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ORIGINAL RESEARCH

Multiyear Pilot of a Sociocultural Identities Assessment, Integration, and Skills Sustainment Protocol (The Identities Protocol) Embedded Within an Adolescent DBT Partial Hospitalization Program

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SOCIAL AND CULTURAL IDENTITIES including, but not limited to, ethnicity, race, sexual orientation, age, gender expression, health status and disability, socioeconomic status, migration status, indigenous heritage, and national origin, have an enormous and enduring impact on how individuals view themselves, how others view them, and how they experience and navigate the world (e.g., Meyer & Northridge, 2007; Turan et al., 2019; Williams et al., 2021). Aspects of sociocultural identity development and their impact on psychosocial health and well-being are especially pronounced and important during adolescent development (e.g., Taggart et al., 2019). Adolescence is an essential developmental period for exploration and learning about how one's context and identities—those observable (e.g., race) and concealable (e.g., religion; mental health history)— impact thoughts, feelings, behaviors, relationships, and sense of self. How adolescents navigate and are supported in their identities can have a lasting impact on psychosocial outcomes across the entire life course (e.g., Wong et al., 2014).

It is well established that youth with one or more contextually marginalized sociocultural identities are at increased risk for mental health problems (e.g., Race; English et al., 2020; Ethnicity; Sirin et al., 2019; Sexual Orientation; Russell & Fish, 2019; Religion; Ahmed et al., 2019; Socio-Economic-Status; McLaughlin et al., 2018). While sociocultural identities can be conceptualized in many ways, the current project operationalizes sociocultural identities using the ADDRESSING Framework (Hays, 2022). ADDRESSING is a pedagogical acronym and intersectionality broaching tool that encapsulates multiple social and cultural identities that may influence psychological functioning and well-being. In the current use, the acronym stands for ***A**ge and generational influences, **D**isability status* (e.g., physical, cognitive, sensory, intellectual), ***D**iagnosis status* (e.g., mental health), ***R**eligion and spirituality, **E**thnicity and race, **S**exual orien-

*tation and expression, **S**ocioeconomic status, Indigenous heritage, **N**ational origin and current national status,* and ***G**ender identity and expression*.[1] One of the most well-supported theories for why youth with one or more marginalized identities may experience more mental health problems is "minority stress theory" (e.g., Meyer, 2003). Minority stress theory posits that individuals belonging to context-specific marginalized groups experience increased oppressive and stressful experiences that occur across every level of the social ecology and that thereby transfer risk to a host of psychological health problems (e.g., Meyer, 2003). There are few psychosocial experiences for youth that can be more damaging than identity invalidation and identity-based othering. It is as if to say, "You are not accepted for who you are, and you do not belong here."

Past research has elucidated a number of psychosocial processes that may attenuate the relation between identity-based othering and negative mental health outcomes (for a review, see Pascoe & Smart Richman, 2009). Four candidate psychosocial intervention domains that have garnered strong empirical support within the youth mental health space include: (1) strengthening connection to one's sociocultural identity—both identity specific and intersectional (e.g., Brown & Tylka, 2011; Gillespie et al., 2023); (2) engaging with positive social support related to one's identities (e.g., Brondolo et al., 2009; Park et al., 2018); (3) utilizing acceptance and reframing strategies of identity-based othering (e.g., Bridge et al., 2023; Salcido & Stein, 2023); and (4) participating in community-focused actions to influence structural change (e.g., Muldoon et al., 2021; Nash et al., 2024; Ortega-Williams & Harden, 2022). Furthermore, although a comparatively much smaller body of research, CBT-informed youth intervention programs directly targeting links between identity-based othering and negative mental health outcomes have demonstrated significant promise, including programs for sexual minority youth (Bauermeister et al., 2022; Bridge et al., 2023; Pepping et al., 2017) and refugee/immigrant youth of color (Ellis et al., 2013; Miller et al., 2022).

Given the strong theoretical and empirical base, as well as promising youth mental health intervention work, there is still a paucity of scalable psychosocial therapeutic protocols that can be integrated into existing empirically grounded mental health treatment settings to give patients and providers scaffolding for intersectionality-engaged and culturally responsive interventions. One intervention platform that has received strong support for its ability to provide a supportive context for diverse adolescents with significant mental health problems is Dialectical Behavior Therapy for Adolescents (DBT-A; Rathus & Miller, 2014). DBT-A is a structured therapeutic approach specifically designed to address the emotional and behavioral challenges faced by adolescents. DBT-A includes individual and group-based interventions combining cognitive-behavioral techniques with mindfulness practices to help adolescents manage intense emotions and improve their interpersonal relationships (Rathus & Miller). One essential element of the biosocial theory that informs DBT is the proposed role of validation and invalidation in human suffering (Rathus & Miller). The DBT-A model, which in many ways is parallel and theory-aligned to minority stress theory, posits that experiences of invalidation greatly increase suffering, and that there are tools and strategies that an individual (and family) can learn and deploy to be more effective in a sometimes oppressive and unfair world. DBT promotes the idea of radical acceptance—a concept that acknowledges that in order to build for change we must confront the world as it is (e.g., racism

[1]In past psychosocial intervention work using the ADDRESSING Model (Winer et al., 2018), and in consultation with its developer, Dr. Pamela Hays, we adjusted "***D**evelopmental or other **D**isability*" to "***D**isability status*" and "***D**iagnosis status*." This change was made to foster deeper discussion about the role of mental health stigma as a common experience among psychiatric patients.

is unfair; many systems are unjust and perpetuate inequities), with the hope to make it how it should be (e.g., Pierson et al., 2022; Oshin & Rizvi, 2024). Indeed, teaching youth in mental health treatment contexts about the links between individual, family, community, and structural factors, as well as associated skills for coping and action, can plausibly foster a validating context for youth to explore how their sociocultural group memberships and their experiences of psychological stress and resilience are linked (e.g., Lei, et al 2024; Muldoon et al., 2021).

Additionally, DBT-A places a major focus on learning psychosocial skills in a group setting—a format that has been shown to be effective for adolescents (e.g., Miller et al., 2007), and may be especially effective when teaching concepts related to shared accountability in healing and justice (Pierson et al., 2022). Group learning for adolescents provides opportunities for youth to learn together in a collaborative and structured manner. This structure—one that balances opportunities for peer validation and normalizing, peer feedback, and concrete learning with mental health providers—creates a uniquely rich context for identity assessment, integration, and skills learning.

The Present Project

Seeking to bridge a gap in the mental health services landscape for adolescents receiving intensive mental health treatment, we built, adapated, and implemented a four-module Identity Assessment, Integration, and Skills Sustainment protocol (referred to as "The Identities Protocol") within an adolescent DBT partial hospitalization program (PHP). The goal of the intervention was to provide essential new curriculum to enhance and deepen the cultural-responsivity of the program and increase effective DBT skill learning and sustainment for youth. Building from the four candidate processes for attenuating the link between identity-based othering and mental health outcomes in youth outlined above, program-level goals of developing and integrating The Identities Protocol into treatment was to explicitly (1) provide an opportunity for psychoeducation and self-reflection among patients and providers about the impact of identity-related oppression, stigma, bias, and marginalization on mental health; (2) to increase patients' sense of belongingness and alliance with providers, fellow patients, and the broader program, especially for patients who might often feel marginalized or "othered" in traditional mental health treatment settings; and (3) to teach and practice strategies about how to apply DBT skills to support individual, family, and structural healing. Importantly, this project builds and extends on a previous intervention and implementation, led by the first author, in an adult CBT PHP using a single-session design with similar goals (Winer et al., 2018. That single session protocol, which has since been

implemented across numerous programs, is structurally similarly to the first module in the expanded four-module, Identities Protocol.

The efforts of the current project may be considered as a Stage 1 treatment development program (see Onken et al., 2014). We focused on the development and refinement of an intervention and conducted preliminary patient feedback assessments to determine initial acceptability and feasibility with the goal of more formal Stage 2 efficacy trials in the future. Our aim in this paper is to share our efforts in developing, expanding, and implementing this work within an active and clinically complex adolescent treatment setting as one example of how to intentionally integrate, implement, and sustain empirically grounded modular protocols for sociocultural identity assessment and treatment integration within youth mental health service delivery, and DBT-A programs in particular.

Method

Program Structure

The four-session Identities Protocol was implemented within the 3East Adolescent DBT Partial Hospitalization Program based at McLean Hospital in a suburban Boston-area community. Data collection occurred between February 2021 and May 2024. The 3East Adolescent DBT Partial Hospitalization Program provides intensive, full-model DBT for adolescents and young adults aged 14 to 24 and has been continuously operating for more than 15 years. Patients present to the program with a wide range of psychiatric diagnoses and symptoms, including, but not limited to, anxiety disorders, mood disorders, personality disorders (specifically borderline personality disorder), suicidal ideation, emotion dysregulation, and self-harming behaviors. Referral sources include outpatient therapists, emergency rooms, inpatient units, residential programs, and schools. Prior to admission, youth are interviewed by staff clinicians to assess clinical history and presenting problems, as well as their commitment to and motivation for DBT partial-hospital-level treatment. The program is a fully adherent DBT program, meaning it includes all four pillars of comprehensive DBT (individual therapy, skills training, skills coaching, and consultation team) and employs therapists highly trained in DBT. Typical program enrollment is 20 clinical days (6.5 hours each day) with the option of extending up to 10 days. Programming includes an average of five groups per day, two individual DBT therapy sessions per week, one family therapy session per week, and one psychopharmacology consultation session per week. Patients have access to in-person skills coaching during program hours and can access 24/7 coaching during off-hours via phone from a program clinician-on-call. Similarly, parents/caregivers have access to a 2-hour weekly skills group to learn a similar DBT curriculum. They also have access to their own off-hours phone coaching from the program director. For a comprehensive review of the program structure see (Tung et al., 2024).

