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ORIGINAL RESEARCH

Coaching Third Parties for Suicide Prevention

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Veterans are at significantly increased risk for suicide compared to the general population (Ramchand, 2022; Schafer et al., 2022). Over half of veterans who died by suicide were not connected to care (Ramchand, 2022; Schafer et al., 2022). There are numerous reasons why a veteran does not seek mental health treatment, including logistical barriers, stigma, and poor prior experiences with treatment (Pietrzak et al., 2009). In the absence of accessing traditional services directly, many may use other resources such as friends, family, and crisis call centers.

Crisis call centers have drastically expanded since the rollout of the National Suicide Prevention Lifeline in 2005, with some evidence that call centers can reduce distress (Gould et al., 2007) and suicide re-attempt rates (Ho et al., 2011). However, only 43.9% of suicidal callers to a crisis call center followed up with a referral to a mental health provider, the majority of whom called a previously established mental health provider, and less than 15% contacted a new mental health resource (Gould et al., 2012). Thus, many individuals who call a crisis line will not initiate recommended care, and people who ultimately die by suicide may be less likely to use a crisis line in the first place (Bidwell & Bidwell, 1971). Leveraging the social support network of at-risk individuals may offer opportunities to promote connection to care by reducing barriers. Between 25–29% of calls to crisis centers are made by third parties, typically family members who are worried about someone at risk for suicide (Britton et al., 2022; Gould et al., 2022). In evaluations of imminent crisis calls with third parties, up to 44% of third parties ultimately engage in some type of intervention/behavior toward suicide prevention in a loved one after a call, such as calling emergency response or involving another

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The authors report there are no competing interests to declare.

Ethics approval statement: This project (1748509-1, CIC Suicide prevention coaching quality improvement) was deemed to be a quality assurance project by the Corporal Michael J. Crescenz VA Medical Center.

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person to add support (Gould et al.). However, little is known about the optimal strategies to engage the support network when the suicidal concern is not imminent and their supports have the time and opportunity to proactively connect their loved one to care or take safety measures at home.

Some suicide prevention interventions might be well-suited to a task-shifting away from mental health providers and toward concerned members of the community (Kanzler et al., 2021). Such strategies could provide skills and communication coaching to individuals who are worried about a veteran and want to encourage them to seek mental health care (Sayers et al., 2021). However, navigating suicidal crises through a third party introduces unique challenges and opportunities that require additional attention.

The aim of this exploratory quality improvement project was to understand the opportunities, challenges, and needs of staff working in a national Veterans Affairs call center, Coaching Into Care, which supports third parties who are worried about the mental health of a veteran. We conducted a documentation review of calls that were identified as including some concern related to suicide risk. We coded documentation for the presence/absence of risk factors for veterans, suicide risk assessment, and suicide prevention interventions that were employed in the call center.

Methods and Materials

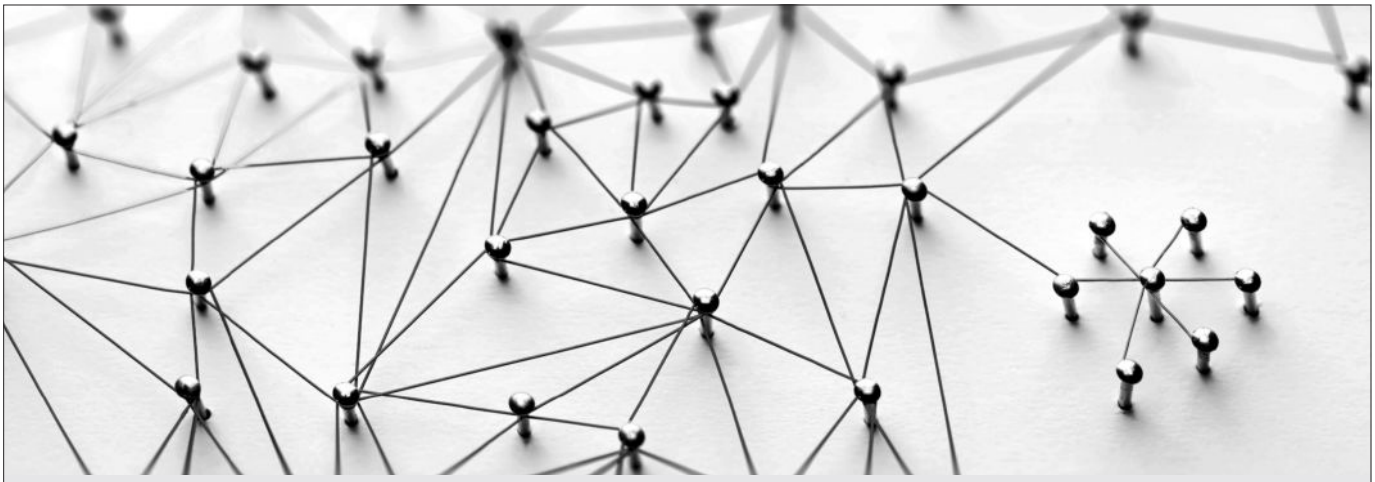
Study Sample

The Institutional Review Board at the Corporal Michael J. Crescenz VA Medical Center deemed that this quality improvement protocol (174850S9-1) did not constitute research activities. Of the 1,581 unique callers to Coaching Into Care in a 6-month window between July 1, 2021, and December 31, 2021, 225 callers (14.4%) focused on suicide risk in some manner. Responders to the call center receive initial calls and triage calls to coaches for clinical management after an initial assessment. Responders all have at least a bachelor's degree. Coaches provide coaching to callers and have either a master's or doctoral degree.

Responders and coaches document their calls while on the phone with the caller and immediately after. They follow a charting system that provides prompts for key features, such as resources that the callers were referred to as well as information about presenting concerns for the caller and contextual information relevant to the topic. Documentation was eligible for review if the caller concern was listed as "suicide risk immediate"; "suicide risk future"; or "emergent" (from a list of potential caller concerns); or the note had a keyword of "suicide" or "involuntary commitment." The cases identified only by "involuntary commitment" were reviewed and added if in the body of the narrative there was mention of past or present suicidal ideation/plan/attempt. All others were not included in these analyses. Data were extracted until May 13, 2022. All the staff members were trained to detect the features of high-risk calls (i.e., presence of immediate or emergent risk) that required a consultation with a licensed provider for unlicensed staff.

Measures

A team of four independent coders collaboratively identified the codebook. Upon generation of a first draft of the codebook, the team further developed it using an iterative method of independently reviewing cases, followed by consensus meetings and further refining of the codebook. This process started with one case example, then proceeded to three and then four case examples at each step of the process until the com-



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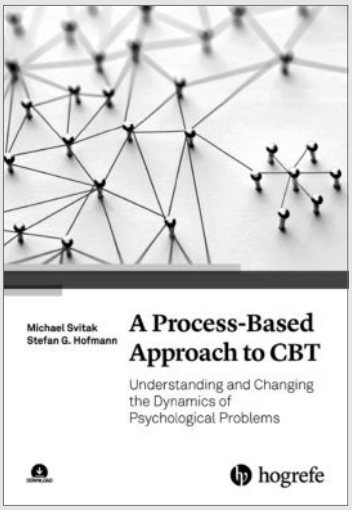

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A Process-Based Approach to CBT

Understanding and Changing the Dynamics of Psychological Problems

New

The process-based approach to cognitive-behavioral therapy (CBT) is a unique method for understanding psychological problems as complex networks of interacting processes. It allows therapists to grasp the individuality, complexity, and dynamics of psychological disorders – things that often get missed in diagnosis-oriented approaches. The authors, both experienced researchers and practitioners of this method, explore how understanding these complex networks enables therapists using CBT to focus on the core processes responsible for a person's suffering.

First, the reader is shown how emotional, cognitive, behavioral, and somatic processes interact in maintaining maladaptive states and how this approach identifies the points at which therapeutic interventions can be applied to achieve maximum leverage. This is followed by guidance on implementing the approach in practice, including addressing diagnostic issues, to create an individual process-based model network for selecting the right evidence-based interventions. The process-based approach forms a connecting foundation that combines classical CBT with third-wave approaches (acceptance commitment therapy, schema therapy) and integrates helpful recent developments in psychotherapy research, such as evolutionary theories. Practitioners will find the downloadable tools in the appendix invaluable for their clinical practice. This book is of interest to clinical psychologists, psychiatrists, psychotherapists, mental health practitioners, students, and trainees.

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pletion of the final codebook. Each coder was then assigned to code three cases on their own and three cases of their colleagues for calculation of inter-rater reliability. The reliability process was repeated until the team achieved adequate reliability (Kappa > .70). A total of 40 cases (17.5%) were double-coded (final Kappa = .72, 80.8% agreement).

Results

Demographics

Of the 225 callers, 30.2% identified as a parent and 28.9% as a romantic partner/spouse. Most callers (74.2%) were women. Many callers (47.6%) were referred from the Veterans Crisis Line, with some coming from other VA services/staff (4.9%), some from the internet (3.1%), and the remainer from unknown sources (15.1%), other unspecified sources (6.7%), or the engagement tactic was not documented (22.7%). Callers identified that the veteran they were concerned about served in the Army (18.7%), Marines (10.7%), Navy (6.7%), Air Force (5.8%), Army National Guard (0.9%), Air National Guard (0.4%), and Coast Guard (0.4%; not documented 56.4%). The veterans were identified as having served in OEF/OIF/OND (37.8%), Vietnam (4.4%), Gulf War (2.2%), Pre-Vietnam (1.3%), Post-Vietnam (0.4%), Post-Gulf War (0.4%; not documented 53.3%). Many callers lived in the same household (24.7%) city (16.1%), or state (6.3%) as the veteran.

