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ORIGINAL RESEARCH | **Who Is Treating Stigmatized Psychological Conditions? Relative Availability of Providers and Evidence-Based Treatment for Hoarding and Borderline Personality Disorder**

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HOARDING DISORDER AND BORDERLINE PERSONALITY DISORDER (BPD) are two psychiatric conditions which have grown in public recognition in recent years, in part through their portrayal in the media (e.g., “Hoarders” on A&E and “My Crazy Ex-Girlfriend” on the CW). However, they are also two of the more stigmatized disorders (Hazell et al., 2022; Proser et al., 2024), potentially due to media portrayals increasing a sense of difference (Bates et al., 2020) from the general population. The extent to which stigma related to these disorders may have affected availability of psychotherapy has not yet been systematically documented. Indeed, although there has been some investigation of the ratio of treatment-seeking patients to available providers for BPD (Iliakis et al., 2019), to our knowledge, there are no published data on the availability of treatment for hoarding disorder.

Although research directly investigating stigma towards hoarding disorder is limited, a recent systematic review concluded that there is notable stigma towards hoarding disorder in the general public, and that many individuals with hoarding disorder experience stigma (Prosser et al., 2024). Some findings suggest stigma towards hoarding may be more intense than towards other disorders, including OCD and schizophrenia (Prosser et al., 2024). Hoarding patients report higher perceived daily discrimination than do matched counterparts with OCD (Williams et al., 2025). Hoarding stigma may impact treatment availability through multiple pathways. Self-stigma is associated with increased hoarding severity (Krafft et al., 2023). The literature is mixed on the connection between self-stigma and treatment-seeking behavior in adults with hoarding symptoms (e.g., Chasson et al., 2018; Robertson et al., 2020). An online study of U.S. adults with clinically significant hoarding symptoms found that scores on a measure of disdain (e.g., “How good or bad do you think is a person with hoarding disorder compared to everyone else in the general population?”) were negatively correlated with endorsement of the item “I am willing to ask for help” (Chasson et al., 2018). In contrast, in an Australian online study on adults with elevated hoarding symptoms, internalized stigma was not found to be correlated with “likelihood of seeking treatment” (Robertson et al., 2020). In one qualitative study on this topic in the U.S., many participants reported that stigma impacted their help-seeking behavior, while a smaller number said it did not impact help-seeking or were unsure about its impact (Bates, 2023). These mixed findings could be associated with cultural differences (United States vs.

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Australia) as well as the difference in the operationalization of treatment-seeking behavior (“willing to ask for help” vs. “likelihood of seeking treatment”). Finally, mental health professionals report more negative feelings towards hoarding patients (compared with nonhoarding patients), including increased frustration and irritation (Tolin et al., 2012), although providers of hoarding treatment tend to endorse lower levels of stigma than the general population (Larkin et al., 2025).

Notably, stigma in relation to personality disorder diagnoses is sparsely studied when compared to other disorders. This may, in part, be due to the belief that patients with personality disorders are “difficult” to work with and that real change or growth for these patients is extremely limited, if even seen as possible at all. For example, previous work that investigated the perceptions of mental health workers found that people with personality disorder diagnoses are often seen to be in control of their behaviors (more so than people with other diagnoses), which in turn, appears to color their interpretations of the patient’s actions (Lewis & Appleby, 1988). For instance, the study found that psychiatrists were often more judgmental and pejorative when given vignettes that included a personality disorder diagnosis than when they were not. Second, clinicians given these vignettes would refer to previous suicide attempts as “attention seeking” only when a personality disorder diagnosis was included in the description (Lewis & Appleby, 1988). As such, the study demonstrated that individuals with a personality disorder diagnosis were much less likely to receive the same amount of concern and to have their reported symptoms be taken as seriously as those without such a diagnosis. Arguably, this is completely counter to these diagnoses, as individuals with personality disorder diagnoses have demonstrated significant decreases in quality of life, even after controlling for sociodemographic variables, somatic health, and other psychiatric diagnoses (Cramer et al., 2006).

Individuals with the BPD label are often described as “treatment resistant” and even “manipulative.” Unfortunately, this can result in views that lead mental health practitioners to stigmatize and even discriminate against these individuals.

Stigma within personality disorders is most often studied in relation to BPD, which is also generally the most studied personality disorder (Liu et al., 2024; Paris, 2019). Individuals with the BPD label are often described as “treatment resistant” and even “manipulative.” Unfortunately, this can result in views that lead mental health practitioners to stigmatize and even discriminate against these individuals. Some evidence suggests that individuals with BPD report higher internalized stigma compared to bipolar disorder (Quenneville et al., 2020). Furthermore, experimental evidence suggests that public stigma is higher for BPD than bipolar disorder (Elliott & Ragsdale, 2025). As such, this stigma can have massive impacts for individuals with BPD. Importantly, research has demonstrated that much of the stigma is structural in nature, with

a recent meta-analysis demonstrating specific themes (for a review, see Klein et al., 2022). Beyond the structural stigma, there are also influences on the interpersonal dynamics between health practitioners and patients. For instance, individuals with BPD report having problems with communication and interpersonal conflicts with their health practitioners and reported being treated disrespectfully or even discriminated against based on their BPD diagnosis (Klein et al., 2022; Lawn & McMahan, 2015; Veysey, 2014).

Stigma towards hoarding disorder and BPD may interfere with willingness to seek treatment and with providers' willingness to learn about and offer treatment for these disorders. Additional factors may also limit treatment-seeking behaviors for adults with hoarding disorder, including lack of insight, desire for self-reliance, and cost (Robertson et al., 2020). Additionally, the majority of hoarding treatment offered in the community tends to be group-based (Casey, 2024), which is counter to patient preference (Robertson et al., 2020) and may decrease treatment-seeking.

However, information about treatment access for these disorders is limited. Thus, our primary aim for the current study was to investigate the relative prevalence of mental health treatment for two stigmatized disorders (hoarding disorder and BPD) compared with similarly severe psychiatric diagnoses of perceived lower stigma (OCD and bipolar disorder, respectively). Hoarding disorder was compared to OCD because of the historical combination of the two disorders (Mataix-Cols et al., 2010). BPD was compared to bipolar disorder due to the long-standing history of symptom overlap and debate in the literature about these disorders. For example, some have called for BPD to be a part of the bipolar spectrum (Smith et al., 2004). In fact, studies have found that about 20% of individuals with Bipolar II and 10% of individuals with Bipolar I will also meet criteria for BPD (Zimmerman & Morgan, 2013). Our secondary and tertiary aims were to investigate the percentage of treatment providers who list evidence-based treatments for these disorders and to conduct a preliminary survey of providers' training in evidence-based treatments in order to assess whether this may be an area of improvement for mental health practitioners and training programs.

Methods

All study procedures were approved by the local institutional review board (IRB-24-447). Using the "Find a Therapist" feature on the Psychology Today website (link available [here](#)), we were able to estimate the relative number of mental health clinicians who treat hoarding disorder, OCD, bipolar disorder, and BPD for each U.S. state. Data was abstracted from the Psychology Today website between January 7th and January 11th, 2025. Prevalence rates of diagnoses based on the DSM-5 (hoarding disorder: 2.5%; OCD: 1.2%; bipolar: 1.5%; BPD: 2.7%; American Psychiatric Association, 2022) and population information from the 2020 U.S. Census for each state (U.S. Census Bureau, 2020) were then used to approximate the number of available providers for each case.

As a secondary estimate of clinicians likely to be using evidence-based therapies, we also used the "Find a Therapist" feature on the Association for Behavioral and Cognitive Therapies (ABCT) website (link available [here](#)). For each therapist who came up during the ABCT search, we then recorded the following information: contact information (name and email address), degree (e.g., LPC,

PHD), population served (i.e., children, adolescents, adults, and / or older adults), and specific mentioning of any evidence-based treatments for hoarding disorder (David et al., 2022) or BPD (Crotty et al., 2024; cognitive behavioral therapy [CBT], acceptance and commitment therapy [ACT], dialectical behavior therapy [DBT], exposure therapy, cognitive rehabilitation and exposure therapy [CREST], motivational interviewing [MI], compassion-focused therapy [CPT], interpersonal psychotherapy [IPT], schema therapy). Data was extracted from the ABCT website between September 6th and October 8th, 2024.

We then distributed an anonymous survey via email to the providers identified as treating hoarding disorder, OCD, bipolar disorder, and BPD to determine the extent of evidence-based training for these disorders. The email provided a brief explanation of the study and included a link to complete the anonymous online survey administered using REDCap (Research Electronic Data Capture) hosted at Mississippi State University (Harris et al., 2009; 2019). Of the 384 emails that were sent out to mental health providers, 29 emails were undeliverable (e.g., email address was no longer active). Using the information on the ABCT website (e.g., name, degree, phone number), we were able to locate updated email addresses and redistribute the survey to these providers. Thirty-two providers subsequently clicked on the link, indicated their consent to participate, and completed the survey. The survey asked for background information (i.e., age, gender, race, location of practice, highest degree, field); what percentage of patients they treat have a primary diagnosis of hoarding disorder, bipolar disorder, personality disorders, and / or obsessive-compulsive disorder; and what training they had received for these disorders.

Results

General Availability of Providers for Stigmatized Disorders

Across the U.S., there were 9,807 providers in the Psychology Today network who self-describe as able to treat hoarding disorder, 78,912 who treat OCD, 95,731 who treat bipolar disorder, and 49,216 who treat BPD (see Table 1 for frequency by state). The estimated number of patients per provider was calculated at the state level and varied substantially across states and disorders, with the best ratio being OCD in Connecticut (22 patients per provider) and the worst ratio being hoarding disorder in Alabama (2,204 patients per provider). On average, there were 1,012 patients per provider for hoarding disorder, 65 patients per provider for OCD, 61 patients per provider for bipolar disorder, and 207 patients per provider for BPD (see Table 2 for estimates by state).