Program Content

Seventy percent of group intervention content and material delivered in the program is adapted directly from DBT *Skills Training Manual* (Linehan, 2015) and *DBT Skills Manual for Adolescents* (Rathus & Miller, 2014). The remaining 30% of the program curriculum is derived from other sources and/or developed by staff members of the program (e.g., CBT skills for exposure therapy; building independent living skills). Yet, across this comprehensive group programming—running close to 100 different group protocols each month—no intervention in the program explicitly focused on broaching issues of sociocultural identities as they relate to psychological suffering and

DBT skill building. This is especially notable given that the majority of patients in the program identify as holding one or more intersecting marginalized identities—most commonly a sexual orientation minority status and the presence of a significant mental health problem that is commonly stigmatized because of severity (e.g., borderline personality disorder; self-harming behaviors; bipolar disorder). The current program was designated as program evaluation and exempt from Institutional Review Board (IRB) oversight based on guidelines from the IRB at McLean Hospital.

Patient Demographics

The program serves approximately 85 patients each year. Patients are 17 years old on average (*SD* = 2.8). Demographics reflect the patients served during the period of data collection, February 2021 through May 2024. Regarding gender, 59.1% of patients reported identifying as female, 18.3% as male, 10% as nonbinary, 3.9% as questioning, 2.2% transgender female, 1.8% transgender male, 0.4% a different gender, and 4.3% chose not to answer. Regarding sexual orientation (patients were able to select more than one option), 41.9% identified as straight, 34.1% as bisexual spectrum, 10.8% as gay/lesbian, 9.3% as don't know/questioning, 7.5% as queer, 4.3% as asexual, 1.8% as a different sexual orientation, and 0.4% chose not to answer. When asked to report their ethnicity/race (patients were allowed to check more than one option), approximately 79.6% identified as White, 13% as Asian, 8.2% as Latino, 3.6% as Black, 2.5% as Native American or Alaskan Native, 0.4% Native Hawaiian or Pacific Islander, and 2.9% endorsed another ethnicity or race.

Group Facilitators

Treatment groups were facilitated by a pair of group facilitators, as is common in DBT programs. Dyadic co-leadership is also often ideal in psychological intervention groups focused on sociocultural identity factors in treatment because leaders can model effective cross-identity dialogue (e.g., Ellis et al., 2013). Over the course of data collection, seven of the authors led and co-led groups. Three out of these seven providers were working within the program as part of a time-limited clinical training program (e.g., clinical practicum; postdoctoral fellowship). The first author developed and led the implementation of the protocol over time, training the other providers to run the group independently with consultation when indicated. The co-leaders all occupied a range of both historically dominant and historically marginalized identities as defined within the ADDRESSING Framework (e.g., race, ethnicity, gender expression, sexual orientation). Modeling and selective disclosure of various aspects of identity was an important part of group facilitation (e.g., positionality framing). All leaders had significant experience and training in the delivery of mental health services to diverse adolescents, and received weekly peer and faculty supervision and consultation.

The context of reception is an essential element for implementing interventions when explicitly discussing sensitive and, at times. politically charged topics (e.g., Zúñiga et al., 2007). Prior to implementation of The Identities Protocol, multiple meetings were held with all providers in the program to elicit feedback and explore opportunities and concerns. The program runs multiple weekly community meetings (some with staff only; some with all staff and patients) where concerns or feedback related to all clinical programming are regularly surfaced and acted upon. This created the opportunity for a continuous feedback loop for program tailoring. Within the treatment program the group was often referred to as "ADDRESSING Identities."

The Identities Protocol—Summary of Modules

Module 1 (ADDRESSING Identities) introduces the ADDRESSING framework (see Hays, 2022) with a facilitated discussion about the various parts of an individual's identity and how identities are inherently context dependent and intersectional. The frameworks of ecological systems theory (Bronfrebrener, 1992) and intersectionality (Crenshaw, 2005) are introduced to create shared definitions and foundational learning from which to build. Using the ADDRESSING acronym, with associated definitions, the group explores how social and cultural identities explicitly and implicitly influence how we experience the world (i.e., how we think, feel, and behave) and how others experience us. For group and out-of-group practice, youth are encouraged to complete an ADDRESSING self-assessment form, giving them the opportunity to explore how they identify and how their identities impact their mental health. Youth are invited to share their reflections and reactions of engaging with the self-assessment in group and out of group. *Module 2 (Seeing the MIST)* introduces and explores implicit bias and stereotyping using an acronym developed by the first author: MIST (**m**icroaggression; **i**mplicit bias; **s**tereotype threat; **t**argeted identities). The group explores explicit and implicit forms of othering; how these show up in a youth's day-to-day experiences; and how to disrupt them. The analogy of MIST is used as a teaching tool to explore how something can be fully present yet difficult to see (e.g., water droplets of mist in the air) and the accumulated harm that can result when not attended to (e.g., a metal bicycle sitting outside on misty mornings starts to rust, then breaks). *Module 3 (Culturally Responsive DBT Skills)* explicitly links a youth's newly learned DBT skills within the broader program to examples of implementing these skills during experiences of identity-based othering and invalidation. This module provides a diversity of opportunities for youths to thoughtfully explore how the four domains of DBT skills (distress tolerance, interpersonal effectiveness, emotion regulation, and mindfulness) can be used in specific circumstances they may encounter. These include, but are not limited to, how to self-validate following experiences of discrimination/othering; how to use interpersonal effectiveness skills when one's identities have been invalidated; and how to give effective feedback to others related to sociocultural identities. *Module 4 (Socio-Cultural Identities Can Be...)* makes space to look further at the complexities of identities and their integration into a coherent sense of self, one that may be in flux, or fragmented, for adolescents with severe emotion regulation challenges. The module creates space for youth to explore how identities are context-specific, categorical vs continuous, stable vs changing, hidden vs observable, and historically dominant vs targeted. Youth are encouraged to connect their learnings from the past three modules to this broadened sense of self and youth are encouraged to "put topics on the agenda" related to their emerging skill use and plans/feedback for skill use moving forward. An auxiliary protocol to Module 4 (*What Do I Do With My Guilt?*) was implemented if a supermajority (more than two thirds of current patients) discussed specific challenges related to the guilt they experienced related to historically dominant identities (e.g., White; Male; High SES). This module extended the discussion of self and identity to provide specific strategies related to utilizing "equity orientated actions" for individual and community justice geared towards the work of allies and advocates. Across all modules youth are encouraged to bring thoughts, reflections, and worksheets to their individual DBT sessions to "go deeper" with their therapist and, when indicated, within family therapy meetings. For further information about modules, selected worksheets are available for free and approved download at www.multiculturalpsychology.com.

Data Collection and Analysis

Patient Feedback Measure

A total of 133 anonymous patient feedback forms were completed and collected. The Identities Protocol feedback survey included six quantitative statements and two open-ended questions relevant to group participation. In order to encourage genuine feedback without concerns related to how feedback would be received, program participation surveys were completed anonymously, opt-in (not mandatory), and not linked to patient outcomes. The strength of this strategy was to encourage fully candid feedback in topic domains that even in an inviting and accepting program patients, at times, felt hesitant to discuss. The drawback, understandably, is that survey data cannot be linked to patient outcomes or connected longitudinally to other surveys completed by the same patient. One hundred thirty-three responses does not equal 133 unique respondents but 133 individual surveys completed. Our feedback responses reflected participation in Module 1 (*ADDRESSING Identities*: $n = 50$), Module 2 (*MIST*: $n = 31$), Module 3 (*Culturally Responsive DBT Skills*: $n = 25$), and Module 4 (*Sociocultural Identities Can Be*: $n = 18$). There were an additional nine responses in which the module number was unknown/not recorded by the participant. The total n decreases with each module because facilitators in this rolling admission program (i.e., new patients start and end the program multiple times each week) were given flexibility to "start from the beginning" if a supermajority of patients (more than two thirds of current patients) had not yet received Module 1.

The Identities Protocol Feedback Survey—Quantitative Items

For the quantitative items, patients responded on a 1–5 Likert scale, 1 (*Strongly disagree*) to 5 (*Strongly agree*). See Table 1 for a list of all items in addition to their means and standard deviations. The quantitative items were developed to be as quick to complete as possible. Youth attend multiple groups in a row each day with 10-minute

Table 1. Means and Standard Deviations of The Identities Protocol Feedback Survey Items

Question	Mean (SD)
During this group I thought about aspects of my identities (e.g. race, ethnicity, age, sexual orientation, diagnosis, disability status, socioeconomic status, gender identity, citizenship status, etc.)	4.33 (0.98)
This group provided information about how and/or why aspects of my identities may be relevant to my mental health treatment	3.79 (1.09)
This group provided information about how to potentially use DBT concepts and skills to navigate identity contingent experiences	3.39 (1.17)
I think aspects of my identities are relevant to my mental health and overall well-being	4.14 (1.01)
How enjoyable or interesting was this group?	4.05 (1.08)
How helpful was this group?	3.82 (1.17)

Note. Means based on 1-5 Likert scale, 1 = *Strongly disagree* and 5 = *Strongly agree*

breaks in between, and the survey was designed to be administered directly after group, between other groups, or during lunch. Three items assessed the content of the groups, for example, "This group provided information about how and/or why aspects of my identities may be relevant to my mental health treatment"; and two items assessed the acceptability of the groups, for example, "How helpful was this group?"

Across the four modules, the mean scores responses were between 3.39 (*SD* = 1.17) and 4.33 (*SD* = 0.98), indicating that participants generally agreed or strongly agreed with the statements (see Table 1). Participants agreed that the group offered time to think and discuss aspects of their identities (*M* = 4.33, *SD* = .98). Of the four modules, youth reported that Module 3 was the most helpful (*M* = 4.36), the most enjoyable (*M* = 4.3), most pertinent to their well-being (*M* = 4.5), most DBT-related (*M* = 4.04), and most relevant to their mental health (*M* = 4.2).