The callers noted a number of psychosocial stressors for Veterans, including issues with finances or unemployment (n = 61, 27.1%, not documented n = 134, 59.6%), issues with housing (n = 42, 18.7%; not documented n = 146, 64.9%), issues with justice involvement (n = 35, 15.6%; not documented n = 156, 69.7%), issues with environment (n = 17, 7.6%, not documented n = 169, 75.7%), issues with social connection (n = 68, 30.4%; not documented n = 111, 49.5%), and issues with education (n = 4, 1.8%, not documented n = 180, 80.3%).

Symptoms

We coded for up to 5 psychiatric symptoms in the veteran as reported by the caller and documented in the contact notes. The most commonly noted veteran symptoms about which the caller was concerned included mood/anxiety/depression symptoms (n = 105, 46.7% of all callers), substance use (n = 100, 44.4%); PTSD/trauma (n = 82, 36.4%), anger (n = 61, 27.1%), isolation (n = 29, 12.9%), psychosis/delusions/hallucinations (n = 27, 12.0%), sleep difficulties (n = 21, 9.3%), and other (n = 24, 10.7%).

Treatment

Sixty-six (29.3%) callers reported that the veteran was currently in VA mental health treatment, 15.1% were previously in VA mental health treatment, and 24.4% were not currently/previously in VA mental health treatment (9.8%, unsure; 21.3%, not documented). In terms of community mental health treatment, 11.1% callers reported that the veteran was currently in community mental health treatment, 3.6% had been in the past, and 30.2% were not in community treatment (8.9%, unsure; 46.2% not documented). In terms of inpatient treatment, 12.4% were currently hospitalized, 20.0% had been in the past, and 3.1% had never been hospitalized (3.1%, unsure; 61.3%, not documented).

Suicide Ideation and Behavior

Most callers (62.7%) reported that the veteran had expressed current suicidal

ideation, and 18.7% reported that the veteran expressed suicidal ideation in the past (14.2% unsure; 4.4% not documented). Suicide plans were current in 29.3% of the total sample (43% of those who reported suicidal ideation) and had been documented as occurring the past in 1.3% (12% unsure; 46.2% not documented). Current suicide intent was documented in 24.9% (39% of those who reported suicidal ideation), past suicide intent 8.4%, no suicide intent in 8.4% (16.4% unsure; 41.8% not documented). In terms of suicide attempts, 18.7% documented 1 prior suicide attempt, 5.3% had more than 1 suicide attempt, 6.2% had no prior suicide attempts (3.1% unsure; 66.7% not documented).

Callers noted current access to lethal means in 35.6% of cases (11.1% denied; 5.3% unsure; 48.0% not documented). The most common lethal means documented was firearms (19.1%), multiple disclosed (8.0%), and drug/poison ingestion (3.1%; not documented 56.9%). One case noted that a veteran died by suicide after coaching had been initiated (0.4%) and one died by other means (0.4%).

Interventions

Callers were contacted over an average of 4.68 weeks (median =2.43) and had an average call length of 20.61 minutes (median = 17.25). The total interactions with callers ranged from 1 – 15 (mean = 2.7, SD = 1.9), which is more than calls not characterized by suicide risk (mean = 2.2, SD = 2.1, $t[1,578] = -3.14$, $p < .01$). Most callers were coded as open to intervention (83.4%; 5.8% not at all open to intervention; 5.3% unsure; 5.8% not documented). There was documentation that the coach/responder had conducted communication skill training in 39.6%, lethal means safety in 12.9%; safety planning in 10.7%, and psychoeducation in 53.3%. Additionally, 72.4% were provided with educational resources about the Veterans Crisis Line, 911, emergency rooms and/or a suicide prevention coordinator.

Of callers who noted that the veteran was not engaged in VA or community mental health care at the beginning of coaching (n = 141), 10.6% had engaged in care by the end of coaching and another 5.7% had care scheduled but not yet attended, whereas 36.9% had not engaged in care, 5.7% callers were unsure, and 41.1% were not documented. When this analysis was restricted to include only those callers who actually completed a coaching or follow-up call (i.e., any communication after the initial call; n = 86 of those not in care at the beginning of coaching who completed any coaching/follow-up calls), 16.3% reported that the veteran had engaged in care by the end of coaching and another 9.3% had care scheduled but not yet attended, whereas 36.1% had not connected to care, 7.0% were unsure and 31.4% were not documented.

Discussion

In this quality improvement project, callers to a noncrisis national call center reported significant concerns about suicide risk in veterans in at least 14% of calls. Most callers were women who were either romantic partners or parents of veterans. Veterans had access to lethal means in over one-third of cases and had explicit suicidal plans in nearly one third of cases, which is likely an underestimate given that this was frequently not documented. The clinical documentation revealed a need to standardize assessment of suicide risk and lethal means safety through a concerned caller. The documentation indicated that staff regularly assessed and documented suicidal ideation, but less frequently other suicide risk factors (i.e., lethal means safety, suicide plans). The documentation review revealed several opportunities and barriers to supporting callers who are concerned about veterans at risk for suicide and improving their

training. More standardized training to make sure all coaches have similar skills might benefit callers and staff.

Callers reported a wide range of risk factors, including current and past suicidal ideation and attempts, access to lethal means, and lack of connection to mental health care. Only 29% of callers indicated that their veteran was connected to VA mental healthcare and another 8% only using community mental healthcare, leaving a full 63% of veterans without any known treatment engagement. High rates of treatment disconnection suggest the need to consider a task-shifting approach (Kanzler et al., 2021) for lethal means safety and suicide prevention services for concerned third parties (discussed below). Most callers identified as women who, on average, report less confidence in their firearm storage knowledge than men (Logan & Lynch, 2021); there is potential to work directly with callers to increase their firearm storage knowledge and confidence. More research is needed on the most effective and ethical strategies to engage third parties in suicide prevention and lethal means safety interventions, especially for veteran families. In our sample, 15–20% of veterans were newly connected to care through coaching. These statistics are comparable to statistics for when veterans call a crisis line on their own (15%; Gould et al., 2022) but are noteworthy in that care connection was achieved without contact with the veteran. The only comparable effort to engage third-party callers to a community crisis line found that among this group, 37% fewer of their loved ones engaged in formal mental health services in a posttreatment follow-up (Mishara et al., 2005).

Our results demonstrated a gap in service availability when a veteran was not in an imminent crisis. Even well-trained clinicians experience low self-efficacy with supporting patients who are suicidal (Quinnett, 2019; Sethi & Shipra, 2006). The documentation review revealed opportunities to train callers in understanding risk factors for suicide, "myth-busting," communication skills, and skills to navigate emotional reactions to the topic, all direction for future intervention research.

In addition, the documentation review revealed that working with a third-party caller raises unique challenges. Crisis lines regularly receive third-party callers, constituting up to 25–29% of calls (Ammerman et al., 2022; Britton et al., 2022; Gould et al., 2022). However, there is very little research to guide how best to engage these third parties and ensure that interventions are safe and efficacious. When a veteran was not connected to care, there may be a benefit to teaching callers about suicide risk assessment, lethal means safety, and other strategies typically implemented in a mental health clinic. Task-shifting efforts, referred to as gatekeeper training, teach lay individuals to assess suicide risk and refer individuals to treatment with mixed evidence (Holmes et al., 2021). Coaching third-parties may provide an opportunity to improve the effectiveness of gatekeeper training by providing individualized support through role-plays, audit and feedback, modeling, and other implementation strategies (Chauhan et al., 2017).

Our findings are consistent with prior reports from other crisis call centers wherein only half of helpers assessed suicidal ideation (Mishara et al., 2007). The mission of the Coaching Into Care call center at the time of this QA study was promoting connection to care. Despite this, our findings demonstrated that staff on this noncrisis line regularly (not consistently) assess suicide risk and are requesting support in this endeavor. In part due to these observations, the Coaching Into Care call center focuses more narrowly on coaching family members supporting a veteran with recent suicidal ideation and/or behaviors.

These findings have implications for all mental health professionals that receive

calls from concerned family members. Family members and concerned friends are often eager to know how to support their loved one in getting connected to care. In a call center for promoting connection to care, there are opportunities for additional training in teaching callers to recognize risk/resilience factors, brief interventions such as the Safety Planning Intervention (Stanley & Brown, 2012), lethal means safety, and navigating complex caller emotions. Future research is needed to evaluate optimal strategies for task-shifting these skills toward the support network. We need to evaluate the extent to which (a) it is feasible, acceptable, appropriate, efficacious and safe to train callers in these skills; and (b) these skills can be implemented while preserving the relationship between the veteran and the caller.

There are several limitations to this quality improvement project that require consideration. Findings are not intended to generalize to other settings. Nevertheless, many of the lessons learned from this project have implications for front-line staff who receive inquiries to connect third parties into care. In addition, review of documentation is unable to inform interventions that were delivered to the callers but not included in the notes. The absence of documentation does not necessarily imply the absence of an assessment or intervention, though the staff were trained to thoroughly complete documentation. Future research should conduct fidelity monitoring on coaching calls with third parties to provide objective information about interventions provided.

Conclusions

Our quality improvement project demonstrates that staff at a noncrisis call center regularly, but not consistently, assess for suicidal ideation in veterans through the caller, a third party. The documentation review revealed that staff may benefit from additional training in suicide risk assessment, brief suicide prevention interventions, and lethal means safety to optimally facilitate coaching. In particular, there appears to be a mismatch between the frequency with which lethal means are identified as present in the home and the implementation of lethal means safety conversations—this gap suggests room for the development of an intervention to support responders in coaching callers in conversations and actions around lethal mean safety. Future research should explore strategies to safely and effectively promote task-shifting of suicide risk assessment and prevention interventions toward callers who are worried about a veteran.

