capabilities (Goldfried, 2019). Goldfried suggests that these techniques, relevant to all psychotherapies, may build consensus among clinicians, a core understanding that will allow the field to progress. Further, embracing an integrative approach provides clinicians with the shared vocabulary needed to unify polarized theoretical camps. Much like many of the actions taken throughout his career, Goldfried's cam-

paign for consensus reflects a desire to sacrifice political allegiance to improve clinical effectiveness.

At the end of the ceremony, facilitator Dr. Chris Molnar asked Goldfried what each attendant could do to help psychotherapy reach consensus. After joking that it would take “a magic wand,” he emphasized the value of adopting language and conducting research that bridges the theoretical divide. Each of the speakers echoed this sentiment, with Frances stating that “we can honor Marv best by pursuing his efforts to unify psychology.” Perhaps it is our responsibility to answer this call, much like Dr. Goldfried has done throughout his career, and challenge what we believe if it may help our patients.

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ORIGINAL RESEARCH

Promoting Youth Mental Health Through Community-Generated Innovation

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Mary Cheryl B. Gloner is the Chief Executive Officer and Peying Lee is the Program Coordinator of Project Safety Net. Alayna L. Park was a representative on the Project Safety Net Partners Council from 2021-2022.

The data that support the findings of this study are available from the corresponding author, AP, upon reasonable request.

All study procedures were reviewed and approved by the Institutional Review Board of Palo Alto University (2021-072).

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There have been reverberating calls to promote youth mental health for more than 20 years (Garland et al., 2010; Office of the Surgeon General, 1999; Soni, 2009; Weist, 2005). Over recent years, the prolonged effects of the COVID-19 pandemic on education and social-emotional learning have prompted an upsurge in attention to youth mental health promotion (Gruber et al., 2021; Office of the Surgeon General, 2021). In response to these calls to action, youth mental health advocates have emphasized the urgent need to screen for youth mental health problems to identify and address symptoms and other sequelae before they begin to interfere with functioning (Guo & Jhe, 2021; Last et al., 2021); to disseminate information about mental illness and available welfare and mental health resources to improve recognition and prevention of mental health problems (Kelly et al., 2007; Lasecke et al., 2022); to increase the availability and accessibility of mental health resources, particularly for underresourced and marginalized communities (Atkins et al., 2017; Torres Sanchez et al., 2022); to recruit, train, and employ more mental healthcare professionals (Barnett et al., 2018; Konrad et al., 2009); and to increase funding to execute these ideas for promoting youth mental health (Cooper & Aratani, 2009). A glaring issue, however, is that it is not possible to immediately and simultaneously invest, implement, and sustain all of these avenues for promoting youth mental health within the current mental healthcare infrastructure.

Innovation Processes

Innovation tournaments are a process for identifying a large set of solutions, comparing solutions, and ultimately selecting one or more winning solutions (Terwiesch & Ulrich, 2009). This process has long been used by companies to select which products to develop, by movie studios to select which pitches to fund, and by competition shows, such as *American Idol*, to select the winning contestant. More recently, implementation scientists have used innovation tournaments to crowdsource ideas from clinicians for solving intractable problems in mental healthcare (Last et al., 2021; Sibley et al., 2022). For example, Stewart and colleagues (2019) used an innovation tournament to solicit ideas from clinicians on how their agencies could support the use of evidence-based practices. Clinicians submitted 65 ideas related to training, financing, clinician support and preparation, and supervision. An expert panel of agency staff, city administrators, and behavioral scientists then rated each idea and selected six winning ideas—effectively identifying the top 10% of ideas that could be further discussed and acted upon. Given the plethora of existing possibilities for promoting youth mental health, there is likely value in leveraging innovation processes to understand which ideas are most important to community members and are feasible to move into action.

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Rehman Abdulrehman

Developing Anti-Racist Cultural Competence

In today's society, anti-racist cultural competence is an essential skill and not something meant only to be addressed by some. Issues tied to resolving racism and understanding and including diverse cultural points of view remain highly conflictual – and the ability to deal with these issues effectively is often hindered by fear, anxiety, and a misunderstanding of what it means to be culturally competent without making people feel like outsiders. While many other models of cultural competence approach the issue as though looking into a fishbowl, this book views the issue as everyone swimming in the water together, as part of a common ecosystem and community.

Abdulrehman provides a direct, no-nonsense, and practical approach to this challenging and complex topic, using real-life examples to help the reader to approach sensitive cultural issues confidently and humbly. He looks in detail at how we can understand our biases and how they impact our engagement and trust with marginalized people of color. The less addressed issues of ethnic and cultural identity development, and understanding internalized racism and how it too can impact cross-cultural engagement are also presented. This book provides a unique perspective that addresses anti-racism and cross-cultural interactions as a process for better understanding how you see the world – a very different process than merely describing how others see the world differently from you. This volume is suitable not only for psychology professionals, but anyone who wants to explore what it means to be anti-racist and culturally competent.

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Community members, including mental healthcare professionals, youths, and parents, were invited to nominate ideas for promoting youth mental health and later evaluate the importance and feasibility of community-generated ideas.

Implementation Processes

Powell and colleagues (2012) distilled strategies for facilitating the implementation of evidence-based practices into six processes: planning (e.g., assessing local needs and cultivating relationships with community members); educating (e.g., developing and distributing educational materials, and providing training and ongoing consultation); financing (e.g., providing financial support, reducing client fees, and increasing financial incentives); restructuring (e.g., modifying the content, format, provider, or site of services); managing quality (e.g., developing and using tools and systems for monitoring and improving the quality of services); and attending to the policy context (e.g., changing laws). These implementation processes can be made relevant to youth mental health promotion, for example, by assessing local youth mental health needs (planning), teaching community members how to recognize mental health problems (educating), increasing funding for social-emotional learning (financing), disseminating mental health promotion resources in multiple formats and languages (restructuring), disseminating mental health promotion resources that are supported by research (managing quality), and advocating for policies that promote well-being, inclusivity, and equity (attending to the policy context).

Findings on the relative importance of these six implementation processes have been mixed, with some studies showing preferences for planning (Sibley et al., 2022), other studies showing preferences for educating (Stewart et al., 2019), and still other studies showing preferences for financing (Candon et al., 2022). It is likely that the perceived importance of implementation processes may depend on contextual factors, such as the problem being addressed and the community members being asked. Notably, most studies investigating preferences for implementation processes have asked mental healthcare professionals to evaluate strategies for implementing evidence-based practices. Promoting youth mental health may require similar or different processes than implementing evidence-based practices. Additionally, different community members may have different perspectives on which strategies are important and feasible for promoting youth mental health.

The Current Study

The present study used an innovation tournament to understand community perceptions of strategies for promoting youth mental health. Community members, including mental healthcare professionals, youths, and parents, were invited to nominate ideas for promoting youth mental health and later evaluate the importance and feasibility of community-generated ideas. Findings from this study offer important insights into the youth mental health promotion initiatives that community members hope to see, as well as which initiatives to consider prioritizing in an effort to meet community members' needs.

Method

This study used a mixed method design, in which qualitative and quantitative data were collected and analyzed sequentially (qualdc/da → QUANdc/da; see Palinkas et al., 2011; 2019). The function of this approach was development (i.e., using one method to answer questions that will enable use of the other method to answer other questions), such that qualitative methods were used to identify strategies for promoting youth mental health and quantitative methods were used to evaluate the importance and feasibility of those strategies. All study procedures were approved by the Institutional Review Board of Palo Alto University (2021–072).

Procedure

This study is the result of a partnership between the research team and Project Safety Net (PSN) following discussions on how to promote youth mental health and suicide prevention in Santa Clara County, CA. PSN is a nonprofit organization dedicated to promoting youth mental health and suicide prevention through community education and outreach, policy and advocacy, and the coordination of youth mental health services.

The first phase of this innovation tournament took place from October 2021 to January 2022, when PSN Partners were invited by email to nominate ideas for promoting youth mental health via an online survey. PSN Partners are a coalition of mental healthcare and healthcare professionals, educators, city administrators, and other community leaders from 55 organizations across Santa Clara County. PSN Partners were also encouraged to forward the idea generation survey to youths, parents, and staff in their respective organizations. Participants who consented to participate in this phase of the study were directed to complete the idea generation survey and received $10 for completing the survey. Parental consent and youth assent was obtained before any youths completed the idea generation survey.

The research team then reviewed all 46 nominated ideas and developed a refined list of 18 ideas. Specifically, similar ideas were combined and/or collapsed; ideas that lacked sufficient detail (e.g., "We recommend any resource that's good for kids") were eliminated; and ideas were rephrased to reflect parallel structure.

The second phase of this innovation tournament took place from April 2022 to June 2022, when PSN Partners were invited by email to rate the importance and feasibility of the refined list of 18 ideas via an online survey. PSN Partners were also encouraged to forward the idea evaluation survey to youths, parents, and staff in their respective organizations. To assess the generalizability of community member preferences, adults across the United States were also recruited via Prolific, an online research panel service, to participate in this phase of the innovation tournament. Prolific has been shown to produce higher quality data than other online research platforms (e.g., Amazon Mechanical Turk, CloudResearch; Peer et al., 2022). Participants who consented to participate in this phase of the study were directed to complete the idea evaluation survey. Parental consent and youth assent was obtained before any youths completed the idea evaluation survey. Consistent with Prolific's ethical reward principles (Prolific, 2022), online research panel participants received $5 for completing the idea evaluation survey. Local participants received $10 for completing the idea evaluation survey, as requested by PSN.

Phase I: Idea Generation

Sample

Ideas for promoting youth mental health were nominated by 15 individuals: 1 mental healthcare professional, 1 youth, and 13 other community members (e.g., librarian, religious leader, educator); 33% of participants endorsed having children living in their home. Participants ranged in age from 18 to 52 (M = 33.46, SD = 11.52); 2 participants did not report their age, 1 of whom completed the youth-version of the survey. Participants identified as women (67%) and men (27%). Participants identified as non-Hispanic White (27%), Asian or Asian American (27%), Hispanic, Latine, or Spanish origin (20%), Black or African American (20%), and mixed race/ethnicity (7%).

Measure

Participants (i.e., youths and adults) were invited to nominate ideas for promoting youth mental health through an online survey hosted by Qualtrics, which was available in English, Spanish, and Chinese. Specifically, adult participants were prompted to respond to three questions: (1) What information or support would help you advocate for youth mental health? (2) What information or support would help you advocate for a

Table 1. Descriptions and Examples of Ideas for Implementing Youth Mental Health Promotion Strategies

Implementation Process	Description	Example Idea
Planning	Ideas related to assessing local needs, seeking input from stakeholders, and cultivating relationships with stakeholders	"I think it would be good to start the conversation with the diverse youths we are trying to support."
Educating	Ideas related to developing and distributing educational materials, and providing training and ongoing consultation	"It would be helpful if there were conversations starters/ conversation guides on how to talk to youth about mental health and suicide prevention, so that it becomes a part of everyday conversation."
Financing	Ideas related to offering free or low-cost services, providing financial support, and increasing financial incentives	"I would like to know more about affordable services that youth can access."
Restructuring	Ideas related to modifying the content, format, provider, or site of services	"Having someone that looks like me speak out about mental health in relation to race, culture, and the sense of belonging in a multicultural location."
Managing Quality	Ideas related to using evidence-based practices, improving the quality of services, and monitoring the effectiveness and/or cultural responsiveness of services	"Better resources and help. It is far too hard to get good mental health support and services."
Attending to the Policy Context	Ideas related to changing laws, and advocating for youth mental health	"...[therapists] who take insurances without guidelines they need to stick to... They need to stop being controlled by what the government decides is the standard for mental health."

community where diverse youth feel safe, supported, and accepted? (3) What would help you refer youth to mental health resources? The phrasing of these questions was adjusted for the youth version of the survey, such that the questions focused on their experience (e.g., What would help you or your peers access mental health resources?). All prompts were developed from input from PSN Partners and the research team.

We used various methods to detect fraudulent responses and ensure high-quality data. Participants were required to correctly answer "5 + 1 = ?" by selecting "6" in a multiple choice item. They were also asked to verify they were not a robot by clicking a checkbox via a CAPTCHA item. Additionally, responses within and across participants that contained the same five or more consecutive words were excluded from analyses.

