ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

the Behavior Therapist

ISSN 0278-8403 Volume 47, Issue 7 | October 2024

Editor: Gregory S. Chasson, Ph.D.

Editorial Board
Copyright transfer
Submission Guidelines

> *Academic Forum*

> *Clinical Practice Forum*

> ABCT MATTERS

> THIS MONTH'S ADVERTISERS

ERRATUM: The article "Experiences of Physically Disabled and Blind People in Psychotherapy: Lessons for CBT Therapists" published in *the Behavior Therapist, 47*(1), incorrectly lists the authors. The correct order is Marco Gomez and Rhoda Olkin. We apologize for this error.

the Behavior Therapist

Published by the Association for Behavioral and Cognitive Therapies | 305 Seventh Avenue, New York, NY 10001

www.abct.org

The Association for Behavioral and Cognitive Therapies is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles.

the Behavior Therapist Volume 47, Issue 7

ACADEMIC FORUM

Recommendations for Alcohol Administration Experiments Among Participants With Current Suicide Ideation and Behavior

Amanda K. Gilmore, Cecilia J. Moore, and K. Nicole Mullican,
National Center for Sexual Violence Prevention, Mark Chaffin Center for Healthy Development, School of Public Health, Georgia State University

The authors declare no conflicts of interest.

Correspondence to
Amanda K. Gilmore, Ph.D., School of Public Health, Georgia State University, PO Box 3995, Atlanta, GA 30302
agilmore12@gsu.edu

In the past 20 years, suicide rates in the U.S. have increased 31% and suicide has consistently been ranked in the top 10 leading causes of death (Centers for Disease Control and Prevention [CDC], 2023). Alcohol use is associated with suicide (Norström & Rossow, 2016), and alcohol-involved suicides are one type of a growing category of mortality that have been coined “deaths of despair” (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2023). In fact, individuals are 13 times more likely to commit suicide under the influence of alcohol than when sober (Cherpitel et al., 2004). Despite the compelling and consistent link between alcohol and suicide, research has been limited to cross-sectional studies, autopsies, and toxicology findings. There is a dire need to understand in-the-moment factors of alcohol use impacting suicidal ideation and behavior (SIB).

Alcohol administration research has been conducted for decades to understand alcohol’s physiological and psychological effects on a variety of behaviors, including aggressive behavior (Abbey & Helmers, 2020). Although alcohol administration studies typically exclude participants who have had traumatic head injuries, psychiatric illnesses that have required in-patient care, substance use and other mental health disorders that are currently being treated by a mental health professional, and medication use that is contraindicated with alcohol consumption, those studying sexual aggression do not typically assess suicide risk (Davis et al., 2022; George et al., 2009; Leone & Parrott, 2019). NIAAA's 2023 "Guidance for Conducting Alcohol Administration Studies with Human Participants” also does not address screening for research participants’ SIB risk or history, which could partially explain why suicidality is not typically assessed (NIAAA, 2023).

Concurrent with the development of alcohol administration guidelines, safety protocols for conducting clinical assessments with suicidal participants have also been established and implemented for over 45 years (Linehan et al., 2012). Therefore, safety protocols and standard operating procedures have been well-established separately for alcohol administration studies and adults with current SIB. There remains a gap, however, in utilizing alcohol administration with individuals who engage in self-directed aggression (i.e., any behavior intended to harm oneself, including suicide attempts; VandenBos, 2015). Therefore, the purpose of this paper is to outline safety protocols and standard operating procedures for researchers studying in-the-moment effects of alcohol on SIB using alcohol administration experiments with participants experiencing current SIB.

Despite the importance of this research, it likely has not been conducted due to the potential risks and ethical concerns, given the sample required to conduct this work. Because individuals cannot provide informed consent while intoxicated, it is imperative that researchers obtain consent prior to alcohol administration procedures and do so in a manner that ensures participant comprehension and opportunities to ask questions. Researchers and Institutional Review Board (IRB) committees may have concerns that assessment of SIB may "prime" vulnerable individuals and lead to increased suicide risk. However, previous literature has indicated that asking questions related to suicide does not expose participants to undue risk or lead to thoughts of suicide (e.g., Cukrowicz et al., 2010; Reynolds et al., 2006; Schatten et al., 2022). Results from these studies suggest that participants do not experience increased SIB and many participants reported that such questions allowed them to express themselves more effectively (Cukrowicz et al.). In fact, in one study, participants who had been asked about their suicidal thoughts and behavior had decreased suicidal thoughts 1 month after answering questions related to suicide (Cukrowicz et al.). Furthermore, in a sample of suicidal adults who engaged in heavy episodic drinking, pre-post assessment of suicidal urges, suicidal intent, stress ratings, and urges to use drugs/alcohol were significantly lower postassessment than they were preassessment (Ward-Ciesielski & Wilks, 2020). Thus, there is evidence to support that assessment of SIB among adults with current SIB is not harmful and does not lead to increased suicide risk.

Concerns over inducing intoxication in individuals with SIB may also arise. To mitigate those concerns, protocols should require that participants consume the dose of alcohol administered in the laboratory at similar rates at home, ensuring study participation does not expose them to new experiences. The risks are not anticipated to be more than those experienced by the participant in real life given that they are recruited based on current experiences of similar drinking patterns. For example, if providing a dose of .08 in an alcohol administration paradigm, researchers should consider recruiting participants who regularly and recently engaged in heavy episodic drinking. Providing this dose in a lab setting is likely a safer environment than in locations where they are not under the supervision of a clinical psychologist and trained research staff.

IRB committees may also have concerns over researchers' responsibility to provide intensive or ongoing therapeutic care to participants who endorse having a non-zero risk of suicidality. However, as Hom and colleagues (2017) noted, researchers should not serve as participants' primary mental healthcare providers. Rather, they should act only as "informed gatekeepers" who regularly assess for SIB risk and then provide

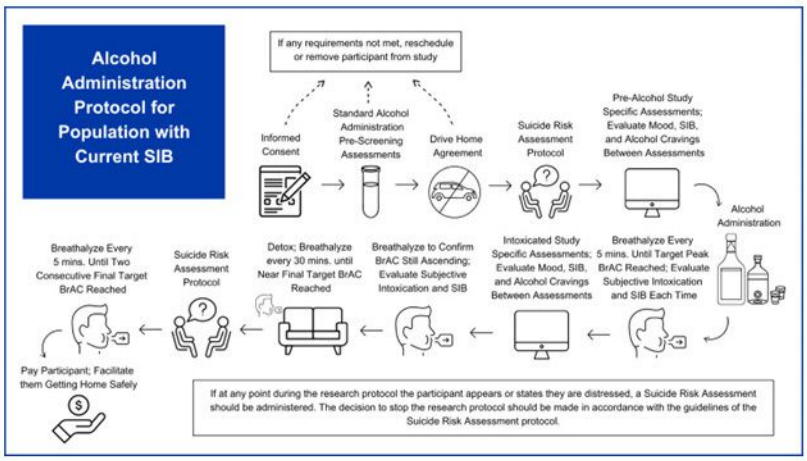

Figure 1. Alcohol Administration Protocol for participants with SIB

proper resources and support in accessing those resources when necessary. As such, research teams should prepare and provide a list of resources to participants that are available nationwide, statewide, and locally.

Nonetheless, risks are still possible, and safeguards must be in place. As such, we recommend the following safety protocols and standard operating procedures for researchers studying in-the-moment effects of alcohol on SIB using alcohol administration experiments with participants experiencing current SIB (see Figure 1):

1. Inclusion and Exclusion Criteria

Although the current norm in alcohol administration protocols is to not assess suicide risk, when risk is assessed it is common for researchers to exclude individuals considered "higher risk," such as those with a current suicide plan. This is meant to recruit a lower-risk sample; however, research shows that passive and active ideation similarly predict suicide risk (Liu et al., 2020), and it is well documented that suicide risk fluctuates over short periods of time (Kleiman et al., 2017), so removing individuals with a current plan does not guarantee a lower-risk sample. Rather than excluding individuals with a current suicide plan, we recommend including participants with current SIB and ensuring that risk assessment is an ongoing process throughout research procedures. This should include a structured suicide assessment and risk management protocol (see #3 below and scoping review by Stevens et al., 2021). Because this population is commonly excluded from research or their risks are not assessed, much is left to learn. Including individuals with varying levels of suicide risk, even those with a suicide plan, will improve generalizability and our overall understanding of suicide risk.