REFERENCES

Ammerman, B. A., Carter, S. P., Walker, K., Gebhardt, H. M., Rojas, S. M., Duman, C., Reger, G. M., & Reger, M. A. (2022). Characterizing Veterans Crisis Line callers and regional follow-up efforts. *Military Psychology, 34*(3), 288–295. https://doi.org/10.1080/08995605.2021.1963631

Bidwell, R. E., & Bidwell, J. J. (1971). Suicide Prevention: A study of the community program in Kansas City. *The Journal of the Kansas Medical Society*, 167–173.

Britton, P. C., Karras, E., Stecker, T., Klein, J., Crasta, D., Brenner, L. A., & Pigeon, W. R. (2022). Veterans Crisis Line Call Outcomes: Distress, Suicidal Ideation, and Suicidal Urgency. *American Journal of Preventive Medicine, 62*(5), 745–751. https://doi.org/10.1016/j.amepre.2021.11.013

Chauhan, B. F., Jeyaraman, M., Mann, A. S., Lys, J., Skidmore, B., Sibley, K. M., Abou-Setta, A., & Zarychanksi, R. (2017). Behavior change interventions and policies influencing primary healthcare professionals' practice—An overview of reviews. *Implementation Science, 12*(1), 3. https://doi.org/10.1186/s13012-016-0538-8

Gould, M. S., Kalafat, J., Harrismunfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior, 37*(3), 338–352. https://doi.org/10.1521/suli.2007.37.3.338

Gould, M. S., Lake, A. M., Kleinman, M., Galfalvy, H., & McKeon, R. (2022). Third-party callers to the national suicide prevention lifeline: Seeking assistance on behalf of people at imminent risk of suicide. *Suicide and Life-Threatening Behavior, 52*(1), 37–48. https://doi.org/10.1111/sltb.12769

Gould, M. S., Munfakh, J. L. H., Kleinman, M., & Lake, A. M. (2012). National suicide prevention lifeline: Enhancing mental health care for suicidal individuals and other people in crisis. *Suicide & Life-Threatening Behavior, 42*(1), 22–35. https://doi.org/10.1111/j.1943-278X.2011.00068.x

Ho, W.-W., Chen, W.-J., Ho, C.-K., Lee, M.-B., Chen, C.-C., & Chou, F. H.-C. (2011). Evaluation of the suicide prevention program in Kaohsiung City, Taiwan, using the CIPP evaluation model. *Community Mental Health Journal, 47*(5), 542–550. https://doi.org/10.1007/s10597-010-9364-7

Holmes, G., Clacy, A., Hermens, D. F., & Lagopoulos, J. (2021). The Long-Term Efficacy of Suicide Prevention Gatekeeper Training: A Systematic Review. *Archives of Suicide Research, 25*(2), 177–207. https://doi.org/10.1080/13811118.2019.1690608

Kanzler, K. E., Kilpela, L. S., Pugh, J., Garcini, L. M., Gaspard, C. S., Aikens, J., Reynero, E., Tsevat, J., Lopez, E. S., Johnson-Esparza, Y., Ramirez, A. G., & Finley, E. P. (2021). Methodology for task-shifting evidence-based psychological treatments to non-licenced/lay health workers: Protocol for a systematic review. *BMJ Open, 11*(2), e044012. https://doi.org/10.1136/bmjopen-2020-044012

Logan, T., & Lynch, K. (2021). Factors Associated with Firearm-Related Risk Reduction Strategies Among Men and Women Handgun Owners: A New Direction to Increase Public Safety. *Violence and Gender, 8*(2), 85–94. https://doi.org/10.1089/vio.2020.0104

Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., Raymond, S., Marcoux, I., Bardon, C., Campbell, J. K., & Berman, A. (2007). Comparing models of helper behavior to actual practice in telephone crisis intervention: A Silent Monitoring Study of Calls to the U.S. 1-800-SUICIDE Network. *Suicide & Life-Threatening Behavior, 37*(3), 291–307. https://doi.org/10.1521/suli.2007.37.3.291

Mishara, B. L., Houle, J., & Lavoie, B. (2005). Comparison of the effects of four suicide prevention programs for family and friends of high-risk suicidal men who do not seek help themselves. *Suicide & Life-Threatening Behavior, 35*(3), 329–342. https://doi.org/10.1521/suli.2005.35.3.329

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Perceived Stigma and Barriers to Mental Health Care Utilization Among OEF-OIF Veterans. *Psychiatric Services, 60*(8), 1118–1122. https://doi.org/10.1176/ps.2009.60.8.1118

Quinnett, P. (2019). The Role of Clinician Fear in Interviewing Suicidal Patients. *Crisis, 40*(5), 355–359. https://doi.org/10.1027/0227-5910/a000555

Ramchand, R. (2022). Suicide Among Veterans. *Rand Health Quarterly, 9*(3), 21.

Sayers, S. L., Hess, T. H., Whitted, P., Straits-Tröster, K. A., & Glynn, S. M. (2021). Coaching Into Care: Veterans Affairs Telephone-Based Service for Concerned Family Members of Military Veterans. *Psychiatric Services, 72*(1), 107–109. https://doi.org/10.1176/appi.ps.201900113

Schafer, K. M., Duffy, M., Kennedy, G., Stentz, L., Leon, J., Herrerias, G., Fulcher, S., & Joiner, T. E. (2022). Suicidal ideation, suicide attempts, and suicide death among Veterans and service members: A comprehensive meta-analysis of risk factors. *Military Psychology, 34*(2), 129–146. https://doi.org/10.1080/08995605.2021.1976544

Sethi, S., & Shipra, U. (2006). Attitudes of clinicians in emergency room towards suicide. *International Journal of Psychiatry in Clinical Practice, 10*(3), 182–185. https://doi.org/10.1080/13651500600633543

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256–264. https://doi.org/10.1016/j.cbpra.2011.01.001

ORIGINAL RESEARCH

Suicide Safety Planning With Sexual and Gender Minority College Students: Recommendations for Clinicians

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SUICIDE is the second leading cause of death among college-aged students in the United States (Centers for Disease Control and Prevention, 2020). The 2022 National College Health Risk Assessment reported that 11.4% of college students have seriously considered suicide and 2.9% attempted suicide within the past year (American College Health Association, 2022). Studies have shown that individuals who identify as sexual and gender minorities (SGM), including but not limited to lesbian, gay, bisexual, transgender, queer, intersex, and asexual, have higher rates of suicidal thoughts and behaviors than their heterosexual cisgender peers (Ivey-Stephenson et al., 2020; Jackman et al., 2019).

The Safety Planning Intervention (Stanley & Brown, 2012) is a brief, single-session intervention designed to equip clients experiencing suicidal thoughts with strategies that empower them to resist suicidal urges, with the aim to reduce the individual's suicide risk. Suicide safety planning has generated substantial empirical support in recent years (e.g., Ferguson et al., 2021; Marshall et al., 2023; Stanley et al., 2018). For example, in a study of over 1,600 patients across 9 hospital emergency departments, use of the Safety Planning Intervention with follow-up calls was associated with 45% fewer suicidal behaviors as compared with typical care over a 6-month follow-up period (Stanley et al., 2018).

In suicide safety planning a clinician assists the patient in developing a six-step plan for managing suicidal thoughts (Stanley & Brown, 2012). The intervention is designed so that patients progress through steps in sequential order if previous step(s) were deemed ineffective at resolving or reducing the crisis to a manageable experience. The first step of suicide safety planning is to recognize warning signs (i.e., physiological reactions, thoughts, behaviors) that a suicidal crisis is approaching. The second step is to identify internal coping strategies, or activities an individual can do alone (e.g., meditation, baking, painting), to provide distraction towards the possible impeding crisis. The third step is to identify people and places that may provide distraction for the individual. The fourth step is to identify people that the patient can ask for help during a crisis. The fifth step involves identifying professionals or agencies an individual can contact for help during a suicidal crisis (e.g., 988 Crisis & Suicide Lifeline, local emergency departments; see Suran, 2023). Finally, the patient identifies ways to make their environment safer (e.g., storing firearms at a location outside of home) to reduce access to potential lethal means for suicide (Stanley & Brown).

Safety Planning With Sexual and Gender Minority Populations

Minority stress theory proposes that SGM individuals face unique stressors and stigmas compared to their heterosexual peers, which predisposes this population to an increased risk of poor health outcomes and consequences (Meyer, 2003). As such, the

unique stressors that SGM individuals face (e.g., discrimination, microaggressions) have been identified as factors that may elevate risk for suicide-related thoughts and behaviors (Lawlace et al., 2022). SGM individuals, especially young people, may experience rejection from close family members (Reczek, 2020), internalized stigmatization, and a lack of social support (Lawlace et al.), all of which have been associated with increased risk of suicidal ideation (Hill & Pettit, 2012; Lawlace et al.).

The American Psychological Association Guidelines for Sexual Minority individuals were updated in 2021, urging mental health professionals to acknowledge the various types of discrimination SGM individuals face and to consider the implications these stressors may have in a clinical setting (American Psychological Association, 2021). These guidelines are grounded in the minority stress theory (Meyer, 2003). Yet, these guidelines have not yet been explicitly applied to suicide safety planning. Given the unique stressors and discrimination faced by SGM individuals, it is possible that efforts to tailor suicide safety plans may benefit this population. This study sought to explore whether SGM college students provide content tailored to their SGM status on suicide safety plans compared to the content provided by their non-SGM peers, as well as the extent to which tailored content is associated with increased satisfaction with and use of safety plans among SGM students. Results may inform recommendations for clinicians implementing suicide safety planning interventions with SGM clients.