Data Analysis

The first and fourth authors independently coded community-generated ideas for promoting youth mental health as relating to planning, educating, financing, restructuring, managing quality, and/or attending to the policy context (see Table 1 for code definitions and examples). Any discrepancies were resolved through consensus.

Phase II: Idea Evaluation

Local Sample

Ideas for promoting youth mental health were rated by 75 individuals recruited locally: 26 mental healthcare professionals, 12 youths, and 37 other community members; 20% of participants endorsed having children living in their home. Participants ranged in age from 15 to 73 (M = 31.34, SD = 13.09). Participants identified as women (77%), men (20%), and nonbinary (3%). Most participants were non-Hispanic White (52%), followed by mixed race/ethnicity (20%), Asian or Asian American (17%), and Hispanic, Latine, or Spanish origin (9%).

National Sample

Seventy-one individuals were recruited through Prolific: 1 mental healthcare professional and 70 other community members. Nearly one-third (30%) of participants endorsed having children living in their home. Participants ranged in age from 18 to 67 (M = 31.67, SD = 9.33) years old. Participants identified as women (58%), men (37%), and nonbinary (3%). Most participants were non-Hispanic White (75%), followed by mixed race/ethnicity (11%), Hispanic, Latine, or Spanish origin (4%), Black or African American (3%), and Asian or Asian American (1%).

Measure

The importance and feasibility of ideas for promoting youth mental health were assessed using an online survey hosted by Qualtrics. Specifically, participants were prompted to rate the importance of 18 ideas for promoting youth mental health using a 5-point Likert scale ranging from 1 (*not at all important*) to 5 (*extremely important*). Participants were also asked to rate the feasibility of each idea using a 5-point Likert scale ranging from 1 (*not at all feasible*) to 5 (*extremely feasible*), with a response option to indicate that they were "unsure about feasibility." The order in which ideas for promoting youth mental health were presented to participants was randomized using Qualtrics. This online survey was available in English, Spanish, and Chinese.

To detect fraudulent responses and ensure high-quality data, we used novel quality check items, instructional manipulation checks, and CAPTCHA check boxes. Novel quality check items included an open-ended item asking participants to report their birth

year; responses that did not match age inputted in the demographic section of the survey were flagged by researchers as possible fraudulent responses. Embedded in the survey were four instructional manipulation check items: (i) participants were required to correctly answer “5 + 1 = ?”; (ii) participants were required to select the mammal from a list of various responses; (iii) participants were required to select “slightly important” for an attention check item presented in random order in the survey; and (iv) participants were required to select “slightly feasible” for another attention check item presented in random order in the survey. Participants who failed any of these checks were not included in analyses.

Data Analyses

Descriptive statistics were used to describe the perceived importance and feasibility of ideas for promoting youth mental health. Analyses of variance (ANOVAs) were used to estimate differences in perceived importance and feasibility of youth mental health promotion ideas between mental healthcare professionals, parents, and youths. Independent samples *t*-tests were used to assess for differences in perceived importance and feasibility of youth mental health promotion ideas between participants recruited locally or from across the country through Prolific. Given the multitude of planned analyses, a Bonferroni correction was applied: $\alpha = .05 / 18 = .0028$.

Results

Phase I: Idea Generation

Community members nominated a total of 46 ideas for promoting youth mental health. These ideas were related to educating ($n = 21$), managing quality ($n = 12$), planning ($n = 8$), restructuring ($n = 7$), attending to the policy context ($n = 5$), and financing ($n = 4$) (see Table 1).

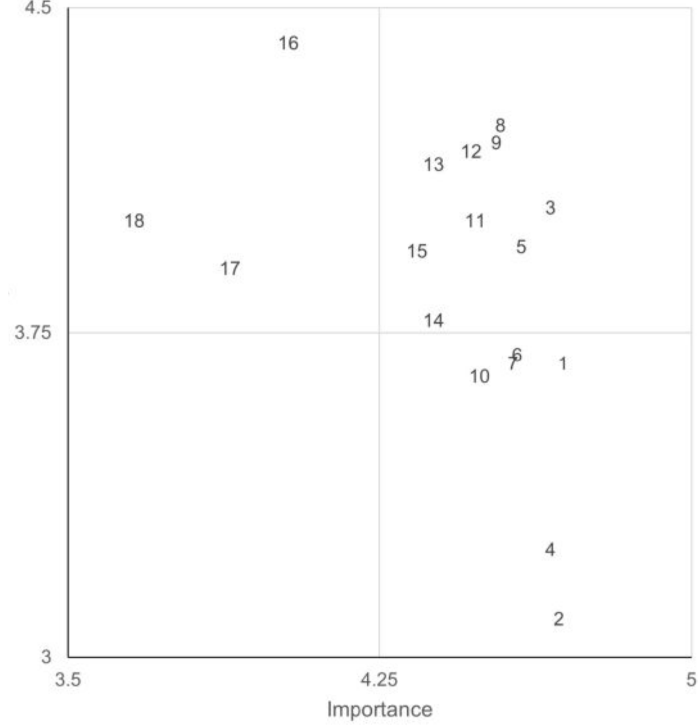

Figure 1. Community members’ perceived importance and feasibility of youth mental health promotion ideas

Phase II: Idea Evaluation

All ideas for promoting youth mental health were rated by community members as being very to extremely important (see Figure 1). Providing families with effective mental health services was rated as being most important (M = 4.69, SD = .61), followed closely by providing families with free or low-cost mental health services (M = 4.68, SD = .61), increasing county, state, and/or federal funding for mental health services (M = 4.66, SD = .67), and teaching children and adolescents about signs of mental illness and ways to cope (M = 4.66, SD = 59).

Community members rated all ideas for promoting youth mental health as being moderately to extremely feasible (see Figure 1). Providing resources (e.g., fact sheets or videos) on recognizing and coping with mental illness and suicidality were rated as being most feasible (*M* = 4.42, *SD* = .82), followed by teaching parents about signs of mental illness and ways to help children cope (M = 4.23, SD = .80), and teaching community members (e.g., teachers and pediatricians) about how to be allies to minoritized children and adolescents (*M* = 4.19, *SD* = .85).

Perceptions by Sample

There were no significant differences in perceived importance of youth mental health promotion ideas between participants recruited locally and those recruited from across the country through Prolific. Local participants (*M* = 3.73, *SD* = .94) perceived providing families with mental health resources in multiple languages as significantly less feasible than participants recruited from across the country (*M* = 4.30, *SD* = .74), $t(143) = 4.01$, $p < .0001$. Local participants (*M* = 3.74, *SD* = 1.01) also perceived developing an online resource that includes ratings and reviews of local mental health services as significantly less feasible than participants recruited from across the country (*M* = 4.28, *SD* = .85), $t(141) = 3.50$, $p = .0006$.

Perceptions by Various Community Members

Among mental healthcare professionals (*n* = 27), increasing county, state, and/or federal funding for mental health services was rated as most important (*M* = 4.89, *SD* = .32), followed by providing families with effective mental health services (*M* = 4.81, *SD* = .40), training and employing diverse mental healthcare professionals (*M* = 4.74, *SD* = .45), and teaching parents about how to build a strong parent-child relationship (*M* = 4.74, *SD* = .45). Providing resources on recognizing and coping with mental illness and suicidality was rated as most feasible (*M* = 4.41, *SD* = .89), followed by seeking input from adolescents on efforts to promote mental health (*M* = 4.33, *SD* = .88), and teaching parents about signs of mental illness and ways to help children cope (*M* = 4.19, SD = .68).

Among parents (*n* = 36), providing families with effective mental health services (*M* = 4.75, *SD* = .69) and with free or low-cost mental health services (*M* = 4.75, *SD* = .65) were tied as most important, followed by teaching children and adolescents about signs of mental illness and ways to cope (*M* = 4.72, *SD* = .51). Providing resources on recognizing and coping with mental illness and suicidality was rated as most feasible (*M* = 4.33, *SD* = .86), followed by teaching community members about how to be allies to minoritized children and adolescents (*M* = 4.23, *SD* = .84) and providing families with mental health resources in multiple formats (*M* = 4.22, *SD* = .90).

Among youths (*n* = 12), teaching children and adolescents about signs of mental illness and ways to cope was rated as most important (*M* = 4.58, *SD* = .67), followed by

Table 2. Perceived Importance and Feasibility of Specific Ideas for Implementing Youth Mental Health Promotion Strategies

Youth mental health promotion idea	Importance				Feasibility			
	Y	P	MH	*F*	Y	P	MH	*F*
1. Providing families with effective mental health services	4.33 (.98)	4.75 (.69)	4.81 (.4)	2.11	3.27 (1.10)	3.74 (.89)	3.67 (.78)	1.13
2. Providing families with free or low-cost mental health services	4.33 (.98)	4.75 (.65)	4.70 (.47)	1.56	3.27 (1.01)	3.21 (1.14)	2.77 (.86)	2.14
3. Increasing county, state, and/or federal funding for mental health services	4.50 (.80)	4.69 (.75)	4.89 (.32)	1.70	3.22 (1.20)	3.33 (1.24)	2.81 (.90)	2.80
4. Teaching children and adolescents about signs of mental illness and ways to cope	4.33 (.78)	4.56 (.73)	4.59 (.69)	.50	4.33 (.78)	4.20 (.90)	4.19 (.68)	.22
5. Training and employing diverse mental health professionals	4.42 (.79)	4.67 (.76)	4.74 (.45)	.98	3.67 (1.23)	3.92 (.84)	3.89 (.93)	.27
6. Teaching parents about how to effectively communicate with their child	4.42 (.79)	4.64 (.54)	4.59 (.5)	.71	3.00 (1.26)	3.71 (.93)	3.63 (.88)	2.47
7. Teaching parents about how to build a strong parent-child relationship	4.33 (.98)	4.61 (.64)	4.74 (.45)	1.57	3.08 (1.08)	3.77 (.81)	3.85 (.82)	3.23*
8. Teaching parents about signs of mental illness and ways to help children cope	4.58 (.67)	4.72 (.51)	4.70 (.54)	.28	3.42 (1.24)	4.14 (.85)	4.11 (.89)	2.70
9. Teaching community members, such as teachers and pediatricians, about how to be allies to minoritized children and adolescents	3.83 (1.34)	4.42 (.73)	4.44 (.64)	2.65	4.00 (1.21)	3.97 (.75)	3.56 (.80)	2.63
10. Advocating for county, state, and/or federal policies that promote mental health	4.42 (.67)	4.44 (.77)	4.63 (.56)	.60	3.30 (.67)	3.54 (1.15)	3.28 (.94)	1.11
11. Providing families with mental health resources in multiple languages	4.08 (1.08)	4.64 (.64)	4.70 (.47)	3.51*	3.58 (1.24)	4.17 (.88)	3.52 (.89)	4.40*
12. Seeking input from adolescents on efforts to promote mental health	4.50 (.80)	4.53 (.61)	4.59 (.64)	.20	3.92 (1.00)	4.14 (1.05)	4.33 (.88)	1.07
13. Providing families with culturally sensitive mental health services	4.00 (1.21)	4.31 (.89)	4.67 (.62)	2.78	3.75 (1.22)	3.86 (1.13)	3.78 (.89)	.06
14. Providing families with mental health resources in multiple formats, such as digital resources or in-person services	3.75 (1.06)	4.44 (.77)	4.48 (.58)	4.74*	3.82 (.75)	4.22 (.90)	4.00 (.83)	1.15
15. Teaching community members, such as teachers and pediatricians, about signs of mental illness and ways to help children cope	4.50 (.67)	4.64 (.54)	4.63 (.49)	.35	4.42 (.67)	4.23 (.84)	3.85 (.91)	2.61
16. Providing resources, such as fact sheets or videos, on recognizing and coping with mental illness and suicidality	3.75 (.87)	4.08 (.97)	4.22 (.8)	1.28	3.83 (.83)	4.33 (.86)	4.41 (.89)	1.73
17. Seeking input from parents on efforts to promote mental health	3.42 (1.08)	4.14 (.83)	4.00 (.73)	3.03	3.45 (.93)	3.92 (.94)	3.96 (1.02)	1.09
18. Developing an online resource that includes ratings and reviews of local mental health services	3.25 (.87)	3.78 (1.07)	3.30 (1.03)	3.90*	3.92 (1.00)	4.08 (.94)	3.35 (1.02)	6.74**

Note: Y = youth. P = parent. MH = mental healthcare professional. Mean (SD). *$p < .05$. **$p < .0028$.