Providers in the ABCT Network

HOARDING DISORDER. Across the United States, 68 mental health providers on the ABCT “Find a Therapist” website listed hoarding disorder as a psychiatric disorder that they treat (see Table 3 for frequency by state). Of the 64 providers that provided information about their credentials, 60 (94%) listed Ph.D. as their highest degree, 3 listed LPC, and 1 listed PsyD. Of the 67 providers that had information available about population treated, 66 (99%) treat adults, 54 (81%) treat older adults, 30 treat children (45%), and 46 (69%) treat adolescents. Out of the 68 providers who listed treating hoarding disorder, 46 (68%) listed CBT as a treatment option, 12 (18%) listed ACT, 10 (15%) listed DBT, 7 (10%) listed exposure therapy, and 1 listed compassion-focused therapy. No clinicians listed

Table 1 - Number of Mental Health Clinicians Listed as Treated Hoarding Disorder, OCD, Bipolar Disorder, or Personality Disorders across the United States using the Psychology Today Network

State	Total Number of Providers	Hoarding Disorder	OCD	Bipolar Disorder	Borderline Personality Disorder
Overall	253851	9807	78912	95731	49216
Alabama	2481	57	550	675	362
Alaska	605	15	110	152	91
Arizona	6794	146	1447	1776	1008
Arkansas	1777	59	419	535	322
California	>10000	1338	9476	>10000 (n/a)	5497
Colorado	>10000	312 (n/a)	2488 (n/a)	3119 (n/a)	1590 (n/a)
Connecticut	7697	189	1936	2096	1113
Delaware	1314	37	308	428	155
Florida	>10000	646 (n/a)	5088 (n/a)	6020 (n/a)	3040 (n/a)
Georgia	>10000	255 (n/a)	2024 (n/a)	2991 (n/a)	1210 (n/a)
Hawaii	1494	56	277	340	154
Idaho	2376	65	502	669	380
Illinois	>10000	552 (n/a)	4026 (n/a)	4912 (n/a)	2252 (n/a)
Indiana	4341	114	960	1203	709
Iowa	2164	61	494	566	434
Kansas	2729	73	562	739	426
Kentucky	2726	76	665	868	424
Louisiana	2756	66	577	822	375
Maine	2198	41	480	546	246
Maryland	9715	239	2070	2850	1152
Massachusetts	>10000	372 (n/a)	2974 (n/a)	3642 (n/a)	1635 (n/a)
Michigan	>10000	336 (n/a)	2607 (n/a)	3073 (n/a)	1638 (n/a)
Minnesota	5350	151	1101	1298	905
Mississippi	1097	36	234	346	181
Missouri	4876	115	975	1216	689
Montana	1682	39	333	440	238
Nebraska	1671	43	414	594	336
Nevada	2668	105	645	852	484
New Hampshire	2059	64	455	520	271
New Jersey	>10000	355 (n/a)	3752 (n/a)	3997 (n/a)	1838 (n/a)
New Mexico	1737	39	300	416	194
New York	>10000	779 (n/a)	8007 (n/a)	7040 (n/a)	4638 (n/a)
North Carolina	>10000	270 (n/a)	2566 (n/a)	3359 (n/a)	1552 (n/a)
North Dakota	353	9	84	97	76
Ohio	8071	216	2053	2609	1375
Oklahoma	2448	70	469	641	266
Oregon	7193	175	1214	1474	701
Pennsylvania	>10000	368 (n/a)	3471 (n/a)	4110 (n/a)	2025 (n/a)
Rhode Island	1828	66	451	562	220
South Carolina	4166	131	926	1118	558
South Dakota	436	18	97	132	120
Tennessee	5307	122	1119	1358	669
Texas	>10000	615 (n/a)	4662 (n/a)	6855 (n/a)	3065 (n/a)
Utah	5247	123	1373	1209	889
Vermont	1779	42	335	304	206
Virginia	>10000	284 (n/a)	550 (n/a)	3374 (n/a)	1591 (n/a)
Washington	>10000	286 (n/a)	2090 (n/a)	2413 (n/a)	1205 (n/a)
West Virginia	569	26	163	194	111
Wisconsin	3636	135	925	1032	513
Wyoming	511	20	108	149	87

Note - The Psychology Today search feature did not show all providers when the number of providers was >10,000. This creates an underestimation for overall number of providers in several states, as well as the number of providers treating bipolar disorder in California.

Table 2 - Estimated Number of Patients per Mental Health Provider for Hoarding Disorder, OCD, Bipolar Disorder, or Personality Disorders across the United States using the Psychology Today Network

State	2020 Census Population Estimate	Estimated Number of Patients per Provider			
		Hoarding Disorder	OCD	Bipolar Disorder	Borderline Personality Disorder
Alabama	5,024,279	2204	110	112	375
Alaska	733,391	1222	80	72	218
Arizona	7,151,502	1225	59	60	192
Arkansas	3,011,524	1276	86	84	253
California	39,538,223	739	50	59	194
Colorado	5,773,714	463	28	28	98
Connecticut	3,605,944	477	22	26	87
Delaware	989,948	669	39	35	172
Florida	21,538,187	834	51	54	191
Georgia	10,711,908	1050	64	54	239
Hawaii	1,455,271	650	63	64	255
Idaho	1,839,106	707	44	41	131
Illinois	12,812,508	580	38	39	154
Indiana	6,785,528	1488	85	85	258
Iowa	3,190,369	1308	78	85	198
Kansas	2,937,880	1006	63	60	186
Kentucky	4,505,836	1482	81	78	287
Louisiana	4,657,757	1764	97	85	335
Maine	1,362,359	831	34	37	150
Maryland	6,177,224	646	36	33	145
Massachusetts	7,029,917	472	28	29	116
Michigan	10,077,331	750	46	49	166
Minnesota	5,706,494	945	62	66	170
Mississippi	2,961,279	2056	152	128	442
Missouri	6,154,913	1338	76	76	241
Montana	1,084,225	695	39	37	123
Nebraska	1,961,504	1140	57	50	158
Nevada	3,104,614	739	58	55	173
New Hampshire	1,377,529	538	36	40	137
New Jersey	9,288,994	654	30	35	136
New Mexico	2,117,522	1357	85	76	295
New York	20,201,249	648	30	43	118
North Carolina	10,439,388	967	49	47	182
North Dakota	779,094	2164	111	120	277
Ohio	11,799,448	1366	69	68	232
Oklahoma	3,959,353	1414	101	93	402
Oregon	4,237,256	605	42	43	163
Pennsylvania	13,002,700	883	45	47	173
Rhode Island	1,097,379	416	29	29	135
South Carolina	5,118,425	977	66	69	248
South Dakota	886,667	1231	110	101	200
Tennessee	6,910,840	1416	74	76	279
Texas	29,145,505	1185	75	64	257
Utah	3,271,616	665	29	41	99
Vermont	643,077	383	23	32	84
Virginia	8,631,393	760	188	38	146
Washington	7,705,281	674	44	48	173
West Virginia	1,793,716	1725	132	139	436
Wisconsin	5,893,718	1091	76	86	310
Wyoming	576,851	721	64	58	179

Note - Number of patients was estimated using the prevalence rates for each disorder provided in the DSM-5 and the 2020 Census population estimate of each state.

Table 3 - Number of Mental Health Clinicians Listed as Treated Hoarding Disorder, OCD, Bipolar Disorder, or Personality Disorders across the United States using the ABCT Network.

State	Hoarding Disorder	OCD	Bipolar Disorder	Personality Disorders
Overall	68	326	88	91
Alabama	0	2	0	0
Alaska	0	0	0	0
Arizona	0	2	0	1
Arkansas	0	2	0	1
California	8	69	18	11
Colorado	0	0	0	1
Connecticut	3	12	1	1
Delaware	0	0	0	0
Florida	3	12	2	4
Georgia	0	10	1	1
Hawaii	0	0	0	0
Idaho	1	1	1	0
Illinois	5	12	4	3
Indiana	1	3	0	0
Iowa	0	2	0	0
Kansas	1	2	1	0
Kentucky	0	0	1	1
Louisiana	0	2	0	0
Maine	1	3	0	0
Maryland	0	0	1	0
Massachusetts	3	24	3	6
Michigan	0	5	3	2
Minnesota	1	9	3	1
Mississippi	0	0	0	0
Missouri	0	1	0	0
Montana	1	2	1	1
Nebraska	0	1	0	0
Nevada	0	1	0	0
New Hampshire	3	3	1	0
New Jersey	0	13	2	3
New Mexico	0	1	0	1
New York	14	13	24	31
North Carolina	3	8	1	3
North Dakota	1	1	0	0
Ohio	1	7	4	3
Oklahoma	0	0	0	0
Oregon	0	0	2	0
Pennsylvania	4	23	4	6
Rhode Island	1	1	0	1
South Carolina	1	2	1	1
South Dakota	1	1	0	0
Tennessee	0	2	1	0
Texas	3	9	4	2
Utah	1	3	0	1
Vermont	0	0	0	0
Virginia	2	9	3	0
Washington	0	0	0	0
West Virginia	0	3	0	0
Wisconsin	1	2	1	5
Wyoming	0	0	0	0

Note - The ABCT search feature allows for filtering for “personality disorders” but not borderline personality disorder specifically.