Hypotheses

This study hypothesized the following:

1. SGM college students would emphasize social contacts who are SGM individuals and/or SGM allies on steps three and four of their safety plans.
2. SGM college students would emphasize social settings that provide an accepting environment toward SGM individual on step three of their safety plans.
3. SGM college students would be more comfortable accessing SGM-specific crisis resources than general crisis resources.
4. Among SGM college students, there would be a positive correlation between the degree of SGM-specific tailoring of their safety plan content and reported satisfaction/utilization of their safety plan.

Method

Participants and Procedures

Participants (n = 135) were undergraduate students at a university in the southern United States, 18–30 years of age (M = 18.50, SD = 3.30), who reported past-year suicidal ideation. Participants self-identified their gender identity as female (70.4%), male (24.4%), and transgender/gender-diverse (5.2%). Participants reported their race/ethnicity as non-Hispanic White (47%), Hispanic (13.3%), African American or Black (26.5%), and other (13.2%). Participants self-identified as heterosexual/straight (51.9%), followed by bisexual (22.2%), pansexual (7.4%), questioning (4.4%), gay (4.4%), asexual (3.7%), lesbian (3.7%), and queer (2.2%). Participants self-identified as either a sexual and/or gender minority individual (40.7%) or a nonsexual and/or gender minority individual (59.3%).

All participants provided informed consent before participating in the study, and all procedures were approved by the Institutional Review Board prior to the study being conducted. After providing consent, participants completed a baseline assessment on Qualtrics to gather data regarding their history of suicidal ideation and/or behavior,

along with detailed demographics. As part of a larger randomized trial comparing the quality of different methods of creating suicide safety plans, participants were then randomly assigned to one of three safety planning intervention administration methods: standard safety planning with a graduate student clinician, The Safety Planning Assistant (a web-based safety planning module; Hill et al., 2020), or www.mysafetyplan.org (a web-based safety plan form; Vibrant Emotional Health, 2023). All safety plans followed the sequence of steps outlined by the Stanley and Brown (2012) model of suicide safety planning. Following completion of the initial visit, participants were provided a copy of their safety plan along with a list of mental health resources. Additionally, all participants completed a posttreatment assessment on Qualtrics to gather feedback and data concerning their overall satisfaction with the intervention, the likelihood that they would utilize the safety plan in a suicidal crisis, and the elements included on their safety plan. Two weeks following the initial study visit, participants were asked to complete a brief follow-up assessment via email, regarding their use of the safety plan. Of 135 participants, 96.3% (n = 130) completed the 2-week follow-up.

Measures

Demographics

Participants completed a questionnaire that provided basic demographic information, including age, sexual orientation, gender identity, and ethnicity.

Generalized Anxiety Disorder-7 (GAD-7)

The GAD-7 (Spitzer et al., 2006) is a seven-item questionnaire designed to assess past 2-week anxiety symptoms. Responses are scored on a 4-point scale ranging from 0 (*Not at all*) to 3 (*Nearly every day*). Total scores range from 0–21 with greater scores indicating greater frequency and intensity of anxiety symptoms. Prior research indicates excellent internal consistency and validity (Löwe et al., 2008; Spitzer et al., 2006;).

Center for Epidemiologic Studies Depression Scale-10 (CESD-10)

The 10-item version of the CES-D (Andresen et al., 1994; Irwin et al., 1999) was used to assess depressive symptoms. Responses are scored on a 4-point scale ranging from 0 (*rarely or none of the time—less than 1 day*) to 3 (*most of the time—5 to 7 days*). Total scores range from 0–30, with greater scores indicating greater depressive experiences. Prior research has demonstrated excellent internal consistency and validity (Irwin et al., 1999; Rice & Shorey-Fennell, 2020).

Suicide Ideation Scale

The Suicide Ideation Scale (Rudd, 1989) is a 10-item questionnaire used to measure the frequency of a range of suicidal cognitions. Items are scored on a 5-point frequency scale ranging from 1 (never or none of the time) to 5 (always or a great many times). Total scores range from 10 to 50, with higher scores representing greater frequency in suicidal ideation. The Suicide Ideation Scale has demonstrated excellent internal consistency and validity (Luxton et al., 2011).

Client Satisfaction Questionnaire-8 (CSQ-8)

The CSQ-8 (Larsen et al., 1979) is an eight-item questionnaire designed to assess client satisfaction of mental health services they have received. Items are scored on a 4-point scale with greater scores indicating greater client satisfaction. The CSQ-8 has excellent validity and internal reliability along with high levels of customer acceptability (Attkisson & Zwick, 1982).

Post–Safety Plan Survey

All participants were administered a post–safety plan survey to assess the content provided on their safety plan as well as participants' likelihood of using various crisis resources. For SGM participants, the post–safety plan survey also evaluated the degree of SGM-specific tailoring of their safety plan. The degree of SGM-specific tailoring was measured via self-report questions that asked participants to report the degree to which each step of their safety plan was related to their SGM identity or to what extent they considered whether a particular person or place was safe/accepting of SGM individuals. Degree of tailoring was computed as the summation of self-reported relations between content and SGM identity on steps one (warning signs), two (coping strategies), three (social contacts and settings that provide distraction), and four (social contacts who can provide help). Degrees resulted in total scores ranging from 0–52, with greater scores indicating a greater degree of SGM-specific tailoring. A full list of ad hoc items used in this survey can be found in Supplemental Table 1.

Safety Plan Utilization

Participants' intent to use their safety plan was assessed by asking participants, "If you were to need help, would you utilize the safety plan you created?" on a scale of 1 (*No, definitely not*) to 4 (*Yes, definitely*). Participants' actual utilization of their safety plan during the 2-week period between participants' initial study visit and follow-up survey was measured by asking participants to indicate whether they had used their safety plan since their visit; "Have you used your safety plan since your first study visit?" with options "Yes" or "No."

Data Analyses

Data were evaluated using IBM SPSS Statistics (Version 29). Prior to analysis, data were cleaned to remove duplicate responses to the surveys, with the first complete survey response retained (n = 4 duplicate surveys were removed). Descriptive statistics, Pearson's correlations, chi-squared analyses, and t-tests were used to examine the hypotheses.

Results

To better characterize the sample, means and standard deviations of clinical study variables (suicidal ideation, depressive symptoms, and anxiety symptoms) are provided in Table 1. Participants reported moderate levels of depressive symptoms (M = 14.81, SD = 4.56), anxiety symptoms (M = 17.19, SD = 4.90), and suicidal ideation (M = 20.01, SD = 7.95). There were no significant differences between SGM and non-SGM participants with respect to any of the clinical variables (see Table 1).

Hypothesis 1: SGM College Students Will Emphasize Social Contacts Who Are SGM Individuals and/or SGM Allies on Steps Three and Four of Their Safety Plans

On the post–safety plan survey, SGM participants were asked to report the SGM status of each of the social contacts identified on steps three (someone to provide distraction) and four (someone to ask for help) of the safety plan. On step three, 85.5% of SGM participants chose at least one SGM individual and/or SGM ally to provide distraction during a crisis. SGM individuals and/or SGM allies comprised 67.2% of all individuals chosen by SGM participants on step three. SGM participants were asked to rate how important it was to them that the first individual listed on step three was an SGM or SGM ally on a scale of 0 (*not at all*) to 4 (*extremely important*); the average rating was 3.31 (SD = 1.20).

Table 1. Means and Standard Deviations for Clinical Characteristics of the Sample by Sexual and Gender Minority Identity

	SGM Participants M(*SD*)	Non-SGM Participants M(*SD*)	Full Sample M(*SD*)
Suicidal Ideation	18.91 (6.50)	20.78 (8.77)	20.01 (7.95)
Depressive Symptoms	15.02 (4.61)	14.68 (4.54)	14.81 (5.04)
Anxiety Symptoms	17.58 (4.72)	16.91 (5.04)	17.19 (4.90)

Note. SGM = sexual or gender minority individual

Table 2. Self-Reported Mean Likelihood to Utilize Each Crisis Resource

Crisis Resource	SGM M(*SD*)	Non-SGM M(*SD*)
988	57.67 (*30.40*)	54.30 (*34.28*)
Crisis Text Line	64.47 (*31.57*)	54.10 (*35.35*)
Trevor Lifeline	53.49 (*28.22*)***	11.31 (*23.13*)***
Trevor Text Line	61.61 (*29.26*)***	10.43 (*21.86*)***
Local Emergency Room	46.40 (*38.89*)	40.26 (*33.97*)
Contacting the Police	30.46 (*36.22*)	30.24 (*31.33*)

Note. SGM = sexual or gender minority individual; ***$p < .001$

On step four, 81.1% of SGM participants chose at least one SGM individual and/or SGM ally to provide help during a crisis. SGM individuals and/or SGM allies comprised 63.6% of all individuals selected by SGMs on step four. When asked to rate how important it was that the first individual on step four was an SGM or SGM ally on a scale of 0 (*not at all*) to 4 (*extremely important*); the average rating of importance was 3.02 (*SD* = 1.43).

Hypothesis 2: SGM College Students Will Emphasize Social Settings That Provide an Accepting Environment Toward SGM Individuals on Step Three of Their Safety Plans

On the post–safety plan survey, SGM participants were asked to provide details about locations selected as providing distraction in step three. When asked to rate how important it was that each social setting provides an accepting environment for SGM individuals on a scale of 0 (*not at all*) to 4 (*extremely important*), the average rating was 2.85 (*SD* = 1.56). Participants were asked to categorize each of their distracting settings into one of six broad categories: home, someone else's home, public retail setting, public community setting, college campus setting, or religious setting. Pearson's chi-square test revealed that SGM participants were significantly less likely than non-SGM participants to select their home, X^2 (5) = 4.321, p = .038, or a religious setting, X^2 (5) = 5.467, p =.019, as one of their social settings to provide distraction.