Notably, mental healthcare professionals and youths noted the importance of securing county, state, and federal funding to promote youth mental health, suggesting the perceived need for financial resources to fund other implementation processes. Other studies in implementation science have found that funding often drives successful evidence-based practice adoption ...

increasing county, state, and/or federal funding for mental health services (M = 4.50, SD = .80), seeking input from adolescents on efforts to promote mental health (M = 4.50, SD = .80), and teaching community members about how to be allies to minoritized children and adolescents (M = 4.50, SD = .67). Teaching community members about how to be allies to minoritized children and adolescents was rated as most feasible (M = 4.42, SD = .67), followed by teaching parents about signs of mental illness and ways to help children cope (M = 4.33, SD = .78) and teaching community members about signs of mental illness and ways to help children cope (M = 4, SD = 1.21).

There were significant differences between community members in feasibility ratings for developing an online resource that includes ratings and reviews of local mental health services, $F(2) = 6.74$, $p = .002$. Results from a Tukey's post hoc test showed that parents (M = 4.08, SD = .94) perceived this idea to be significantly more feasible than mental healthcare professionals (M = 3.35, SD = 1.02). There were no other significant differences in importance and feasibility ratings between community members (Table 2).

General Discussion

This study examined mental healthcare professionals, parents, youths, and other community members' perceptions of the importance and feasibility of various community-generated ideas for promoting youth mental health. This study was designed to lend insights toward strategies that different community members deem important, which we hope youth mental health promotion researchers, practitioners, policymakers, and advocates will consider when deciding worthwhile avenues to pursue.

An innovation tournament was used to identify and then evaluate ideas for promoting youth mental health. Community members nominated ideas across all six implementation processes (i.e., planning, educating, financing, restructuring, managing quality, and attending to the policy context; Powell et al., 2012), with the majority of ideas pertaining to improving mental health literacy through educational materials and trainings. This finding is consistent with other innovation tournaments that have found that clinicians often nominate ideas related to training as ways to improve implementation of evidence-based practices (Stewart et al., 2019). Promoting youth mental health through educating community members is sensical, as awareness of mental health problems and effective treatments is foundational for advocating for mental healthcare reform. Our results also suggest that educating (e.g., "providing resources on recognizing and coping with mental illness and suicidality") may also be a relatively feasible implementation process—but may or may not be the implementation process to prioritize.

Of the various strategies for promoting youth mental health, community members perceived the provision of effective mental health services to be the most important. This prioritization is aligned with longstanding and ongoing efforts to improve the quality and effectiveness of community mental health services for children and adolescents (Daleiden et al., 2006; Hoagwood et al., 2014; McHugh & Barlow, 2010; Nakamura et al., 2011; Office of the Surgeon General, 2021). This finding also raises questions about which implementation process to prioritize, given that the delivery of effective mental health services necessitates the following: planning by mental health organizations and relevant partners to implement efficacious mental health treatments; educating mental healthcare professionals in efficacious mental health treatments; financing the implementation of efficacious mental health treatments and related supports (e.g., training, supervision, consultation); restructuring mental health service systems to sustain implementation of efficacious mental health treatments; managing the quality of mental health services through data systems and support networks; and attending to policies that promote implementation of efficacious mental health treatments, among other implementation strategies. Notably, mental healthcare professionals and youths noted the importance of securing county, state, and federal funding to promote youth mental health, suggesting the perceived need for financial resources to fund other implementation processes. Other studies in implementation science have found that funding often drives successful evidence-based practice adoption (Eisman et al., 2020; Pegg et al., 2021; Reeves et al., 2019; Saldana et al., 2014). As such, efforts to increase funding dedicated to youth mental health promotion may have a broad impact in terms of promoting youth mental health.

Limitations

This study has several strengths, such as containing a sample that included both mental healthcare professionals and community members outside of mental health care. Additionally, results are generalizable with direct implications for our community partner due to participant recruitment at a local and national level. However, limitations included the submission of relatively general strategies for promoting youth mental health by many participants, although the level of detail in these responses was consistent with other innovation tournaments (e.g., Sibley et al., 2022; Stewart et al., 2019). This limitation may be counterbalanced by the substantially fewer personnel hours required to collect information regarding specific strategies via innovation tournaments compared with field observations and qualitative interviews (Becker-Haimes et al., 2022). It is also noteworthy that considerable overlap has been found between the content of strategies derived from an innovation tournament and observations and interviews. Given that this study sought to gather community member perceptions about youth mental health promotion priorities—and respond to the immediate need for information from a community partner—an innovation tournament was appropriate for meeting these interrelated objectives. However, research studies seeking specific ideas for promoting youth mental health should consider alternative participatory design methods. Another limitation is that this study included relatively few youths, and those youths were likely associated with PSN-affiliated organizations and therefore may view mental health promotion strategies as more important than a typical adolescent. As scholars have advocated (Kornbluh et al., 2015; Ozer, 2017; Rodríguez & Brown, 2009), and as suggested by findings from our study, there is value and utility in engaging youths to identify ways to promote youth mental health. Accordingly, future scientific and practical endeavors aiming to promote youth mental health should actively recruit youth partners

to better understand their needs and experiences, as well as to identify and implement relevant and appropriate strategies.

Conclusion

In the ongoing youth mental health crisis, it can be difficult for individuals and organizations aiming to promote youth mental health to figure out where to start. Among various community members, there seems to be consensus that funding is needed to implement and sustain youth mental health promotion efforts—but this may be easier said than done. Although strategies for financing youth mental health promotion are viewed as important, they are also perceived to be less feasible than other strategies. In the current funding climate, it is critical to consider how to optimize existing resources for promoting youth mental health, in addition to continuing to advocate for further supports. The path to resolving the youth mental health crisis will be long, but the community-generated ideas outlined in this paper can give some direction of where to go next.

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ORIGINAL RESEARCH

Factors Associated With Burnout Among Cognitive-Behavioral Therapists During COVID-19

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Mental health professionals, along with all health care workers, experienced numerous professional stressors during the COVID-19 pandemic, including increases in all major categories of mental health diagnoses among their clients, increases in workload and patients seen per week, and a rapid conversion to providing telehealth-based services (American Psychological Association, 2022), not to mention living through the pandemic themselves. Unsurprisingly, multiple studies have found high levels of burnout among mental health clinicians following the onset of COVID-19. For instance, a multi-year, cross-sectional survey conducted by the APA (2022) found that levels of self-reported burnout among active licensed psychologists in the United States was higher in both 2021 and 2022 than in 2020 (when the pandemic started). Additionally, a prospective study examining burnout among psychotherapists working within the United States Department of Veteran's Affairs (VA) observed that the percentage of respondents who endorsed indications of burnout increased from 40% in 2019 (prior to COVID-19) to 56% in the first year after the start of the pandemic (Rosen et al., 2023). As burnout among mental health providers can have important impacts on both professional and personal functioning and well-being, improving our understanding of factors related to burnout can hopefully inform strategies for helping clinicians function more optimally in all areas of life as COVID-19 transitions from pandemic to endemic.

An emerging body of research conducted over the last few years is starting to bring factors associated with burnout among mental health providers during the pandemic into sharper focus. Trombello et al. (2022) surveyed 62 psychologists with appointments at a single academic medical center in the Southwest. Their survey included a single-item measure of burnout and questions assessing personal and professional demographic data, as well as levels of job stress and satisfaction. Consistent with the previously described studies, rates of burnout in the sample were high, with nearly half (48.4%) of participants meeting the study's criteria for continuous burnout. Higher levels of burnout were significantly related to being earlier in one's career, higher levels of job stress, lower levels of job satisfaction, having less control over one's workload, and having insufficient time for documentation.

Several additional studies suggest the need for further exploration of psychological factors related to clinician burnout, and not only career and workplace variables (e.g., stage in career, job stress). Focusing on early career counselors (6 months to 3 years of experience) in India, Sandu and Singh (2021) examined the relationship between burnout (using the Counselor Burnout Inventory) and a range of adaptive and maladaptive cognitive emotion regulation strategies (Cognitive Emotion Regulation Questionnaire; Garnefksi et al., 2002). Three of the nine strategies assessed were significantly

correlated with burnout, with higher burnout being associated with greater rumination and less use of positive reappraisal and refocusing on planning. Additionally, a survey of 252 mental health professionals in Australia (Malouf et al., 2023) examined correlates of burnout and found that psychological inflexibility (Acceptance and Action Questionnaire–II; Bond et al., 2011) was one of several factors related to experiences of burnout one year into the pandemic.

A recent study by Kotera et al. (2021) offered an even more extensive examination of psychosocial correlates of clinician burnout following the onset of COVID-19. One-hundred and ten practicing psychotherapists in the United Kingdom completed measures of burnout, self-compassion (Self-Compassion Scale–Short Form; Raes et al., 2011), work-life balance (Work Life Balance Checklist), and telepressure (defined as internal pressure to respond quickly to work-related electronic messages; Barber & Santuzzi, 2015). A notable strength of the study was the inclusion of a brief version of the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), one of the most widely used measures of workplace burnout. The MBI has three subscales representing distinct conceptual components of burnout: emotional exhaustion (feeling overextended and emotionally depleted), depersonalization (feeling detached from clients), and lack of personal accomplishment (feeling incompetent and having low experiences of success and achievement). Study results demonstrated that emotional exhaustion and depersonalization (the personal accomplishment subscale was not administered) were correlated with the other factors in expected directions; higher levels of both dimensions of burnout were associated with less self-compassion and work-life balance, higher work hours, and greater telepressure. Regression analyses revealed that work-life balance was the strongest predictor of both emotional exhaustion and depersonalization. Furthermore, mediation analyses also showed that self-compassion partially mediated the relationship between work-life balance and emotional exhaustion but did not mediate the relationship between work-life balance and depersonalization.

Taken together, these studies provide preliminary evidence that a range of variables are related to clinician's experiences of burnout as they have navigated the COVID-19 pandemic. However, all four studies used a different measure of burnout and examined different sets of correlates, and two of the studies (Sandu & Signh, 2021; Trombello et al., 2022) included very specific samples of clinicians with unclear generalizability (e.g., early career psychologists in India, psychologists at a single academic medical center). A primary aim of the current study was to provide a more comprehensive picture of this area of study by (1) using a gold-standard measure of workplace burnout (the MBI), (2) including a wide range of potential correlates of burnout drawn from the existing literature, and (3) recruiting a national sample of licensed mental health therapists in the United States. A secondary aim was to examine factors associated with burnout among cognitive-behavioral therapists specifically. Our interest in learning more about the experiences of this group of providers was based both on our own experiences as CBT providers, as well as the relative lack of research on the experiences of evidence-based clinicians during COVID-19. Thus, all participants included in the final sample identified as providing cognitive-behavioral forms of therapy. Finally, the study had a tertiary aim of exploring changes in perception about the use of telehealth among providers who treat clients at higher risk for nonsuicidal self-injury (NSSI) and suicide ideation and attempts, given that pre-COVID, relatively few therapists treating suicidal clients chose to do so via telehealth (Gilmore & Ward-Ceisielski, 2019). To address this question, we made efforts to recruit therapists providing comprehensive dialectical behavior therapy (DBT), as they routinely work with clients with high-risk

behaviors (e.g., NSSI, suicide attempts).

Our study hypotheses included the following:

1. Therapists with fewer years of work experience will report higher levels of burnout.
2. Higher levels of burnout will be associated with less work-life balance and greater telepressure.
3. Higher levels of burnout will be associated with lower self-compassion, higher psychological inflexibility, greater use of maladaptive cognitive emotion regulation skills, and less use of adaptive cognitive emotion regulation skills.
4. DBT therapists will report higher levels of burnout than non-DBT therapists and will report also holding more positive views about using telehealth with high-risk clients than they held prior to COVID-19.

Method

Procedures

We recruited licensed mental health clinicians who identify as evidence-based practitioners via survey invitations posted to listservs and message boards for national psychological professional associations, including the Association for Behavioral and Cognitive Therapies, Anxiety and Depression Association of America, International OCD Foundation, and International Society for the Improvement and Teaching of Dialectical Behavioral Therapy. Additionally, we sent survey invitations to 120 evidence-based clinics across the United States (identified primarily via professional organizations and certification bodies that are strongly aligned with adherence to evidence-based practices). Participants provided informed consent to participate in the study and then completed survey measures via SurveyMonkey. Study recruitment took place between November 2022 and March 2023. The study was approved by the Behavioral Health Research Collective Institutional Review Board.