Table 4 - Survey of Prevalence of Stigmatized Psychiatric Diagnoses in Caseload for (N = 32) Mental Health Providers Who Treat Hoarding Disorder, OCD, Bipolar Disorder, and/or Personality Disorders

% of Patients with a Primary Diagnosis	Hoarding Disorder (N = 11) n (%)	OCD (N = 30) n (%)	Bipolar Disorder (N = 19) n (%)	Personality Disorders (N = 18) n (%)
1-10	10 (91%)	6 (20%)	14 (74%)	12 (67%)
11-20	1 (9%)	5 (17%)	5 (26%)	2 (11%)
21-30	0	2 (7%)	0	1 (6%)
31-40	0	2 (7%)	0	2 (11%)
41-50	0	7 (23%)	0	0
51-60	0	2 (7%)	0	0
61-70	0	1 (3%)	0	1 (6%)
71-80	0	3 (10%)	0	0
81-90	0	2 (7%)	0	0

Table 5 - Survey of Training for (N = 32) Mental Health Providers Who Treat Hoarding Disorder, OCD, Bipolar Disorder, and/or Personality Disorders

Type of Training	Hoarding Disorder n (%)		OCD n (%)		Bipolar Disorder n (%)		Personality Disorders n (%)	
	Total	Treats HD (N = 11)	Total	Treats OCD (N = 30)	Total	Treats Bipolar (N = 19)	Total	Treats PDs (N = 18)
Required Class in Graduate School	4 (13%)	1 (9%)	12 (38%)	11 (37%)	12 (38%)	9 (47%)	13 (41%)	9 (50%)
Elective Class in Graduate School	2 (6%)	1 (9%)	9 (28%)	11 (37%)	2 (6%)	2 (11%)	6 (19%)	5 (28%)
On the Job Training Under a Supervisor	20 (63%)	9 (82%)	28 (88%)	9 (30%)	18 (56%)	14 (74%)	23 (72%)	15 (83%)
Training Outside of School	20 (63%)	8 (73%)	27 (84%)	28 (93%)	12 (38%)	10 (53%)	21 (66%)	16 (89%)
Self-taught	21 (66%)	11 (100%)	28 (88%)	27 (90%)	22 (69%)	17 (89%)	23 (72%)	15 (83%)
Interest in Additional Training	19 (59%)	7 (64%)	13 (41%)	12 (40%)	19 (59%)	13 (68%)	17 (53%)	9 (50%)

CREST or compensatory cognitive training (specific evidence-based treatments for hoarding disorder), MI, IPT, or schema therapy.

OBSESSIVE COMPULSIVE DISORDER. Across the United States, 326 mental health providers on the ABCT “Find a Therapist” website listed OCD as a psychiatric disorder that they treat. Of the 225 providers that had information about their credentials, 199 (88%) listed Ph.D. as their highest degree, 15 (7%) listed PsyD, 9 listed a master’s-level credential (e.g., LCSW, LCPC), 1 was a registered psychiatric nurse, and 1 was a bachelor’s level social worker. Of the 323 providers that had information available about population treated, 292 (90%) treat adults, 208 (64%) treat older adults, 129 treat children (40%), and 204 (63%) treat adolescents. Out of the 326 providers who listed treating OCD, 195 (60%) listed CBT as a treatment option, 56 (17%) listed ACT, 49 (15%) listed DBT, 59 (18%) listed exposure therapy, 8 (2%) listed MI, 2 (1%) listed compassion-focused therapy, 4 (1%) listed IPT, and 2 (1%) listed schema therapy.

BIPOLAR DISORDER. Across the United States, 88 mental health providers on the ABCT “Find a Therapist” website listed bipolar disorder as a diagnosis they treat. Of the 76 providers that had information about their credentials, 71 (93%) listed Ph.D. as their highest degree, 2 (3%) listed PsyD, and 3 (1%) listed a master’s-level credential (e.g., LCSW, LCPC). Of the 82 providers that had information available about population treated, 78 (95%) treat adults, 59 (72%) treat older adults, 26 (32%) treat children, and 49 (60%) treat adolescents. Out of the 88 providers who listed treating bipolar disorder, 47 (53%) listed CBT as a treatment option, 15 (17%) listed ACT, 3 (3%) listed exposure therapy, 1 (1%) listed compassion-focused therapy, 19 (22%) listed DBT. No providers listed IPT or schema therapy.

PERSONALITY DISORDERS. Across the United States, 91 mental health providers on the ABCT “Find a Therapist” website listed personality disorders as a diagnosis that they treat. Of the 57 providers that had information about their credentials, 45 (79%) listed Ph.D. as their highest degree, 6 (11%) listed PsyD, and 6 listed a master’s-level credential (e.g., LCSW, LCPC). Of the 90 providers that had information available about population treated, 85 (93%) treat adults, 54 (59%) treat older adults, 25 treat children (27%), and 55 (61%) treat adolescents. Out of the 91 providers who listed treating personality disorders, 50 (56%) listed CBT as a treatment option, 22 (24%) listed ACT, 48 (53%) listed DBT, 13 (15%) listed exposure therapy, 3 (3%) listed MI, 2 (2%) listed IPT, and 1 (1%) listed schema therapy.

Provider Survey

The average age of participants was 45 ($SD = 11.8$, range 31-77). Four (12.5%) participants identified their gender as man / male; 28 (87.5%) identified as woman / female. The majority of participants identified their race as White or Caucasian ($n = 29$; 91%), with one participant identifying as Latinx and one participant choosing to not identify their race. Participants practiced across 19 different states, with California being the modal location ($n = 7$). Seventy-five percent of participants reported their highest degree was a Ph.D. in Psychology ($n = 24$), 12.5% ($n = 4$) had a PsyD., and 12.5% had a master’s degree in Marriage and Family Therapy ($n = 3$) or Counseling ($n = 1$).

Of the 32 respondents to the survey, 11 (34%) reported having at least some patients with a primary diagnosis of hoarding disorder in their caseload;

30 (94%) reported having at least some patients with a primary diagnosis of OCD in their caseload; 19 (59%) reported having at least some patients with a primary diagnosis of bipolar disorder in their caseload; and 18 (56%) reported having at least some patients with a primary diagnosis of a personality disorder in their caseload (see Table 4). All respondents reported they had training in at least one of the four stigmatized disorders on the survey (see Table 5). Three participants (9%) reported no training in hoarding disorder; 5 (16%) reported no training in bipolar disorder, 3 (9%) reported no training in personality disorders, and 1 (3%) reported no training in OCD. Forty-four percent of participants (n = 14) reported no required class in graduate school in any of the four disorders.

Discussion

This study provides an initial estimate of the relative availability of providers and evidence-based treatments for two stigmatized psychological conditions: hoarding disorder and BPD. On average across the U.S., there are approximately 16.5 times more patients per provider for hoarding disorder than for OCD and 3.5 times more patients per provider for BPD than for bipolar disorder. Our survey of clinicians in the ABCT directory who treat at least one of the four disorders examined suggests that even for OCD and bipolar disorder, evidence-based treatment is not routinely being taught in graduate schools and there is substantial interest in additional training.

Despite the very limited number of providers who offer treatment for hoarding disorder relative to its prevalence, even those providers are treating a small number of hoarding patients (0-20% of their caseload). This suggests that there is not just a lack of treatment supply, but also a lack of demand for hoarding disorder treatment. Stigma may be a contributing factor that leads people with hoarding disorder to refrain from seeking treatment (e.g., Bates, 2023; Chasson et al., 2018), but other barriers to hoarding treatment should be explored, such as lack of awareness about where to seek treatment or practical barriers (e.g., cost, location). Few treatment providers reported receiving training on hoarding disorder treatment in graduate school. Although hoarding is a relatively recent addition to the DSM, integrating training on hoarding disorder into graduate coursework is necessary to improve treatment access.

There is likely a plethora of reasons that fewer clinicians are treating BPD compared to bipolar disorder. For instance, bipolar disorder is more highly researched and receives much more funding compared to BPD (Zimmerman et al., 2016), and this likely has had significant downstream effects in training, outreach, and treatment. Additionally, because BPD is labeled as a “personality disorder,” these symptoms (e.g., affective instability, self-harming behaviors) are often attributed directly to the person instead of the pathology and may be perceived as unlikely to change. This can lead clinicians with this bias away from wanting to work with these populations, especially knowing that treatment for BPD is often time-intensive and can at times be emotionally demanding. Other explanations for barriers to treatment for BPD also include financial concerns and comorbidity with psychiatric or medical disorders (in addition to stigmatization and marginalization within mental health care systems; Lohman et al., 2017).

Another theme identified in the current study is the lack of training in

schema therapy, with 0-2% of providers reporting schema therapy as a treatment they provide. Schema therapy is a primary therapy that can be used to treat borderline personality disorder (Stoffers-Winterling et al., 2012), as well as other personality disorders (Zhang et al., 2023). As such, training programs and practitioners may wish to consider providing and seeking out additional training for this therapeutic approach in order to better treat individuals presenting with personality pathology.

Limitations

This project was designed to assess a snapshot of the relative availability of the mental health treatment for two highly stigmatized disorders. Future studies with a broader scope should consider more comprehensive survey methods, including incorporating qualitative interviews. We also procured the provider data using the Psychology Today and ABCT websites; we did not have access to the databases underlying these directories and thus were unable to integrate the lists of available providers to determine the number of unique providers represented across the two websites and across states. Because we coded the data by hand (i.e., instead of extracting the data using a computer program), we only looked at total number of providers for each state on the Psychology Today website and did not analyze that information further as we did with the ABCT website, which had fewer providers listed and was thus more feasible to code for type of provider and types of therapies offered. Because some states had more than 10,000 providers listed in the Psychology Today network, the total number of providers listed in Table 1 is an underestimation, as is the number of providers for bipolar disorder in California.