2. Preprotocol Procedures

Each research session should begin with obtaining informed consent and a signed Drive Home Agreement. This agreement should outline that participants agreed to not drive a motor vehicle after leaving the laboratory and include a plan for how they will get home safely (i.e., they will be transported home via public transportation [e.g., a taxi] or the participant will prearrange their own transportation [e.g., a ride from a family member or friend]). Sessions should also begin with a suicide risk assessment protocol. We recommend the University of Washington Risk Assessment Protocol (UWRAP), because it was specifically developed to be used during research studies that recruit participants with SIB (Linehan et al., 2012) and has been used in numerous studies evaluating suicide (Reynolds et al., 2006; Schatten et al., 2022; Ward-Ciesielski & Wilks, 2020). It includes: preassessment risk-assessment questions, a mood-improvement protocol (to be collaboratively filled out with the participant), a debriefing checklist and protocol, and a suicide/distress intervention protocol to be implemented in case a participant's suicidal urges rise above a certain degree. The preassessment questions are helpful in understanding a participant's baseline mood and SIB risk, while the mood-improvement protocol provides a list of coping strategies and enjoyable activities that the participant can engage in to improve their mood should distress occur. Alternative suicide risk assessment options, among others, include the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011), the Suicide Risk Assessment and Management Decision Tree (Decision Tree; Chu et al., 2015; Joiner et al., 1999), and the Collaborative Assessment and Management of Suicidality (CAMS; Comtois et al., 2011; Ferguson et al., 2021).

The UWRAP has not been updated to include comprehensive lethal means counseling; however, this could be added to any suicide risk assessment or protocol. For

example, the Stanley Brown Safety Plan is a popular safety plan that includes a section on access to lethal means (Stanley & Brown, 2012). The federally funded Suicide Prevention Resource Center also offers a free, 2-hour-long course titled Counseling on Access to Lethal Means, which researchers can take to bolster their skills in this area of concern (Sale et al., 2018).

3. Procedures During Research Protocol

To ensure SIB does not increase during alcohol administration procedures, we recommend assessing subjective intoxication and suicidal urges every 5 minutes (e.g., "On a scale of 1 [*no urges at all*] to 10 [*the strongest, most intense urges possible*], rate the intensity of your urge to commit suicide and to self-harm") in conjunction with breathalyzer assessments until target breath alcohol concentration (BrAC) is reached. Suicidal urges and mood should continue to be assessed before and after each research task. In line with the UWRAP guidelines, if a participant's suicidal urges increase by 2 points or more (on the 7-point scale) over their baseline scores (e.g., if a participant reported an urge of 3 at the onset of the study and the urge increases to 5) or if a participant reports a suicidal urge of 4 or above, then the Suicide/Distress Intervention Protocol should be implemented (Linehan et al., 2012). If at any point during the research protocol a participant appears or states they are distressed, a suicide risk assessment should be administered. The decision to stop the research protocol should be made in accordance with the guidelines of that protocol. Moreover, participants posing imminent danger to themselves should not leave the laboratory until their suicide risk decreases and/or mood improves. Clinically trained supervisors should be available during the study to intervene.

4. Procedures After Detoxification Protocol

End each session with a UWRAP Debriefing Checklist and Protocol, or if you've chosen another suicide risk assessment, like the C-SSRS, then readminister the same one you used at the start of the session to assess if suicidal urges have increased from when the participant entered the research session. If during the debriefing questions it becomes clear that the participant's suicidal urges have increased, act according to the UWRAP's scoring guidelines referenced above, or according to the guidelines of the suicide risk assessment you are following. Again, clinically trained supervisors should be available during the study and ready to intervene in this case. As mentioned above, researchers should also create a mental health resource guide that they give to all participants for proper after-care; this could include contact information for the Crisis Text Line, local community-based and private practice mental health centers, substance use rehabilitation centers, and the closest local psychiatric wards. Researchers should also help the participant contact these resources or the specific people identified in their safety plan as needed. If suicidal urges have not increased, we recommend administering breathalyzer assessments every 5 minutes until final detoxed BrAC is reached. At that time, participants should be paid and researchers should help participants get home safely in accordance with the plan outlined in their Drive Home Agreement.

Due to the increase in suicide rates (CDC, 2023) and the consistent finding that alcohol is associated with SIB, it is imperative to understand the physiological and psychological effects of alcohol on SIB using in-the-moment alcohol administration experimental paradigms. These safety protocols and standard operating procedures allow for important research questions to be asked in a way that can directly inform suicide prevention

among intoxicated individuals. Specifically, experimental paradigms with alcohol administration among suicidal participants with current SIB can identify in-the-moment risks that instigate and attenuate this type of thinking and behaviors. Additionally, these types of studies could test possible real-time interventions for participant' suicidal thoughts and demonstrate their efficacy. This is crucial as suicide research and prevention has not yet made an impact on suicide rates in the U.S.

REFERENCES

Abbey, A. & Helmers, B. R. (2020). Sexual aggression analogues used in alcohol administration research: Critical review of their correspondence to alcohol-involved sexual assaults. *Alcoholism, Clinical and Experimental Research, 44*(8), 1514–1528.

Centers for Disease Control and Prevention. (2023, August 2). *Suicide data and statistics*. U.S. Department of Health and Human Services https://www.cdc.gov/suicide/suicide-data-statistics.html

Cherpitel, C. J., Borges, G. L., & Wilcox, H. C. (2004). Acute alcohol use and suicidal behavior: A review of the literature. *Alcoholism, Clinical and Experimental Research, 28*(5), 18S-28S.

Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized assessment of suicide risk in clinical practice: An empirically informed update. *Journal of Clinical Psychology, 71*(12), 1186–1200. https://doi.org/10.1002/jclp.22210

Comtois, K. A., Jobes, D. A., S. O'Connor, S., Atkins, D. C., Janis, K., E. Chessen, C., Landes, S. J., Holen, A., & Yuodelis, F. C. (2011). Collaborative assessment and management of suicidality (CAMS): feasibility trial for next-day appointment services. *Depression & Anxiety, 28*(11), 963–972. https://doi.org/10.1002/da.20895

Cukrowicz, K., Smith, P., & Poindexter, E. (2010). The effect of participating in suicide research: does participating in a research protocol on suicide and psychiatric symptoms increase suicide ideation and attempts? *Suicide & Life-Threatening Behavior, 40*(6), 535–543. https://doi.org/10.1521/suli.2010.40.6.535

Davis, K. C., Neilson, E. C., Kirwan, M., Bird, E. R., Eldridge, N., George, W. H., & Stappenbeck, C. A. (2022). The interplay of sexual arousal and power-related emotions in men's alcohol-involved sexual aggression intentions. *Journal of Sex Research, 59*(6), 765–779. https://doi.org/10.1080/00224499.2021.1972923

Ferguson, M., Rhodes, K., Loughhead, M., McIntyre, H., & Procter, N. (2021). 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

George, W. H., Davis, K. C., Norris, J., Heiman, J. R., Stoner, S. A., Schacht, R. L., Hendershot, C. S., & Kajumulo, K. F. (2009). Indirect effects of acute alcohol intoxication on sexual risk-taking: The roles of subjective and physiological sexual arousal. *Archives of Sexual Behavior, 38*(4), 498–513. https://doi.org/10.1007/s10508-008-9346-9

Hom, M. A., Podlogar, M. C., Stanley, I. H., & Joiner, T. E., Jr. (2017). Ethical issues and practical challenges in suicide research: Collaboration with institutional review boards. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 38*(2), 107–114. https://doi.org/10.1027/0227-5910/a000415

Joiner, T. E., Walker, R. L. Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional Psychology: Research and Practice, 30*, 1-7.