The Identities Protocol Feedback Survey—Narrative Responses

The feedback survey also included two open narrative style questions: (a) "Something I learned or thought about in this group was ..." and (b) "Any other suggestions, reflections, or feedback you would like to share?" Although a formal qualitative study is beyond the scope of the current paper, thematic analysis was conducted.

In response to the question "Something I learned in this group was...," patients described learning about how different sociocultural identities interact with other sociocultural identities to inform intrapersonal and interpersonal thoughts, feelings, and behaviors. Additionally, youths commonly noted the role of power/privilege or the visible/less visible nature of identities. Illustrative quotes include, "I thought about my different identities and how they intersect to effect privilege"; "I thought more about non-visible identities"; "I learned about many different identities in this group that I would not normally think about ..."; "The intersection of my identities and those of people around me and how they impact our relationship"; "How certain identities affect other people's lives in many different ways—was interesting to hear about others' experiences"; and "I thought about different aspects of my identity and how they have changed or stayed the same over time."

In response to the question "Any other suggestions, reflections, or feedback you would like to share?" approximately half of the patients wrote "N/A," "no," or left the question blank. Other youth reflected that they enjoyed the open discussion as well as learning more about their peers' different identities. Illustrative quotes of this theme included: "I enjoyed this class and learning about other people's identities and experiences"; "I enjoyed the aspect of sharing and did not feel pressured. I learned things about my peers that make me feel like I can relate"; "This was very interesting, I liked the discussion"; and "I really liked this group! It was really nice getting validated by others."

While there was limited negative or constructive feedback, several patients reflected that, if anything, they wanted more time in the group and/or additional links to DBT skills. For example, "Maybe connecting back to DBT a bit more even though it may be hard to do so in the short period of time"; "I think with the time we had it makes sense, but I would like to dive deeper into DBT application"; and "I really like [the] ADDRESSING [group], but I wish it was longer..."

Clinician Reflections From Discussions and Observations With Patients

In addition to survey-based results, program clinicians provided their feedback based on their experience facilitating the groups or hearing directly from patients. A

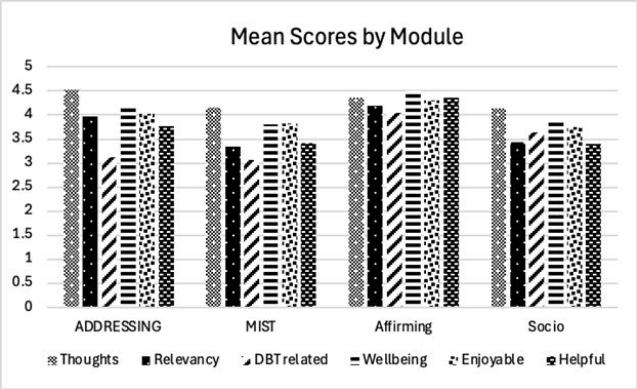

Figure 1. Mean patient feedback scores across each module of The Identities Protocol. Note. Question labels on *x*-axis correspond with questions listed in Table 1 (i.e. Relevancy = "This group provided information about how and/or why aspects of my identities may be relevant to my mental health treatment"). Means are based on 1-5 Likert scale, 1 = *Strongly disagree* and 5 = *Strongly agree*.

common tradition in the program, at program discharge, is to ask youths to identify their favorite group in the program. Anecdotally, as reported by the program director (P.W.), "ADDRESSING Identities" is one of the most common answers (out of a total of 23 groups). Group facilitators commonly report that patients expressed gratitude and genuine interest in the content and discussions focused on during the group.

Examples of patient reflections during group sessions are also important to share. Patients commonly reflected on their struggles with disclosing mental health diagnoses (notably, personality disorders and thought disorders) to family and friends due to perceived stigma and the cultural beliefs their family and friends hold about people with mental illness. Patients who identified as gender and/or sexual minorities commonly discussed struggles with the "coming out" process, and how, when, and with whom discussions of their gender or sexual identity should be integrated into mental health treatment. Patients who identified with pronouns (e.g., they/them) different than those assigned at birth (e.g., she/hers) and/or who used a name different than their name assigned at birth (e.g., their "dead name") commonly reflected struggles with parents/caregivers in these domains.

Participants also commonly discussed the intersection of gender and sexual identities with religious, spiritual, and ethnocultural identities and traditions they grew up with (e.g., experiencing increased stress due to their community's specific beliefs about gender and sexuality). Patients of racial and ethnic minority backgrounds commonly discussed experiences of being in a predominantly White treatment environment—the majority of clinicians and patients in the program identify as White. While patients of racial and ethnic minority backgrounds reported the group was affirming and helpful in broaching this observable truth, some patients reported that even with such a group, discussions of race in a majority White context felt uncomfortable. Interestingly, individuals with primarily historically privileged identities have also reported the group was helpful. For example, male patients, often White, discussed feeling emasculated in receiving intensive mental health services and discussed ways of coping with the stigma of engaging with mental health services.

Limitations and Future Directions

The current project presents promising preliminary feedback from patients; however, a number of limitations should be noted. First, while the feedback data reported

by patients is encouraging, further work is needed to more directly link patient participation in the Identities Protocol to relevant clinical and psychosocial outcomes within the DBT program. Furthermore, it will also be important to better understand how learning and skill use from these modules is retained and implemented over time following discharge. Second, the current program serves primarily older adolescents, and the majority of patients are White (79.6%). As a result, future work is needed to clarify if/how this protocol could be delivered effectively, or where adaptations or tailoring are needed, in youth treatment contexts with varying constellations of identities represented in the room (e.g., programs with majority patients of color; programs where for most youth English is a second language; programs with younger patient populations). Preliminary work delivering these and adapted protocols in intensive youth treatment contexts is currently underway in several other academic psychiatric hospital settings (e.g., Charity-Parker, 2023; L. Rodriguez & Y. Anglero-Diaz, personal communication, July 31, 2024)), as well as when embedded within school-based models for group service delivery for immigrant/refugee youth (e.g., Winer et al., under review)). Last, while the program includes parents/caregivers in treatment (e.g., parent/caregiver DBT skills group, family sessions), these parents/caregivers were not specifically taught content from The Identities Protocol unless it was brought up in the context of a family session. Future work could explore how more direct and proactive integration of The Identities Protocol in parent coaching could create space for parents/caregivers to learn tools and skills for exploring and discussing their own and their child's identities.

Conclusion

In summary, we sought to increase the cultural responsiveness of a comprehensive adolescent DBT program by creating and implementing a four-session group intervention focused on sociocultural identity assessment, integration, and skill sustainment (i.e., The Identities Protocol) that builds and expands upon a previously developed one-session group intervention delivered in an academic adult CBT partial hospital setting (Winer et al., 2018). Based on patient and provider feedback, The Identities Protocol was highly acceptable. Furthermore, the protocol was sustained (and continues to run) over multiple years with a diversity of providers delivering the protocol. Future studies are now needed to evaluate the effects of this intervention on treatment outcomes and to identify potential mechanisms of action underlying any clinical improvements. Building equitable behavioral health systems requires many integrated elements, one of which could include protocols like this. In that regard, it is essential that programs and systems do not view new intervention protocols like this as their only "DEI" strategy or their single "anti-racism" or "health equity" focused initiative. The Identities Protocol, and similar patient-facing interventions, is one of many scalable tools and culturally responsive processes (e.g., needs assessment; training; supervision; consultation; dedicated funding; buy-in across levels of the hierarchy) that may increase the sustainability and equity of identity-affirming youth mental health programming. It, like all aspects of DBT, needs to be a "both and."

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CBT South African Style

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In the southernmost region of the African continent lies the sprawling city of Cape Town. This historic vista winds around steep slopes of a unique mountain range that extends to the iconic seascape of the Cape of Good Hope where the Atlantic and Indian oceans meet. This bucolic setting was the location of the 2024 South African conference on CBT, which drew participants from as far as the United Kingdom, Japan, Egypt, Zimbabwe, the United Arab Emirates, as well as all corners of South Africa (SA). SA is one of 53 countries on the continent and is the second-most populous area located entirely south of the equator. With over 62 million people, SA is the world's 23rd-most populated nation (South African census of 2022). It's also one of the most beautiful continents I've ever visited.

I was honored to be invited to present a keynote address at this conference, along with several of my illustrious colleagues from the United States, including Judith Beck, Ph.D., Lata McGinn, Ph.D., and Allen Miller, Ph.D. Several other well-known SA colleagues who hosted as well as presented at the conference were David Edwards, Ph.D., Dan Stein, Ph.D., Shane Pienaar du Bruyn, D.Phil., and Jaco Rossouw, Ph.D., along with several British researchers and clinicians. This invitation had particular sentimental value for me: SA was the boyhood home of my very first mentor in behavior therapy, the late Joseph Wolpe, M.D. During my early training in the latter part of the 1970s, predating my fellowship training with the late Aaron T. Beck, M.D., Wolpe would periodically share with me stories about his upbringing in Witwatersrand, an area known for several north-flowing rivers that form various waterfalls. The name Witwatersrand means "white water ridge" in the Afrikaans language. I was no doubt excited to finally see this breathtaking land that I heard about so many years ago.

Culture and Languages

SA is known for its ethnic and cultural diversity. Its colorful mix of nationalities has resulted in SA's nickname, "The rainbow nation." Many of the young women can be seen walking about with their long hair braids dyed the colors of the rainbow. SA has 11 official languages, including English. While most SAs can communicate in more than one language, English is the most commonly spoken and the language of official business and commerce.

The country's multicultural mosaic offers a number of wonderful cuisines that involve various styles of seafood. *Bobotie* (or pronounced ba-bo-tea) is considered by many to be one of the SA national meals, a meat-based dish and one of the most well-known examples of Cape Malay cuisine.