Participant Characteristics

A total of 168 therapists were included in the final sample. The average age of participants was 42.3 (*SD* = 10.7) and they reported having been licensed for a mean of 10.5 years (*SD* = 8.7; range: 1–42). Most participants identified as female (*n* = 144, 85.7%), White (*n* = 146, 86.9%), Not Hispanic or Latino (*n* =149, 88.7%), and straight/heterosexual (*n* = 129, 76.8%). Ninety-four (56%) therapists identified as doctoral level (Ph.D./Psy.D./M.D.) and 74 (44%) identified as master's level (M.A./M.S./M.S.W.). Therapists reported their primary work setting as: private/group practice (*n* = 106, 63.1%), hospital (*n* = 31, 18.5%), community mental health center (*n* = 9, 5.4%), university or academic department (*n* = 7, 4.2%), or other (*n* = 15, 8.9%). Participants from 29 U.S. states and territories were included in the study.

Participants provided additional information characterizing their clinical practice, including average number of direct clinical care hours in a typical week, percentage of direct clinical care hours delivered via telehealth in a typical week prior to COVID-19, and percentage of direct clinical care hours delivered via telehealth in a typical week at present. All participants self-identified as evidence-based clinicians and only those who reported providing cognitive-behavioral forms of therapy were included in the current analyses (with 15 individuals excluded for this reason).

Measures

Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981). The Human Services Survey version of the MBI assesses frequency of 22 job-related feelings and experi-

ences and is designed to assess burnout in individuals working in human services settings, including health care and mental health facilities. The MBI has three subscales: Emotional Exhaustion (MBI-EE), Depersonalization (MBI-D), and Personal Accomplishment (MBI-PA). Subscale scores are generated by calculating the sum of the items comprising each subscale. Higher scores on the MBI-EE and MBI-D subscales indicate higher levels of burnout, whereas a higher score on the MBI-PA indicates lower burnout. Subscale scores range from 0–54 for the MBI-EE subscale and 0–30 for the MBI-D subscale. For the current study's purpose, we only included MBI-EE and MBI-D subscale scores in our analyses, as there is support for the idea that these two subscales (and not the Personal Accomplishment subscale) form the core of burnout (Worley et al., 2008). Cronbach's alphas for the MBI-EE (9 items) and MBI-DP (5 items) subscales were .94 and .72, respectively.

Cognitive Emotion Regulation Questionnaire 18-Item Version (CERQ-short; Garnefski & Kraaij, 2006). The CERQ-short version assesses nine cognitive emotion-regulation coping strategies that a person may employ to cope with negative or unpleasant experiences, including adaptive strategies (positive refocusing, refocusing on planning, positive reappraisal, putting into perspective, acceptance) and maladaptive strategies (self-blame, other-blame, rumination, catastrophizing). Subscale scores corresponding to each coping strategy range from 2–10, with higher scores indicating more frequent use of that strategy. As all nine subscales of the CERQ-short are comprised of two items, Spearman-Brown coefficients were calculated to evaluate reliability. Eight of the subscales demonstrated adequate reliability (values between .65 and .83), whereas the Rumination subscale demonstrated poor reliability in this sample (.46). As a result, caution should be taken when interpreting findings related to this subscale.

*Self-Compassion Scale-Short Form (SCS-SF; Raes et al., 2011).*The 12-item SCS-SF measures the extent to which an individual responds to themselves with warmth and understanding in the face of difficulty or suffering. The scale authors recommend using the total score when using the short form due to lower internal consistencies for lower-order factor subscales; total scores range from 12–60, with higher scores indicating greater levels of self-compassion. The measure was highly reliable in the current sample (α = .87).

Acceptance and Action Questionnaire II (AAQ-II; Bond et al., 2011). The AAQ-II is a 7-item measure of psychological inflexibility. It yields a total score ranging from 7–49, with higher scores indicating higher levels of psychological inflexibility. The scale demonstrated high reliability (α = .89).

Work-Life Climate Scale (WLCS; Sexton et al., 2016). The WLCS measures healthcare worker attendance to nonwork needs with frequency ratings for eight behaviors during the preceding week (e.g., skipping meals, arriving home late from work, working a shift or day without taking breaks, changing personal or family plans due to work). Response options for each behavior include: rarely or none of the time (<1 day), some or a little of the time (1–2 days), occasionally or a moderate amount of time (3–4 days), all of the time (5–7 days), and not applicable. The total scale score is calculated as the mean of scale items. Higher scores, representing poorer work-life integration, have been found to be associated with burnout in healthcare workers (Schwartz et al., 2019). Cronbach's alpha for the scale was .71.

Workplace Telepressure (Barber & Santuzzi, 2015). The Workplace Telepressure scale yields a mean score from six items that assess individual preoccupation and urges to respond to work-related messages over technology (e.g., email, voicemail, text message). Higher scores indicate greater feelings of telepressure. The measure demon-

strated excellent reliability in the current sample ($\alpha = .90$).

DBT Providers Experiences. To identify DBT therapists, we asked participants to respond yes or no to the following question: "Do you provide comprehensive DBT and/or sit on a DBT team that provides comprehensive DBT (comprehensive DBT includes individual DBT, DBT skills group, consultation team, and phone coaching)?" We chose to use this as a screening question to help ensure that therapists were more likely to be providing adherent DBT. We developed 12 survey questions for DBT therapists about their perceptions of the use of telehealth with clients with various high-risk behaviors (e.g., NSSI, active suicide ideation, a recent suicide attempt) prior to COVID-19 and at the time of the survey, as well as other aspects of the experience of delivering DBT treatment via telehealth (e.g., feeling more burnout when providing DBT or out-of-session phone coaching when treating client via telehealth versus in person, whether telehealth makes it harder to develop rapport with clients or connect with their DBT consultation team members). Questions were developed with consultation from members of a DBT-Linehan Board Certified DBT team. All items were rated on a 5-point Likert scale ranging from "Strongly Disagree" to "Strongly Agree."

Analyses

We used Pearson-correlations to examine the relationships between burnout, demographic, behavioral, and psychological variables. Based on the results of the correlation analyses, variables with significant associations with burnout were entered into multiple linear regression models to predict levels of emotional exhaustion and depersonalization. Independent sample t-tests were used to examine the likelihood of significant differences in burnout between DBT and non-DBT providers, as well as between participants working in private/group practice and non-private/group practice settings. Dependent sample t-tests were used to examine the likelihood of significant differences between DBT providers' perceptions of the appropriateness of telehealth pre-COVID and at the time of the study. Significance levels were set at $p \leq .05$ for all analyses. Analyses were conducted using SPSS 19.

As would be expected, age and years of clinical experience postlicensure were strongly related ($r = .80$). Therefore, we chose to only include years of clinical experience postlicensure in all related analyses.

Results

Burnout

Regarding the degree of burnout in the current sample, participants reported higher levels of emotional exhaustion (MBI-EE; M = 25.2, $SD = 11.9$) and similar levels of depersonalization (MBI-D; $M = 5.8$, $SD = 4.8$) as compared to existing norms for mental health workers (Maslach et al., 2018).

Consistent with our hypothesis, years of clinical experience postlicensure was negatively correlated with both emotional exhaustion (MBI-EE; $r = -.31$, $p < .01$) and depersonalization (MBI-D; $r = -.19$, $p = .01$), with early-career providers reporting higher levels of burnout. Therapists in the current study reported working an average of 20.0 direct clinical care hours per week ($SD = 8.2$), with an average of 12.2 of those hours being conducted via telehealth ($SD = 7.9$). The number of direct clinical care hours worked per week was significantly related to depersonalization (MBI-D; $r = .25$, $p < .01$) but not emotional exhaustion (MBI-EE; $r = .08$, $p = .29$). Additionally, no significant relation was observed between the percentage of direct clinical hours provided via telehealth per week and either aspect of burnout (MBI-EE; $r = .05$, $p = .51$; MBI-D; $r = .08$, $p = .29$).

Study findings also provided support for our other hypotheses regarding other work-related variables: emotional exhaustion and depersonalization were significantly related to work-life balance and telepressure (see Table 1), with less work-life balance and greater telepressure being associated with higher levels of both dimensions of burnout. Moreover, participants in private/group practice reported significantly lower levels of emotional exhaustion (Private/Group $M = 23.22$, $SD = 12.0$; Not Private/Group $M = 28.55$, $SD = 11.0$), $t(166) = -2.87$, $p < .01$) and depersonalization (Private/Group $M = 5.18$, $SD = 4.4$; Not Private/Group $M = 6.79$, $SD = 5.2$), $t(166) = -2.14$, $p < .05$) than participants working in non-private practice settings.

Regarding the psychological variables examined, results also supported the majority, but not all, of our primary hypotheses. As can be seen in Table 1, both psychological inflexibility and self-compassion were significantly related to levels of burnout in the current sample in the expected directions. Findings regarding cognitive emotion regulation strategies, however, were mixed (see Table 1). Notably, maladaptive cognitive emotion regulation strategies were significantly related to emotional exhaustion and depersonalization, but adaptive cognitive emotion regulation strategies were not. This pattern was quite pronounced, with all four of the maladaptive strategies being significantly associated with both emotional exhaustion and depersonalization and none of the five positive strategies being related to either. Inter-correlations between the nonburnout study variables are presented in Table 2.

Based on the results of the correlation analyses, variables with significant associations with burnout were entered into separate multiple linear regression models to assess their relative contribution to emotional exhaustion and depersonalization. Variables entered into both models included: years of clinical experience postlicensure, work setting (private/group practice vs. non-private/group practice), work-life balance, telepressure, psychological inflexibility, self-compassion, and all four of the maladaptive cognition emotion regulation strategies (i.e., self-blame, rumination, catastrophizing, and other blame). Additionally, average number of direct care hours per week was entered into the model predicting depersonalization, as it was correlated with this dimension of burnout but not with emotional exhaustion. The results of the regression

Table 1. Correlations Between Burnout and Work-Life Balance, Telepressure, Psychological Inflexibility, Self-Compassion, and Cognitive Emotion Regulation Strategies

	MBI-Emotional Exhaustion	**MBI-Depersonalization**
Work-Life Balance (WLCS)	.53**	.43**
Telepressure	.25**	.18*
Psychological Inflexibility (AAQ-II)	.53**	.44**
Self-Compassion (SCS-SF)	-.44**	-.38**
Adaptive Cognitive Emotion Regulation Strategies (CERQ-short)		
Acceptance	-.09	-.11
Positive Refocusing	-.06	-.06
Refocus on Planning	.00	-.02
Positive Reappraisal	-.10	-.12
Putting into Perspective	-.04	.02
Maladaptive Cognitive Emotion Regulation Strategies (CERQ-short)		
Self-Blame	.31**	.31**
Rumination	.35**	.19*
Catastrophizing	.30**	.31**
Other Blame	.15*	.19*

Note. $^{*}p \leq .05$. $^{**}p \leq .01$.

analyses are summarized in Table 3.

The regression models accounted for 40% (adjusted R^2) of the variance in emotional exhaustion, $F(10, 143) = 11.02$, $p < .001$, and 29% (adjusted R^2) of the variance in depersonalization, $F(11, 142) = 6.76$, $p < .001$. Work-life balance, psychological flexibility, and rumination were significant unique predictors of emotional exhaustion, whereas work-life balance, number of direct clinical care hours worked per week, self-blame, and other blame were significant unique predictors of depersonalization. Multicollinearity was not an issue for either model (VIF < 2.5).