Kleiman, E. M., Turner, B. J., Fedor, S., Beale, E. E., Huffman, J. C., & Nock, M. K. (2017). Examination of real-time fluctuations in suicidal ideation and its risk factors: Results from two ecological momentary assessment studies. *Journal of Abnormal Psychology, 126*(6), 726–738. https://doi.org/10.1037/abn0000273

Lago-Gonzalez, L., Bronchain, J., & Chabrol, H. (2021). Psychopathic and borderline traits in a college sample: Personality profiles and relations to self-directed and other-directed aggression. *Personality and Individual Differences, 168*, Article 110390. https://doi.org/10.1016/j.paid.2020.110390

Leone, R. M., & Parrott, D. J. (2019). Acute alcohol intoxication inhibits bystander intervention behavior for sexual aggression among men with high intent to help. *Alcoholism, Clinical and Experimental Research, 43*(1), 170–179. https://doi.org/10.1111/acer.13920

Linehan, M. M., Comtois, K. A., Ward-Ciesielski, E. F. (2012). Assessing and managing risk with suicidal individuals. *Cognitive and Behavioral Practice, 19*(2), 218-232.

Liu, R. T., Bettis, A. H., & Burke, T. A. (2020). Characterizing the phenomenology of passive suicidal ideation: A systematic review and meta-analysis of its prevalence, psychiatric comorbidity, correlates, and comparisons with active suicidal ideation. *Psychological Medicine, 50*(3), 367–383. https://doi.org/10.1017/S003329171900391X

National Institute on Alcohol Abuse and Alcoholism. (2023, August 2). *Alcohol and "Deaths of despair."* https://niaaa.scienceblog.com/227/alcohol-and-deaths-of-despair/

National Institute on Alcohol Abuse and Alcoholism. (2023, July 5). *NIAAA guidance for conducting alcohol administration studies with human participants*. https://www.niaaa.nih.gov/research/guidelines-and resources/guidance_conducting_alcohol_administration_studies_human_participants

Norström, T., & Rossow, I. (2016). Alcohol consumption as a risk factor for suicidal behavior: A systematic review of associations at the individual and at the population level. *Archives of Suicide Research, 20*(4), 489-506.

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *The American Journal of Psychiatry, 168*(12), 1266–1277. https://doi.org/10.1176/appi.ajp.2011.10111704

Reynolds, S. K., Lindenboim, N., & Comtois, K. A. (2006). Risky assessments: Participant suicidality and distress associated with research assessments in a treatment study of suicidal behavior. *Suicide and Life-Threatening Behavior, 36*(1), 19–34.

Sale, E., Hendricks, M., Weil, V., Miller, C., Perkins, S., & McCudden, S. (2018). Counseling on access to lethal means (CALM): An evaluation of a suicide prevention means restriction training program for mental health providers. *Community Mental Health Journal, 54*(3), 293–301. https://doi.org/10.1007/s10597-017-0190-z

Schatten, H. T., Allen, K. J. D., Carl, E. C., Miller, I. W., III, & Armey, M. F. (2022). Evaluating potential iatrogenic effects of a suicide-focused research protocol. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 43*(6), 508–515. https://doi.org/10.1027/0227-5910/a000823

Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256–264.

Stevens, K., Thambinathan, V., Hollenberg, E., Inglis, F., Johnson, A., Levinson, A., Salman, S., Cardinale, L., Lo, B., Shi, J., Wiljer, D., Korczak, D. J., & Cleverley, K. (2021). Core components and strategies for suicide and risk management protocols in mental health research: A scoping review. *BMC Psychiatry, 21*(1), 1–14. https://doi.org/10.1186/s12888-020-03005-0

U.S. Department of Health and Human Services. (2009). *Code of federal regulations, Title 45, Public welfare, Part 46: Protection of human subjects*. Rockville, MD: Office for Human Research Protections.

VandenBos, G. R. (2015). *APA dictionary of psychology* (2nd ed.). American Psychological Association.

Ward-Ciesielski, E. F., & Wilks, C. R. (2020). Conducting research with individuals at risk for suicide: Protocol for assessment and risk management. *Suicide & Life-threatening Behavior, 50*(2), 461–471. https://doi.org/10.1111/sltb.12602 ■

Repackaging Exposure Therapy as the Practice of Approach: A New Idea for an Old Problem

Keith S. Cox, *University of North Carolina, Asheville, and Responder Support Services, Asheville*

ORCID ID: https://orcid.org/0009-0001-8569-849X

The author declares no conflicts of interest.

Correspondence to
Keith S. Cox, Ph.D., Psychology Department, University of North Carolina-Asheville, 1 University Heights, Asheville, NC, 28804
kcox2@unca.edu

WHAT IS THE MOST EFFECTIVE way psychotherapists could improve mental health in America today, given existing technology and the current knowledge base? I believe the answer is the widespread use of exposure therapy (ET). This answer reveals a triumph and a tragedy of mental healthcare in the United States. ET is putatively the most powerful clinical tool available to therapists, yet it is widely underutilized (Becker et al., 2004; Becker-Haimes et al., 2017) and/or misunderstood (Murray et al., 2022).

ET is a triumph of clinical care and psychological theory in that a small set of principles and techniques effectively treat a broad range of disorders. While there have been developments in ET theory (e.g., inhibitory learning vs. extinction learning vs. emotional processing theory) and the application of exposure (e.g., focus on between- vs. within-session habituation; flooding vs. graded), the core practices of ET have largely remained the same for decades, demonstrating the lasting power of this approach to healing the human psyche.

Researchers have shown there are multiple reasons ET is underutilized and misunderstood, from systemic barriers (McLean et al., 2024) to therapist misconceptions (Deacon et al., 2013). Even large-scale, institutionally backed efforts to promote ET in contexts like the Veteran's Health Administration have not overcome these problems (e.g., Rosen et al., 2016).

I propose the standard branding and framing of ET are two big reasons ET is dramatically underused. ET is a theoretical and scientific success story but a marketing failure. We, the practitioners and researchers of ET, often don't know how to best think and talk about this powerful intervention. The ways we do can be unappealing to patients and, on the clinician side, make it more likely that only steel-stomached behaviorally oriented therapists (i.e., a minority of clinicians) regularly use ET (Schneider et al., 2020). I propose a new way to think and talk about ET to make it more compelling for patients to do and providers to implement. Still, the proposal does not change that ET, like most things of value, is hard and requires work for both patients and providers.

Words Matter: Approach, Not Exposure

From a historical perspective, it makes sense that exposure was named exposure. The psychotherapy treatments that formalized ET for widespread clinical use in the 1960s through the 1990s drew on the behavioral tradition in which animal laboratory experiments were a primary form of research. Dogs or rats or pigeons were presented a stimulus, and this action was called "exposure." ET pioneers (e.g., Wolpe, Meyer, and Foa) drew on this tradition. In that cultural moment, psychotherapy needed to lean on medico-scientific concepts to establish itself as evidence-based and worthy of government funding and insurance reimbursement. But is exposure a sensible term for appealing to 21st century therapists and therapy consumers? To see, let's try an exercise. What comes to mind when you hear the word *exposure* completely outside the frame of therapy or the lab? (I know, an impossible task given this essay, but humor

me.) Here are some possibilities: exposure to toxins (e.g., Camp Lejeune water contamination for a Marine Corps veteran), exposure to the elements (i.e., freezing to death), or an old man in the park with a trench coat exposing his genitals. These connotations are not helpful for persuading therapists and patients to use ET. We are asking people to do hard things while talking about the hard things in unappealing ways. As a comms strategy, it's a loser.

I propose new terminology for ET that is more appealing and more accurate. Researchers, government scientific panels, and insurance boards can keep the term *exposure* if they like. But it should be renamed *approach* with clients and clinicians. Approach is more accurate as it is more agentic. Exposure suggests passivity on the part of the client, but completing exposure exercises demands proactive exertion and willpower from clients. It is anything but passive. It is not something done to clients (outside of bad therapy). It is something they do. (Bringing a tarantula into the office in treating spider phobia is probably the closest therapists come to presenting a stimulus; even then, we get client buy-in beforehand, so "expose" is not an accurate verb.) Moreover, *approach* describes what the client psychologically or behaviorally does—that is, goes towards the avoided/obsessed-over stimulus.