Hypothesis 3: SGM College Students Will Be More Comfortable Accessing SGM-Specific Crisis Resources Than General Crisis Resources

All participants were asked to rate the likelihood of using each of six crisis resources on a scale of 0 (*not at all*) to 100 (*extremely important*) (see Supplemental Table 1). A dependent samples *t*-test revealed that the reported likelihood of SGM participants using SGM-specific crisis resources (e.g., the Trevor Project hotline/text line; *M* = 59.94,

SD = 27.14) and their likelihood of using general crisis resources (e.g., 988 Suicide & Crisis Lifeline; *M* = 63.61, *SD* = 27.91) were not significantly different, $t(54) = .781$, $p = .44$. On the post–safety plan survey, SGM participants indicated that they preferred for their mental health provider to be accepting toward SGM individuals (*M* = 78.20, *SD* = 31.13), and generally preferred for their mental health providers to have received specialized training for counseling SGM individuals (*M* = 57.48, *SD* = 35.07).

Hypothesis 4: Among SGM College Students, There Will Be a Positive Correlation Between the Degree of SGM-Specific Tailoring of Their Safety Plan Content and Reported Satisfaction/Utilization of Their Safety Plan

SGM participants' mean satisfaction with their safety plan following the initial study visit was 3.31 (*SD* = 0.81), and average intent to use their safety plan was 3.27 (*SD* = 0.59). The degree to which each SGM safety plan was tailored with respect to an individual's identity as an SGM individual was computed. The method for computing the measure of safety plan tailoring is shown in Supplemental Figure 1. Among SGM participants, there was no significant relationship between the degree of SGM-specific tailoring and safety plan satisfaction ($r = .01$, p = .93), intent to use the safety plan ($r = .15$, $p = .29$), or actual use of the safety plan at follow-up ($r = .06$, $p = .69$).

Discussion

In an effort to provide empirically informed clinical recommendations for suicide safety planning with SGM individuals, the present study examined the content, preferences, and satisfaction of safety plans developed by SGM college students. SGM individuals are at elevated risk for suicide-related thoughts and behaviors (Ivey-Stephenson et al., 2020; Reczek, 2020) and suicide safety planning is an evidence-based brief intervention for reducing risk of suicide attempts (e.g., Stanley et al., 2018). However, SGM individuals often experience discrimination and rejection from their families and communities (e.g., Hill & Pettit, 2012), which may impact the manner in which they identify social supports and safe public spaces when completing a suicide safety plan. This study evaluated whether SGM individuals provide content tailored to their SGM identity on their suicide safety plans and the extent to which such tailoring was important to these individuals. The findings of this study may help clinicians guide SGM clients to create a more personalized safety plan that better addresses the unique stressors they encounter as SGM individuals.

The first hypothesis was that SGM participants would emphasize social contacts who are SGM individuals and/or SGM allies on steps three and four of their safety plans. Results indicate that SGM participants felt it was important to consider the SGM status of the individuals they selected. The majority of SGM participants chose at least one SGM individual or SGM ally on their safety plan and over half of the individuals identified on steps three and four of the safety plan were known to the participants as SGM individuals or SGM allies. Previous research has shown that SGM individuals are more likely to experience tension in their relationships with family and friends based on their sexual orientation and/or gender identity (Reczek, 2020). Feeling that their sexual orientation or gender identity is not accepted by others may trigger feelings of perceived burdensomeness (Hill & Pettit, 2012), a known proximal risk factor for suicidal ideation (Joiner, 2005; Van Orden et al., 2010). Thus, clinicians working with SGM clients should consider a possible preference for SGM individuals or allies for providing social support and distraction. For example, when a client has difficulty identifying individuals to provide support, clinicians typically offer a few suggestions to assist the client in developing a

SGM individuals often experience discrimination and rejection from their families and communities . . . , which may impact the manner in which they identify social supports and safe public spaces when completing a suicide safety plan.

complete and detailed safety plan. When working with SGM individuals, clinicians should take the time to ask clients to consider whether they feel it is important that their support persons be SGM individuals or allies and to consider who in their life might fulfill that role. Clients, especially youth or other vulnerable populations, may feel pressured to include suggestions given by a therapist as part of their safety plan. Suggesting individuals who are not allies may be perceived as invalidating by clients or might lead clients to include unsupportive individuals as social supports.

The second hypothesis was that SGM college students would emphasize social settings that provide an accepting environment toward SGM individuals on step three of their safety plans. SGM participants indicated that, on average, it was important the social settings they selected provide a safe and accepting environment for SGM people. Compared to non-SGM participants, SGM participants were significantly less likely to identify their home or any religious setting as one of their social settings that can provide distraction during a suicidal crisis.

It may be beneficial for clinicians guiding SGM clients through safety plans to be mindful of the complex family relationships and home lives of some SGM individuals. Research focused on SGM-specific family behaviors demonstrates that family members' acceptance is associated with low risk of suicidality and depression, while family members' rejection is associated with increased risk for these negative health outcomes (Ryan et al., 2009). Thus, the home environment may not be considered a safe place for some SGM young people. Similarly, religious environments, which some individuals find comforting and supportive, may not be viewed as safe spaces for SGM individuals, and thus may not be optimal choices for safety plans with SGM individuals. For clients struggling to identify social settings that provide distraction, clinicians should be careful to avoid suggesting spaces that may place youth in unwelcoming environments, as being in these spaces may introduce additional stressors during a vulnerable time. For example, if an individual experiencing suicidal thoughts seeks out a safe public space but then encounters discrimination or microaggressions due to their sexual orientation or gender identity, this negative experience, coupled with a vulnerable state, may result in increased perceptions of worthlessness, hopelessness, or suicidal intent. Clinicians should discuss clients' preferences for safe spaces and clients' comfort in various public spaces when engaging in safety planning. It will also be critical for clinicians to have a working knowledge of which local spaces provide safe and accepting environments for SGM individuals (e.g., local LGBTQ-friendly cafes, bookstores, community centers, etc.).

The third hypothesis was that SGM college students would be more comfortable accessing SGM-specific crisis resources than general crisis resources. Results indicated

that there was no significant difference between SGM willingness to use resources tailored to SGM individuals compared to their willingness to use general crisis resources. Clinically, tailoring step five of the safety plan by including SGM-specific crisis resources (such as the Trevor Project hotline) is perhaps the most widely implemented safety plan modification for SGM individuals. The presence of national SGM-specific crisis resources makes this an easy action step for clinicians to implement and does not require extensive local knowledge. Including these alternative hotlines may give clinicians the sense of having provided a sensitive and tailored experience to SGM patients. However, these findings indicate that, on average, SGM participants were not more willing to use SGM-specific crisis resources than generic crisis resources. It is certainly useful for clinicians to offer SGM-specific crisis resources, as some patients may prefer them, but, on average, this modification may have a minimal utility. Instead, clinicians should take care to personally tailor multiple aspects of the suicide safety plan, to ensure the entire safety planning experience is relatable and applicable to SGM clients.

The final hypothesis was that there would be a positive correlation between the degree of SGM-specific tailoring and reported satisfaction with/use of SGM participants' safety plans. Results indicated that there was no significant relationship between degree and either outcome. Of note, participants were not instructed to tailor the content of their safety plans. Thus, any tailoring was done by the participants, without encouragement from study staff. Overall, SGM participants reported they were quite satisfied with and were very likely to use the safety plan created at their initial study visit, indicating a possible ceiling effect with regard to safety plan satisfaction. Of note, though hypothesis four was not supported, safety plan satisfaction was positively correlated to both intent to use and actual use of safety plans. This strong relationship indicates that clinicians might wish to regularly gauge client satisfaction after completing a safety plan and take steps to address dissatisfaction, if indicated by clients.

Limitations and Future Directions

The results of this study should be considered within the context of the study limitations. The present study utilized a relatively small sample of predominantly White, female-identifying students from a large university in the southern United States. This relatively homogeneous and small sample size resulted in limited statistical power for detecting effects in our quantitative analyses. Additionally, this study took place over a 2-week period, which is a relatively short period of assessment. This may have resulted in a lower utilization rate across the sample. Future studies should attempt to utilize a more heterogeneous sample, particularly one with a greater number of transgender and gender diverse individuals, to improve the generalizability of findings. Additionally, future research should attempt to replicate findings over a longer trial period to better evaluate the effectiveness and utilization of the developed safety plans. This research may also involve manipulations in the administration of the intervention to explore effects of involving an SGM clinician in relation to client satisfaction and effectiveness.

Overall, these findings provide insight on safety plan content provided by SGM individuals. Based on the findings, we provide a few suggestions for clinicians utilizing suicide safety planning with SGM clients. Although suicidal thoughts and behaviors often stem from concerns outside of one's SGM identity, clinicians should carefully consider the unique minority stressors experienced by SGM individuals and the ways in which those stressors might impact the steps of suicide safety plans.

REFERENCES

American College Health Association. (2022). American College Health Association-National College Health Assessment (ACHA-NCHA) III: Undergraduate Student Reference Group Executive Summary Spring 2022. *Journal of American College Health*. Available at: https://www.acha.org/documents/ncha/NCHA-III_SPRING_2022_UNDERGRAD_REFERENCE_GROUP_EXECUTIVE_SUMMARY.pdf

American Psychological Association, APA Task Force on Psychological Practice with Sexual *Minority Persons. (2021). Guidelines for Psychological Practice with Sexual Minority Persons*. www.apa.org/about/policy/psychological-practice-sexual-minority-persons.pdf.