Experiences of DBT Providers

The study's final aim was to assess DBT therapists' perceptions of the appropriateness of telehealth for high-risk clients and to assess other aspects of their experiences of providing DBT via telehealth. A subset of the total study sample (n = 82) identified as providing comprehensive DBT and/or sitting on a DBT consultation team that provides comprehensive DBT. The demographic characteristics of these therapists were similar to those of the total sample, with the exception that DBT therapists identified as slightly

Table 2. Correlations Between Work-Life Balance, Telepressure, Psychological Inflexibility, Self-Compassion, and Cognitive Emotion Regulation Strategies

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Work-life balance	-												
2. Telepressure	.29**	-											
3. Psychological inflexibility	.52**	.19*	-										
4. Self-compassion	-.51**	-.41**	-.69**	-									
5. Acceptance	-.09	-.15	-.17*	.23**	-								
6. Positive refocusing	-.17*	-.01	-.12	.18*	.16*	-							
7. Refocus on planning	-.06	.05	-.16*	.14	.25**	.15*	-						
8. Positive reappraisal	-.10	-.23**	-.19*	.28**	.40**	.22**	.34**	-					
9. Putting into perspective	-.06	-.04	-.10	.19*	.25**	.33**	.27**	.29**	-				
10. Self-blame	.23**	.20*	.42**	-.45**	.07	-.15	.08	.02	-.04	-			
11. Rumination	.19*	.18*	.29**	-.28**	.12	-.10	.25**	.01	-.19*	.31**	-		
12. Catastrophizing	.14	.22**	.39**	-.29**	-.00	-.06	.01	-.20**	-.13	.31**	.45**	-	
13. Other blame	.14	.00	.07	-.06	.11	-.00	.17*	-.02	.01	.01	.16*	.31**	-

Note. 1 = WLCS; 3 = AAQ II; 4 = SCS-SF; 5-13 = CERQ-short subscales. *$p \le .05$. **$p \le .01$.

Table 3. Multiple Linear Regression Results for Emotional Exhaustion and Depersonalization (n = 154)

Variable	MBI-Emotional Exhaustion				MBI-Depersonalization			
		95% CI for *B*				95% CI for *B*		
	B	*LL*	*UL*	β	*B*	*LL*	*UL*	β
1. Years since licensure	-.18	-.37	.01	-.13	-.02	-.10	.06	-.04
2. Average clinical care hours per week	-	-	-	-	.10*	.02	.18	.17
3. Work setting	-2.04	-5.32	1.23	-.08	-1.10	-2.49	.30	-.11
4. Work-life balance	6.54**	2.98	10.10	.29	1.68*	.15	3.21	.19
5. Telepressure	.45	-1.28	2.18	.04	-.01	-.76	.74	-.00
6. Psychological inflexibility	.44*	.08	.79	.24	.04	-.11	.19	.06
7. Self-compassion	-.52	-4.05	3.02	-.03	-.66	-2.16	.85	-.09
8. Self-blame	.41	-.69	1.51	.05	.62*	.14	1.09	.21
9. Rumination	1.13*	.04	2.22	.15	-.21	-.68	.25	-.07
10. Catastrophizing	.06	-1.24	1.36	.01	.53	-.03	1.08	.16
11. Other blame	.35	-1.00	1.70	.04	.64*	.07	1.22	.16

Note. 3 = Private/group practice and non-private/group practice; 4 = WLCS; 6 = AAQ II; 7 = SCS-SF; 8-11 = CERQ-short subscales.
*$p \le .05$. ** $p \le .001$.

more White (n = 76, 92.7%) and a higher proportion were master's-level clinicians (58.5%).

Contrary to our hypothesis, DBT therapists did not endorse significantly higher levels of emotional exhaustion (DBT M = 25.2, SD = 11.7; CBT M = 24.9, SD = 11.9), $t(161) = 0.13$, $p = .90$) or depersonalization (DBT M = 6.3, SD = 4.6; CBT M = 5.1, SD = 4.6), $t(161) = 1.57$, $p = .12$, than cognitive-behavioral therapists in the sample who did not provide comprehensive DBT.

However, our hypothesis that DBT therapists would report holding significantly more positive views about the appropriateness of telehealth for clients with a range of high-risk behaviors than they held prior to COVID-19 was strongly supported (see Figure 1). Dependent-samples t-tests indicated that participants believed it was significantly more appropriate to provide DBT to individuals with NSSI, $t(80) = -15.58$, $p < .001$, active suicidal ideation, $t(80) = -12.64$, $p < .001$, or a recent suicide attempt, $t(80) = -10.94$, $p < .001$, than they did prior to COVID-19. A similar finding was observed for therapists' current and pre-COVID perceptions of the appropriateness of conducting DBT

Table 4. DBT Therapists' Perceptions of Telehealth, Burnout and Alliance

	Mean (*SD*)
Prior to transitioning to doing telehealth during COVID-19, I believed that it was appropriate and effective to deliver individual DBT via telehealth for individuals with current non-suicidal self-injury (NSSI) behaviors.	2.44 (*1.0*)
I currently believe it is appropriate and effective to deliver individual DBT via telehealth for individuals with current non-suicidal self-injury (NSSI) behaviors.	4.41 (*0.9*)
Prior to transitioning to doing telehealth during COVID-19, I believed that it was appropriate and effective to deliver individual DBT via telehealth for individuals with active suicide ideation.	2.31 (*1.1*)
I currently believe it is appropriate and effective to deliver individual DBT via telehealth for individuals with active suicide ideation.	4.20 (*1.2*)
Prior to transitioning to doing telehealth during COVID-19, I believed that it was appropriate and effective to deliver individual DBT via telehealth for individuals with recent suicide attempts.	2.10 (*1.1*)
I currently believe it is appropriate and effective to deliver DBT skills training groups via telehealth.	3.77 (*1.4*)
Prior to transitioning to doing telehealth during COVID-19, I believed that it was appropriate and effective to deliver DBT skills training groups via telehealth.	2.53 (*1.1*)
I currently believe it is appropriate and effective to deliver DBT skills training groups via telehealth.	4.11 (*1.1*)
I feel more overall clinical burnout when working with DBT clients via telehealth than when I work with them in person.	3.01 (*1.4*)
I feel more clinical burnout in response to out-of-session coaching (e.g., telephone calls, texting) when working with DBT clients via telehealth than when I work with them in person.	2.62 (*1.3*)
It is harder to build and maintain the kind of therapeutic alliance needed to do effective DBT when working with clients via telehealth vs. in person.	2.95 (*1.3*)
I am able to connect just as well with my DBT consultation team via virtual meetings as I did/do via in person meetings.	2.99 (*1.3*)

Note. Participants made ratings on a scale of 1 = *Strongly Disagree*, 3 = *Neither Agree nor Disagree*, to 5 = *Strongly Agree.*

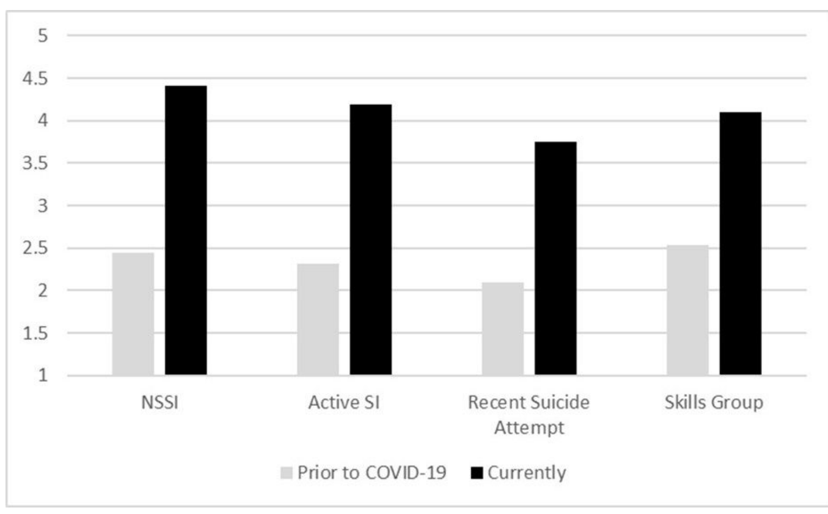

Figure 1. DBT Therapists' Perceptions of the Appropriateness of Telehealth
Note. Participants rated appropriateness on a scale of 1 = *Strongly Disagree*, 3 = *Neither Agree nor Disagree,* to 5 = *Strongly Agree.*

skills groups via telehealth, $t(80) = -11.08$, $p < .001$.

Table 4 summarizes ratings that DBT therapists made about these and other aspects of their experiences of providing DBT via telehealth.

Discussion

Taken together, the current findings contribute to a growing literature examining burnout in mental health providers since the onset of COVID-19. Our results replicated those of several prior studies and largely supported our hypotheses. Results showed higher levels of the emotional exhaustion dimension of burnout in the current sample than in prior published norms, which aligns with recent data collected since the onset of the pandemic (APA, 2022; Rosen et al., 2023). As predicted and consistent with prior work (Kotera et al., 2021; Sandhu & Singh, 2021; Trombello et al., 2022), correlation analyses indicated that early-career psychologists had higher levels of burnout and higher burnout was also associated with several work-related factors, including higher work hours per week, poorer work-life balance, and greater feelings of telepressure. Therapists working in non-private/group practice settings (e.g., hospitals, community mental health centers, university/academic departments) also reported greater burnout, perhaps reflecting less flexibility in their work schedules and less autonomy and control over their work-related activities. Additionally, as with prior studies (Kotera et al.; Malouf et al., 2023; Sandhu & Singh), higher burnout was related to greater psychological inflexibility, lower self-compassion, and greater use of maladaptive cognitive emotion regulation strategies.

Multiple linear regression models accounted for a significant portion of the variance in both emotional exhaustion (40%) and depersonalization (29%). Consistent with prior research (Kotera et al., 2021), work-life balance emerged a significant unique predictor of both dimensions of burnout. This replication, despite using a different measure of work-life balance, suggests this may be an important target of intervention. As the data are cross-section in nature, it could be that poor work-life balance (e.g., skipping meals, working a day without breaks, coming home late from work) contributes to worse emotional exhaustion, or that it results from it, or both. Regardless of the direction of the relationship, shifting these behaviors may be particularly important for clinicians experiencing high levels of burnout, and could also be a focus of interventions designed

. . . correlation analyses indicated that early-career psychologists had higher levels of burnout and higher burnout was also associated with several work-related factors, including higher work hours per week, poorer work-life balance, and greater feelings of telepressure.

to prevent burnout or detect early warning signs. Aside from work-life balance, psychological inflexibility and rumination were also significant unique predictors of emotional exhaustion, though the latter finding should be interpreted with caution given the poor reliability of the Rumination subscale of the CERQ-short in this sample. Interventions targeting these processes, such as Acceptance and Commitment Therapy (ACT), cognitive restructuring, and/or mindfulness-based interventions, might also prove helpful. With regard to the depersonalization dimension of burnout, other significant unique predictors included average number of direct clinical hours worked per week, as well as self-blame and other blame. The finding that higher work hours was related to higher depersonalization replicates the finding by Kotera et al. and suggests, at a minimum, a role for screening for depersonalization in settings with higher clinical caseloads. A range of interventions might be useful in targeting the cognitive emotion-regulation strategies of self-blame and other blame, including defusion from these thought patterns, self-compassion exercises, and cognitive restructuring. All of these intervention suggestions need to be evaluated for efficacy with reducing specific dimensions of burnout.

Interestingly and counter to our hypothesis, we found that none of the adaptive cognitive emotion-regulation strategies examined were significantly related to either dimension of burnout (emotional exhaustion or depersonalization). This contrasts with findings from Sandhu and Singh (2021), who observed that therapist burnout was related to two of these adaptive strategies (refocusing on planning and positive reappraisal). Key differences in the demographic characteristics between the two studies provide potential explanations for the discrepant findings. First, the prior study only examined early-career psychologists (6 months to 3 years postlicensure), whereas the current study included therapists with a wider range of postlicensure experience (M = 10.5 years postlicensure). Second, the prior study sampled therapists in India, whereas our participants were practicing in the U.S. It is possible that cultural differences and/or differences in levels of postlicensure career experience could account for the different results. For example, it may be that use of certain adaptive cognitive emotion-regulation (and other) strategies are more related to experiences of burnout among early-career providers because they might have a more limited set of skills for managing burnout than providers with more years of clinical experience. Future research should include participants with different years of career experience and cultural backgrounds to further explore the relationships between these factors.

In addition to replicating and expanding upon prior research, the current study has several notable strengths. We utilized the MBI, a gold-standard measure of burnout, included a more comprehensive set of factors associated with burnout in the same study, and recruited a national sample of licensed therapists in the U.S. Moreover, burnout was examined among CBT therapists, who have been relatively understudied,

and the sample size was larger than prior studies (Kotera et al., 2021; Sandhu & Singh, 2021; Trombello et al., 2022; but see Malouf et al., 2023, for exception).