SAs are also passionate about music, often using song and dance to express social and political ideas. They are additionally known worldwide for their skill in a number of sports, including rugby, cricket, golf, and soccer, of which they are immensely proud.

SA has unfortunately experienced its struggles in the wake of apartheid.

Apartheid, which means "separateness" in Afrikaans, was a system of racial segregation in SA that lasted from 1948 to 1994. Apartheid policies dictated where people

could live and work, what type of education they could receive, whether they could vote, with whom they could associate, and which public facilities they could use. The Popular Registration Act of 1950 classified SAs into four categories: "white, bantu (Blacks), coloreds (those of mixed race), and Asians." The policies created separate residency areas, job categories, public facilities, transportation, education, and health systems, and strictly prohibited social contact between the races. Apartheid policies also included prohibiting mixed marriages, banning certain racial or ethnic groups from accessing certain meetings and unions, restricting movement, and prohibiting access to certain public domains. In fact, several novels have been written about this topic, including the popular work by Alan Paton, *Tales From a Troubled Land* (1961).

In brief, apartheid sparked significant international and domestic opposition, resulting in some of the most influential global social movements of the 20th century (Lodge, 2011). It was the target of frequent condemnation in the United Nations and brought about extensive international sanctions, including arms embargoes and economic sanctions on SA (Lodge, 1983). During the 1970s and 1980s, internal resistance to apartheid became increasingly militant, prompting brutal crackdowns by the National Party ruling government and protracted sectarian violence.

Between 1987 and 1993, the National Party entered into bilateral negotiations with the African National Congress (ANC), the leading anti-apartheid political movement, for ending segregation and introducing majority rule. In 1990, prominent ANC figures such as Nelson Mandela were released from prison (Riba, 2023). Apartheid legislation was repealed on June 17, 1991, leading to multiracial elections in April 1994.

Mental Health Problems

SA has its share of widespread mental health disorders. According to the second annual State of the World Report 2021 from Sapien Labs, SA ranks as one of the worst countries for mental health (Sapien Labs, 2022). Experts estimate that it is both the public stigma attached to mental illness as well as the lack of mental health support in public medical facilities that has contributed to the condition (Gumede, 2021). Common mental illnesses have increased sevenfold since the onset of the coronavirus disease (Foundation for Professional Development, 2023). Factors contributing to the causation and exacerbation of mental illness in SA include poverty, unemployment, inequality, violence, gender-based violence, and political upheaval. In a sample study of over 1,000 children and adolescents who were assessed in psychiatric clinics in Johannesburg, well over two-thirds of them experienced disruptive behavior disorders, including ADHD, and over one-third had anxiety or affective disorders, with 17% involving elimination disorders (Vogel & Holford, 1999). Anxiety disorders are also prevalent and include generalized anxiety, separation anxiety, panic, and social and school phobia (Kleintjes, et al., 2006). Much of the adult population also experiences anxiety disorders, including post-traumatic stress disorder (PTSD). Anxiety often goes hand in hand with dysthymia, major depressive disorders, and substance dependence and abuse. In fact, substance use disorders are also highly prevalent in SA with high rates of fetal alcohol syndrome (Edwards et al., 2012). As a result, CBT has become widely used and incorporated in the mental health system. The professional board for psychology, in particular, requires that in order for mental health professionals to register with the Health Professions Counsel of SA (HPCSA), they must demonstrate proof of having completed professional training at least at the master's level with a 12-month internship as well as 1 year of community service within public health for clinical psychologists. There unfortunately is a disparity between private and public health care in SA. The majority of clinical and

counseling psychologists work in private practice and offer services for those who can afford to pay. On the other hand, public health systems provide services to most citizens (46 million; Statistics of South Africa, 2016), while those who have health insurance (14 million) can access private health care. With the desegregation of the health care system post-apartheid, and much progress in improving accessibility to care, the quality of care in public hospitals and community clinics remains suboptimal and uneven compared to the quality of care in the private health care sector. The demand for mental health professionals has been rising, and there is a need for more professionals who are employed by the state (Health Systems Trust, 2008). Health services provided within communities via primary health care clinics are provided mostly by nurses with the support of general medical practitioners. There are limited posts available for psychologists within the public health system (Lund et al., 2010). Most psychologists work in private practice. There are currently 13,000 psychology practitioners (such as psychologists, registered counselors and psychometrists) registered with the Board of Psychology (PsySSA, 2017) and 8,600 psychologists (HPCSA, 2018).

The Prominence of CBT in South Africa

Early on in SA, the work of the late Joseph Wolpe became very popular, particularly the use of reciprocal inhibition and systematic desensitization with the treatment of behavioral and anxiety disorders. This was followed by the late Arnold Lazarus's multimodal therapy. Jack Rachman is also well known for his work in OCD and related anxiety disorders.

While CBT has been growing in popularity in SA, statistics indicate that mental health professionals use CBT much less than their counterparts in other regions of the world and there is still much more emphasis placed on training in the psychodynamic approach as of 2012 (Edwards et al., 2012). Only about 6% of SA clinical psychologists could be characterized as cognitive behavioral therapists. However, this has since begun to change and has been rapidly gaining in popularity in the past decade. Other approaches have involved schema therapy, dialectical behavior therapy, rational emotive behavior therapy, unified protocol, acceptance and commitment therapy, postmodern or systems approaches. However, there exists limited evidence to suggest the availability of evidence-based psychological treatments, including CBT, for clinical populations within the public health system (Lund, et al., 2010). The only CBT intervention that has been systematically integrated into the public health system is the matrix model of outpatient treatment of substance abuse (Mosel, 2023). It should be noted that there have been repeated calls for psychological treatments to be more accessible and relevant to the needs of the population in South Africa (Ahmed & Pillay, 2004). A review of 15 published SA studies suggests that CBT is effective and viable in SA contexts and that, if widely offered, would be able to provide relief (Young, 2009).

It is also reported that African students with social phobias responded well to a group therapy program based on Clark and Wells's evidence-based treatment approaches (Edwards et al., 2003; Edwards & Kannan, 2006). PTSD has also responded well to CBT. In the city of Johannesburg, an integrative approach to PTSD that is similar to contemporary CBT models has also been used, including in many other African countries (Eagle, 1998, 2005).

Trauma support and treatment has proven to be one of the most effective interventions in SA in the aftermath of traumatizing events (Wyk & Edwards, 2005). Research on the treatment of PTSD with trauma-focused CBT interventions is ongoing (Booysen, et al., 2024; Kaminer et al., 2023; Rossouw et al., 2016) with both adults and youth.

These researchers have looked at the implementation of task-shifted treatment provision of prolonged exposure for adolescents, prolonged exposure for primary care (with adults), and a shortened TF-CBT intervention for youth. Their research supports that these interventions, which developed in high-income countries, can be implemented within a task-shifted community or school-based environment with excellent response to treatment.

Research on the adaptation of CBT for a South African cultural context is ongoing and employs a framework with several key steps, including (1) selecting a best-fit treatment through formative research; (2) culturally adapting the treatment in consultation with local stakeholders (community members, experts, patient populations); (3) piloting the culturally adapted treatment; and (4) further modifying the treatment based on lessons learned from the pilot. The Alan J. Fisher Centre for Public Mental Health operates several programs, such as PRIME (Programme for improvement improving mental health care), ASSET (NHR Global Health Research Unit on Health System Strengthening in Sub-Saharan Africa), AFFIRM (AfRICA Focus on Intervention Research for Mental Health), EconIPV-MH (Investigating economic and intimate partner violence outcomes of mental health trials in LIMICs), and CHANCES (Poverty reduction, mental health and the chances of young people understanding mechanisms through analyses from six LIMICs). Several of the interventions studied have a CBT foundation.

A program known as the Trauma Clinic in SA involves assessment and intervention programs for organizations and communities affected by traumatic events such as work-related trauma, criminal violence, and motor vehicle accidents. A major component of this program includes CBT interventions, the results of which have been supported by data from randomized controlled trials (Bryant et al., 1998; Bryant et al., 2003). The results indicated that CBT markedly reduced incidences of PTSD.

One of the most important aspects of CBT is that it can be integrated within various cultures, which makes it ideal for a country such as SA (Naeem & Kingdon, 2012). This is especially so with the impact of poverty and legacy of apartheid (Neswiswa & Jacobs, 2024). Those psychologists in SA who employ CBT approaches agree that it is easily transported to the local context because of the practical nature of the approach and the transparent nature of the relationship between the therapist and the client.

During the SA conference on CBT in Cape Town, Peter Phiri, Ph.D., gave an excellent presentation on depression and cultural consideration in Africa, which was well received. In recent years, a local professional society for CBT practitioners that provides a network of vetted CBT therapists and offers resources and accreditation in CBT has been developed: the Cognitive Behavioral Therapy Association of South Africa (CBTASA). According to the organization's website, CBTASA was initiated by the late Kevin Bolon, but was officially founded in October of 2019. The organization, also affiliated with the European Association for Behavior Cognitive Therapy (EABCT), strives to improve community well-being. All of the CBT generations are represented by CBTASA in which treatment fidelity is encouraged. This includes CBT models and competent applications of methods. The organization encompasses an "Academy" division, which arranged the inaugural congress, but also collaborates with universities, and nongovernment and private organizations on the dissemination of CBT. A newsletter is published biannually and is available upon request.

Personally, I have been very impressed with the number of our SA colleagues who have done an outstanding job in promoting CBT in their nation. The use of CBT in SA has a unique style in that it has to blend with so many different cultures in a sometimes politically volatile climate. This can often make for a precarious task. It should also be

noted that several universities in SA have taught quality CBT courses over the years, including Rhodes University in Grahamstown, the University of Cape Town, the University of the Western Cape, the University of Pretoria, North-West University, University of the UFS, as well as Stellenbosch University.