Conclusion

Despite relatively high prevalence rates, hoarding disorder and borderline personality disorder remain two diagnoses marred by stigma, which may be influencing availability of treatment providers. While our estimation of available providers at a national level is likely an overestimation, the state-level estimations should remain relatively accurate and provide strong evidence for the under-treatment of both hoarding disorder and BPD, particularly in comparison to related psychological conditions.

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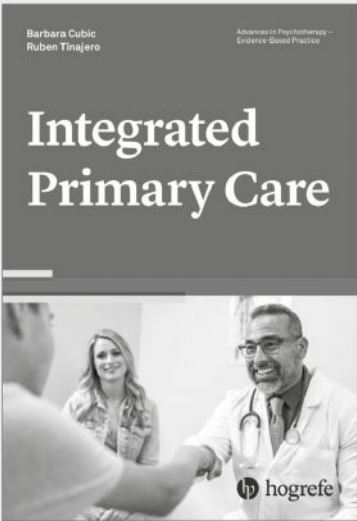
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ORIGINAL RESEARCH | **Pilot-Case-Series Combining Symptom-Specific Group and Ultra-Brief Individual Cognitive Behavioral Therapy for Negative Symptoms in an Early Intervention in Psychosis Service**

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NEGATIVE SYMPTOMS (NSs) OF PSYCHOSIS involve “a lessening or absence of normal behaviors and functions related to motivation and interest, or verbal / emotional expression” (Correll & Schooler, 2020). Common NSs include alogia (poverty of speech), avolition-apathy (lack of goal-directed activity due to reduced motivation), affective flattening (reduced emotional expressiveness) and anhedonia-asociality (lack of pleasure and sociality; Correll & Schooler, 2020). Such symptoms frequently appear in the early stages of psychosis (Galderisi et al., 2018), often before the onset of positive symptoms (an der Heiden et al., 2016), occur more frequently in men (Carter et al., 2022) and in those who have reduced functioning (Carbon & Correll, 2014). Symptoms can be primary, manifesting from the underlying pathophysiology of psychosis, or secondary, arising from other factors (Correll & Schooler, 2020; Mosolov & Yaltonskaya, 2021). This includes the social environment (e.g., lack of social support), comorbidities (e.g., anxiety or depression), medication (e.g., side effects) or due to positive symptoms (e.g., social withdrawal due to persecutory delusions). Thus, there are potential opportunities for secondary prevention (Jackson & Birchwood, 1996).

NSs are associated with debilitating impairments in social, academic, occupational domains and quality of life, often to a greater degree than positive symptoms (Batinic, 2019; Foussias et al., 2014). NSs are strong predictors of having a poorer prognosis (Klingberg et al., 2011), and often result in readmission to hospital following discharge (Patel et al., 2015). Following a first episode of psychosis (FEP), approximately 90% of patients display at least one NS (an der Heiden et al., 2016) and often to a higher severity in comparison to later on in the illness trajectory (Mezquida et al., 2017).

Despite their clinical importance, NSs are not often targeted within FEP interventions (Addington et al., 2003). The National Institute for Health and Care Excellence (NICE, 2014) guidelines recommend a combination of both pharmacological and psychosocial treatments following a FEP. However, medications display limited benefits to NSs, and currently no medication is officially approved for the treatment of these symptoms (Aleman et al., 2017; Barnes & Schizophrenia Consensus Group of British Association for Psychopharmacology, 2011). Thus, studies have assessed cognitive-behavioral therapy for psychosis (CBTp), the leading psychosocial therapy recommended for chronic psychosis and FEP. Both one-to-one CBTp and gCBTp have been explored, with

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few studies exclusively targeting NSs in CBTp.

In chronic samples, one-to-one CBTp has shown some promise at various follow-ups (e.g., Startup et al., 2004; Turkington et al., 2008), and in two meta-analyses (Velthorst et al., 2015; Wykes et al., 2008). However, the majority of the included studies in these meta-analyses assessed NSs as a secondary outcome measure of CBTp, thus did not specifically target them and did not require patients to present with NSs at all. Such studies are prone to floor effects where, if patients do not have many NSs to begin with, little improvement is expected. If patients have severe NSs in such studies where CBTp focuses on positive symptoms primarily, then perhaps only secondary NSs are addressed if improvements are noted (e.g., NSs caused by positive symptoms). In the meta-analysis by Riehle et al. (2020) included studies only primarily targeted NSs and required patients to have NSs; CBTp was more effective than treatment-as-usual, but showed no difference to cognitive remediation therapy, similar to previous studies (Klingberg et al., 2011). Nevertheless, there was high heterogeneity in the severity of NSs before the intervention across the selected studies. Altogether, research supporting one-to-one CBTp for NSs is somewhat limited.

Group interventions can often be more therapeutic, due to elements of normalization and socialization (Lim et al., 2018) and interpersonal learning, such as the sharing of coping skills (Yalom & Leszcz, 2005). Moreover, group interventions can be beneficial for the recovery of young people with psychosis (Albiston et al., 1998), particularly for NSs (Orfanos et al., 2015). For chronic samples, studies supporting gCBTp are limited and often do not primarily target NSs (e.g., Barrowclough et al., 2006; Bechdolf et al., 2004).

In a novel pilot study, Johns et al. (2002) found that gCBTp specifically targeting negative symptoms reduced avolition / apathy but not total scores, with half of patients reporting less distress on objective and subjective measures (SANS; Subjective Experience of Negative Symptoms Scale [SENS; Selten et al., 1993]). However, with a small sample ($N = 4$) and exclusion of positive symptoms, generalizability was limited, warranting further replication. A recent review of randomized control trials found gCBTp had little effect on negative symptoms compared to other interventions, with benefits over standard care seen only on SANS scores in a few studies. Yet, improvements in the Global Assessment of Functioning (GAF; Hall, 1995) was observed (Guaiana et al., 2022). This is particularly in the symptom (GAF-S) but not disability (GAF-D) domain in chronic samples with individual CBTp (Kråkvik et al., 2013), though it is unclear if gCBTp shows the same pattern.

Even fewer studies have focused on gCBTp following a FEP (Saksa et al., 2009). Chung et al. (2013) found that gCBTp resulted in a decrease in SANS alogia, anhedonia-asociality, attention and total scores post-intervention, in patients with either a FEP or recent onset psychosis, however there was no control group. While the authors refer to recent onset psychosis as less than 5 years, Birchwood et al. (1998) suggest that a critical period of early psychosis is around 2 to 3 years. When this definition is used for early psychosis, NSs improved in gCBTp and group social skills training in comparison to a waitlist control group (Lecomte et al., 2008), with the authors attributing the positive findings to the fact that symptoms were targeted *earlier*, unlike in previous chronic studies. More recently, Lecomte et al. (2020) found similar beneficial

effects for early psychosis patients, albeit not statistically significant, using group sessions through video calling, and Lepage et al. (2023) also found improvements in NSs when assessing gCBTp for social anxiety. Nonetheless, such studies were not tailored to explicitly target NSs. Indeed, gCBT that targets a single symptom shared by the whole group appears more effective than a generalized approach (Wykes et al., 2005). Gaynor et al. (2011) examined whether gCBTp for NSs specifically had an impact on positive symptoms and NSs, and found NS improvement in the FEP group, but not the chronic group. However, the study did not require patients to present with NSs in its inclusion criteria. Further, there was no subjective component in assessing NS severity, which is problematic as there is often a discrepancy between patient-clinician ratings with NSs scores (Bottlender et al., 2003; Engel & Lincoln, 2017; Mueser et al., 1997). Clinical predictors of this discrepancy include the presence of anxiety (Selten et al., 2000).

Further, research has predominantly focused on either gCBTp or one-to-one CBTp, yet there is evidence to suggest that a *combined* approach may be the most beneficial. Warman et al. (2005), in a chronic sample, found that this combined approach resulted in the SANS total score improving in nearly all patients by at least a 30% reduction; these beneficial findings continued at the 11-month follow-up. Further, offering an individual component, particularly a brief form of CBTp, is beneficial when specific symptoms are being focused on, such as in NS-specific studies (Health Quality Ontario, 2018). Sperry and Binenszok (2019) introduce the concept of “ultra-brief” therapy, suggesting that a small number of symptom-focused CBT sessions that are 10-20 minutes long are effective.

The present pilot-case-series study therefore examines the feasibility, acceptability, safety and satisfaction of the combined approach of ultra-brief one-to-one and gCBTp for early course patients exclusively focusing on NSs. Addressing other limitations of previous studies, we include both clinician- and patient-rated scales including medication-resistant patients with persistent NSs without excluding those with positive symptoms. Given the impact NSs can have on functioning (e.g., Foussias et al., 2014), we incorporate this into the chosen scales. We present a further element of patients subjectively charting NSs weekly, using this to tailor their one-to-one CBTp sessions, as per the vision of the National Health Service Long Term Plan personalization of care approach (National Health Service, 2019).

Methods

Design

This pilot-case-series study employed a within-subjects repeated measures design (e.g. Steel et al., 2019). Six ultra-brief, symptom-specific one-to-one and hour-long gCBTp sessions were conducted consecutively, on a weekly basis. Data for assessment measures (SANS, GAF-D, GAF-S, SENS) were collected at two time points: (1) prior to the first group session (approximately within 3 weeks), (2) after the final group session (approximately within 2 weeks). However, the SENS distress-bother scores (see Procedure) were only specifically collected prior to each of the groups within the one-to-one sessions (six measurement points). Satisfaction comments were collected after the final group session.