Study findings also contribute to knowledge about the experiences of DBT providers and their perceptions of the appropriateness of telehealth for high-risk clients following COVID-19. Results indicated that DBT therapists had comparable levels of burnout relative to non-DBT therapists. Although contrary to our prediction, this finding is somewhat consistent with prior work which found that DBT and non-DBT providers had similar levels of burnout, depending on the type of burnout examined. Specifically, Warlick et al (2021) administered the Copenhagen Burnout Inventory (CBI) to a national sample of clinicians and found that DBT and non-DBT providers had comparable levels of client-related burnout, but that DBT providers had higher levels of personal and work-related burnout as compared to non-DBT providers. That DBT and non-DBT providers had comparable levels of client-related burnout may lend support to the idea that DBT offers protection against burnout (Carmel et al., 2014) given several structural elements of the treatment, such as having multiple team members treat a client, clinicians practicing DBT skills on themselves, and having consistent support from a DBT consultation team (Linehan, 1993). These structural elements may have been maintained by many comprehensive DBT programs during the COVID-19 pandemic, which could have buffered these clinicians against further elevations in burnout. Another notable current finding is that DBT clinicians' perceptions of the appropriateness of telehealth with clients demonstrating a range of high-risk behaviors shifted to become more favorable from pre-COVID to the time the study was conducted. As many DBT clinicians provided services via telehealth for these high-risk clients during the pandemic, it is likely that this shift in attitudes was influenced by clinicians' direct experiences with providing telehealth services to these clients and observing their effectiveness. However, it is important to note that clinician's pre-COVID beliefs were assessed retrospectively and at the same time point as their present beliefs.

The current study provides important information for understanding factors related to burnout in CBT therapists that can potentially inform intervention efforts. For instance, the finding that levels of burnout were higher among providers with fewer years of postlicensure experience (a repeated finding in the literature) suggests that interventions may be particularly needed for early-career therapists. Though it may seem intuitive that clinicians might experience more burnout further into their careers, the data indicate that it could be beneficial to provide more training on ways to identify and manage burnout during graduate training programs to help buffer therapists from burnout in the early stages of their careers. Additionally, the current study, as well as those conducted since the onset of COVID-19, provide clear evidence that a range of factors are related to clinician burnout; consequently, a multidimensional approach to intervention would likely be most effective. Fortunately, strategies aimed at changing responses to unhelpful patterns of thinking and behavior, which CBT therapists are uniquely trained to address, seem particularly well suited for targeting the correlates of burnout identified in this study (e.g., work-life balance, telepressure, maladaptive cognitive regulation strategies, self-compassion, psychological inflexibility). Thus, it is likely that CBT-oriented interventions would be an ideal starting point for helping CBT therapists reduce their own levels of burnout.

There are several important limitations of the current study that may provide avenues for future work in this area. Although the current sample was larger than those of most studies examining therapist burnout since the onset of COVID-19, it is critical to replicate the findings in even larger and more diverse samples. Participants in this study

were majority female, White, non-Hispanic/Latino, and straight/heterosexual. It is essential to examine these research questions in samples that are more diverse in terms of various cultural factors, including but not limited to race, ethnicity, gender, and sexual orientation. Moreover, though participants were recruited nationally, certain areas of the U.S. (i.e., Midwestern and Southern states) were underrepresented in the final sample. The current data were also cross-sectional; it would be quite helpful for longitudinal studies to examine the directionality of the impacts on burnout and the variables examined. Currently, we do not know whether the associated factors lead to higher burnout, are a result or higher burnout, or whether the relationships are bi-directional. A further limitation is that the extent to which the current findings are contextually linked to the experience of being a mental health professional during the COVID-19 pandemic is unknown. More research is needed over time to substantiate whether the associations observed transcend that specific context. As with all survey studies, sampling bias may have influenced the current findings, as those who chose to respond to the study could have been different in key ways from those who did not. For instance, clinicians with higher burnout may have been less likely to take the time to participate in the study. However, the converse could also be true: providers with higher burnout might have been more motivated to take part in a study that was relevant to their experiences. As no data are available for those who declined participation, any differences from study participants, and their potential relationships with the findings, are unknown. Finally, although this study examined a more comprehensive set of factors related to burnout than many prior studies, there are certainly other important factors likely associated with burnout that we did not include (e.g., other demographic variables, experiences of workplace discrimination) or did not have adequate statistical power to examine in more fine-grained detail (e.g., specific type of workplace setting). Continued exploration and understanding of the range of factors that can lead to, and result from, therapists' experiences of burnout is essential for developing more effective interventions to enhance clinicians' quality of life and clinical effectiveness.

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Sex, Posttraumatic Cognitions, and Suicide Ideation Among Veterans Seeking Trauma-Focused Treatment

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Clinical research has long recognized the significance of altered posttraumatic thoughts and beliefs about oneself, others, and the world in the etiology of posttraumatic stress disorder (Beck et al., 2011; Brown et al., 2018; Horowitz et al., 2018). The development of entrenched, global negative thoughts and beliefs, or posttraumatic cognitions (NPC; e.g., *I deserve bad things to happen to me*, or *The world is not a safe place*) (Ehlers & Clark, 2000) in the wake of trauma exposure predicts both the development (Van Buren & Weierich, 2015) and maintenance of PTSD (Foa et al., 1999; Robinaugh et al., 2011; Scher et al., 2017). A wealth of empirical work has shown that NPCs predict PTSD symptom severity across populations and trauma types (Ehring et al., 2006), and NPCs have been shown to mediate PTSD symptom reduction across therapy modalities (LoSavio et al., 2017; McLean et al., 2015; Szoke et al., 2024) and to drive PTSD symptom change in prolonged exposure therapy (Brown et al.; Zalta et al., 2014). Of note, research has also shown a relationship between NPC severity and common negative consequences of trauma exposure, including aggression (Crocker et al., 2016), depression (Beck et al., 2015; Christ et al., 2021) and broadly self-destructive behavior (Holliday et al., 2020), raising questions concerning the relationship between NPCs and the development of suicide ideation (SI) and behavior in trauma survivors. The importance of identifying and exploring a relationship between NPCs and suicide behavior is underscored by recent data concerning suicide rates in military and veteran populations. An estimated 17–20 veterans commit suicide each day in the United States (Sall et al., 2019; Department of Veterans Affairs, 2018), and suicide remains the second leading cause of death among veterans below the age of 45. While overall risk for mortality among veterans from all causes combined is 24–25% lower than that of the general public, risk of death by suicide is 41–61% (57.30% as listed by the 2022 national report) higher across branches (Kang et al., 2015). Thus, exploration of the relationship between NPCs and suicide behavior to inform risk and prevention efforts must be prioritized.

A potential relationship between NPCs and suicide behavior is supported by both theoretical and empirical evidence. More specifically, based on examination of both

theoretical and empirical fit (Hiskey et al., 2015), DSM-5 NPC symptoms (DSM-5 Criteria D2 and D3; American Psychiatric Association, 2013) were combined with symptoms of emotional numbing (e.g., detachment and estrangement from others) to form a new symptom cluster: negative alterations in cognition and mood. Significantly, numbing symptoms have been associated with the development of suicide behavior in previous research (Boffa et al., 2017; Davis et al., 2014). Further, NPCs have been directly connected to the development of suicide behavior in several recent studies. In a military sample, McLean et al. (2017) showed the relationship between PTSD symptom severity and SI was mediated by negative thoughts about the self. Similarly, both Horwitz et al. (2018) and Monteith et al. (2019) found negative thoughts about the self specifically were associated with current suicide behavior in veteran samples (SI in Horwitz's study, both SI and attempt in Monteith's study). Finally, two recent studies have observed that NPCs mediate the relationships between SI and other clinically relevant variables: revictimization (Xu et al., 2024), findings concerned NPCs about the self specifically, and discrimination (Jeon et al., 2024) in a civilian sample. Taken together, these findings support a relationship between SI and NPCs.

Recent work suggests that understanding the relationship between NPCs and suicide behavior may require consideration of additional clinical and demographic variables. Specifically, research suggests that cognitions driving suicide behavior vary meaningfully across sex, raising the possibility that sex differences in NPCs may reveal significant information about suicide behavior in trauma survivors (Canetto, 2009; Canetto & Sakinofsky, 1998; Tannahill et al., 2022). Broadly, a variety of research findings support clinically meaningful differences in the presentation of both suicide behavior and PTSD symptoms, and NPCs in female veterans. For example, a recent large study observed that risk of death by suicide was increased in male veterans as a function of comorbid substance use, but not female veterans (Hoffmire et al., 2021). Unfortunately, findings concerning the nature of sex differences in NPCs specifically are mixed; three studies (Cromer et al., 2010; Daie-Gabai et al., 2011; Tolin & Foa, 2006) have reported more severe NPCs in female civilians on one or more subscales, four studies (Tannahill et al.; Holliday et al., 2014; Moser et al., 2007; Sexton et al., 2017) reported no sex differences, and two studies (Monteith et al., 2019; Daie-Gabai et al., 2011) reported a stronger association between negative cognitions about the self and PTSD severity in males. Tolin and Foa (2002) have hypothesized that disparate results concerning sex-differences in NPCs may result from variability in trauma type (e.g., sexual assault occurring more frequently among women and people assigned female sex at birth; Briere et al., 2003) and PTSD symptom severity (Blais et al., 2022; Bryan et al., 2015). Supporting this assertion, in a mixed sex-sample Sexton and colleagues (2018) found that veterans who endorsed military sexual trauma also endorsed significantly higher NPCs than those who endorsed other trauma types. The relationship between NPCs and SI in veterans within and across sex groups remains understudied yet may be essential to inform the development of lifesaving treatments and risk management strategies. Based on current findings, conclusions concerning the relationship between sex and NPCs are difficult to form, particularly among veterans. To date, no published studies have deliberately examined the relationship between NPCs and SI across sex.

The purpose of this study was to investigate sex differences in the relationship between NPCs and SI, as well as possible differences resulting from trauma-type exposure, among veterans seeking trauma-focused care. Of note, Sexton and colleagues (2018) reported a four-factor model of NPCs, incorporating a separate factor composed of beliefs related to the ability to cope with stress, which provided the best fit for veter-

ans endorsing military sexual or combat traumas. We elected to utilize that model in this study to facilitate examination of the relationship between suicide and ability to cope for the first time. As such, NPCs were considered within a four-factor model throughout this work; NPCs were separated into those concerning distorted sense of self (SELF), perception of blame (BLAME), capacity to cope (COPE), and one's sense of comfort and generalizations about the world (WORLD).

First, consulting theory and review of previous findings, we hypothesized that NPCs related to SELF and COPE would evidence the strongest relationships with SI across sexes. Second, we hypothesized despite mixed findings in the literature (a) that female veterans would report higher NPCs, and (b) that SELF and COPE NPCs specifically would be more robustly associated with SI in female than male veterans, even when all other NPCs, PTSD symptom severity, and trauma type (MST vs. combat) were controlled for.