In speaking with a number of CBT therapists in SA, it appears that they have had great success using CBT interventions with many of the clients and are doing very effective work. It is estimated that the use of CBT will enjoy a growth spurt in the future as the demands of the populus increase.

In line with the CBTASA congress theme, "CBT—Application and Accessibility in Africa," the aim is to upskill therapists and to promote task sharing and internet-based CBT on the continent. This ideal is shared by the World Confederation of Cognitive and Behavioural Therapies (WCCBT) and EABCT's PAN (Pan African CBT Network), which led to a meeting between interested parties and stakeholders during the congress. Some were from WHO collaborating centers and had participated in the WHO manual for the implementation of relevant psychological interventions (https://www.who.int/publications/i/item/9789240087149). This event was hosted by Lata McGinn, Ph.D., President of the WCCBT.

In conclusion, as SAs share their beloved Table Mountain located in the heart of Cape Town, delegates at the CBTASA congress united and participated in the stability of a common interest and what CBT has to offer—to help others in one spirit of an evidence-based approach. Like the two oceans that meet at the Cape of Good Hope, collaborated outcomes promise to flow forward from this inaugural event that will hopefully become a beacon of success for the future.

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Social Justice and ABCT: The Specter of Unintended Consequences

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THE HISTORY OF SCIENCE is filled with stories of how investigators and broader scientific movements with righteous intentions harmed individuals (for a detailed illustration, see Gould, 1996). Social science, in particular, has a checkered history in its attempts to directly intervene in human behavior that result in unintended harmful outcomes. Individual therapy approaches have historically been assumed to be benign, at worst, if the intervention does not produce the desired effects. This assumption has been deemed dubious (Lilienfeld, 2007) and recent recommendations for systematic assessment of harms have been put forth (McKay et al., 2018). In this article, we raise concerns about potential unintended harmful consequences, specifically antisemitism, from the well-intentioned social justice model of mental healthcare, which the Association for Behavioral and Cognitive Therapies (ABCT) has recently embraced. Specifically, as the social justice model rightfully addresses the unique needs of historically oppressed groups, it can also indirectly lead to a desire for retribution against groups defined as oppressors.

The rapid embrace of the social justice movement by ABCT, as evidenced, for example, by the invited address on Liberation Psychology by Bryant (2023) and throughout the recent two-issue special series on harms in the misapplication of cognitive-behavioral therapy in *the Behavior Therapist* (Miller & van Dyk, 2023; van Dyk & Miller, 2023) reflects a sincere desire to promote the well-being of groups of people who have historically faced injustice. Although there is not yet a single agreed-upon social justice model in psychology (Thrift & Sugarman, 2019), a common perspective is the rejection of neoliberalism—an economic philosophy that emphasizes free markets, deregulation, privatization, and minimal government intervention—which is seen as contributing to structural inequities (discussed in Fraser, 2009). Framed as an effort to address long-standing intergenerational harms resulting from political oppression, this perspective has a noble aim that is likely agreeable to any pluralistic-minded clinician. There is little dispute that systematic political oppression has occurred and continues to affect marginalized groups through harmful policies. Contemporary methods to treat intergenerational trauma and associated psychopathology that emphasize social justice models aim to integrate a range of culturally informed psychosocial approaches to address the historical harms due to oppression (discussed in Comas-Diaz & Jacobsen, 2024). Although descriptions of social justice–based approaches to treatment appear clear and straightforward, as with prior therapy movements, the potential risks of these approaches are not always immediately evident. Integrating these models with the extensive research base of CBT would seem to be a logical and beneficial next step.

One strength of the broader CBT movement has been the assessment of treatment targets. In this regard, a search of the available research reveals limited empirical investigation of how historical oppression is reliably and validly assessed. There is preliminary evidence that some assessment tools are valid measures of intergenerational trauma (reviewed in Isobel et al., 2018), but evidence for their specificity is less clear-cut. As contemporary social justice activism is encouraged on the part of the client and therapist as prescriptive for addressing historical oppression and trauma (Comas-Diaz & Jacobsen, 2024), it is imperative for clinicians to have a sound understanding of political movements and historical contexts.

As much as we agree with the importance of equality and inclusivity, we argue that ABCT risks unintended consequences by embracing the kind of social justice perspective described above, particularly when navigating complex political and historical trends. Historical social justice activism, such as the civil rights movement, motivated by the same noble aim, was steeped in the idea of universalism—the belief that all people, regardless of their individual differences, are fundamentally equal and deserving of the same rights, opportunities, and treatment. Universalism is a primary recognition of the common humanity and dignity of individuals who are all deserving of basic human rights, with a secondary respect for the amazing unique differences of individuals that fill out and give meaning to their common humanity. Enlightenment thinkers codified universalism as a force against injustice. Briefly, the Enlightenment stressed that human reasoning could serve to improve the lives of humanity (Conrad, 2012), with universalism as a key tenet of this philosophical movement. Indeed, Martin Luther King, Jr., used the ideals of universalism as the foundation of his movement, whereby it was emphasized that we must recognize the worth of each individual and judge each person on the "content of their character and not the color of their skin."[1]

In contrast, the social justice movement of today criticizes universalism and falsely claims that it attempts to "impose certain cultures on others in the name of abstract humanity that turns out to reflect just the dominant culture's time, place, and interests" (Neiman, 2023, p. 30). Recent analyses have even recommended the complete abandonment of this philosophy as a guide to psychotherapy (Sue et al., 2024). However, the shift away from universalism in this new social justice movement raises concerns, as it shares troubling similarities with certain totalitarian doctrines. Adolph Eichman and Nazi legal theorist Carl Schmidt both suggested that "universalist concepts of humanity are Jewish inventions meant to disguise particular Jewish interests seeking power in non-Jewish society" (Neiman, p. 30). As Susan Neiman aptly points out, this ideology is dangerously close to the contemporary (and misguided) argument that "Enlightenment universalism disguises particular European interests seeking power in an increasingly non-white world" (Neiman, p. 31). The new social justice rejects universalism's focus on unique individuals as individuals, even within particular groups with which they identify (Sue et al.), and embraces tribalism instead (i.e., Neiman).

Tribalism is dangerous when its focus on power is combined with a rejection of universalism because nuance, complexity, and uniqueness are replaced with simple characterizations of identity groups, generalized accusations of oppression, and universal assumptions about individuals. Accusations of oppression against groups and assump-

[1]Neiman (2023) expresses reservation in using the term "tribalism," noting that some people might take offense at the word as some kind of insult to groups for whom tribalism is part of their social structure and in this context it is being used in a somewhat negative way. However, there are also no suitable social constructs to capture the phenomenon. Yascha Mounk (2023) also talks about this phenomenon throughout his book and uses the words "warring tribes" in discussing the likely consequences of this ideology in the context of distributive justice in healthcare.

tions about individual identity based solely on group affiliation can be misguided when the nuance, complexity, and uniqueness favored by universalism are eschewed (e.g., Talisse, 2019).[2] Tribalism also leads to a desire for retribution which, problematic in its own right, is even more problematic when such retribution is directed by misguided assumptions about groups and their individual members. Thus, clinicians who embrace the social justice model are also embedded in a social system that implicitly stresses retribution against groups and their individual members for real or perceived perpetrated wrongs. Recent research demonstrates that a moral desire for retribution among politically left-leaning individuals can emerge when the public narrative suggests an imbalance in control between the out-group (oppressed) and the perceived in-group (oppressor) (Kunst, et al., 2018). In other words, when presented with an individual who is assumed to be a member of an oppressed group, the quest to identify and punish the perceived oppressor is a naturally occurring consequence. This moral stance is not new for the political left. Survey data from the mid-1970s showed that politically left-leaning college students endorsed the idea that they held morally superior positions and that those holding positions they disagreed with were deserving of punishment (Glantz, 1975). Retribution as a fundamental response to perceived injustice is natural. Quick, intuitive, and automatic, "cognitions and emotions in [this] response appear as a scripted package typically involving anger and the desire to punish" (Sivasubramaniam, 2017). This retributive impulse is fed by the idea that punishment restores a power imbalance that is caused by a transgression, and studies show that individuals are "more than willing to indulge it even if it is costly to them" (Sivasabrumariam). This response can be tempered with a recognition of ambiguity, nuance, and facts unique to particular situations—a response that entails thoughtful consideration (Sivasabrumariam). The motive of retribution on the new social justice model, however, is potentially quite dangerous precisely because the rejection of universalism toward tribalism amounts to a worldview that fails to see the nuance, ambiguity, and facts regarding situations or individuals that would otherwise temper its force.

It is on this point that ABCT, and the social justice movement in general, encounters a problem: Within this framework, Jews have been cast as oppressors (Rubin, 2013; Spinner-Halev, 2001; Walker et al., in press). This stance existed in social justice therapy groups before Hamas attacked Israel on October 7, 2023, and has only accelerated since. According to Talisse (2019), this is to be expected since as people more strongly align themselves to a certain identity, their beliefs often become more extreme. To illustrate, a recent article documented extensive discrimination toward Jewish therapy clients and Jewish therapists, particularly if they expressed solidarity with Israel (Deutch, 2024). The extent of discriminatory and antisemitic actions, framed in the context of social justice (Friedersdorf, 2024; Kim, 2024; Rosman, 2024), has been well-documented through campus protests in the spring of 2024 and in the significant spike in hate crimes against Jews since the start of the Israel-Hamas war. In the 2 months following the attacks of October 7, 2023, there was a 337% increase in hate crimes against Jews (Anti-Defamation League, 2023). The universal recognition of the human desire for freedom, compassion, and empathy, as well as the recognition that all people experience pain and suffering, is at the core of universalism (Mathu, 1999) and rightly remains at the center of any effective psychotherapeutic endeavor. The explicit abandonment of this Enlightenment principle opens the door to potential discrimination on

[2] Talisse (2019) explains in greater detail, calling it *belief polarization*. As people more fervently identify with a particular group, their beliefs tend to become more extreme. This can lead to a tendency to label individuals in other groups in negative ways, even often solely on the basis of looks.

the basis of the endorsement of relativism in its place and broad-based, often misguided, assumptions about circumstances, groups, and individuals.