Importantly, *approach* readily suggests targeting the problematic maintenance factor of avoidance whereas exposure does not. What's the opposite of exposure? Shelter? I like having shelter—it's a basic human need. The opposite of approach is avoidance, the main clinical target in ET. Thus, exposure therapists are advocating for approach over avoidance, not exposure over shelter. So let's call it like it is instead of using terminology from 1950s pigeon research.

There is also a theoretical reason for this name change. Approach fits better with evolutionary and animal behavior accounts of psychopathology. Animals in the wild and across evolutionary history approach, avoid, or freeze in response to aversive or threatening stimuli. They do not expose themselves to such stimuli.

Finally, the proposed rebrand of ET is an extension of what is already present in ET manuals and trainings, and already part of the practice of skillful clinicians—the use of empowering and compelling language when discussing ET with clients. For example, ET manuals talk about "revisiting painful memories" or "facing your fears" (Foa et al., 2019) and skillful clinicians know to use language that speaks to the individual client in front of them and not confuse clients with technical jargon.

"Imagination," "Action," "Body" Instead of "Imaginal," "In Vivo," "Interoceptive," Respectively

Exposure is often described as coming in three varieties: *imaginal, in vivo*, and *interoceptive*. These terms are less helpful for communicating with clients and clinicians today, even as they made sense during the development of ET. To start, is imaginal a made-up word? Turns out it isn't, but I thought it was until I looked it up just now. So it's probably not relatable for clients. Here's an irony: As I write this, Google Docs suggests I change imaginal to imaginary. I agree, Google Docs, a change is needed. *In vivo*: I am a Latin nerd but most people and providers who don't live in Vatican City find the usage of Latin in everyday life to be pretentious or incomprehensible. I love fancy words like *interoceptive*. They make me feel smart. But most people don't like five-dollar SAT words. Here's the rebrand: Imaginal exposure is *approach with imagination*—using the incredible human power of imagination and memory to heal. In vivo exposure is *approach with action*—strategic action to foster restoration and greater capability. Interoceptive exposure is *approach the body*—somatic exercises that bring relief and growth.

The Practice of Approach

Now "approach" is not just three activities. The name should convey its breadth. So the full name of ET can be *the practice of approach*. Why? Because it is a skill to be learned that takes repetition, you are *practicing* it with a team (group therapy) or a coach (therapist). *Practice* is when you get your "reps in," like a workout at the gym. *Practice* can be hard, but it pays off at game time. *Practice* also undermines anticipatory anxiety and perfectionism. It's OK to mess up in practice or not be good at it right away; practice connotes that approach is a skill to be learned, which is how expert exposure therapists teach and talk about it. *Practice* also evokes spiritual *practice*s such as prayer, contemplation, and religious visualization. This connotation is attractive to spiritual/religious clients and also accurately reflects we are doing something profound. Finally, the practice of approach conveys that this is a general orientation to life, so helps clients generalize approach over avoidance in areas not directly targeted in therapy. They are not having a specific stimulus exposed to them. They are learning to become someone who approaches instead of someone who avoids.

One key to discussing the practice of approach is that it is always two things and not just one. It is always approach *and* process. It is not just approach. When we discuss ET we are too heavily focused on exposure and not enough on processing the exposure. We mistakenly give the impression that ET is mostly one thing instead of at least two. While both inhibitory learning models and emotional processing theory (EPT) process exposures through discussions of expectancy violations and meaning making, many non-ET therapists might miss this. They may see ET as a brute act of exposing the client to the feared stimulus, which relies mostly on habituation for its therapeutic effects. But ET consistently advocates for postexposure processing, a client-directed time for dialogue about the meanings and insights the exposure experience has afforded. Thus, in the second exposure, the stimulus is changed, if even so slightly. It is modified by client-won deliverances from the first round of postexposure processing. This dynamic iteratively plays out over exposure round 2 to round *n* with an ever-growing bundle of client-generated meanings and insights. ET is a dance of action and meaning, new action and new meaning. It is not raw habituation, just getting to boredom with the terrors of the past or of our mind.

Many non-ET providers miss this fuller picture. They do not see exposure as an expert coach, using practical wisdom, carefully planning the approach with the client, the coach cheering from the sidelines as the client approaches, and then afterward the coach carefully helping the client work out what has been learned. Nor do they see that it is the repetition with modification that allows for approach and processing to be both simple and profound, straightforward but go deep. (User warning: some therapists only want to process and don't want to approach but this is often therapeutically inert as PTSD or OCD eats the lunch of insight-without-action every time. Processing must be *post*-approach not instead of approach.) Finally, non-ET therapists are often not aware of the rich therapeutic relationship, trust, and respect that develops over the course of multiple doing-oriented approach/exposures, and as such do not have access to this relationship springboard.

Transdiagnostic, Transtheoretical ET

I have written a self-help book that describes the practice of approach in a transdiagnostic way. The practice of approach is for problematic patterns of avoidance/obsession that arise in many disorders: OCD, PTSD, depression, anxiety disorders, eating dis-

orders, and so on. The targets of approach are *habits of avoidance/obsession* that are a (clinical) *problem* (HAPs and HOPs for short). The four moves against the dominance of HAPs and HOPs are: identify, map, act, rejoice. Identify the problematic avoidance/obsession pattern. Map out its presence in the client's life. Act to alter or eliminate it through practicing approach and processing. Rejoice as the client consolidates gains and sees who they have become.

This transdiagnostic framing for ET fits with a transtheoretical conceptualization that could broaden ET's appeal beyond behaviorists. Crucially, the idea of approaching persistently avoided/obsessed-over stimuli has arisen in numerous psychotherapy traditions because approach/exposure captures fundamental truths about the human condition. Both behaviorists and other traditions, though, have not recognized this consilience, in part because we and they have been siloed in our terminological and conceptual habits. The new terminology of the practice of approach (over avoidance) makes it easier to build conceptual bridges to other theoretical orientations. For example, when a practitioner of emotion-focused therapy (EFT) for individuals hears about "exposure," they might not readily see two-chair exercises, a common EFT technique, as a form of approach/exposure. In two-chair, two chairs are set up and the patient iteratively and imaginatively approaches avoided emotions or conversations with the self or others, switching seats between the two chairs. The patient approaches, experiences, and then processes the avoided content. This is imaginal exposure with props, but most don't realize it. An EFT therapist, though, might appreciate that two-chair is *approaching with imagination*—using the capacities of human imagination to go towards avoided content. The EFT therapist might then take up the ET insight that repetition of approach is often needed for durable new learning to take root and so practice two-chair more than the few number of times that EFT typically indicates. Here, ET wisdom can improve exposure activities already happening in another tradition. And if the EFT therapist can see two-chair as approach, they might be more open to see other forms of approach as therapeutic, e.g., *approaching the body* in panic disorder.

Here are three more possibilities of approach consilience across traditions: (a) EMDR therapists use approach with imagination for traumatic memories in PTSD and for avoided internal content with other disorders; (b) in some psychodynamic traditions, avoidance is cast as a defense mechanism that is interrupted through the self approaching the self, i.e., what behavioral therapists might call avoiding avoidance with respect to internal content; (c) third-wave CBT often uses forms of ET reframed through the lenses of mindfulness, distress tolerance, and acceptance, as it targets experiential avoidance (Hayes, 2020). The term exposure and its connotations can shut down bridge building to these traditions, especially nonbehavioral ones. But what if we communicate with practitioners in these traditions using (some of) their terms to help them refine and expand the approach practices they are already doing? More ET gets done.

This is not a common factors argument or an argument that many psychotherapy traditions are fundamentally compatible. Instead, this is an attempt to increase the usage of approach/exposure practices so patients who see therapists in other traditions have better access to one of the most effective therapy interventions. Fidelity to the core principles and practices of ET is essential, but we do not want to miss opportunities for nonbehavioral therapists to use approach/exposure because we are unimaginative and rigid in our rhetorical practices.