Andresen, E. M., Malmgren, J. A., Carter, W. B., & Patrick, D. L. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. *American Journal of Preventive Medicine, 10*(2), 77-84. doi: 10.1016/S0749-3797(18)30622-6

Attkisson, C. C., & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning, 5*(3), 233-237. https://doi.org/10.1016/0149-7189(82)90074-X

Centers for Disease Control and Prevention. (2020). *CDC WONDER: Underlying cause of death, 1999–2019.* US Department of Health and Human Services. https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html

Ferguson, M., Rhodes, K., Loughhead, M., McIntyre, H., & Procter, N. (2022). The effectiveness of the safety planning intervention for adults experiencing suicide-related distress: a systematic review. *Archives of Suicide Research, 26*(3), 1022-1045. https://doi.org/10.1080/13811118.2021.1915217

Hill, R. M., Dodd, C. G., Gomez, M., Do, C., & Kaplow, J. B. (2020). The Safety Planning assistant: Feasibility and acceptability of a web-based suicide safety planning tool for at-risk adolescents and their parents. *Evidence-Based Practice in Child and Adolescent Mental Health, 5*(2), 164–172. https://doi.org/10.1080/23794925.2020.1759469

Hill, R. M., & Pettit, J. W. (2012). Suicidal ideation and sexual orientation in college students: The roles of perceived burdensomeness, thwarted belongingness, and perceived rejection due to sexual orientation. *Suicide and Life-Threatening Behavior, 42*(5), 567-579. https://doi.org/10.1111/j.1943-278X.2012.00113.x

IBM Corp. (2023). IBM SPSS Statistics for Windows, Version 29.0.2.0 Armonk, NY: IBM Corp

Irwin, M., Artin, K. H., & Oxman, M. N. (1999). Screening for depression in the older adult: criterion validity of the 10-item Center for Epidemiological Studies Depression Scale (CES-D). *Archives of Internal Medicine, 159*(15), 1701-1704. doi:10.1001/archinte.159.15.1701

Ivey-Stephenson, A. Z., Demissie, Z., Crosby, A. E., Stone, D. M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students—youth risk behavior survey, United States, 2019. *MMWR Supplements, 69*(1), 47–55. https://doi.org/http://dx.doi.org/10.15585/mmwr.su6901a6

Jackman, K. B., Bosse, J. D., Eliason, M. J., & Hughes, T. L. (2019). Sexual and gender minority health research in nursing. *Nursing Outlook, 67*(1), 21-38. https://doi.org/10.1016/j.outlook.2018.10.006

Joiner, T. (2005). *Why people die by suicide*. Harvard University Press. [Google Scholar]

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: development of a general scale. *Evaluation and Program Planning, 2*(3), 197-207. https://doi.org/10.1016/0149-7189(79)90094-6

Lawlace, M., Newcomb, M. E., & Whitton, S. W. (2022). Minority stressors and suicidal ideation in sexual and gender minority youth assigned female at birth: Prospective associations and racial differences. *Suicide and Life-Threatening Behavior, 52*(6), 1168-1177. DOI: https://doi.org/10.1111/sltb.12912

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical Care, 46*(3), 266-274. doi: 10.1097/MLR.0b013e318160d093

Luxton, D. D., Rudd, M. D., Reger, M. A., & Gahm, G. A. (2011). A psychometric study of the suicide ideation scale. *Archives of Suicide Research, 15*(3), 250-258. http://dx.doi.org/10.1080/13811118.2011.589720

Marshall, C. A., Crowley, P., Carmichael, D., Goldszmidt, R., Aryobi, S., Holmes, J., Easton, C., Isard, R., & Murphy, S. (2023). Effectiveness of suicide safety planning interventions: a sys-

tematic review informing occupational therapy. *Canadian Journal of Occupational Therapy, 90*(2), 208-236. https://doi.org/10.1177/00084174221132097

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. (2021). Minority stress, distress, and suicide attempts in three cohorts of sexual minority adults: A U.S. probability sample. *PLOS ONE, 16*(3). https://doi.org/10.1371/journal.pone.0246827

Reczek, C. (2020). Sexual-and gender-minority families: A 2010 to 2020 decade in review. *Journal of Marriage and Family, 82*(1), 300-325. https://doi.org/10.1111/jomf.12607

Rice, S. P., & Shorey-Fennell, B. R. (2020). Comparing the psychometric properties of common measures of positive and negative emotional experiences: implications for the assessment of subjective wellbeing. *Journal of Well-Being Assessment, 4*, 37-56. doi:10.1007/s41543-020-00025-1

Rudd, M. D. (1989). The prevalence of suicidal ideation among college students. *Suicide and Life-Threatening Behavior, 19*(2), 173-183. doi: 10.1111/j.1943-278X.1989.tb01031.x

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-352. https://doi.org/10.1542/peds.2007-3524

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097. doi:10.1001/archinte.166.10.1092

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256–264. https://doi.org/10.1016/j.cbpra.2011.01.001

Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., Chaudhury, S. R., Bush, A. L. & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry, 75*(9), 894-900. doi:10.1001/jamapsychiatry.2018.1776

Suran, M. (2023). How the new 988 lifeline is helping millions in mental health crisis. *JAMA*. doi:10.1001/jama.2023.14440

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575–600. https://doi.org/10.1037/a0018697

Vibrant Emotional Health. (2023). *My Safety Plan*. https://www.mysafetyplan.org

ORIGINAL RESEARCH

Bridging Gaps and Enhancing Support: Stakeholder Perspectives on Optimizing a Transition Program for Autistic Youth and Young Adults

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Autistic adolescents and young adults face lower employment, education, and quality of life outcomes as compared to their nonautistic peers (Lawson et al., 2020; Nord et al., 2016). To address these issues, the Stepped Transition to Employment and Postsecondary Education Success (STEPS; White et al., 2017) program was developed to help students successfully transition into adulthood. Given the established effectiveness of STEPS (e.g., White et al., 2021), we sought input from community partners to reduce the gap between mental health and developmental disability support (Laxman et al., 2019; White et al., 2023) and to maximize the program's scalability and accessibility through the use of a community engagement framework. This study examined the perspectives of community stakeholders on different aspects of the program's development, such as the barriers and facilitators to implementing STEPS and how to make the program more scalable and accessible for families, clinicians, and educators.

Method

This study was part of an ongoing clinical trial evaluating a new transition support program for autistic adolescents and young adults, which has been IRB-approved. We invited 13 people (11 female and 2 male) across the three meetings. We reached out to those associated with autism services in Alabama and North Georgia (e.g., program director, psychologist, etc.) and individuals with knowledge of insurance (e.g., administrator) and funding mechanisms. These community partners and stakeholders from external agencies were invited to participate in an Implementation Advisory Panel (IAP) consisting of three 1-hour semistructured focus groups via Zoom, and each partner provided informed consent before participating in the study. Data from these IAP focus groups consisted of detailed observation notes taken by two research team members that were then compared and synthesized. The team used noncoding thematic analysis methods (Wolgemuth et al., 2024) to develop the salient themes from each IAP. Ten partners attended the first two IAP meetings with integrated breakout rooms and whole-group discussions focused on the strengths, weaknesses, untapped opportunities, scalability, and difficulties of implementing STEPS. The third and final IAP meeting had five IAP members in a whole group discussion format and focused on accessibility and acceptability.

Results

STEPS: Strengths, Weaknesses, Untapped Opportunities, and Threats

The first IAP meeting focused on strengths, weaknesses, untapped opportunities,

and threats for the implementation of STEPS. In terms of strengths, IAP members discussed the need for transition programs, the accessibility of this service, and the importance of focusing on this particular age range. Regarding weaknesses and untapped opportunities, there were questions about how this program differed from other transition programs and curiosity regarding the best way to market to clinicians. Threats to the program were brought forth regarding motivation and buy-in from clients and their families. One IAP member stated, "You (any service provider) can provide the service as much as possible but are limited without buy-in," which is something to remember as this is the first time this program has been at this scale in implementation. Related to billing and the financial side of STEPS, there were a few discussions and related questions. For instance, because Medicaid covers individuals until their 21st birthday, some wondered what would happen to those involved in STEPS over the age of 21. Another discussed topic was related to state differences in reimbursement policies and procedures. Overall, interest in STEPS was high, and the sentiment was positive. IAP members requested more information about the program.

STEPS: Scalability and Future Expansion

The second meeting concentrated feedback on expanding the reach of STEPS within Alabama and nationally, as well as identifying contacts and partners to aid in scaling the program. Regarding scalability, IAP community partners provided the names of specific contacts that would be instrumental in expanding reach within the state and brainstormed possible sources and contacts that may support broader interest and implementation. To attract the interest of clinicians in expanding the reach of STEPS, there was a discussion of addressing the financial benefits of providing STEPS as a service, partnering with an autism-focused organization, and creating a certificate program. Additionally, two IAP members brought up that "it is all about quality assurance" and fidelity when considering future clinician training, highlighting the need for clinicians to feel confident and the importance of tailoring training based on their experience and comfort with autism to increase the program's success. IAP members also discussed how to attract educators' interest in STEPS; as such, there was discussion of establishing STEPS as a science-backed, evidence-based standard of care and implications for Individualized Education Program (IEP) planning and developing an in-service program with continuing education credit for teachers.

STEPS: Increasing Motivation and Engagement

During the third and final meeting, the main focus was making the program more appealing and accessible for clinicians and families. The IAP carefully analyzed feedback from counselors regarding the program's benefits and challenges and discussed strategies to enhance clinician effectiveness and client and parental engagement. The IAP stressed the importance of personalizing the program for each individual, integrating engaging activities, and encouraging clients to take ownership of their progress, which is critical for improving engagement and achieving targeted outcomes in transition readiness. Moreover, the IAP members shared valuable insights on how to understand their clients' motivations and how to target them, even beyond the scope of STEPS. They suggested that being more of a mentor than a therapist could be beneficial, as it helps clients to feel more motivated and invested in the program. The IAP also acknowledged "that clients may only see the value of working on specific skills once they experience failure," which facilitates insight and engagement. Finally, an emphasis on how these goals could be helpful for parents was highlighted, such as when their

teenager drives to the store to buy groceries, instilling in them a sense of reassurance and confidence in such programs. In other words, "seeing achievements in these set goals could be pointed out to parents how beneficial it's (STEPS) going to be."