Participants

Potentially eligible patients were aged 18-38 years from the Harrow and Hillingdon Early Intervention in Psychosis Service (EIPS). EIPS care coordinators (CCOs) selected the most severe, entrenched cases experiencing NSs, considering both male and female participants, ultimately resulting in 10 male participants that were eligible. However, data for only 6 of these patients were used as 4 patients were excluded from the study. Exclusion was determined by the fact that these patients did not fully engage, as they did not attend at least three of the six group sessions. Indeed, 1 patient did not attend any of the ultra-brief one-to-one and gCBTp sessions and 3 patients only attended for 1 week. Key socio-demographic characteristics recorded included age, gender, ethnicity and clinical characteristics included diagnosis, psychosis illness length and duration of untreated psychosis (see Table 3). To note, of the 2 patients included in the study who had prior CBTp, one patient had previously attended 3 sessions of a CBTp for voices group and 1 patient had previous CBTp with a trainee clinical psychologist. One excluded patient had previously attended gCBTp for delusions sessions (Raune et al., 2016). No discernable differences were observed between included and excluded participant groups, as participants were all male, with no notable variations in age, ethnicity, diagnosis, or duration of untreated psychosis.

Inclusion / Exclusion Criteria

Within the service, only FEP cases were accepted. For the purposes of this study, suitability included patients having a diagnosis of an early course psychotic disorder (as defined by a psychiatrist using the International Classification of Diseases [ICD; World Health Organization, 2022]) and experiencing at least one persistent NS of psychosis. NSs needed to be present for a minimum of 3 months, as indicated by the Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1983). Due to limited resources within the team, focus was given to participants most severe and entrenched NSs (as judged by the referring clinician). Patients were excluded from the study if they posed significant risk of harm-to-self and / or -others (indicated by the risk screening forms completed by CCOs). Patients were not excluded if they were also experiencing positive symptoms (e.g., delusions or hallucinations), as they often feature in this patient group. Thus, excluding such patients by having a strict inclusion criterion would reduce the ecological validity of the findings, raising a potential ethical issue of refusing treatment to those who may benefit from the group. Additionally, given that this is a routine service evaluation study and not a research trial, the exclusion of such patients was not warranted.

Assessment Measures

Both clinician- and patient-rated scales were used to assess clinical change, to create the most informative picture of patients' NSs (see Table 1 for assessment measures). Clinically significant (CS) improvement was defined as per the cut-off points for each measure.

Procedure

CCOs were interviewed, by an assistant psychologist or trainee clinical psychologist, to identify potential medication-resistant group members with persistent NSs. CCOs also provided clinical, demographic and risk screening forms alongside baseline SANS and GAF scores. CCOs then provided an information sheet to patients, highlighting the aims and purpose of the group and that participation is voluntary. If the patient expressed an interest, they were contacted by either the assistant or trainee clinical psychologist by telephone for further details. If the patient remained interested, they were invited to complete written informed consent to publish and the SENS.

An ultra-brief personalized CBTp session lasting 10-15 minutes prior to each group session was scheduled. CBT techniques such as behavioral activity scheduling, motivational interviewing, therapeutic optimism and personalized problem-solving skills were implemented. Further, patients were asked on a weekly basis within these ultra-brief sessions as to whether their subset of symptoms still bothered them and to what degree (0 = *No Distress*, 5 = *Very Much Distress*). This was referred to as a “distress-bother” score. This resulted in a tailored list of the patient’s specific subset of NSs, self-identified as present in the SENS. The purpose was to track weekly changes in distress. Thus, each patient had a different number and type of subset of NSs, individualized to them.

The weekly syllabus content for the group sessions was devised by a clinical psychologist in discussion with the rest of the clinical team. Sessions were 1 hour and ran for 6 consecutive weeks. Patients were provided handouts and between session homework tasks for behavioral activation.

By the end of the final group session, all patients had completed the SENS, SENS distress-bother scores and satisfaction questionnaire. After the final session (approximately within 2 weeks), CCOs provided SANS and GAF ratings for the patients.

Group Syllabus: “Get Going Group”

The group syllabus content for the “Get Going Group” (see Table 2 for a summary) was generally informed by a biopsychosocial cognitive theoretical model of psychosis (Garety et al., 2007) combined with evidence-based gCBT intervention techniques for NSs (e.g., Guaiana et al., 2022). The rationale for the general session content was guided by NICE (2014) recommendations, to offer psychosocial treatments (such as CBT) following a FEP. More specifically, techniques were evidenced based on theoretical research of NS maintenance (e.g., Rector et al., 2005) and reviews of CBT effectiveness for NSs (e.g., Guaiana et al., 2022). Included were techniques for NSs such as targeting low anticipatory pleasure (e.g., Rosebrock et al., 2021), challenging defeatist beliefs (e.g., Grant et al., 2008) and completing behavioral related tasks both within- and between-groups (e.g., Rector et al., 2005). Psychoeducation was delivered whereby patients were educated about NSs to aid in the identification of biological, psychological, and social triggers as well as maintenance factors that may be involved in the exacerbation of NSs (e.g., Oneib et al., 2025). Examples include an under / over stimulating environment (e.g., Drake & Sederer, 1986; Wing & Brown, 1970), lack of sleep (e.g., Davies et al., 2017), drugs (e.g., Radhakrishnan et al., 2014) and anticipatory pleasure

(e.g., Rosebrock et al., 2021). Further elements to the sessions included challenging meta-cognitive beliefs, unhelpful coping strategies and teaching practical strategies to help prevent the perpetuation of vicious maintenance cycles (e.g., Beck et al., 2009). Each patient, during the session and for homework, filled in a range of personalized sheets to build up an individualized set of biopsychosocial factors, their “Health Improvement Plan” (see Supplementary Materials), which they could use in future to continue to improve NSs.

Ethical Implications

Ethical implications were considered at all times during the interviewing of patients. Patients were notified that should they become distressed at any point during the group, they should inform the group facilitators. Any clinical / risk information was documented in patient case-notes. Research ethical approval was not required as this study was a service evaluation project; however, written informed consent to publish was obtained.

Analysis

Descriptive statistics were deemed to be the most appropriate analysis, due to the study’s small sample size ($N = 6$) and were used to assess patient change in the SANS, GAF and SENS. Post-intervention total scores were compared to pre-intervention total scores to determine whether a patient transitioned from a dysfunctional to a functional range; comparing this to clinical cut-off points for each measure would indicate a CS change (Evans et al., 1998; Jacobson et al., 1984). In addition to this, it was key to determine whether a change was reliable. A reliable change would indicate whether an observed change could be attributed to measurement error / chance or to another factor, such as the intervention. This was calculated by employing the Reliable Change Index (RCI) formula by Jacobson and Truax (1991) to calculate reliability of scores before and after the intervention, for the SANS, GAF and SENS. For the satisfaction questionnaire, frequency data was produced for the quantitative, closed-ended questions (e.g., whether the patients “enjoyed attending the group”). To note, there was not enough data to conduct a qualitative analysis on the open-ended questions asked. Nonetheless, examples are reported.

Results

Sample Characteristics

The demographic and clinical sample characteristics for the six participants, as well as the four excluded participants, are shown in Table 3.

Assessment Measures

Total scores for each patient for the SANS, GAF-D, GAF-S and SENS can be seen in Tables 4-7. Two patients (P1 and P2) attended all six one-to-one and gCBTp sessions (100% attendance), one patient (P3) attended five one-to-one and gCBTp sessions (83% attendance), one patient (P4) attended four one-to-one and gCBTp sessions (66.7% attendance) and two patients (P5 and P6) attended half of the one-to-one and gCBTp sessions (50% attendance).

Overall, for the SANS, CS improvement was determined by the clinical cut-

off points being ≤ 2 for each item (Andreasen et al., 2005), therefore a total score of ≤ 50 indicates minimal NSs. P2, P3, P4 and P5 all decreased in their post-intervention NS severity to a score of ≤ 50 , demonstrating clinical improvement. P1 increased in their post-intervention NS severity to a score of > 50 , demonstrating clinical worsening. P6 increased their score post-intervention, thus also worsened, however this was not CS. Reliability, as per the RCI, was calculated to be 22.09, using the internal consistency score of 0.89 (Andreasen 1983). As per Levine and Leucht (2013), the overall mean change score percentage of -21.66 indicates “improvement,” in the form of less severe NSs. Thus, only three patients (P2, P3, and P4) improved and one (P1) worsened to a clinically significant and reliable (CSR) degree.

There was missing data for one patient for the GAF-D and GAF-S. CS improvement was determined by the cut-off points for the GAF-D and GAF-S being a total score of > 60 (Curtis et al., 2001), indicating high overall functioning. Three patients, P2, P3, and P5, increased in their post-intervention GAF-D scores, however only P3 and P5 demonstrated CS improvement as their post-intervention score was > 60 . Two patients, P4 and P6, decreased in their post-intervention GAF-D scores to a score of < 60 , demonstrating clinical worsening. Reliability, as per the RCI, was calculated to be 8.98, using the internal consistency score of 0.81 (Vatnaland et al., 2007). The overall mean change score percentage of +2.68% indicates clinical improvement in the form of higher global functioning (Amri et al., 2014; Correll et al., 2023). Thus, only two patients (P3 and P5) improved to a CSR degree, and two patients (P4 and P6) worsened to a CSR degree.

For the GAF-S, four patients (P3, P4, P5 and P6) increased in their post-intervention scores and these patients demonstrated CS improvement, scoring > 60 . One patient (P2) decreased in their post-intervention score to < 60 , demonstrating clinical worsening. Reliability, as per the RCI, was calculated to be 18.57, using the internal consistency score of 0.81 (Vatnaland et al., 2007). A change score percentage of +40.08% indicates clinical improvement, in the form of higher global functioning (Amri et al., 2014; Correll et al., 2023). Thus, only three patients (P3, P4 and P5) improved to a CSR degree. P2 worsened to a CS degree, however not reliably.