Three Motivating Frames for Appealing to Clients and Nonbehaviorist Clinicians

There are underutilized cultural and psychological resources for motivating client

and clinician engagement with ET. Here are three frames that might motivate ET engagement for a patient or provider. (User warning: ET manuals are exquisite in their efficiency. Use of frames should not unduly slow down the start of approach/exposure and should be tailored to the individual.) Moreover, these frames each tap into something big about the human condition and thereby show that approach works because it addresses who we fundamentally are.

Frame 1

Recent personality science has come to see modern Western individuals as storytellers with maybe the most momentous story we tell as the one we have going about our own life—who we were, are, and will be (McAdams, 2021; Pasupathi & Adler, 2021). This is called the *life story,* the internalized and evolving narrative of the self (McAdams & Cox, 2010). The life story contains plots, characters, episodes, story arcs, all drawn from the individual's experience, and is conceptualized as a key construct for understanding modern Western persons, i.e., our patients. As opposed to their location in the five-dimensional space of the Big 5, or their MMPI-2 profile, many people readily see themselves through their life story and find telling and thinking about their life story affirming (e.g., this often interferes with efficient intake sessions). Crucially, psychopathology impacts the life story in numerous ways (e.g., Cowan et al., 2021). The primary trauma memory becomes the life story's center of gravity in PTSD or dark themes dominate the story in mood disorders. Therapy consumers often see therapy as the space to revise their life story. We can use this to motivate ET buy-in. The practice of approach can be cast as the workshop for broken life stories. When we are in the powerful grip of anxiety, depression, or PTSD, we can't but spin darkened tales about our past, present, and future. Our clients have probably already tried on their own to re-narrate their life story with a brute act of will and have failed and come to us for help. They've been trying to carve marble with a plastic knife. But the practice of approach gives them a hammer and chisel. Approach activates the relevant schema, beliefs, and emotions, and processing affords the time to consolidate learning from the approach experience and alter distorted schema and beliefs. This work allows for the possibility of re-narrating the life story in more adaptive, resilient ways. I become a new me because the practice of approach helps me tell a new story about me. We can explain approach as getting into a cold pool and noticing that the water doesn't feel so cold after a bit, and we can also harness the appeal of approach as the workshop for broken life stories. This is not just salesmanship. Approach with productive processing often does lead to revising the life story in significant ways, I believe. This is a gem of ET that many of us miss, given the lack of attention clinical psychology pays to the life story.

Frame 2

Approach is crucial to many of our most beloved stories as the drama of approach captures something central about the human experience. Our culture lionizes heroes of approach, and we can use these heroes to inspire our client's usage of ET. We can fill up the cupboard of clinical metaphors by raiding movies, shows, and literature.

The basic form of the approach hero is central to so many stories because it is an important human story—the quest (Campbell, 1949). The hero is beset by their darkness, foe, or fear. The hero is defeated or retreats and cowers (the onset of the disorder). Darkness is in apogee, seemingly for good (disorder maintenance). The hero finds new strength or knowledge. Maybe through connecting with their pack or a new teacher (like a therapist), maybe with a visit of the spirit, maybe they learn of powers (in therapy) they

didn't know they had. Through practice, the hero grows into new strength and knowledge. The hero summons the courage to face the darkness and the second battle begins (starting approach). The battle is not cupcakes and roses, bon bons and licorice (practicing approach). The battle is bloody. The hero's strength is tested and holds. The new sword they've forged withstands the steel of darkness's blade. The new knowledge turns out to be true and is well applied (processing approach). The hero triumphs and darkness retreats in defeat or lies dead on the battlefield. The hero takes the mantle of the new order (remission). (FYI, Joseph Campbell devotees please stand up and be recognized.)

Here are a few stories where I see approach heroes (possible spoiler alerts!): *Harry Potter* (Harry faces Voldemort and the Horcrux), Stephen King's *It* (gang of friends face Pennywise), *Stranger Thing*s Season 4 (Max and El and Vecna), *The King's Speech* (the prince, the therapist, the stutter, and the speech), *I May Destroy You* (Arabella and her rape), *Rocky IV* (Rocky vs. Drago), *Mare of Easttown* (Mare facing the death of her child), *Never Ending Story* (Atreyu battles The Nothing), *The Lion, The Witch, and the Wardrobe* (Aslan faces darkness and death), *Empire Strikes Back* (Luke faces Darth Vader and inner demons).

Clients select an approach hero(s) that fits for them and consider how to apply insights from the hero's story to their own story, especially the new story they want to create. They might rewatch/reread the movie/show/book. They might buy a poster or figurine of the hero as a motivator. Maybe they bring the figurine to therapy. So our clients imagine El, Luke Skywalker, Harry, Rocky, Mare, Arabella, Atreyu, or Aslan, as guiding lights as they face their own foes in the practice of approach. They are not alone. They have us and a hero.

Frame 3

The practice of approach is not just cutting-edge science. It's also ancient wisdom (from Buddhism and Islam and Christianity). Neuroscientists are conducting cutting-edge research to map how the brain changes during the practice of approach (e.g., Rauch et al., 2018), but the practice also goes back, way back. Its first documented use in Western psychotherapy was in Holland 170 years ago (Hackmann et al., 2011). Still, the truths of the practice of approach are so fundamental to the human condition, it can't be that Western therapists were the first to discover them. Indeed, Machig Labradön, an 11th-century Buddhist nun in the Himalayas, shows this (Allione, 2008). (I hear a 9th-century Persian Muslim, Abu Zayd Ahmed ibn Sahl Balkhi, also developed a form of approach [Saeed et al, 2024].) Labradön developed a sophisticated version of approach with imagination, repeatedly engaging feared internal experience through imaginal practices. The practice is a 1,000-year-old pearl of Buddhist wisdom. It is called Chöd, and Tsutrim Allione, the primary contemporary Western Buddhist interpreter of Labradön, calls the practice *feeding your demons*. Moreover, the writings of contemporary Buddhist teachers often suggest approach-like practices, e.g., Yongey Mingyur's discussions of "putting wood on the fire" or Thich Nat Hahn's discussions of repeated careful attention to psychological pain (Hahn, 2006; Mingyur & Tworkov, 2019). Mingyur and Hahn do not elaborate a program as detailed as what Allione relates about Labradön, but they make clear that repeatedly, intentionally approaching distressing internal content is a path to reducing *samsara*, suffering.

I believe my own tradition of Christianity has developed an approach ethos and instilled it in central stories of Jesus. An imaginative narration of Jesus' passion can be framed as Jesus approaching the cross even as he asked for this cup to be taken from

him. Jesus, for a Christian therapist or client, can be interpreted as a cosmic approach hero who faced death repeatedly and rose on the third day. He was afraid, asked to avoid, and then seeing the false reward of avoidance resolved to approach that which he feared, revealing the depth and essence of his faith. Bravery is not action in the absence of fear, it is approach despite its presence. Moreover, early Christian contemplative practices (desert fathers and mothers) can be framed as using approach with imagination to overcome spiritual adversaries. (Caution, evoking Jesus shouldn't turn into an opportunity for self-judgment for the guilt-prone client, i.e., past avoidance is not "sin.")

Frames 1–3, and other creative ones you come up with, can be used to motivate the practice of approach at the stages of buy-in, preparation, completion, and postapproach meaning making. This should be tailored to the client's culture and interests and should always be aimed at increasing successful completion of a course of ET (and not, for example, religious belief).

Limitations and Future Directions

I use these ideas in my clinical practice and see positive responses, but marketing or clinical research has not examined the impact of this proposal. In that way, this proposal is *not* evidence-based. Here are the two main empirical questions for this proposal that necessitate testing: (1) Are clinicians more likely to seek training in and consistently use the proposed ET (vs. traditional ET)? (2) And, as a result, are clients more likely to initiate and complete the proposed form of ET (vs. traditional ET)? The core of ET is the same but testing this repackaging is still needed.

Research might also investigate how exposure therapists, outside of highly controlled trials, talk and write about exposure with trainees, clients, and the broader public. Findings could inform this proposal.

If the proposal is found worthwhile, a communication and training campaign is needed. How can non-ET clinicians be reached with this new message? How can faculty in clinical training programs be persuaded to teach repackaged ET, especially those at master's programs in clinical social work and counseling? How can the public at large and those seeking therapy hear about repackaged ET, popular press books, and social media platforms?