Discussion

Engaging autism community stakeholders in order to bridge the gap between mental health and vocational rehabilitation can enhance the inclusivity and effectiveness of STEPS and similar transition programs (Castruita Rios et al., 2023; Doda et al., 2024). These IAP meetings enabled stakeholders to enhance the STEPS program by evaluating and strategizing on clinician engagement, marketing, and participant motivation. However, challenges such as funding effective programs and effectively reaching the target community need consideration and planning in order to broadly disseminate and implement such a program. It is essential to note the possible obstacles in uptake of any new program like STEPS, such as time for training, consultations, and motivation from the clinician. However, there are ways to overcome these obstacles, such as investing in financial incentives, partnerships, and educational credits. Including stakeholder perspectives can help develop strategies that address the unique needs of autistic individuals and their families, fostering a more supportive and community-aligned approach.

REFERENCES

Castruita Rios, Y., Park, S., Chen, X., & Tansey, T. N. (2023). Collaborations to Support Employment Outcomes of Youth With Disabilities. *Rehabilitation Counselors and Educators Journal, 12*(1). https://doi.org/10.52017/001c.72655

Doda, V., Kennedy, C., & Kaur, M. (2024). Policies for Individuals With Autism: Gaps, Research, and Recommendations. *Cureus, 16*(1), e51875. https://doi.org/10.7759/cureus.51875

Lawson, L. P., Richdale, A. L., Haschek, A., Flower, R. L., Vartuli, J., Arnold, S. R., & Trollor, J. N. (2020). Cross-sectional and longitudinal predictors of quality of life in autistic individuals from adolescence to adulthood: The role of mental health and sleep quality. *Autism, 24*(4), 954–967. https://doi.org/10.1177/1362361320908107

Laxman, D. J., Taylor, J. L., DaWalt, L. S., Greenberg, J. S., & Mailick, M. R. (2019). Loss in services precedes high school exit for teens with autism spectrum disorder: A longitudinal study. *Autism Research: Official Journal of the International Society for Autism Research, 12*(6), 911–921. https://doi.org/10.1002/aur.2113

Nord, D. K., Stancliffe, R. J., Nye-Lengerman, K., & Hewitt, A. S. (2016). Employment in the community for people with and without autism: A comparative analysis. Research in Autism Spectrum Disorders, 24, 11–16. https://doi.org/10.1016/j.rasd.2015.12.013

White, S. W., Elias, R., Capriola-Hall, N. N., Smith, I. C., Conner, C. M., Asselin, S. B., Howlin, P., Getzel, E. E., & Mazefsky, C. A. (2017). Development of a College Transition and Support Program for Students with Autism Spectrum Disorder. Journal of Autism and Developmental Disorders, 47(10), 3072–3078. https://doi.org/10.1007/s10803-017-3236-8

White, S. W., Schall, C., Santos, J. D., Maddox, B. B., Hillier, A., Klinger, L., & Pugliese, C. (2023). Promoting Quality of Life: Suggestions for Mental Health Care Providers Working with Young Autistic Adults. Autism in adulthood: challenges and management, 5(4), 347–355. https://doi.org/10.1089/aut.2022.0106

White, S. W., Smith, I. C., Miyazaki, Y., Conner, C. M., Elias, R., & Capriola-Hall, N. N. (2021). Improving Transition to Adulthood for Students with Autism: A Randomized Controlled Trial of STEPS. Journal of Clinical Child & Adolescent Psychology, 50(2), 187–201. https://doi.org/10.1080/15374416.2019.1669157

Wolgemuth, J. R., Guyotte, K. W., & Shelton, S. A. (Eds.). (2024). Expanding approaches to thematic analysis: Creative engagements with qualitative data. Routledge.

The 2024 Student Research Symposium: Reflections and Recommendations

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On May 31, 2024, ABCT's Student Special Interest Group (SIG) hosted its second annual Student Research Symposium, a free and virtual conference organized with the intention of expanding access to research-sharing opportunities for student-level researchers. The current article discusses the background and strengths of the event, improvements from last year's inaugural Symposium, and recommendations for future similar events given feedback received from attendees.

Inspiration

An article (Hart, 2023) outlining the origin of the Student Research Symposium and last year's event is available in the September 2023 issue of *the Behavior Therapist*. Nevertheless, we will briefly summarize the Symposium's inspiration. The inspiration for this Symposium came in the fall of 2022 when Grace was organizing the Student SIG's presence at the annual ABCT convention's SIG poster exposition. It quickly became apparent that merit was not the only criterion determining who could participate in this opportunity. Instead, many brilliant young scholars were unable to attend the convention, despite being invited to do so, due to myriad barriers: visa restrictions, health vulnerabilities, financial constraints, and others. In light of this, it was clear that the student community would benefit from an event that mitigated these barriers, for example, by being hosted online, free of charge. Thus, the Student Research Symposium was born, taking practical inspiration from the Suicide Research Symposium organized by Program Chairs Keyne C. Law, Ph.D., and Megan L. Rogers, Ph.D., as well as Reshef et al.'s 2020 publication *How to Organize an Online Conference* and Son et al.'s (2022) *Ten Steps to Organize a Virtual Scientific Symposium and Engage Your Global Audience*.

Format

The Student Research Symposium is a 1-day virtual conference consisting of live paper presentations, data blitzes, and professional development panels. Each live session was moderated by a member of the Symposium's organizing team. This year, we were fortunate to feature a keynote speech by Dr. Sarah Hope Lincoln, Advancing Knowledge: Empowering Student Research and Increasing Accessibility. Dr. Lincoln's slides are available on the Student SIG's website. Additionally, we hosted a poster session via X (formerly Twitter). Posters were uploaded to the SIG's X account and tagged with #ABCTStudentSymposium2024 so that all posters could be easily accessed in a centralized, virtual location. The day was concluded by brief closing remarks by the Student SIG's co-chairs.

We hosted the Symposium through ABCT's Zoom account, and we recommend that other SIGs considering webinars or virtual events do the same as this account can host up to 300 attendees for unlimited time. Event registration was handled through Eventbrite.

The Event

In total, this year's Student Research Symposium included 327 registered attendees and featured over 100 presentations. Roughly 62% of these presentations were given by undergraduate students and postbaccalaureate researchers, and 38% were by graduate students. To our knowledge, we featured presentations from seven countries: Nigeria, India, China, Vietnam, Brazil, Canada, and the United States. Attendees indicated that they tuned in from all of these countries, in addition to Algeria and the Philippines. Roughly 59% self-reported as identifying as a person from an underrepresented background in psychology.

Feedback from a survey distributed to all registered attendees at the conclusion of the Symposium revealed overall positive appraisals of the event. Attendees were asked to indicate their opinions about the Symposium on scales of 1 (*being the worst*) to 10 (*being the best*). For example, one question asked, "How well do you feel the Symposium met its goals, as outlined in the Symposium itinerary?" On average, respondents (n = 18) gave the Symposium a rating of 9.2 for meeting its stated goals.

A summary of quantitative results can be seen below.

How well do you feel the Symposium was advertised?	How accessible did you find this Symposium to be?	How useful did you find the Symposium to be in supporting your academic/professional development?	How well organized did you find the Symposium to be?	Please rate your overall experience with the Symposium:
7.67	8.89	8.83	8.86	8.84
How well do you feel the Symposium met its goals, as outlined in the Symposium program?*	**Please rate the quality of your experience communicating with the organizers (i.e., ABCT Student SIG executive board members)**	**How helpful did you find the organizers when you had questions?**	**Please rate your experience with the session(s) that you attended.**	**Please rate your experience with the "finding your niche" session:**
9.22	9.17	9.33	8.78	8.66

*(i.e., "We organized this symposium with the intention of expanding access to research-sharing opportunities. We know that there are many barriers inherent to traditional conference formats [e.g., financial, health-related, visa issues, etc.]. It is our hope that this Symposium will continue to serve as an opportunity for promising emerging psychological scientists who are facing such barriers to showcase their scholarship and connect with others!")

Strengths

The response the Symposium received this year vastly exceeded our expectations. We enjoyed over five times as many registered attendees, and roughly three times as many presentations as last year. We suspect that this growth was attributable to the wider awareness and credibility of being a second-year event and our partnership with the American Psychological Association's Division 37–Society for Child and Family Policy and Practice. This partnership arose rather spontaneously when Division 37 emailed our SIG seeking advice on how they might organize something similar to the Student Research Symposium. At that time, we shared that we would be happy to provide any helpful information, and asked if they would instead like to combine efforts by partnering with us in this year's event. Graciously, they agreed. Division 37 supported the event by advertising the Symposium among their network, and organizing two professional development sessions: one featuring current graduate students in diverse

psychology programs (e.g., Marriage and Family Therapy, Clinical Psychology, and Counseling Psychology), and one featuring current professionals in diverse roles (e.g., a teaching-focused professor, a member of a government agency, a practicing clinician, and more). We look forward to continuing this partnership next year.

In light of feedback from last year's attendees, this year's professional development panels (i.e., those organized by Division 37 and a panel at the end of the day on finding one's "niche" in graduate school) were far more expansive, seeking to address topics of interest not only to undergraduate students and postbaccalaureate researchers, but graduate students as well.

In addition to providing a more easily accessible and free opportunity for students to share their research and learn from others, we believe that a strength of our Symposium lies in providing a relatively low-stakes environment to practice scientific communication, a skill that has received significant attention in recent years as being critical yet underdeveloped in many researchers.