Table 1. Demographic and Clinical Characteristics of the Sample: Logistic Regression Results

N	**Male 864**	**Female 82**	**Test of difference**	***p***
	Mean (SD) or n (%)	Mean (SD) or n (%)		
Age	**46.67 (16.08)**	**36.81 (10.93)**	**5.43**	**0.00**
Trauma Type (combat)	821 (95.00%)	34 (41.42%)	-	-
Suicidal Ideation (present)	317 (36.70%)	30 (36.58%)	-	-
Yrs of Education (>12th grade)	722 (83.60%)	70 (85.36%)	-	-
Marital status (married)	470 (54.40%)	23 (28.00%)	-	-
PCL total score	**61.09 (12.56)**	**65.12 (13.42)**	**2.76**	**0.01**
PTSD dx	587 (67.93%)	57 (69.51%)	-	-
PTCI (SELF)	3.56 (1.41)	3.84 (1.57)	3.01	0.83
PTCI (WORLD)	**5.09 (1.32)**	**5.47 (1.79)**	**7.02**	**0.01**
PTCI (BLAME)	**2.72 (1.42)**	**3.27 (1.79)**	**11.51**	**0.00**
PTCI (COPE)	3.52 (1.65)	3.42 (1.76)	0.31	0.59

Regression: SI (males) Predictor Variable	B	SE	p	Adjusted OR
PTCI (SELF)	**1.45**	**0.53**	**0.01**	**4.28**
PTCI (BLAME)	0.35	0.26	0.18	1.42
PTCI (WORLD)	0.20	0.16	0.23	1.22
PTCI (COPE)	**0.30**	**0.13**	**0.02**	1.34
Trauma type (combat)	-0.15	0.36	0.68	0.86
PCL total	-0.04	0.03	0.18	0.96

Regression: SI (females) Predictor Variable	B	SE	p	Adjusted OR
PTCI (SELF)	-1.10	1.57	0.48	0.33
PTCI (BLAME)	-1.01	0.81	0.21	0.37
PTCI (WORLD)	-0.64	0.47	0.17	0.53
PTCI (COPE)	-0.26	0.33	0.42	0.77
Trauma type (combat)	0.90	0.57	0.26	2.46
PCL total	0.10	0.09	0.11	1.11

Notes. PTSD = Posttraumatic stress disorder; dx = diagnosis; PTCI = Posttraumatic Cognitions Inventory; PCL = PTSD Checklist, PTCI SELF = PTCI Negative thoughts about the self subscale; PTCI BLAME = PTCI self-blame subscale, PTCI WORLD = PTCI negative cognitions about the world subscale. Bolded text within tables indicates significance (p-values provided in table as well). All results have been rounded within two decimal places for consistency.

Methods

Participants and Procedure

Participants were 946 veterans presenting for trauma-focused treatment at a Midwestern VHA (see Table 1 for demographics). veterans completed self-report questionnaires (including the PTCI, PCL-C, BDI-II, demographics, and report on history of trauma exposure) as part of the intake and treatment planning process. Diagnostic criterion for PTSD was assessed and confirmed for all participants using the CAPS and MINI structured clinical interviews. The PCL-C was then used to relate symptomatology to an index event. Sex was established by self-report of sex assigned at birth (n = 864 male, n = 82 female). In addition to PTSD (67.93% of male veteran subsample, 69.51% of female subsample), a majority of participants in both groups met criteria for one or more mood (55.34% male, 63.40% female), other anxiety (19.8% male, 21.95% female), or substance use disorder (24.30% male, 14.63% female). Just over one-third of veterans of each sex group separately (36%) endorsed current SI with undetermined suicide intent. veterans came from a variety of service eras including Vietnam, most commonly (42.05%), or Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) (43.75%) for male veterans and OEF/OIF (48.8%) for female veterans. Participants were predominantly Caucasian (84.70% male, 67.45% female). The VA Ann Arbor Healthcare System's Human Subject Committee approved this research protocol.

Measures

The Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999) was used to examine veteran NPCs. The PTCI, a 36-item self-report measure, was divided into four subscales based on Sexton and colleagues (2018) factor analytic study conducted in a related sample. Subscales were examined separately: Negative Cognitions About the Self (SELF, 18 items), Negative Cognitions About the World (WORLD, 8 items), Self-Blame (BLAME, 5 items), and Negative Beliefs about Coping Competence (COPE, 3 items). The PTCI has demonstrated adequate psychometric properties in past studies (Sexton et al.).

In addition, measures of depressive and PTSD symptom severity were administered; participants completed the PTSD Checklist-Civilian version (PCL-C; Weathers et al., 1993), a DSM-IV-TR correspondent measure of past-month PTSD symptom severity, and the Beck Depression Inventory-II (BDI-II), a widely used measure of depressive symptom severity (Beck et al., 1996). Only BDI-II item nine, which refers to the presence of "suicidal thoughts or wishes," was used in analyses to confirm the presence of SI. Specifically, BDI-II item nine was used to group veterans into those who reported current SI (i.e., responded with a "1" or higher) and those who did not (i.e., those who responded "0" to item nine).

Data Analysis

Data analyses proceeded in three steps. First, independent samples t-tests and chi-square tests were conducted to compare male and female veterans with respect to age, PTSD symptom severity (PCL total), and PTCI subscale scores. Second, to evaluate our first hypothesis, bivariate correlations were calculated in each group to examine patterns in reported NPC, SI, trauma type, and other variables of interest (see Table 2). To evaluate hypothesis 2a, Fisher's z-tests were used to examine differences in the magnitude of relationships across male and female veteran groups. Finally, to evaluate hypothesis 2b, two logistic regressions, one for each sex, were conducted to evaluate NPC subscale scores as predictors of SI. Trauma type (military sexual vs. combat

trauma) and PTSD symptom severity were entered as a covariates in both equations. A priori power analyses confirmed the sample size in both groups was adequate (provided at least 80% statistical power) to detect small to moderate effect sizes ($d = .45$) at a conventional significance level of 0.05 (Faul et al., 2007).

Results

Sample Characteristics

Table 1 shows demographic and clinical characteristics of the sample. Independent sample *t*-tests indicated male veterans were, on average, significantly older than female veterans ($p < .001$), while female veterans reported significantly more severe symptoms of PTSD ($p = .01$). Despite the difference, mean PTSD symptom ratings in both groups were suggestive of clinically significant symptoms of PTSD based on comparison to other veteran samples (Yeager et al., 2007) (Males $M = 61.09 \pm 12.56$; Females $M = 65.12 \pm 13.42$). Female veterans reported significantly higher PTCI BLAME ($t = 11.51$, $p = .001$) and WORLD subscales than males ($t = 7.02$, $p = .008$). PTCI SELF and COPE subscale scores did not differ significantly across sex. Of further interest, veterans both

Table 2. Bivariate Correlations Between NPC, SI, Trauma Type, and Other Variables of Interest

Both Sexes	1	2	3	4	5	6	7	8
1. Sex	1							
2. SI	.00	1						
3. PTCI Total	.07*	.45**	1					
4. PTCI SELF	.06	.46**	.96**	1				
5. PTCI BLAME	.08**	.29**	.79**	.66**	1			
6. PTCI WORLD	.10**	.26**..	.67**	.57**	.39**	1		
7. PTCI COPE	-.02	38**	.77**	.71**	.54**	.42**	1	
8. Trauma Type	-.52*	-.04	-.15*	-.12**	-.14**	-.18**	-.05	1
9. PCL Total	.10*	.27*	.58**	.57**	.45**	.28**	.42**	-.135**

Males (N = 864)	1	2	3	4	5	6	7
1. SI	1						
2. PTCI Total	.46**	1					
3. PTCI SELF	.48**	.96**	1				
4. PTCI BLAME	.30**	.79**	.66**	1			
5. PTCI WORLD	.27**	.67**	.58**	.38**	1		
6. PTCI COPE	.38**	.77**	.71**	.54**	.44**	1	
7. Trauma Type	-.02	-.14**	-.11**	-.11**	-.11**	-.07*	1
8. PCL Total	.27**	.57**	.55**	.44**	.28**	.40**	-.10*

Females (N = 82)	1	2	3	4	5	6	7
1. SI	1						
2. PTCI Total	.30**	1					
3. PTCI SELF	.36**	.96**	1				
4. PTCI BLAME	.20	.79**	.68**	1			
5. PTCI WORLD	.18	.66**	.53**	.42**	1		
6. PTCI COPE	.27**	.75**	.73**	.59**	.36**	1	
7. Trauma Type	-.19	-.15	-.13	-.21*	-.31**	-.07	1
8. PCL Total	.28*	.70**	.75**	.48**	.21	.55**	-.15

Notes. PTCI = Posttraumatic Cognitions Inventory; PTSD = Posttraumatic stress disorder; PCL = PTSD Checklist, PTCI SELF = PTCI Negative thoughts about the self subscale; PTCI BLAME = PTCI self-blame subscale, PTCI WORLD = PTCI negative cognitions about the world subscale; PTCI COPE = Negative cognitions about coping competence. For all analyses, ‘Sex’ was coded male = 1, female = 2, “Trauma Type” was coded military sexual trauma (MST) = 1, combat trauma = 2. *$p < .05$, ** $p < .001$. All results have been rounded within two decimal places for consistency.

within and across sexes with MST reported significantly higher scores on all four PTCI subscales (all *p*'s < .001). Female veterans were proportionally more likely seek treatment for MST compared to their male veteran cohort (5% of males, 58% females), but no difference was observed in the number of veterans reporting SI with MST vs. combat trauma in either sex.

Bivariate Relationships With Sex

Consistent with hypotheses, SELF scores were positively correlated with SI (r = .46), and PTSD symptom severity (r = .57) in the combined sample and in both male and female veterans separately (*r*'s .75–.46; See Table 2). PTCI total score and all other subscale scores (WORLD, BLAME, and COPE) were significantly correlated with SI and PTSD symptom severity in both the combined sample (*r*'s =.26–.57) and in male veterans only (*r*'s =.27–.55). In female veterans, only PTCI total (r = .28) , SELF (r = .36) and COPE (r = .27) were significantly correlated with SI. PTCI total score and all subscale scores except WORLD were significantly correlated with PTSD symptom severity among female veterans (*r*'s = .47–.75). Interestingly, trauma type was significantly associated with WORLD, SELF, and BLAME subscales in the full sample, as well as SI (r = –.524). Specifically, veterans with MST (coded as 1, combat coded as 2) reported more negative self-BLAME and fewer SELF and WORLD NPCs, and they were more likely to report SI. For male veterans, all NPC subscales were higher for MST than combat while, for female veterans, MST was associated with more elevated NPCs of the WORLD and self-BLAME. SI was not significantly associated with trauma type in male or female veterans alone. Small to moderate negative correlations between trauma type and PTCI total, SELF, and COPE subscale scores were observed in the combined sample and among male veterans only, suggesting male veterans with MST reported slightly higher SELF and COPE on average relative to male veterans reporting exposure to combat trauma.

Fisher's z tests were performed to evaluate differences in the magnitude of observed relationships between NPCs and SI in female vs. male veterans. The strength of observed relationships did not differ across sex groups for SELF (z = 1.218, p = .112), COPE (z = 1.069, p = .142), or PTCI total score (z = 1.61, p = .054), though a nonsignificant trend toward a more robust relationship in males for PTCI total was observed.

Sex, NPCs, and SI

Table 1 also presents results from two logistic regression models (conducted separately in male and female veterans). In both models, each of the four PTCI subscales were entered as predictors in addition to trauma type (MST vs. combat), and PTSD symptom severity (PCL total score). In male veterans, Nagelkerke's R^2 suggested that the regression model accounted for 31.60% of the variability in SI. Both SELF (Wald =7.67, p =.006) and COPE (Wald = 5.57, p = .018) were significant. More specifically, adjusted odds ratios suggested that male veterans were 328.8% more likely to report SI for every point increase in SELF subscale score (OR = 4.28), and 34.3% more likely to report SI for every point increase in COPE. Among female veterans, however, the omnibus test of model coefficients was not significant. None of the variables included significantly predicted reported SI among female veterans in this model. Of note, to further explore the relationship between NPCs and SI in female veterans, an exploratory logistic regression model run post-hoc with only the four NPC subscales included as predictors (removing trauma type and PTSD symptom severity). As in the original model, the omnibus test of model coefficients was not significant (p = .055).

Discussion

In line with a priori hypotheses, results reflected a robust connection between SELF NPCs and SI in veterans of both sexes. Contrary to hypotheses, however, relationships between SI and NPCs did not differ in magnitude by sex. Further contrary to hypotheses, male veterans scores on both the SELF and COPE subscales of the PTCI predicted SI with trauma type, PTSD symptom severity, and all other NPC subscales in the model; no significant predictive relationships were observed in the female model. In the male veteran group, odds ratios for both subscales were large (SELF) to moderate (COPE), suggesting that the observed relationships between SELF, COPE, and SI in male veterans were clinically meaningful.