An astounding amount of psychological suffering could be allayed if ET were used consistently in psychotherapy in the U.S. Efforts to date to make ET widely available (e.g., the VHA's efforts to promote ET) made meaningful but smaller impacts on this problem. The proposed repackaging of ET might be a new way forward on this now old problem. The practice of approach is unlikely to become the next mental health craze, but it could develop into a new mainstay of transdiagnostic, transtheoretical therapy in a way that standard ET has not. If we come to think and talk about ET as the practice of approach, the workshop for broken life stories, with approach heroes like Aslan and Harry Potter, and spiritual direction from Machig Labradön or Jesus, maybe the use of ET will increase.

REFERENCES

Allione, T. (2008). *Feeding your demons: Ancient wisdom for resolving inner conflict.* Little, Brown Spark.

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy, 42*(3), 277-292. https://doi.org/10.1016/S0005-7967(03)00138-4

Becker-Haimes, E. M., Okamura, K. H., Wolk, C. B., Rubin, R., Evans, A. C., & Beidas, R. S. (2017). Predictors of clinician use of exposure therapy in community mental health settings. *Journal of Anxiety Disorders, 49*, 88-94. https://doi.org/10.1016/j.janxdis.2017.04.002

Campbell, J. (1949). *The hero with a thousand faces*. Princeton University Press.

Cowan, H. R., Mittal, V. A., & McAdams, D. P. (2021). Narrative identity in the psychosis spectrum: a systematic review and developmental model. *Clinical Psychology Review, 88,* 102067. https://doi.org/10.1016/j.cpr.2021.102067

Deacon, B. J., Farrell, N. R., Kemp, J. J., Dixon, L. J., Sy, J. T., Zhang, A. R., & McGrath, P. B. (2013). Assessing therapist reservations about exposure therapy for anxiety disorders: The Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders, 27*(8), 772-780. https://doi.org/10.1016/j.janxdis.2013.04.006

Foa, E. B., Hembree, E. A., Rothbaum, B. O., & Rauch, S. A. M. (2019). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide* (2nd ed.). Oxford University Press. https://doi.org/10.1093/med-psych/9780190926939.001.0001

Hackmann, A., Bennett-Levy, J., & Holmes, E. A. (Eds.). (2011). *Oxford guide to imagery in cognitive therapy.* Oxford University Press.

Hanh, T. N. (2006). *True love: A practice for awakening the heart*. Shambhala Publications.

Hayes, S. C. (2020). *A liberated mind: How to pivot toward what matters.* Penguin.

McAdams, D. P. (2021). *Narrative identity and the life story. Handbook of personality: Theory and research* (4th ed., pp. 122-141). The Guilford Press.

McAdams, D. P., & Cox, K. S. (2010). *Self and identity across the life span. In Handbook of lifespan development* (pp. 158-207). Wiley.
https://doi.org/10.1002/9780470880166.hlsd002006

McLean, C. P., Cook, J., Riggs, D. S., Peterson, A. L., Young-McCaughan, S., Borah, E. V., ... Rosen, C. S. (2024). Barriers and potential solutions to implementing evidence-based PTSD treatment in military treatment facilities. *Military Medicine, 189*(3-4), 721-731. https://doi.org/10.1093/milmed/usac240

Murray, H., Grey, N., Warnock-Parkes, E., Kerr, A., Wild, J., Clark, D., & Ehlers, A. (2022). Ten misconceptions about trauma-focused CBT for PTSD. *The Cognitive Behaviour Therapist, 15,* e33. https://doi.org/10.1017/S1754470X22000307

Pasupathi, M., & Adler, J. M. (2021). Narrative, identity, and the life story: Structural and process approaches. *The handbook of personality dynamics and processes* (pp. 387-403). Academic Press.

Rauch, S. A., Simon, N. M., Kim, H. M., Acierno, R., King, A. P., Norman, S. B., ... Hoge, C. W. (2018). Integrating biological treatment mechanisms into randomized clinical trials: Design of PROGrESS (PROlonGed ExpoSure and Sertraline Trial). *Contemporary Clinical Trials, 64*, 128-138. https://doi.org/10.1016/j.cct.2017.10.013

Rinpoche, Y. M., & Tworkov, H. (2019). *In love with the world: A monk's journey through the bardos of living and dying*. Random House.

Rosen, C. S., Matthieu, M. M., Wiltsey Stirman, S., Cook, J. M., Landes, S., Bernardy, N. C., ... Watts, B. V. (2016). A review of studies on the system-wide implementation of evidence-based psychotherapies for posttraumatic stress disorder in the Veterans Health Administration. *Administration and Policy in Mental Health and Mental Health Services Research, 43*, 957-977. https://doi.org/10.1007/s10488-016-0755-0

Saeed, S. I., Ahmed Sr, J. O., Kakamad, K., & Najmadden, Z. (2024). Abu Zayd Ahmed ibn Sahl Al-Balkhi (850-934): A Pioneer in the Field of Psychotherapy and Mental Health. *Cureus, 16*(8).

Schneider, S. C., Knott, L., Cepeda, S. L., Hana, L. M., McIngvale, E., Goodman, W. K., & Storch, E. A. (2020). Serious negative consequences associated with exposure and response prevention for obsessive-compulsive disorder: A survey of therapist attitudes and experiences. *Depression and Anxiety, 37*, 418-428. https://doi.org/10.1002/da.23000 ■

Elections and Member Directory Enhancements

Courtney L. White, *ABCT Chief Executive Officer*

SEVERAL YEARS AGO, we moved the ABCT elections from April to November with the idea that the proximity to the convention (time and space) would increase participation. That did not occur. So, we are returning to our original, long-standing approach of nominations opening in the fall (October/November) and closing in February, with elections in April. Watch these electronic pages and the web for announcements of both nominations and elections.

We've made improvements to several of our services, and we'd like to highlight them.

First, we've refined how the search queries function in our Find a CBT Therapist Directory. Results are randomized within the specified criteria, with those participating in the expanded directory appearing first, followed by all others.

Note that you must select participation in the directory and populate your clinical address in our database.

The expanded directory is optional—it includes priority ranking, font and graphic highlighting, and other benefits, such as the ability to have multiple clinical sites displayed in various searches. There is a nominal fee for these added benefits.

Second, we have added the Find a Researcher Directory. The directory is searchable by anyone, but only ABCT members can be in the directory. It is intended to allow those conducting research to promote their needs and allow those looking to work in existing projects an easy way to find entrée into those research projects. You can find the directory on our home page under FOR STUDENTS and FOR PROFESSIONALS.

In both the Find a CBT Therapist Directory and Find a Researcher Directory, they only work as well as the data you supply. You can update your information at any time for both the Find a Clinician directory and the Find a Researcher directory from your ABCT account profile. While editing your profile, you are also able to opt in to one or both directories, if applicable. If you opted in previously, and would no longer like to be listed, you can also change your response via your profile to opt out. When you renew your membership, make sure you spend a moment in these two sections; if you have already renewed, why not go back and make sure your demographic data is all up to date. ■

Autism SIG

Supports and Accommodations for the 2024 ABCT Annual Convention

We are pleased to offer the following supports, with the goal to increase accessibility of the 2024 Convention.

Quiet Rooms: Available throughout the day for any attendee who would like to sit in a calm space with no talking. The Wellness and Prayer Rooms may offer a similar experience.

Quiet Viewing Time at the SIG Expo: The first 30 minutes of the SIG Expo are designated as "Quiet Viewing Time." During this period, the bar will not be open, and both presenters and attendees are encouraged to view posters. Additional Quiet Rooms will be available nearby during the SIG Expo.

Accessible Seating: The front row of chairs during seated presentations will be reserved for attendees with any type of accessibility need that could make sitting further away challenging. There is also extra space in the front row and aisles for wheelchairs and scooters.

Readability of Presentations: Readability suggestions have been shared with presenters to help make slide decks as easy to view as possible.

Communication Preference Tags: Please designate your communication preference using the tags found at registration:

- **Green**: Interested in interaction / Please approach me!
- **Yellow**: Please allow me to approach you first
- **Red**: Not interested in interactions at this time

Event App: Our event app features schedule planning, live updates, and navigation aids to help attendees set up their experience prior to and during the conference.