The importance of addressing recommendations for discarding Enlightenment principles in the name of embracing social justice has relevance specifically to the conduct of cognitive-behavioral therapy (CBT), broadly defined. Most definitions of CBT emphasize the empowerment of clients to address their inner emotional experiences through directly challenging the systems in which they live that might contribute to distress, and through rehearsal of new adaptive skills, all in collaboration with the clinician. Models of CBT have always emphasized their personalized nature (Kazantzis et al., 2018), necessitating that effective clinicians exert cultural knowledge and sensitivity and, if they lack it, seek out appropriate consultation or refer to a clinician who possesses the requisite knowledge. This approach is fully in line with a universalism model and inconsistent with emergent treatment programs that stress relativism and, indirectly or directly, assignation to an oppressor group. The labels "oppressed" and "oppressor" represent a superficial and binary perspective that flattens out the full range of diverse characteristics of any individual. Further, while oppressed individuals can also be oppressors, the problem and harm inherent in identifying entire groups as "oppressors" deprives its members of individual liberty and personal identity. Indeed, Enlightenment thinkers, who were all White European men, would be grouped together as oppressors despite their formulation of universalism being a direct response against the prevailing colonizing approach of the countries where they resided (discussed in McKay & White, in press). Furthermore, while the idea that groups can be both oppressors and oppressed is true in theory, the possibility of it is undermined by the very ideology that is being proposed. Since beliefs about oppressors generate desires of retribution, oppression of an oppressor group is seen by most not as oppression but as justly deserved punishment. It is ironic that this epistemological mindset is so popular, given that it is so antithetical to that of a profession that focuses on each patient as a complex human being and that recognizes and embraces the uniqueness of each individual and the ambiguity and nuance of each situation that ultimately led the individual to seek help. The diminishment of diversity through overly general labels has been decried in the American Pschological Association's (APA) *Inclusive Language Guide* (see the portion on recommended elimination of the use of the term BIPOC; APA, 2023). Despite this, the term "oppressor" has been used to refer to Jews in a contemporary context, without regard for the individual political viewpoint of any single Jewish member of society, a group that comprises less than 2.4% of the U.S. population (discussed in Walker et al., in press). This "othering" and dehumanizing stance would be offensive to any other underrepresented group but goes without protest from the very same social justice advocates within our profession.

Labeling Jews as oppressors also overlooks the long history of antisemitism, which dates back through all of recorded history. In fact, antisemitism has been labeled "the oldest hatred" (discussed in Phillips, 2018). Adherents to the social justice model began to frame Jews as oppressors in the immediate aftermath of the Hamas attacks on Israel, well before any defensive response was mounted (Stephens, 2023)—and they did so without a proper understanding of the ambiguities and nuances of this history and the current war. This is particularly salient given that the current social justice model, expressed through institutional movements such as diversity, equity, and inclusion (DEI) approaches, specifically excludes Jews despite the long-standing discrimination they experience and the fact that they are a clear minoritized group (discussed in Walker et al., in press). In psychology, the neglect of legitimate concerns by Jews was on

specific display in the statement issued by the APA in the immediate aftermath of the October 7, 2023, attacks. In that statement, there was no mention of harm to Jews, and there were numerous inaccuracies regarding the nature of the conflict (discussed in Walker et al., in press).

The relevance of our points to ABCT is highlighted by two important facets. First, although ABCT is a multidisciplinary organization, its membership has long been dominated by doctoral-level psychologists. As such, the training model for most members derives from programs accredited by the APA. The second facet emerges from the first, namely that the APA has been clearly moving in the direction of a full embrace of the social justice movement in doctoral education (i.e., Toporek & Vaughn, 2010) and internship training (Cullinan et al., 2024). Accordingly, as ABCT moves further in the direction of including social justice perspectives on treatment conceptualization, it will be necessary to address the potential harms that might accrue with the abandonment of universalism. We are confident that models of social justice–based treatment can be modified to ensure that nondiscrimination is assured for all potential clients and therapists.

As far as we know, history and political theory are not part of the formal education of mental health practitioners. However, the authors are all students of the history of our profession and acutely aware of social movements that have been harmful to Jews (i.e., eugenics; history reviewed in Farber, 2008). It is in this historical context that we implore our colleagues to think very carefully about what is meant by the term "oppressor" and whether they are engaged in unintentional harm to others. We are confident that members of the organization are compassionate and empathetic. Awareness of the potentially misplaced sense of retribution and its consequences will go a long way toward a truly inclusive social justice framework of CBT.

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Enhancing Well-Being, Fostering Unity and Advocacy Through Rigorous Science in a Time of Uncertainty

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I PROUDLY START my presidency at ABCT after having been a member for 25 years and benefitting tremendously from the professional home that ABCT has been for me. In this time, I have witnessed (and been part of) tremendous organizational growth. For those of you who have been members for similar periods of time, please think back to the much thinner, smaller conference program book, to the larger thicker version, and now to the fully electronic version. When I attended my first AABT conference, not only was the conference smaller, the topics of the symposia and other scientific presentations were significantly more narrow, and I recall the content having a main focus on the efficacy of anxiety disorder treatments with relatively circumscribed samples and studies with high internal validity. The field has grown, we have moved to establishing efficacy for cognitive-behavioral treatments for a wider range of psychological disorders and problems, we have conducted our effectiveness trials with more generalizability, and we are working on expanding the diversity of the participant pool in our studies and our clinical work. However, all things considered, we are simply not making a sufficient dent in the reach of these treatments and therefore the impact of mental health distress regionally, and certainly not globally.

As I start my ABCT presidency, keeping this in mind, I am also serving at a time where we are only a few years and conferences post-pandemic, and a few years into a time where we have had a glaring light shine on mental health disparities in the context of what I consider a global mental health crisis. There are just not enough of us providing evidence-based mental health treatments, and there are not enough policy changes happening to mitigate social and structural problems that differentially contribute to inequities in mental health.

I also start my ABCT presidency at a time when I am aware of some diversity in viewpoints in terms of the direction of the organization and what we need to focus on. We are less than 2 months before a major change in the U.S. government, and one where we, as clinical scientists, may need to keep a watchful eye on the degree to which policies affect mental health, and the degree to which such policies are guided by psychological science. For our organization, this is potentially an inflexion point that we will need to manage.

Taking all of this together, I presented my vision to the Board of Directors and the Change Leaders at the Board meeting before the 2024 conference. I titled my vision talk "Enhancing Well-Being, Fostering Unity and Advocacy Through Rigorous Science in a Time of Uncertainty." In this, I reminded those in attendance of the mission and vision of the organization (https://www.abct.org/about/core-values-mission-and-vision/), which include key terms and phrases such as "advancing the scientific understanding," and "promotion of human wellness … through science." Two especially relevant core values of the organization are, in fact, "science" and "diversity" (the others are "quality," "mentorship," and "accountability"). As a result, I proposed a set of goals for my term.

These include:

Unity: Within the organization there is a need to increase understanding across the different generations of members, bridge a perceived divide between diversity/equity/inclusivity with our scientific core value, and be unified in advocating for evidence-based approaches to improving mental health globally.

Recommit to our core values: Particularly diversity and science. These two concepts are necessarily intertwined and, in order to achieve our mission and vision, it will be important to center these two pillars within the work of the organization so that our science is generalizable and applicable in equitable ways and all our members feel valued.

Achieve organizational standards of best practices: With the growth of the organization over the past 25 years, we also need to do a review of our policies, procedures, structures, and practices at the level of the central office and the organization generally. As many of you know, we have a new Chief Executive Officer (CEO) after bidding a bittersweet good-bye to our long-time, beloved, former Executive Director, M.J. Eimer, who helped us get to where we are over a period of 40 years. I am so happy to report, however, that our new CEO, Dr. Courtney White, is absolutely the person for this job, and we are incredibly fortunate to have him in this role. And, I invite you to join me in supporting him as he helps us shape our best practices to get to where we need to be in years to come.

Communications: As we gear up for the years to come, and as our inclusive and rigorous science continues, we will need to examine how we communicate and disseminate the most important, relevant scientific developments to the audiences that need to hear it to be able to act on it.

The ABCT mission, vision, and core values, particularly science and diversity, are more relevant in this moment in time than ever—and serve as a unifying foundation for the membership. Consistent with all of this, and with my vision as ABCT President this year, the theme of next year's conference will be "Bridging the Divide: Promoting Rigorous Science and Inclusive Affirming Therapies." Please stay tuned for important information sessions and communications leading up to next year's conference that are meant to further maximize both science and inclusivity. Two of these that we will pilot test are: (a) morning plenary sessions to take the place of, or partially take the place of, our invited addresses, and (b) stand-alone oral presentations — to maximize the best science being presented as oral presentations and reduce the need to already be networked within the organization in order to have a chance to present on the podium.

Thank you again for the opportunity to function in this role as President of the organization. I am excited to be part of the growth at such an important time in ABCT history. ■

Saying Goodbye to David Teisler: The End of an Era

"My roundaboutism has muddied the editorial waters yet again"
(Teisler, email communication)

ABCT is losing a true original: David Teisler, Deputy Director, Operations and Publications. He has worked at ABCT for 30 years and is retiring at the end of December 2024.