Notably, observed relationships between SELF and SI are not only consistent with previous findings (Shahar et al., 2013), but also with empirically grounded theory related to both PTSD and SI. Both Social Cognitive Theory (Benight & Bandura, 2004) and Emotional Processing Theory (Rauch & Foa, 2006) as applied to PTSD suggest that a sense of personal inability to handle negative affect leads to the increased symptoms of PTSD posttrauma and maintenance of symptoms over time. Similarly, the Interpersonal-Psychological Theory of Suicide (Joiner, 2007) suggests that SI develops in part because of feeling one does not belong, or that one is a burden to others (Van Orden et al., 2010)—constructs that in themselves arguably represent SELF NPCs and perhaps also COPE, the other subscale observed to be related to SI. Results of this study highlight the potential benefit of attending to specific trauma-related cognitions, particularly those concerning SELF and COPE in male veterans specifically, in efforts to facilitate identification and recovery from PTSD and SI. Further research is warranted to ascertain whether addressing NPCs in male veterans may facilitate a richer understanding of veteran safety risks. Results further support the growing body of literature that recommends evidence-based treatments for PTSD as the first-line intervention for individuals experiencing PTSD and low- to moderate-risk suicidality (i.e., SI without suicide plan or intent or recent suicide attempts) as opposed to engaging in treatments specifically targeting suicidality prior to engaging in trauma-focused treatment (Bryan, 2016). However, mixed results with respect to the relationship between NPCs and sex must be noted. Additional work should be undertaken to identify potential sample-specific characteristics contributing to the observed variability in findings, and therefore of potential relevance to NPC directed treatment.

Findings suggest that NPCs, specifically those specific to SELF and COPE among male veterans, may play a role in the development and maintenance of SI following trauma exposure. If NPCs do maintain SI in male veterans, but not in female veterans, treatments designed for these respective populations should selectively consider the benefit of integrating targeted strategies designed to ameliorate NPCs, though trauma-focused treatment should not be the first-line intervention for individuals who are of high risk of committing suicide. However, additional research is needed to better determine a causal relationship between NPCs and SI among male veterans, and to verify the lack of such a relationship in the high-risk female veteran population.

As noted, despite observed associations between NPCs and SI for male veterans, significant relationships did not emerge for women veterans once potential confounds were controlled. Further research to elucidate potential predictors of female veteran SI, such as repeated or early developmental trauma exposure, sexually assaultive trauma, levels of social support, or current stressors is warranted to replicate and contextualize these findings. Relatedly, some studies including women veterans who died by suicide have identified some associated comorbidities such as substance use, broadly, and

opioid misuse, specifically, that may warrant investigation in relation to SI (Bohnert et al., 2017; Chapmen & Wu, 2014; Ilgen et al., 2010).

Limitations

Several study limitations warrant mention. First, the use of cross-sectional, self-report data precludes discussion of causal relationships between variables and introduces additional potential bias (e.g., demand characteristics affecting reporting; Bowen & Wiersema, 1999). Second, the sample was drawn from a single Midwestern VHA catchment area and included only veterans seeking treatment for PTSD, potentially limiting generalizability, as perceived stigma and feelings of shame often coincide with underreporting trauma symptomatology and treatment resistance (Andresen & Blais, 2019). Third, the sample of male veterans greatly outnumbered that of female veterans (864 vs. 82). Given the substantially larger sample size, the possibility that the greater number of significant findings in the male veteran group was attributable to the disparity in sample sizes (i.e., the male veteran group was a more representative sample) warrants mention. Further, the larger sample of male veterans may likely constitute a more representative sample of that population than the smaller female veteran group. These findings should therefore be interpreted with caution, pending replication. Historically, women were not granted equal privileges in active-duty service. Over time, the opportunity for male and female veterans to serve in similar, combat-oriented roles may influence future findings on exposure to traumatic incidences and development of subsequent psychological symptomatology. Fourth, significant differences between male and female veterans (including age, PTSD symptom severity, and trauma type) were detected. It is possible that some sample-specific differences might have affected results. In general, trauma-exposed women, particularly female veterans, report higher PTSD symptom severity and higher rates of interpersonal trauma (Portnoy et al., 2020; Street et al., 2009) than their male veteran peers, consistent with findings in the present sample.

Last, this study was not able to capture or incorporate findings on veterans who identify as transgender or gender diverse. Although transgender and gender-nonconforming veterans are thought to die by suicide at twice the rate of cisgender peers, currently no extant studies have reported on the impact of NPCs, PTSD symptom severity, and SI in this population relative to cisgender veterans (Tucker, 2019). Replication of these findings is warranted in more diverse, longitudinal samples to (a) facilitate evaluation of the effect of these limitations on findings and extension to identify and (b) test causal relationships between key study variables.

Conclusions

The present study provides evidence for the significance of NPCs, and specifically SELF subtype NPCs, as indicators of SI among veterans, and male veterans specifically. Here, as in previous studies (Daie-Gabai et al., 2011; Kooistra et al., 2023), all forms of NPC were associated with PTSD symptom severity in both sexes, underscoring the importance of NPCs in both treatment and risk assessment. Crucially, however, the relationship between SELF and SI stood out as being both the largest among PTCI subscales across sexes and is consistent with prior PTSD treatment research (McLean et al., 2015; Zalta et al., 2014). Further, among male veterans both SELF and COPE predicted SI, even with important covariates (e.g. trauma type, PTSD symptom severity) taken into consideration.

While longitudinal research is needed to confirm the potential value of NPCs in pre-

dicting risk for the development of suicide behavior, the value of prioritizing SELF NPCs as a treatment target in veterans is apparent. A more detailed examination of the nature and extent of reported SELF and COPE NPCs in trauma-exposed male veterans especially may have the potential to inform risk assessment and the development of suicide prevention and intervention efforts. Such examination may also facilitate exploration of the relationship between trauma and suicide risk, which, at present, is not well understood (Panagioti et al., 2009).

Understanding and preventing suicide in the military, which has risen to the second leading cause of death (Ritchie, 2003), must be prioritized. In addition to facilitating PTSD symptom reduction, monitoring and modification of NPCs, particularly SELF and COPE, may warrant consideration as a strategy for prevention or mitigation of suicide risk. Notably, based on these findings, the efficacy of such an intervention strategy may differ as a function of sex; consideration of sex-differences may be key to the successful development of targeted, effective suicide-prevention and risk reduction strategies across populations.

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Introducing ABCT's New Executive Director

Dr. Courtney L. White, Ph.D., M.L.S., C.A.E., is the incoming Executive Director of the Association for Behavioral and Cognitive Therapies. Dr. White is a longtime association executive who has had a 20-year career in nonprofit leadership and administration. Dr. White holds the Certified Association Executive (CAE) credential from the American Society of Association Executives. He holds a bachelor's degree in English and Communications from Monmouth University, a master's degree in Library and Information Science from Rutgers University, and a Ph.D. in Instructional Management and Leadership from Robert Morris University.

In his research, Dr. White focuses on social justice inequities found at the intersection of race and immigration in higher education. Additionally, he has spent a significant part of his career in association management leading continuing education initiatives via an equity-focused lens.

Dr. White most recently served as Executive Director for the Society of Cardiovascular Anesthesiologists and previously served as Managing Director for the American Thoracic Society where he served for over 15 years. In both roles he worked closely with the Board of Directors to carry out the strategic initiatives of the organization while maintaining fiscal responsibility. Dr. Courtney will begin his tenure at ABCT on June 10. ■

Progress Report: The Inter-Organizational Scientific Task Force on the Harms Associated With Sexual Orientation and Gender Identity and Expression Change Efforts (SOGIECE)

The Association for Behavioral and Cognitive Therapies (ABCT), the American Psychological Association (APA), and the APA Division 12 Society for a Science of Clinical Psychology (SSCP) joined together to establish a task force that would publish a systematic review on the psychosocial harms associated with sexual orientation and gender identity and expression change efforts (SOGIECE)—so-called "conversion therapies." The three organizations sought nominations from practitioners and researchers and appointed members from each organization in December 2022. The task force convened for the first time in January 2023.

Since then, we have expanded the task force and built an international team of researchers with diverse language capabilities who have significant experience in conducting research on sexual and gender minority health, as well as experience conducting systematic reviews and meta-analyses. The task force also consists of members who have considerable clinical experience working with sexual and gender minority people. Members themselves are diverse with respect to sexual orientation and gender expression. The task force members are:

Eugene Botanov, Ph.D., University of Maryland, College Park
Joanne Davila, Ph.D., Stony Brook University
Darren Freeman-Coppadge, Ph.D., Private Practitioner
Trevor Hart, Ph.D., Toronto Metropolitan University
Briana Last, Ph.D., Stony Brook University
John Pachankis, Ph.D., Yale University
David Pantalone, Ph.D., University of Massachusetts Boston
Fernanda Paveltchuk, Ph.D., Universidade Federal do Rio de Janeiro
Matthew Skinta, Ph.D., Roosevelt University

Consultants:
Laurel Scheinfeld, Medical science librarian at Stony Brook University
Richard Bränström, Meta-analysis expert from the Karolinska Institutet in Sweden

Graduate Research Assistants at Stony Brook University:
Benjamin Eisenstadt
Stephan Brandt

The task force has also benefited from significant research assistance from the following people: Elizabeth Aubin (Stony Brook University), Zakary Barron (Roosevelt University), Iris Chiou (Stony Brook University), Madeline Kiefer (Stony Brook University) and Michelle Mariaprabhu (Toronto Metropolitan University).

The task force has received generous funding and administrative support from ABCT to support some of the task force's efforts and has received in-kind support commitments from APA and SSCP.

The task force has made significant progress on the review:

- We have held 30+ hour-long meetings since January 2023.
- We have completed title-and-abstract screening of 6,371 articles for the database search.
- We are currently full-text screening 891 articles, of which 536 have been screened.

At our current screening rate, we expect to begin data extraction in July 2024 and to conduct our analyses in the Fall of 2024. As such, we anticipate that we will be ready to submit a manuscript detailing our findings in late 2024 or early 2025.

Given the urgency of this research for the health and well-being of sexual and gender minority people, we are steadfast in completing our work in a timely manner while simultaneously ensuring a careful and thorough review of the literature. We want to reiterate our gratitude for ABCT's generosity in supporting our work. ■

Call for Applications FELLOWS

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, 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.

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/

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Translating Neuroscience Into CBT Practice

Current Opportunities and Future Directions

ABCT Virtual Summit | June 7, 2024

NYC Pride

ABCT will be participating in NYC's Pride March this year! We invite all interested members to register to march with us. If you are interested in attending, please register here: https://services.abct.org/i4a/forms/index.cfm?id=69. *All invitees are welcome; bring family and friends to come celebrate with us in community together.* ***Registration will remain open until June 20.*** *Confirmation will be sent with time and location of where to meet.*

If you're not in the NYC area but want to show up for Pride while representing ABCT, the International LGBTQ+ Travel Association has a calendar showing Pride events across North America and abroad; take photos and tag us on social media while you're there with #ABCTPride24, to show your support.

We will be marching on Sunday, June 30*. Expect high heat and sunny weather; bring a water bottle and sunscreen if you are attending. All attendees will also receive a complimentary mini Pride flag; feel free to bring your own as well. We look forward to seeing you at Pride this year.*

Sunday, June 30

The Dissemination, Implementation, and Community Engagement Committee (DICEC) Is Seeking New Members

DICEC is responsible for coordinating the issues and activities relevant to the dissemination and implementation component of the ABCT Mission and Strategic Intent. Responsibilities of the committee are broadly defined as promoting activities that (1) foster an inclusive environment for partners from diverse communities, industries, and professional backgrounds to collaborate in the service of ABCT's mission, and (2) foster members' collective expertise in dissemination and implementation, scaling, technology, global health, public health, or other topics relevant to the social impact of cognitive behavioral science. These activities include coordinating and executing ABCT's Champions Program to recognize community partners who further ABCT's mission. In addition to developing standalone initiatives or activities, this committee will necessarily interact in an advisory capacity with the Board of Directors, Special Interest Groups, and many of the committees responsible for ABCT functions, including awards and recognition, convention (e.g., program, local arrangements), continuing education, and membership.

This committee is an especially good fit for early career or full members of ABCT who are involved in research or practice focused on dissemination, implementation, and community engagement related to improving the quality of mental health care and the use of evidence based practices in real world settings. We strongly encourage applications from those members involved in activities that promote the accessibility of science to those outside academia as well as the equitable and meaningful inclusion of people from diverse and historically marginalized communities in scientific and practice contexts.

If you interested in serving, please send an email to Erum Nadeem (erum.nadeem@rutgers.edu) and Mary Jane Eimer (mjeimer@abct.org) with your CV and a sentence or two as to why you'd like to join this committee and why it is a good fit for you. ■