If these supports are helpful to you this year, please be sure to complete the brief survey you will find at the SIG Expo to let us know! Your feedback is invaluable in helping us improve accessibility at future conventions.

ABCT 58th Annual Convention
Opening Our Doors /// Inspiring Community Engagement, Advocacy, and Innovation to Advance CBT
Philadelphia
NOVEMBER 14–17, 2024

For more information about accessibility, child care, hotels, transportation, as well as the Itinerary Planner and full session information, visit https://www.abct.org/2024-convention/

Day of Service

Candles to Crayons: Giving Back to Our Convention Host City

Consistent with this year's convention theme, "Opening Our Doors: Inspiring Community Engagement, Advocacy, and Innovation to Advance CBT," the inaugural ABCT Day of Service project allows ABCT members to connect with and engage in service-learning projects that give back to our 2024 convention host city of Philadelphia. This year's ABCT Day of Service will focus on supporting the **Cradles to Crayons** nonprofit organization!

Cradles to Crayons: Vision, Mission, and Model

Cradles to Crayons provides children from birth through age 12, living in homeless or low-income situations, with the essential items they need to thrive—at home, at school and at play. The organization supplies these items free of charge by engaging and connecting communities. One day every child will have the essentials they need to feel safe, warm, ready to learn, and valued. Cradles to Crayons' efficient and effective three-step model provides kids with the essentials they need, free of charge. This enables the organization to engage communities that have, connecting them with communities that need.

- New and nearly new children's items are collected through grassroots community drives and corporate donations.
- Donations are then processed and packaged by volunteers in the Cradles to Crayon Warehouse warehouse—The Giving Factory®.
- Packages from The Giving Factory are distributed to local children—through a collaborative network of diverse service partners.

► 2024 ABCT Day of Service Opportunities

Volunteers may participate in the ABCT Day of Service in one or more of the following ways:

Off-Site/Hands-On

Day of Service volunteers may participate in a volunteer shift at the "Giving Factory" in Philadelphia. Volunteer activities may include: quality checking shoes, backpacks, and other clothing donations for kids, cleaning shoes, and packing bookbags. This activity will occur on Thursday, November 14, from 10 a.m. to 12 p.m. Volunteers signing up for the activity should plan to leave the conference hotel by 9:30 a.m. the morning of November 14 and aim to return to the hotel around 12:30 p.m.

On-Site/Hands-On

ABCT members are also invited to create personalized "back to school" encouragement cards that will be placed in the school bag kits developed at the Giving Factory. This opportunity will be open to members throughout the duration of the conference (starting Friday at 10:00 a.m. and ending at 11:00 a.m. on Sunday) in Conference Suite II and III, level 3 of the Marriott Hotel.

Online/Remote

During our Day of Service and throughout the conference, ABCT members can make financial contributions directly to the Cradles to Crayons organization through their website:
https://www.cradlestocrayons.org/philadelphia/donate-now/

Donate

Honoring Dr. Mary Cover Jones

Here's an opportunity to make a meaningful contribution: This year, we have been honoring the remarkable Dr. Mary Cover Jones, the "Mother of Behavior Therapy," as we celebrate the 100th anniversary of her groundbreaking work. Dr. Jones's contributions laid the foundation for behavior therapy, and as part of our tribute, we've reprinted her seminal 1924 articles in *the Behavior Therapist*.

Additionally, we have launched the **Dr. Mary Cover Jones "Partners in the Studies of Human Lives" Award and Lecture Series**. The inaugural award will be presented at our Philadelphia convention to clinical scientists whose work embodies Dr. Jones's inspiring legacy.

Along with the family of Dr. Mary Cover Jones, we have formed quite a meaningful partnership with the team at statues.com, who understands how representation matters. Mother-daughter duo, Victoria and Evi Karpos, in their family business established the SculptHER collection to better represent historically impactful women. Their company motto is "shaping history through sculpture," and they have beautifully widened this lens.

We're proud to announce that Dr. Mary Cover Jones will be joining the ranks of iconic women like Eleanor Roosevelt, Ida B. Wells, and Alice Paul in this special collection!

→ **PRE-ORDER your very own Dr. Mary Cover Jones SculptHER 7-inch statue to pick up at ABCT's Annual Convention in Philadelphia this November!**

Receive a limited-edition statue at the convention with every $75 donation to the ABCT Dr. Mary Cover Jones "Partners in the Studies of Human Lives" Award and Lecture Series.

Donations can be made here (i.e., donate $150 and receive 2 statues). To allow for production time, **all donations must be made by OCTOBER 15, 2024**. Through this pre-order,

ALL proceeds will benefit the ABCT Dr. Mary Cover Jones Honorary Award and Lecture Series. After the convention, and starting on December 1, 2024, the statues will be available for sale to the general public through the Statues.com website where a portion of the sales will be donated to the award.

59th Annual Convention
November 20–23, 2025 New Orleans, LA

Call *for* Continuing Education Ticketed Sessions

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

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

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

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

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

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

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

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

Advanced Methodology and Statistics Seminars (AMASS)
Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday or during the course of the Convention. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

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

Submission deadline: ***February 7, 2025 3:00 a.m. EST***

Submissions will be accepted through the online submission portal, which will open after January 1, 2025. Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on "Convention and Continuing Education."

Call for Award Nominations

Awards & Recognition Chair:
Anne M. Donnelly, Psy.D.

To be presented at the 59th Annual Convention in New Orleans

The ABCT Awards and Recognition Committee is pleased to announce the 2025 awards program. Nominations are requested in all categories listed below, including those that might appeal to clinicians, researchers, trainers, and students. Our ABCT community is doing meaningful work, and we encourage you to consider nominating yourself, a student, or a colleague for an award. ABCT values and has committed to supporting individuals from a diverse range of backgrounds with these awards. The Committee also encourages those who have submitted in a prior year and not yet received an award to reapply. If you decide to reapply, please let the Committee Chair know whether you'd like to use your prior submission, and make updates. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Nominate at www.abct.org/awards

Outstanding Clinical Supervisor This is the inaugural year for the Outstanding Clinical Supervisor Award, intended to acknowledge and promote excellence in clinical supervision. Clinical supervision is an essential element in the training of Cognitive Behavioral Therapists. It is one of the most basic ways in which theory and evidence-based interventions are integrated into practice, and plays an essential role in both implementation and dissemination of CBT. Recipients of the Outstanding Clinical Supervisor award from ABCT represent the best that clinical supervision has to offer. This award is given on an annual basis, awarded in even years to a doctoral-level supervisor and in odd years to a master's-level supervisor. This year the award will honor clinical supervisors with a master's degree in their field.

Eligibility Criteria: Candidate must be a current member of ABCT. Candidates must have a master's (odd years) or a doctorate (even years) in their field and have provided clinical supervision to the individual(s) making the nomination. Supervision of psychotherapy: has supervised many graduate students, interns, postdocs, fellows, or residents using empirically supported CBT methods and helped them become effective providers of the best available empirical methods of treatment. Supervision may have been provided on an individual basis or in group format. Please use the nomination form and e-mail nomination materials as one pdf document to ABCTAwards@abct.org Include "Outstanding Clinical Supervisor" in your subject heading. | **Nomination deadline**: March 3, 2025

Career/Lifetime Achievement Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Arthur M. Nezu, Ph.D. is our most recent recipient. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line.
Nomination deadline: March 3, 2025

Outstanding Educator/Trainer This award is given to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Lynn McFarr, Ph.D., is our most recent recipient. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Outstanding Educator/Trainer" in the subject line. **Nomination deadline**: March 3, 2025

Outstanding Training Program This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University, the Florida State University's Clinical Psychology Ph.D. program, the Beck Institute, and the Penn Collaborative for CBT and Implementation Science, University of Pennsylvania, Perelman School of Medicine. Applications should include a nomination form (available at www.abct.org/awards) and two letters of support. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. | **Nomination deadline**: March 3, 2025