David is an individual whose passions extend into his working life. Upon entering his office at 305 Seventh Avenue, the first thing you might notice hanging on the wall is a series of gold-imbued religious icons. Chairs hold piles of envelopes, collected for their rare postal markings (he is a philatelist), plants of all sizes and species line the windows, books about military figures mixed in with style manuals adorn the shelves, along with bound journals (*BT*, *C&BP*, *tBT*) from across the decades, old program books and pamphlets from days of books and paper and ink. Of course, there are photos of animals and loved ones. One could lose a piece of turkey jerky in that office (which may have once happened) and never find it again.

Over the years, in addition to publications, David has been that person in charge of overseeing virtually every new system that ABCT adopted and seeing it through (association software, membership databases, various iterations of ABCT's website, and other technological necessities), working out myriad problems, patiently dealing with multiple and ever-changing personnel, doggedly following various entangled paths along the way; then starting over again when said system/program/platform was deemed outdated.

"Just change browsers and all's right with the world" (Teisler, email communication)

We have learned from David to keep showing up, with humor, with humility, with grace. And always with the assumption that everyone he encounters is equally as bright and quick-witted as he (and this was not always the case).

"Thoughtfulness doesn't hurt. There's always another deadline down the road"
(Teisler, email communication)

David's holiday cards are legendary. If you were lucky enough to receive him as your "Secret Santa," you would receive an epic, rhyming, pun-laden text, the meaning of which no one could gather. His compulsion with language (and yet a stickler for accuracy and grammar) led him to surprise us again and again.

"Ya, nacht nice; niche." (Teisler, email communication)

David cares about CBT and the mission of ABCT and its publications/programs. And he tends to the spirits behind it all: the members, the editors, the vendors, the col-

leagues, the public. His intent: to make everyone else look good and succeed.

> "David's passion for ABCT is palpable, his institutional knowledge downright impressive, and his sense of humor and relatability quite disarming. His presence and contributions will be profoundly missed at ABCT and by *the Behavior Therapist* team. David, I wish you the very best in your well-earned retirement." — Greg Chasson, *tBT* Editor

David's ego is rarely part of the equation as he often toils behind the scenes: writing someone else's copy, answering phones, helping a caller find a therapist, guiding incoming editors, deciphering contracts and agreements, problem solving, taking out the trash, inquiring into the building's recycle program, or heating up a Kielbasa in the microwave. He appears to be as comfortable being in the trenches as he is working out a deal with Elsevier or helping to birth a new journal (*C&BP*).

> "One thing that is special about David is how positive and encouraging he is. I've always felt very supported by him. He strikes the perfect balance of encouraging people to follow their own vision while always being available to help troubleshoot issues or offer advice. His restaurant and wine selection skills, are of course, legendary. He's just a really kind person and it's been such a treat to get to work with him. I will miss him!"
> —Carmen McLean, *C&BP* Editor, 2025-28

> "Working with David at ABCT has been an absolute pleasure. He brought a wealth of experience and insightful guidance, coupled with a generous spirit of encouragement, a balanced perspective, and a touch of humor. These qualities proved invaluable during the challenges I faced as Editor of *Cognitive and Behavioral Practice* (2020–2024). I am deeply grateful for all that David contributed, including his leadership in hosting unforgettable events to honor our outstanding reviewers and editorial team. Some meals—and the camaraderie they inspire—are truly unforgettable." — Nik Kazantzis, *C&BP* Editor, 2020-24

We will miss David's skill in connecting, encouraging, and gently guiding:

> "I've been coming to the convention for over 20 years and David Teisler was pivotal in my engagement with the organization. When I was still in graduate school, he showed me kindness and respect, and made himself available to answer my questions. That never stopped (nor have my questions), and it made a big difference to me. When I was contemplating accepting the role of Coordinator for Publications, the first question I asked was if he was going to be at ABCT during my full tenure in the role. He said yes, and then I said yes. I knew he'd make the work involved tolerable and the process fun. I am thankful to have had the many years of working with David, and I am a lucky person to get to call him a friend." — Susan White, Publications Coordinator, 2021-24

Plant carer, numbers guy, publisher, pun maker, insect rescuer, wordsmith, editor, reader, listener, mentor, team player, champion of CBT—David Teisler has made his mark. He has helped shape the association, and he has made it a better—and far more interesting and alive—place. ABCT will not be the same. We thank him for his service and friendship. ■

2024 Graduate Student Research Grant Winner and Honorable Mention

Every year, ABCT's Research Facilitation Committee awards a Graduate Student Research Grant (GSRG) to provide financial support for a student whose research shows great innovation, creativity, and broader significance. Our 2024 winner is Emily Bibby, a doctoral student in the Relationship Development Center at Stony Brook University, for her project entitled "A Video-Based Single-Session Intervention for Emerging Adults Coping With a Breakup." Our 2024 Honorable Mention is Kendall Poovey, a graduate student in the Disordered Eating, Prevention, Treatment and Health Lab at University of South Florida for her dissertation project entitled "Investigating Gastrointestinal Interoception in the Maintenance of Restrictive Eating Disorders." We sat down with our awardees to learn more about their projects.

2024 GSRG Winner: Emily Bibby

***Tell us about the project the GSRG is funding*:**

The project aims to create and pilot test a web-based video single-session intervention (SSI) including cognitive-behavioral, mindfulness, and acceptance-based approaches, adapted from the Romantic Competence Relationship Education program, to teach emerging adults how to effectively cope with a breakup. To test the efficacy of the breakup SSI, we will conduct a randomized control trial comparing the breakup SSI to popular YouTube videos that focus on dealing with a breakup (i.e., active control group). Thus, our study will not only be to develop and test the efficacy of the SSI on a series of relevant questionnaire outcomes, but also we will test its effectiveness compared to the information and advice currently accessible and commonly viewed online.

What does getting this award mean to you?

I am so grateful for receiving the Graduate Student Research Award. Receiving this award affirms the importance of studying romantic relationships and the impact relationships and breakups can have on individual mental health. I am very passionate about helping people cope with breakups since it is a ubiquitous experience for young adults and can be incredibly distressing, leading many to seek help. Receiving this award highlights the value of my proposed project to help improve the gap between need and access to mental health services for people going through a breakup.

This award will also allow me to expand my research experiences and help prepare me for my research future through developing an SSI and conducting my first randomized control trial. Once completing this project, I will have the experience to continue to develop new SSIs that are needed in the romantic relationship field.

How has ABCT contributed to your development as a researcher and clinician?

ABCT has allowed me to stay up to date on the current romantic relationship research in my field and meet other graduate students with similar research interests. Additionally, I have been able to meet many of the professors whose papers first inspired me to research romantic relationships and whose work has been foundational to my own research endeavors. Attending ABCT conferences each year, especially since starting the clinical work in my program, has allowed me to learn the current applications, findings, and cultural considerations for many of the interventions I have been trained in and use with my clients. ABCT embodies the important connection between research and practice. After each conference and talk I attend, I always come away with new intervention techniques and considerations I can implement in my clinical work.

How did you first become involved in research? What was this first research experience like?

I became involved in research as an undergraduate at Binghamton University after taking Dr. Steven Lynn's psychotherapy course where we learned how research has played an integral role in developing and improving interventions. During my sophomore year, I was accepted to Dr. Lynn's lab as well as Drs. Richard Mattson and Matthew Johnson's joint lab focusing on romantic relationships. My first project with Dr. Mattson entailed learning how to code positive and negative affect during couples' interactions using the Specific Affect Coding System. Watching couples discuss their relationship conflicts helped me understand the importance of open communication. This project first sparked my interest in conducting research on romantic relationships and helping dyads improve their relationships through research and in clinical settings. With Dr. Mattson's dedicated mentorship, I accumulated a wide range of research skills working on numerous projects in the lab and ultimately developed and ran my own study for my honors thesis looking at the misperception of sexual interest.

What does an average day or week look like for you?

Every day and week of my clinical Ph.D. program is a different adventure. I have many different roles that I cycle through during the day: researcher, clinician, student, colleague, teacher, undergraduate mentor, etc. Within my research I may have a day where I am running analyses for one project, and then the next day I am writing a preregistration for a new project or drafting a manuscript. With all the different roles and commitments, I find it is really important for me to use my Google calendar to keep track of all the different meetings, classes, and sessions I have throughout the week and write out all the tasks broken down that I need and would like to accomplish each week. At the start of each day, I pick three main tasks I would like to complete and block off hours in my calendar to ensure I have enough time to finish them.

What drew you to this particular research question?

Relationship breakups are the most common trigger of a first episode of major depressive disorder and one of the largest risk factors for medically serious suicide attempts in young adults. Unfortunately, breakups are a very universal experience, especially among young adults, and it is therefore not surprising how many people seek out therapy after experiencing a breakup. However, there are significant barriers to helping people learn to cope with breakups in a healthy way and a large gap between need and access to mental health services. After scouring the internet and literature, I realized there were not a lot of accessible research-informed resources out there to help people learn to cope with a breakup. I hope that with access to evidence-based tools on how to effectively handle a breakup, people can learn healthy coping skills which they can carry forward when they may experience breakups or other interpersonal distress in the future.

If you weren't pursuing a career in psychology, what would you be doing?

If I wasn't pursuing a career in psychology, I would likely be an opera singer! I attended LaGuardia High School (the *Fame* school) as a vocal major, which first sparked my love of classical music. My passion for music continued in undergrad where I graduated from Binghamton University with two bachelor's degrees in 4 years: a Bachelor of Arts in Psychology and a Bachelor of Music in Vocal Performance. Even though I decided not to pursue music as a career, my experiences singing and performing over the years have helped me become a better research communicator and presenter, whether that be giving talks at conferences or teaching lectures in the classroom.