For the SENS, CS improvement was determined by the clinical cut-off points being ≥ 2 for each item (Selten et al, 1993), therefore a total score of ≥ 49 would indicate a lower severity of overall NS. Five patients (P1, P2, P3, P4 and P5) increased in their post-intervention SENS scores, and all of these patients demonstrated CS improvement as their post-intervention score was ≥ 49 . One patient (P6) decreased in their post-intervention SENS score, however not to a CS degree as their score was still ≥ 49 . Reliability, as per the RCI, was calculated to be 18.09, using the internal consistency score of 0.76 (Selten et al., 1993). A change score percentage of +15.61% indicates clinical improvement, in the form of lower subjective NSs. Thus, no patients improved or worsened to reliable degree.

Figures 1–6 demonstrate weekly breakdown of the distress-bother scores for each patient (due to their size, Figures and Supplemental Materials for this paper have been made available in a separate document, linked [here](#)). It can be seen that there was wide heterogeneity both within- and between-patients across time.

Satisfaction Questionnaire

The frequency of qualitative comments for each question can be seen in Figure 7. As one participant did not attend the final gCBTp session, only five responses were recorded.

Participants were also asked five open-ended questions, including how they benefitted from the group, what was helpful or unhelpful about the group, how the group could be improved, and any other comments. Two participants responded to how they benefitted from the group with “*thinking ahead of the week*” and “*plan my time more.*” Three participants answered what they found helpful about the group with “*to be patient,*” “*hearing others opinions*” and “*coping strategies.*” No patients provided answers for what was unhelpful about the group, improvements for the group, or any other comments.

Discussion

The present pilot-case-series study aimed to examine the feasibility, acceptability, safety and satisfaction of combining ultra-brief one-to-one with gCBTp exclusively targeting NS early course psychosis patients. In this real-world setting, we found heterogeneity in the number, severity, disability, distress and trajectory of persistent NSs. Despite this, we extend previous studies by finding clinical improvements using a novel mixture of: (a) an exclusive single symptom approach (e.g., Johns et al., 2002; Wykes et al., 2005); (b) early intervention focus (e.g., Chung et al., 2013; Gaynor et al., 2011; Lecomte et al., 2008; Lecomte et al., 2020; Lepage et al., 2023); and (c) combination of one-to-one with gCBTp (Warman et al., 2005). Thus, we present a novel clinical template that other services may wish to consider.

Following the intervention, half of the patients reduced the severity of their NSs as per the SANS to both a CSR degree. A reduction in SANS total score for both early course and chronic samples is in line with previous literature (e.g., Chung et al., 2013; Guaiana et al., 2022; Warman et al., 2005). Two patients worsened, one reliably (P1), and one not to a CSR degree (P6). Of note is that these two patients had the lowest preintervention SANS score, so perhaps, this points to a minimum severity of NSs to create a beneficial intervention effect (i.e. a floor effect). Further, P1 also had comorbid associated acute stress disorder partly characterized by anxiety-related NSs (ICD-11) that were not explicitly targeted by this intervention. Yet, on the SENS, P1 subjectively reported CS but not reliable improvement in their NSs, demonstrating potential patient-clinician discrepancies. Perhaps, as in line with Selten et al. (2000), comorbid anxiety symptoms predict this discrepancy. Further, P6 may have worsened (yet not to a CSR degree) due to lack of attendance.

Results for the GAF were mixed, despite Guaiana et al. (2022) finding improvements in GAF scores following gCBTp. For the GAF-D, two patients (P3 and P5) demonstrated higher global functioning both to a CSR degree. P2 may not have improved reliably due to the small sample size, as their score missed the reliability threshold by < 1%. There may be several reasons for why P4 and P6 worsened to a CSR degree on the GAF-D. Both patients had more than one psychotic episode; Wunderink et al. (2019) found that patients with sub-

sequent relapses exhibit more severe functioning impairments. Furthermore, both patients did not attend all sessions. Speculatively, had they attended, social functioning scores may have improved as socialization was a key aspect of the intervention. However, subjectively, P4 strongly agreed that the group improved their functioning and ability to do things, demonstrating another patient-clinician discrepancy within ratings.

Three patients (P3, P4, and P5) demonstrated CSR improvements in GAF-S, with one patient worsening (P2) and one patient improving (P6), yet both not to a reliable degree. However, when asked on the satisfaction questionnaire as to whether they believed the group helped reduce distress regarding symptoms, P2 said yes, demonstrating another patient-clinician discrepancy (Fervaha et al., 2015). Another example is that P6 subjectively on the SENS reported a worsening in their NSs following the intervention, albeit by two points and not to a CSR degree. On face value, this patient only attended half of the six group sessions, thus it could be argued that their SENS score may be due to nonattendance. However, another patient (P5) also attended half the group sessions and reported the most improvement subjectively and objectively in NSs. An alternative explanation is that P6 had a significantly larger psychosis illness length duration (of 42 months). Indeed, P4 and P5, that had the lowest psychosis illness length duration, had the highest SENS change score. Evidence suggests that the longer the duration of active psychosis, the greater the deterioration of functioning outcomes (Pardo-de-Santayana et al., 2020). Overall, for the SENS, five patients (P1-5) reported CS improvement, yet not to a reliable degree. However, as aforementioned, the lack of reliability may be due to the small sample size. SENS improvements have also been found by Johns et al. (2002), however the authors only reported the avolition domain.

It is important to note an average improvement difference of 37.4% between patients' group mean GAF-D (2.68%) and GAF-S (40.08%) scores. Patients improving more on the symptom domain is in line with Kråkvik et al. (2013), who saw this trend in chronic patients following one-to-one CBTp. A possible reason for this trend in our study may be because the focus of the group was mainly psychological CBTp for NSs, rather than assuming the role of other staff such as employment specialists. However, it is also noteworthy that a group average does not reflect individual improvement, as those who reliably improved on the GAF-D did so by nearly a third (28.57%), emphasizing the benefit of a case-series design.

As a wider discussion point, having received prior CBTp was not predictive of session attendance as three of the excluded patients did not have any form of CBTp prior to the group. Although P2 (who had prior one-to-one sessions of CBTp) improved to a CSR degree on the SANS, so did P3 and P4 without prior CBTp. Although P2 and P5 (who had prior gCBTp for voices) improved to a CS degree on the SENS, so did three other patients (P1, P3, and P4). P5 also improved to a CSR degree on the GAF-D and GAF-S, however P3 also improved to a CSR degree on both domains, as well as P4 for the GAF-D. Thus, it is not definitive that limited or non-NS focused prior CBTp contributes more to NS outcomes, functioning or attendance in any way.

Considering the above, our study can be considered feasible, as even though the study was conducted within a routine service with limited

resources, the model of one-to-one and gCBTp ran for 6 consecutive weeks. With regards to acceptability, six patients attended at least three sessions (four of which attended at least four of the six one-to-one and gCBTp sessions). This indicates willingness to reattend despite the engagement difficulties typically associated with NS patients (Gaynor et al., 2014). While four other patients did not attend sufficiently, some drop-out was expected, thus six patients who attended at least half the sessions appears sufficient to demonstrate acceptability. The intervention can be considered safe as including those with positive symptoms and severe NSs did not lead to any serious untoward incidents. One patient did worsen to a CSR degree on the SANS and two patients on the GAF-D, so this is a potential note of caution about including patients with low levels of NSs in this type of intensive gCBTp syllabus. For satisfaction, participants enjoyed the group and reported NS improvement, though none suggested specific group improvements.

There are notable strengths of the present study. First, the study addresses gaps within the literature, insofar as it combined the following features: (a) specifically targeted NSs, (b) is ultra-brief in nature, (c) combined one-to-one and gCBTp, and (d) was for patients following an FEP in an EIPS. Previous literature employs some of these features, but none combined all of these features. Second, the present study included both clinician- and patient-rated scales; integrating subjective along with objective assessment measures in patient care may reveal underlying discrepancies important for the treatment of NSs (Engel & Lincoln, 2017). Third, patients had entrenched NSs and were medication resistant (average SANS preintervention score of 50.00), whereas, in other studies such as Gaynor et al. (2011), patients' baseline NS scores were much lower (average SANS preintervention score of 16.89). This highlights the efficacy of CBTp even in more challenging cases. Fourth, not excluding patients with positive symptoms ensures that the sample reflects the typical clinical population. Fifth, charting the individual SENS distress-bother scores also allowed for personalized monitoring, highlighting specific therapeutic target areas for the one-to-one CBTp sessions. This design feature has rarely been included in the literature, yet potentially permits relating individual techniques to outcomes (Turner et al., 2014), if utilized in a large enough sample to see common intervention impacts. Finally, including both CSR change allows for a meaningful interpretation of the findings.

Some limitations of our study should be borne in mind. First, the sample is small, thus only descriptive statistics could be used. Second, it was an all-male sample; however, males often present with a higher severity of NSs (Carter et al., 2022), thus could be considered representative of this entrenched symptom group. Thirdly, it was unknown whether patients were experiencing external factors (e.g., family support or medication adherence), that may have helped / hindered their NSs during the intervention. As this study was part of a routine service evaluation, not a research study, controlling these variables was not feasible. Finally, there was no follow-up study conducted, thus, it is unknown if the patients were able to maintain their progress. Future research should consider a more rigorous design, controlling for confounding variables, with a large, mixed gendered sample.

In conclusion, a NS-specific intervention combining ultra-brief one-to-one and gCBTp is feasible, acceptable and safe even with the most severe,

entrenched cases following a FEP. In line with Lecomte et al. (2008), targeting NSs earlier, at an early psychosis rather than chronic stage, may lead to beneficial therapeutic results. Our case-series design offers a useful synergistic clinical template for future studies to build on, using a simultaneous combined CBTp approach to aid in the improvement of NS for early course psychosis patients.