Michael J. Kozak Critical Inquiry and Analytical Thinking Award "Clarity of writing reflects clarity of thinking." This statement reflects the overarching goal that Michael J. Kozak sought to achieve, and one he vigorously encouraged others to reach for. His penchant for critical inquiry cut across contexts: whether in providing cognitive-behavioral treatment, offering supervision of treatment, in scientific inquiry and writing, or in advising investigators about how to put their grant applications in the best possible position for success. Dr. Kozak was continuously in search of clarity. Accordingly, recipients of the Michael J. Kozak Critical Inquiry and Analytical Thinking Award from ABCT should embody this same spirit in their own work. Michael was able to both achieve this high standard and promote its achievement in others with great skill and kindness. Recipients should be those who also conduct themselves in such a way in their professional lives. This award is given in alternate years. The recipient will receive $1,500 and a plaque. Please complete the online nomination materials at www.abct.org/awards. Then email the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Michael J. Kozak Award" in the subject line. | **Nomination deadline**:March 3, 2025

The Francis C. Sumner Excellence Award This award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the "Father of Black Psychology," he is recognized as an American leader in education reform. The award is intended to acknowledge and promote excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. Given on an annual basis, it is awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree (PhD/PsyD/EdD/ScD/MD). Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and professional members of ABCT at the time of the nomination. The recipient will re-

ceive $1,000 and a certificate. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org with "Francis C. Sumner Award" in the subject line. **Nomination deadline**: March 3, 2025

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize of $1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 10 years of receiving his/her the doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line. | **Nomination deadline**: March 3, 2025

Charles Silverstein Lifetime Achievement Award in Social Justice
Members of the Association are encouraged to nominate individuals who have made significant and sustained lifetime contributions to advancing social justice initiatives over many years. This award is given at the discretion of the Board of Directors and is designed to recognize the critical, and often underrecognized, contributions from cognitive and/or behavior therapy (CBT) grassroots activists who are from and primarily work with minoritized and oppressed communities. In very rare instances, the award may be given to allies from the CBT field if nominations arise from minoritized members and their perspective is centered. A key element of this award is recognition that grassroots CBT activists typically have less access to power to directly change systems secondary to structural injustice and oppression. Thus, contributions to advancing social justice by grassroots CBT activists may look different than those of allies, even though grassroots activist contributions are no less important and typically confer increased risk for the individual. Eligible candidates for this award do not need to be a current ABCT member but must have a strong historic connection to the CBT field. ABCT membership at some point in the candidate's career is desirable. Please use the nomination form (available at www.abct.org/awards) and email nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and "Silverstein Award" in the subject line. | **Nomination deadline**: March 3, 2025

President's New Researcher Award ABCT's 2024-25 President, Steven A. Safren, Ph.D., invites submissions for the 47th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent, innovative work published in high-impact journals; and promise of contributing to cognitive and behavioral theory to advance the field. Scholars who trained in smaller labs or who work in less research-intensive environments are also encouraged to apply, as the quality and potential impact of one's work, not the number of publications, will be the focus. Requirements: must have had terminal degree (Ph.D., Psy.D., M.D., etc.) for at least 1 year but no longer than 5 years; must submit a recent peer-reviewed, empirical article for which they are the first author; 2 letters of recommendation must be included; the

author's CV, letters of support, and paper must be submitted in electronic form. Self-nominations are accepted and applicants from traditionally underrepresented backgrounds, or whose work emphasizes community engagement or advances our understanding of behavioral health disparities, are particularly encouraged to apply. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org. Include candidate's last name and "President's New Researcher" in the subject line. | **Nomination deadline:** March 3, 2025

Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2024. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted, or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form (available at www.abct.org/awards). Email all nomination materials as one pdf document to ABCTAwards@abct.org and include candidate's last name and "Student Dissertation Award" in the subject line. **Nomination deadline:** March 3, 2025

Distinguished Friend to Behavior Therapy This award is given annually to an individual or organization that supports the aims of ABCT in providing awareness, advocacy, or evidence-based behavioral health services in the field of cognitive and behavioral therapies. Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Recent recipients of this award include Bivian "Sonny" Lee III, Founder and Executive Director of Son of a Saint, New Orleans; Connie and Steve Ballmer and the Ballmer Institute; and Community Behavioral Health and The Evidence-Based Practice and Innovation Center, Philadelphia. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line. | **Nomination deadline:** March 3, 2025

Outstanding Service to ABCT This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form (available at www.abct.org/awards). Email the completed form and any supporting materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Service" in the subject line.| **Nomination deadline:** March 3, 2025

VOTE!

Once again, ABCT is partnering with Vot-ER, a nonpartisan 501c3 that uses healthcare settings to register patients, coworkers, and community members to vote or make a plan to vote safely. Using Vot-ER's online platform, individuals—you, your patients, staff, students, any eligible voter—can check their voter registration status, choose to register to vote, or request a mail-in ballot.

ABCT will have a unique QR code and link (see below) that individuals can scan or visit. As part of this partnership, ABCT members can request a Healthy Democracy Kit, which features online and downloadable information, free print posters for your offices or labs, and sample scripts about the voter registration or vote-by-mail process. You can also request free digital kits or site-based physical resources, including our unique ABCT voter registration badges. Materials are available in English and Spanish.

Add the QR code to your email signature or post to your web sites with the following:

Are you registered to vote?
Are you sure?
You can check here:

Webinars

https://elearning.abct.org

ABCT is sponsored by APA, NBCC, CAMFT, & the New York State Education Department to offer CE

upcoming

Richard Heyman | Intimate Partner Violence: Foundations, Assessment, and Interventions Oct 10 > REGISTER

recorded

Amber Calloway | Delivering Culturally Responsive Cognitive Behavioral Therapy

Martin M. Antony | Group Cognitive Behavior Therapy With Adults

Ann Steffen | Culturally Attuned Behavioral Activation Across the Lifespan

Carolyn Black Becker | Are You Overlooking Eating Disorders in Your Clients? Moving Beyond the Eating Disorder Stereotype to Reduce Diagnostic Error, Improve Ethical Practice, and Enhance Care

Golda Ginsburg | School-Based Interventions for Students with Anxiety

Alec L. Miller | DBT for Suicidal Adolescents

Robert Leahy | Emotional Schema Therapy: Helping Clients Cope with Difficult Emotions

Jeffrey Lackner | CBT for Irritable Bowel Syndrome: Fundamentals of an Evidence-Based Transdiagnostic Approach

Emily Becker-Haimes | Practice-Based Guidance: Should I Recommend Telehealth, Hybrid, or In-Person Sessions for Youth with Anxiety or OCD?

Visit ABCT's eLearning web pages for many more recorded, CE and non-CE, webinars, including 2023 convention recordings (Mini Workshops and Clinical Grand Rounds).

https://elearning.abct.org/

Sanity x ABCT

A collaborative podcast series with Dr. Jason Duncan and ABCT

> episode website

Mary Jane Eimer's Eras Tour: 45 Years of Service
with Mary Jane Eimer & David Barlow

Harms in Therapy | ***with Drs. Ilana Seager van Dyk & Alexandria Miller***

CPT for PTSD | ***with Dr. Patricia A. Resick*** (Episodes 1 & 2)

Starting a Telehealth Practice: What You Need to Know
with Dr. Mary K. Alvord (Episodes 1 & 2)

Parent Child Interaction Therapy | ***with Drs. Kate Gibson & Corey Lieneman*** (Episode 1)

Parent Child Interaction Therapy for Older Children
with Drs. Kate Gibson & Corey Lieneman (Episode 2)

Nonprofit Mental Health Research Careers
with Dr. Shannon Blakey (Episode 1 & 2)

Sleep Health | ***with Dr. Allison Harvey*** (Episodes 1 & 2)

OCD Assessment and Treatment | ***with Dr. Jonathan Abramowitz*** (Episode 1, 2, & 3)

What to Do About Worry | ***with Dr. Robert Leahy*** (Episodes 1 & 2)

Psychedelic Assisted Therapy | ***with Drs. Jason Luoma & Brian Pilecki*** (Episode 1 & 2)

The State of ABCT | ***with Drs. Jill Ehrenreich-May & Sandra Pimentel*** (1 Episode)