Another strength of our event was how it was advertised. Once again, we heavily relied on social media to publicize our event (i.e., Instagram, Facebook, and X). We strongly believe that leveraging "open" (i.e., free to use and available to anyone with a suitable device and internet connection) platforms such as these is essential to reducing epistemic injustice. Many academic opportunities are disseminated via private listservs of professional organizations (whose fees are often far greater than students can afford to pay) and by "word of mouth" (unlikely to reach students who are not fortunate enough to have an advisor seeking such opportunities for them). Although there are legitimate barriers to social media use (e.g., inequitable internet access), it seems to us that social media—which is free to use by anyone with a suitable device and internet connection—is the most equitable means of disseminating opportunities to the student community. Some data seem to support this. As of 2015, the majority of social media users accessed these sites via mobile devices ("Millennials"). As of 2023, 54% of the global population owned a smartphone and 49% of the global population accessed the internet via their mobile device ("smartphones"). Additionally, in 2023 42% of U.S. adults aged 18 to 29—the typical age of students—used X, 67% used Facebook, and 78% used Instagram (Pew Research Center, 2024). Further, as of 2019, there were 2.6 million "academic twitter" users (Yu et al., 2019). As such, we strongly believe that social media provides effective and accessible platforms to disseminate academic opportunities to our target demographic.

However, it must be acknowledged that many students may not be aware that "academic twitter" exists. Further, in recent years many mentors may be hesitant to encourage students to leverage professional social media for various reasons, perhaps most notably the perceived decline in online climate and seeking to boycott certain businesspeople. We believe that people ought to do what their conscience dictates. However, our observation is that the networking and informational opportunities available via social media are very helpful to many students. Therefore, we will continue to leverage these positive aspects in an effort to "level the playing field" of academia.

The logistics of publicizing the Symposium via social media followed much the same protocol as that outlined in last year's article (Hart, 2023). We encourage anyone interested in specifics to reference that publication or contact us directly.

An unexpected but very welcome development at the Symposium was presenters' families tuning in to watch them present. Indeed, we saw this on X as well, with at least one poster presentation being "quoted" by a family member with an encouraging message. This was not something we had considered as a potential benefit of the event's

accessibility, but we were delighted to see this. So often, students and academics—especially those who do not come from academic families themselves—share that they feel that their families do not truly understand the work they do, and that this is sometimes a source of sadness and frustration. We hope that in the future, presenters will feel welcome to invite their support systems (i.e., friends, families, etc.) to attend their presentations, and that this might be an avenue to bridge the gap not only between presenters' scholarship and personal networks, but also a wider nonacademic audience.

Future Recommendations

The top feedback we received this year is that hosting the Symposium on a standard workday (i.e., Friday) made attendance by postbaccalaureate researchers challenging. Therefore, in future years, we will host the event on a Saturday or Sunday. We also received feedback that poster presenters would like the opportunity to present their findings in a live format. We will explore ways to accommodate this, either by finding an additional digital format that could serve as a "poster hall" or expanding the event across two days.

We have used Eventbrite as the registration platform for the Symposium thus far. However, this year they began charging a fee to do so. In the future, we will not use this platform, and will investigate free alternatives.

With a larger virtual event comes greater security threats. To mitigate these risks, it may be necessary in the future for us to limit registration to individuals who can provide an institutional email address. However, this would directly conflict with our desire to allow individuals from nonacademic backgrounds to enjoy the event. We will continue to brainstorm creative solutions to this problem. For now, we anticipate that in cases where an individual would like to present or attend but cannot provide an institutional email address, we would invite them to contact us directly so that we can come to a solution.

Relatedly, future event coordinators should familiarize themselves with the security features available through Zoom or whatever platform is being used. Although we have opted to host our events in "gallery" mode in the past, increasing security threats may necessitate that going forward we rely on "speaker view," hide participants, prevent participants from unmuting themselves, prevent users from accessing annotation features, and use a moderated chat in which participants send questions to a moderator who then repeats them, rather than allowing them to be viewed by all attendees in the virtual chat box. While we believe this would limit the interactivity of the event, which we feel would represent a real loss in the overall experience, ensuring the integrity and safety of our Symposium remains our foremost priority.

Finally, with the scale of the event this year far surpassing what we anticipated, it is clear in hindsight that we would have benefitted from a larger team given that all organizers were volunteers who were either students or postbaccalaureate professionals. In the future, we will explore appointing a "program steering committee" specifically devoted to organizing the Symposium to meet its growing need.

Closing Thoughts

We are grateful to have returned for a second year with even greater interest and support. We firmly believe that free, virtual conferences are feasible and valuable to the research community. Without such opportunities, it will not be possible to cultivate a diverse, inclusive, and rigorous scientific community. It is imperative that the next generation of psychological scientists be composed of the best and brightest our field has

to offer. This is not possible if participation in our field is determined by country of origin, health, and socioeconomic status, or any other criteria apart from intellectual merit. As previously stated, our core team at the Student SIG consists entirely of students and postbaccalaureate researchers. The Student Research Symposium was founded by two undergraduates. We are hopeful that our humble beginnings are a testament to how truly possible it is for barriers to be removed when concerned people are committed to removing them.

In addition to the event that inspired ours (i.e., the Suicide Research Symposium), we have since been excited to learn that other groups have supported similar efforts to provide free and low-cost, virtual research-sharing opportunities. A few that we have been made aware of are: Youth Suicide Research Consortium annual conference: (https://www.youthsuicideresearch.org/), Society for Digital Mental Health annual conference (https://societydmh.org/), and Big Team Science Conference (https://bigteamscienceconference.github.io/index).

An exciting recent development is the Association for Psychological Science announcing their first Global Psychological Science Summit, an upcoming online conference. Although details are currently limited, more information is set to be shared this month: https://www.psychologicalscience.org/conventions/2024-virtual-global-psychological-science-summit. To our knowledge, this is the largest professional organization hosting an online research conference. We look forward to observing how the event develops.

We are grateful to the people who made this year's Symposium possible, namely: APA Division 37 (Dr. Cynthia Brown, Dr. John Cooley, Dr. Shaquanna Brown, Alexandria Winstead, and Annie Ryder); ABCT Central Office (Rachel Lamb and Emily Ravaioli); ABCT Student SIG (Eduardo Hernandez Mozo, Marley Billman Miller, Samantha Klaver, and Torsa Chattoraj). Additionally, we are grateful to the many reviewers who scored abstracts, the individuals and organizations who graciously promoted the Symposium on their social media, all attendees and presenters, and many others.

We look forward to the years to come.

REFERENCES

Hart, F. G. (2023). The 2023 Student Research Symposium: Reflections and Recommendations. *the Behavior Therapist, 46*(6).

Lincoln, S. H. (2024). *Advancing Knowledge: Empowering Student Research and Increasing Accessibility* [Keynote speech]. ABCT Student SIG Research Symposium, Virtual.

Millennials boast huge social networking growth and engagement on smartphones, but older users surprisingly outpace them on tablets. Comscore, Inc. (2015, August 12). https://www.comscore.com/por/Insights/Blog/Millennials-Boast-Huge-Social-Networking-Growth-and-Engagement-on-Smartphones#:~:text=As%20social%20networking%20penetration%20inches,coming%20from%20smartphones%20and%20tablets.

Odabas, M. (2022). *10 Facts About Americans and Twitter.* Pew Research Center. https://www.pewresearch.org/short-reads/2022/05/05/10-facts-about-americans-and-twitter/

Pew Research Center. (2024, January 31). *Social Media Fact Sheet*. Pew Research Center. https://www.pewresearch.org/internet/fact-sheet/social-media/

Reshef, O., Aharonovich, I., Armani, A.M., Gigan, S., Grange, R., Kats, M.A., Sapienza, R. (2020). How to organize an online conference. *Nature Reviews Materials, 5*(4), 253-256. doi: 10.1038/s41578-020-0194-0.

Son, J., Sabio, J., Jain, A., Ulijn, RV. (2022). Ten Steps to Organize a Virtual Scientific Symposium and Engage Your Global Audience. Global Challenges, 6(9), 2200005. doi: 10.1002/gch2.202200005.

Yu, H., Xiao, T., Xu, S., Wang, Y. (2019). Who posts scientific tweets? An investigation into the productivity, locations, and identities of scientific tweeters. *Journal of Informetrics, 13*, 841-855. https://doi.org/10.1016/j.joi.2019.08.001. ■

Call for Papers

Psychedelic-Assisted Psychotherapy

the Behavior Therapist is currently seeking submissions for a special issue: **Psychedelic-Assisted Psychotherapy: The Necessity of Leadership Through Evidence-Based Practice**. The special issue is being guest edited by Drs. Monnica Williams and Matthew Skinta and is tentatively set for an early 2025 publication.

The journal is seeking submissions that focus on issues related to the importance of psychologists and other mental health therapists as leaders in the science of psychedelic-assisted psychotherapy. Although the special issue is open to articles about psychedelic-assisted psychotherapy and current developments, a priority is to showcase articles that highlight the value that cognitive-behavioral therapy and perspectives bring to this domain. This includes, but is not limited to, methodological considerations, the study of set and setting, behavioral articulations of the psychedelic experience, and the integration of cognitive-behavioral innovations as specific tools of preparation and integration. The special issue also aims to publish articles that are representative of diverse communities and that highlight intersectionality (i.e., the intersection of multiple marginalized identities).

If you are interested in submitting an article for consideration, please email Dr. Williams (Monnica.Williams@uottawa.ca) and Dr. Skinta (mskinta@roosevelt.edu) a brief paragraph or abstract describing what you are interested in writing about by Friday, September 6. Article should be between 2,500 and 4,000 words.

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