2024 GSRG Honorable Mention: Kendall Poovey

Tell us about the project the GSRG is honoring:

Prominent theoretical models of restrictive eating disorders (i.e., anorexia nervosa, atypical anorexia nervosa, and avoidant/restrictive food intake disorder) posit that restrictive eating is maintained by gastrointestinal visceral sensitivity (i.e., hypervigilant monitoring of and worry about gastrointestinal cues). However, this theorizing has never been formally

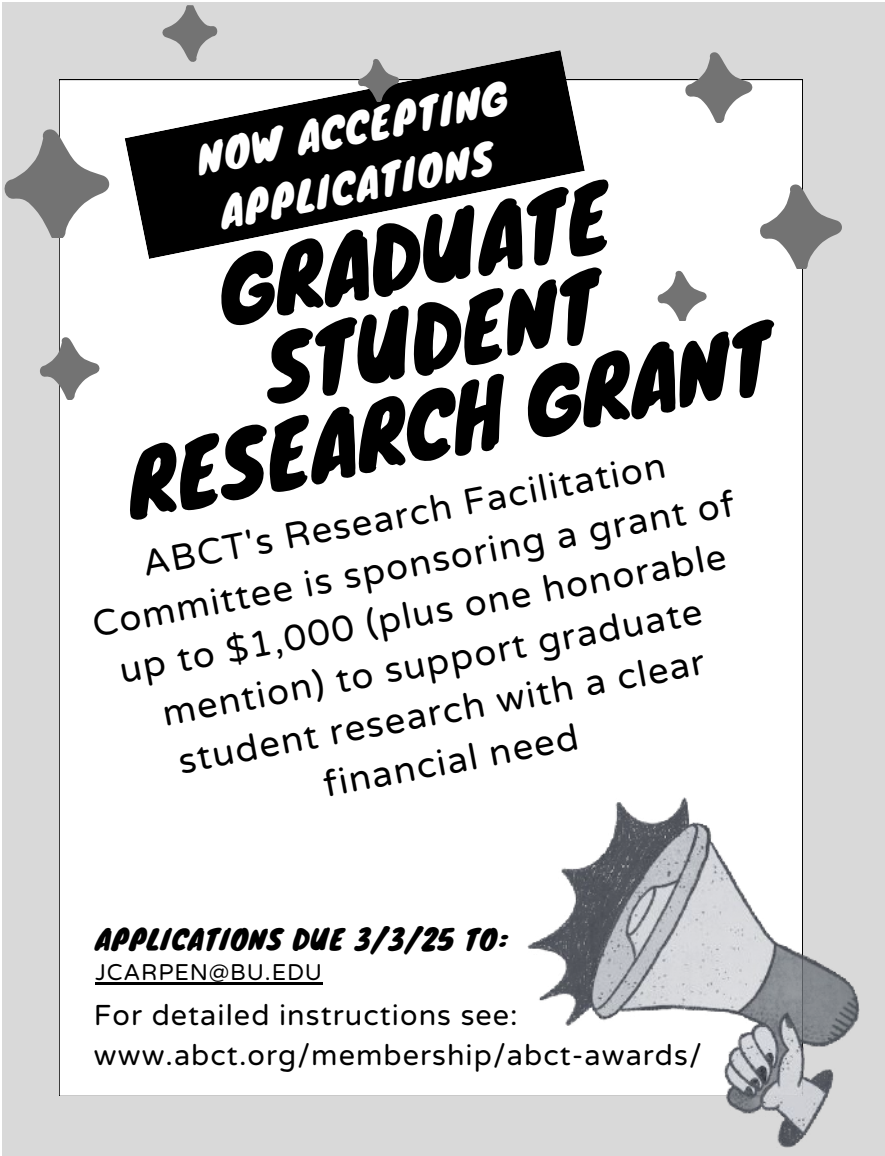
tested. Using ecological momentary assessment (EMA), my dissertation aims to examine daily temporal associations between gastrointestinal visceral sensitivity and disordered eating behaviors. Seventy-five adults at high risk for a restrictive eating disorder will be recruited from a large university community to complete daily surveys (six prompts/day) for 14 days. If hypotheses are supported, exposure to feared GI sensations and the associated cognitions should be key targets in treatment beyond mealtimes, and gastrointestinal visceral sensitivity may be a candidate for just-in-time EMA interventions.

What does getting this honorable mention mean to you?

I feel very honored and thankful that my work was chosen for an honorable mention. This honorable mention provides validation that experts in the clinical psychology area find my work to be rigorous and a significant scientific contribution to the eating disorder field.

How has ABCT contributed to your development as a researcher and clinician?

ABCT has played a significant role in my development as a researcher and clinician. I have attended three ABCT conferences and this upcoming conference will be my fourth. ABCT has provided me with the opportunity to develop my scientific communication skills, network with other graduate students and professors in the eating disorder and broader clinical science field, and learn about upcoming research. My learning from ABCT conference attendance has shaped both my research questions and methodology and given me new insights and perspectives for my clinical training. ■



ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

Bridging the Divide | *Promoting Rigorous Science and Inclusive Affirming Therapies*

59th Annual Convention NEW ORLEANS

November 20–23, 2025

Call *for* Abstracts 2025

Enhancing the reach and impact of cognitive and behavioral therapies requires evidence-based solutions across every level of the translational science continuum. To do this, rigorous approaches to the science and practice of cognitive and behavioral therapies continue to need a broader scope of focus to further generalizability, increase translational impact, identify potential moderators of outcomes, and actively reduce threats to psychological well-being due to structural determinants and a general lack of identity-affirmative care. This broader scope of focus includes accounting for contextual, cultural, and diverse factors, as well as solving problems at the intersection of psychology and public health through scientifically rigorous studies ranging from basic science up and through efficacy/effectiveness and ultimately implementation science. Studies that account for structural and or identity-based (e.g. racial, ethnic, sexual and gender minority) factors that lay the groundwork for increasing the reach and generalizability of evidence-based affirmative treatments are therefore particularly encouraged. Examples include:

Research at the interplay of public health and behavioral health treatment:

- Studies that address how structural/societal/community-level factors influence the experience of mental health distress and resilience.
- Studies that address important cognitive and behavioral variables across the translational spectrum, including basic science, neuroscience, and experimental paradigm studies that will inform treatment with diverse populations (e.g., sexual and gender minority, race, ethnicity). This might include: (a) studies with populations of interest that extend relevant basic and translational science, or (b) studies that examine important variables such as racism, sexism, homophobia, transphobia, and how that impacts the experience of mental health distress.

Studies of affirmative-based cognitive behavioral therapies with diverse populations:

- While principles of learning theory and cognitive-behavioral therapies are considered universal in humans, this point of view can result in CBT being viewed as too narrow in scope. Diverse populations come with different needs that are affected and influence by situation, context, economic, and health disparities. Studies that seek to better understand how to tailor case conceptualization up and through published treatments addressing these factors, in a person-centered affirming way, are also particularly encouraged.
- Research stemming from newly developed and/or adapted behavioral and cognitive therapy intervention studies aimed at improving outcomes for historically excluded populations or populations experiencing marginalization through chronic systems of oppression (e.g., racism, heterosexism, ageism, transphobia) are encouraged.

Online submission portal for general submissions will be available February 7, 2025

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: masterclinicianseminars@abct.org**

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

- For more information or to answer any questions before you submit your abstract, contact the **Research and Professional Development Chair, Emily Bilek: 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, Qimin Liu: 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 ***January 2, 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 Applications FELLOWS

Class of 2025

The ABCT Fellows Committee is pleased to announce that three new fellows were inducted this past year and were acknowledged at the awards ceremony on November 15, 2024. For a complete list of all fellows, please see https://www.abct.org/membership/fellow-members/. ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role.

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

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

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

For more information, please visit the Fellowship application page:

https://www.abct.org/Members/?m=mMembers&fa=Fellow

Deadline: July 1, 2025 is the deadline for applications and letter writers to submit their references for this year.

Applicants will be notified of the decision on their application by October 1, 2025.

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

ABCT

Call *for* Nominations

Are you interested in ABCT governance? We are looking for energetic, dedicated, and passionate ABCT members to run for the following two open leadership positions:

ABCT President-Elect (2025–26)

The ABCT President is the official spokesperson of ABCT and presides over the Board of Directors and all governance activities of the organization.

Representative at Large and Liaison to Academic and Professional programs (2025–28)

The RAL works closely with an appointed Coordinator to support and oversee the work of the following committees: International Associates; Academic Training & Educational Standards; Research Facilitation; Awards & Recognition; Self-Help Book Recommendations; and Dissemination, Implementation, & Community Engagement committees.

← To nominate yourself or your colleague for one of these positions, scan the QR code to access the nomination submission form. **Submit the form by Monday, February 3, 2025**

2025 Election Time Line

- **Oct 31, 2024:** nominations open
- **Feb 3, 2025:** nominations close
- **Feb 28, 2025:** names of candidates announced
- **April 1, 2025:** voting opens
- **April 30, 2025:** voting closes
- **May 15, 2025:** winners announced to membership

Webinars

https://elearning.abct.org

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

upcoming

Matthew Young | Telehealth Parent-Child Interaction Therapy: A Practical Guide for Therapists Jan. 9 > REGISTER

recorded

Richard Heyman | Intimate Partner Violence: Foundations, Assessment, and Interventions

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

Visit ABCT's eLearning web pages for many more recorded, CE and non-CE, webinars.

https://elearning.abct.org/

Sanity x ABCT

A collaborative podcast series with Dr. Jason Duncan and ABCT

> episode website

50th Anniversary of Gerald Davison's ABCT Presidential Address
with Dr. Gerald Davison and Dr. Joel Becker

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)

SPOTLIGHT ON A RESEARCHER

PRESENTED BY ABCT'S
RESEARCH FACILITATION COMMITTEE

Recognizing Excellence in

1. Early Career Research
2. Mid-Career Research
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Winners will be featured on ABCT's website, social media, & at the Convention Award Ceremony

Nominate yourself or someone else!

Fine Print: See nomination form at the QR code for eligibility criteria