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CLINICAL PRACTICE FORUM | **Good Therapy or Good Theater? Disentangling CBT's Specific Effects from Placebo and Nonspecific Factors in Depression**

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DEPRESSION SIGNIFICANTLY DIMINISHES QUALITY OF LIFE and places a heavy burden on healthcare systems and societies (World Health Organization, 2023). The prominence of CBT in clinical guidelines reflects robust meta-analytic findings demonstrating its superiority to no-treatment and waitlist conditions (Cuijpers et al., 2023). Nevertheless, the fundamental question persists: do patient improvements stem from the structured techniques of CBT, such as identifying and challenging maladaptive thoughts and increasing engagement in rewarding activities (Beck, 1979; Hofmann et al., 2012), or from nonspecific influences like expectancy, therapist support, and the broader therapeutic context (Horvath et al., 2011; Wampold & Imel, 2015)? Addressing this issue is crucial for refining both research methodologies and therapeutic practice.

Although procedures such as standardized therapist training with fidelity assessment, blinded outcome evaluation, and objective indicators are widely recommended, they are not consistently implemented in psychotherapy trials. Many depression studies rely primarily on unblinded self-report, objective measures remain uncommon, and monitoring of therapist adherence and competence varies—each of which can bias or obscure estimates of CBT's specific effects (Cuijpers et al., 2023; McLeod et al., 2019).

The paper is organized into four sections. The first delineates the conceptual boundaries between specific mechanisms, nonspecific factors, and placebo effects. The second reviews and integrates the empirical evidence regarding CBT's efficacy. The third critically examines the core methodological challenges that hinder the isolation of CBT's unique therapeutic components. The fourth proposes a framework for disentangling CBT's active ingredients from its contextual influences.

Conceptual Foundations

Evaluating the true efficacy of CBT requires a clear differentiation among three interrelated constructs: specific mechanisms, nonspecific factors, and placebo-related effects. The overlap and distinction between these three concepts is central to interpreting CBT's efficacy. First, specific mechanisms represent the active ingredients unique to CBT, grounded in its theoretical model of depression. These include cognitive restructuring, meaning identifying and challenging distorted thoughts, and behavioral activation, meaning systematically increasing engagement in rewarding activities (Beck, 1979; Fennell, 2012; Kazdin, 2007). Such techniques are delivered within a structured, time-limited framework designed to produce measurable psychological change (Hofmann et al., 2012).

Second, nonspecific factors encompass the shared elements across diverse psychotherapeutic approaches that contribute to outcome regardless of theoretical orientation. The therapeutic alliance, therapist empathy and

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competence, interpersonal warmth, and the broader treatment environment all influence patient improvement independently of any modality's particular content (Boot et al., 2013; Enck & Zipfel, 2019; Horvath et al., 2011; Wampold & Imel, 2015). Although these factors operate beyond the scope of CBT's distinct procedures, they are not mere incidental byproducts of expectation; indeed, process-outcome research has consistently demonstrated that the strength of the therapeutic alliance itself serves as an active mechanism of change (Horvath et al., 2011; Wampold & Imel, 2015).

Third, placebo-related effects form a subset of nonspecific influences emerging from patient expectancy and contextual cues, such as the ritual of therapy and conditioned responses to the clinical setting (Boot et al., 2013; Kirsch, 2019). In psychotherapy research, placebo effects are defined as symptom improvements attributable to belief in the treatment rationale or its ritualistic aspects rather than to the intervention's specific techniques (Gaab et al., 2016; Kirsch, 2019). Expectancy effects alone have been shown to explain a substantial proportion of treatment gains in depression (Wampold & Imel, 2015). Moreover, open-label placebo studies, in which participants knowingly receive an inert intervention, suggest that mechanisms such as classical conditioning, meaning-making, and contextual cues can yield therapeutic benefit even in the absence of deception (Kaptchuk et al., 2010). However, the generalizability of these findings to routine clinical settings remains contested, given their reliance on highly controlled, novelty-rich contexts and the uncertain durability of observed improvements. Within the therapeutic frame, classical conditioning may occur as patients learn to associate elements of the therapy environment, such as the clinician's office or the act of sharing personal struggles, with relief, just as a sugar pill can evoke genuine effects through conditioned responses (Boot et al., 2013; Enck & Zipfel, 2019). Social learning further amplifies these effects: when therapists convey confidence in the treatment and articulate a compelling rationale, patients may internalize these beliefs, thereby enhancing clinical gains.

It is crucial, however, not to conflate placebo-related responses with all nonspecific factors. While expectancy and ritual form one pathway to improvement, other nonspecific elements, particularly the therapeutic alliance and therapist empathy, function as independent, active drivers of change rather than as mere byproducts of expectation (Horvath et al., 2011; Wampold & Imel, 2015). Likewise, specific mechanisms such as cognitive restructuring and behavioral activation remain central to CBT's theoretical model and are hypothesized to effect change through distinct cognitive and behavioral pathways (Beck, 1979; Hofmann et al., 2012).

Evidence on CBT's Efficacy

While CBT is founded upon structured procedures such as cognitive restructuring and behavioral activation (Beck, 1979; Hofmann et al., 2012), the observed magnitude of its effect in clinical trials may also reflect patient expectancy and other contextual influences. Indeed, Kirsch and colleagues (2008) famously demonstrated that up to 75% of the therapeutic gain from antidepressant medication can be ascribed to placebo responses, a statistic frequently invoked in debates over psychological treatments. Parallel investigations in CBT for depression have similarly found that expectancy effects

account for a nontrivial proportion of symptom reduction (Enck & Zipfel, 2019; Kirsch, 2019). Consequently, accurately evaluating CBT's true efficacy demands careful differentiation between its specific mechanisms, namely, the techniques theorized to drive cognitive and behavioral change, and the non-specific or placebo-related factors that may inflate outcome estimates.

Methodologically, this distinction is most rigorously tested through trial designs that employ structurally equivalent comparison groups, active-placebo conditions, or bona fide alternative psychotherapies (Boot et al., 2013; Cuijpers & Cristea, 2016). Comparisons with waitlist controls typically yield large effect sizes ($g \approx 0.8$), yet such contrasts risk exaggeration: participants on a waitlist may experience demoralization or nocebo effects, thereby widening the apparent treatment gap (Cuijpers et al., 2023; Furukawa et al., 2014).

When CBT is evaluated against care-as-usual or other active treatments, effect sizes diminish but generally remain significant (Cuijpers et al., 2024), indicating that some, but not all, of the benefit derives from nonspecific influences. Trials incorporating placebo pill controls provide the sternest test of expectancy: individual patient-data meta-analyses show that CBT maintains a modest but significant advantage over placebo, affirming that its structured interventions confer benefit beyond mere expectation (Furukawa et al., 2014). This finding provides evidence that CBT's benefits are not fully accounted for by placebo-related responses alone.

Additionally, meta-analyses such as those by Wampold and Imel (2015) emphasize common factors as primary drivers of change, whereas those focusing on treatment-specific protocols (e.g., Hofmann et al., 2012) often foreground the unique benefits of CBT techniques. This divergence partly reflects theoretical orientation: process-outcome studies rooted in the contextual model prioritize relational and expectancy-based mechanisms, while technical models emphasize manualized interventions and adherence. Rarely do these frameworks integrate, leading to parallel literatures rather than a cumulative science.

When cognitive-behavioral therapy is pitted directly against other structurally analogous, evidence-based treatments for depression, meta-analytic syntheses consistently find little or no difference in efficacy (Cuijpers et al., 2013, 2014). For example, Cuijpers and colleagues (2020) reported equivalent reductions in symptom severity for CBT, interpersonal therapy, and short-term psychodynamic therapy. This parity, often dubbed the "dodo bird verdict" after Lewis Carroll's whimsical declaration that "everyone has won and all must have prizes," lends weight to the proposition that shared therapeutic factors (expectancy, therapist empathy, and alliance) drive much of the observed benefit (Luborsky et al., 2002; Wampold & Imel, 2015). Yet equivalent outcomes do not by themselves establish a common mechanism: different modalities may operate via distinct psychological pathways. A psychodynamic intervention may alleviate depression by fostering insight into relational patterns, whereas CBT accomplishes similar outcomes through the systematic restructuring of maladaptive beliefs. Moreover, although outcome equivalence highlights the power of nonspecific factors, it does not diminish the value of modality-specific strategies, particularly when long-term maintenance or relapse prevention is at stake. Nor does it automatically justify the preferential

allocation of resources to a single approach, such as CBT, within stepped-care frameworks. Instead, these findings underscore the need for a pluralistic, patient-preference-driven model of care and for future research that directly isolates and compares the unique mechanisms underlying each therapeutic modality.

CBT may also hold advantages in long-term outcomes, particularly in preventing relapse (Bockting et al., 2015). In a seminal trial, Hollon et al. (2005) reported that patients who completed a course of CBT had significantly lower relapse rates 1 year after treatment than those who were treated with antidepressant medication alone. This lasting effect was attributed to CBT's emphasis on skill-building and self-efficacy, capacities that patients can continue to use after therapy ends (Hollon et al., 2014). Nevertheless, findings on long-term outcomes should be interpreted cautiously due to variability in therapist competence, small samples, and inconsistent follow-up periods across studies.

In sum, the robust evidence base for CBT's efficacy in depression must be appraised through the lens of rigorous control conditions that parse specific therapeutic mechanisms from nonspecific and placebo-related influences. Only by matching CBT against structurally equivalent comparators, active placebos, and other bona fide therapies can researchers isolate the unique contributions of cognitive and behavioral techniques, and thereby clarify the sources of its clinical benefit.

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Methodological Challenges

In interpreting CBT's apparent advantages, it is also important to consider the methodological limitations that complicate causal inference. While CBT often outperforms weak or inactive controls and demonstrates parity with other structured therapies, several methodological issues temper our confidence in attributing its benefits solely to specific therapeutic mechanisms (Cuijpers et al., 2023; Hróbjartsson et al., 2014; Schaeuffele et al., 2024; Wampold & Imel, 2015). Specifically, three key methodological challenges make it difficult to isolate CBT's specific effects: (a) the inherent difficulty of blinding participants and therapists in psychotherapy trials, (b) the reliance on subjective self-report outcome measures, and (c) variability in therapist skill and adherence to protocol. Each of these factors can either inflate or obscure observed treatment effects, making it difficult to determine whether CBT's benefits stem from its intended therapeutic mechanisms or from nonspecific influences like expectancy, therapist enthusiasm, or the therapeutic alliance (Boot et al., 2013; Cuijpers & Cristea, 2016; Enck & Zipfel, 2019).

In practice, recommended safeguards are unevenly applied. Primary outcomes are often unblinded self-reports, objective indicators are seldom collected, and adherence / competence monitoring is inconsistent. Stating these safeguards as minimum study standards clarifies that subsequent recommendations target persistent implementation gaps rather than restating settled ideals.

A fundamental challenge is that neither therapists nor patients can be blinded to a psychotherapy condition as they would be in a medication trial. Knowing one is receiving CBT, as opposed to no treatment or another therapy, can introduce performance and detection biases, and improvements may partly reflect participants' and therapists' belief in the treatment rather than the treatment's specific ingredients (Cuijpers et al., 2023; Hróbjartsson et al., 2014). This concern is particularly salient for CBT, which actively involves patients in structured techniques that can heighten expectations of improvement. Kirsch (2019) argues that expectancy effects in depression treatment can account for a substantial portion of symptom reduction, meaning some of the benefit seen with CBT may come from patients' belief that they are receiving an effective therapy. Likewise, Cuijpers and Cristea (2016) caution that many psychotherapy trials likely mix up true treatment effects with placebo-related responses because blinding is not in place.

A second major challenge is the reliance on subjective outcome measures. Depression trials often use self-report questionnaires (such as the Beck Depression Inventory or PHQ-9) as primary outcomes. While these tools are well-validated, they are subjective and susceptible to demand characteristics (Cuijpers & Karyotaki, 2021). In unblinded CBT studies, participants may (consciously or unconsciously) overstate their improvement to align with expectations or to please their therapist, leading to inflated efficacy estimates. Correspondingly, meta-analyses have found that trials relying solely on self-reported outcomes tend to yield larger effect sizes than those that include blinded observer ratings of depression (Cuijpers et al., 2023). *Despite calls for greater transparency, objective indicators like biological markers remain rare*, making it difficult to independently verify improvements (Enck & Zipfel, 2019; Gaab et al., 2016).

Therapist variability presents a third challenge. Unlike medication trials where a dose is identical across participants, the delivery of CBT can vary significantly from one clinician to another. Factors such as a therapist's competence, fidelity to the treatment protocol, and interpersonal style, such as empathy and confidence, can all influence outcomes (McLeod et al., 2019; Wampold et al., 2017). Research indicates that therapist effects account for a notable portion of outcome variance in psychotherapy (Wampold et al., 2017). A particularly skilled or enthusiastic CBT therapist may achieve better patient outcomes not strictly because of CBT's specific techniques, but due to developing a stronger therapeutic alliance and motivating the patient more effectively (Kazdin, 2007; Wampold & Imel, 2015). Such variability limits the replicability of findings and complicates identifying which elements of CBT are most effective.

Collectively, these challenges underscore the need for methodological innovations in psychotherapy research. If therapist-level factors routinely eclipse manualized techniques in explaining outcome variance, our concep-

tualization of “what works” must expand beyond protocol adherence. Future trials should incorporate strategies such as standardized training and fidelity assessment, blinded external ratings of both process and outcome, and the use of objective measures wherever feasible. Modelling therapist competence as a moderator, instead of relegating it to residual variance, will help clarify the extent to which CBT’s structured interventions, versus contextual factors, account for its therapeutic benefits.

Conclusion

The accumulated evidence indicates that CBT yields genuine therapeutic benefits in depression beyond mere placebo responses. Across numerous trials, patients receiving CBT improve more than those in no-treatment conditions, and its effects endure, most notably in reduced relapse rates, suggesting that cognitive and behavioral interventions engender real, lasting change. Yet the frequent finding that CBT performs no better than other structured, theory-driven psychotherapies underscores that much of its impact may derive from nonspecific factors common to all effective therapies, such as patient expectations, the therapeutic relationship, and therapist engagement, rather than from CBT’s unique techniques alone. Moreover, the inherent limitations of psychotherapy research, particularly the impossibility of blinding, the reliance on subjective self-reports, and the variability introduced by therapist competence, require us to temper our confidence in attributing CBT’s effects exclusively to its specific mechanisms.

To strengthen the case that CBT’s benefits extend beyond general factors, future investigations must employ more rigorous and innovative methodologies. Dismantling designs, where full CBT is compared with versions that isolate individual components, such as behavioral activation alone, and additive designs, where the incremental value of introducing or removing specific techniques is tested, offer one approach, despite ethical and logistical challenges around withholding potentially effective elements. From a common-factors perspective, dismantling studies are of limited value because they presume additive, technique-specific effects and may miss mechanisms shared across bona fide therapies; adherents to the dodo bird view therefore regard such designs as only weakly informative. Ultimately, dismantling and additive methods are one tool among several, and should be interpreted alongside mediator analyses and process-based evidence (Wampold & Imel, 2015). Process-based frameworks that examine mediators of change across different modalities may provide a complementary route, revealing whether shifts in dysfunctional cognitions, increases in behavioral activation, or improvements in emotion-regulation skills account for symptom reduction. Adaptive trial designs, including Sequential Multiple Assignment Randomized Trials (SMART), together with formal mediation analyses, promise a more nuanced understanding of what works, for whom, and under what conditions.

Minimum methodological standards to isolate CBT-specific effects in depression are as follows: preregistration with a masked analysis plan (Gaab et al., 2016); standardized therapist training with certification before enrolment and scheduled supervision boosters (McLeod et al., 2019); fidelity and competence monitoring by independent coders who sample at least 20% of

sessions (McLeod et al., 2019; Wampold et al., 2017), apply predefined pass thresholds, implement remediation rules, and report interrater reliability; blinded outcome assessment using independent clinician ratings for the primary endpoint, with documentation and analysis of any blind breaks, and self-report retained as secondary (Cuijpers et al., 2023; Hróbjartsson et al., 2014); inclusion of at least one objective indicator, behavioral or physiological, aligned with hypothesized mechanisms (Enck & Zipfel, 2019; Gaab et al., 2016); early assessment of treatment expectancy and credibility with balance across arms reported (Boot et al., 2013; Kirsch, 2019); and statistical models that treat therapist as a random effect, report intraclass correlations and variance components, and test adherence and competence as moderators (McLeod et al., 2019; Wampold et al., 2017; Wampold & Imel, 2015).

In addition to improved trial architecture, researchers should adopt a clearer evaluative framework to assess the specificity of CBT's effects.

In addition to improved trial architecture, researchers should adopt a clearer evaluative framework to assess the specificity of CBT's effects. A practical set of criteria might include: (a) the use of active control conditions that are matched for therapist time, attention, and treatment credibility, thereby controlling for expectancy and contextual influences (Boot et al., 2013; Cuijpers & Cristea, 2016); (b) blinded outcome assessments, combining both self-report and independent observer ratings, to minimize bias from expectancy or demand characteristics (Cuijpers et al., 2023; Hróbjartsson et al., 2014); (c) measurement of mechanisms of change, such as shifts in dysfunctional cognitions, levels of behavioral activation, or emotion regulation, in order to determine whether symptom reduction can be causally attributed to CBT's hypothesized processes (Gaab et al., 2016; Kazdin, 2007); (d) inclusion of therapist adherence and competence measures to account for the impact of therapist effects on outcome variability (McLeod et al., 2019; Wampold et al., 2017); and (e) follow-up assessments extending 6–12 months to assess the durability of treatment effects, especially given CBT's potential long-term advantage in preventing relapse (Bockting et al., 2015; Hollon et al., 2005). Wherever possible, objective outcome indicators, behavioral tasks or physiological measures, should supplement subjective reports. Accordingly, standardized training with fidelity checks, blinded external ratings, and objective indicators should be treated as required standards rather than optional enhancements.

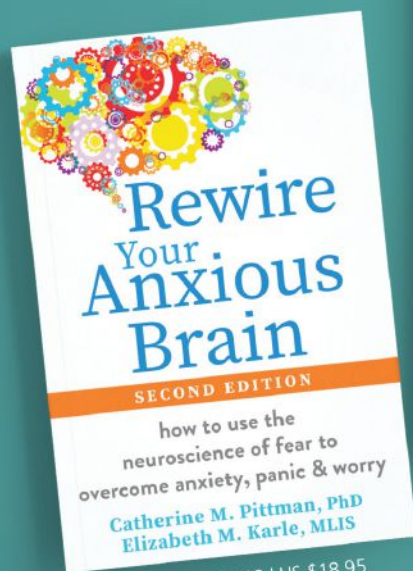
Finally, a deeper investigation into placebo-related pathways, including expectancy-independent mechanisms revealed by open-label placebo studies, may allow clinicians to harness beneficial contextual effects ethically, enhancing patient engagement and positive expectancy without compromising the delivery of evidence-based techniques (Gaab et al., 2016). By designing studies that rigorously account for both specific and nonspecific

influences, we can not only confirm that CBT works but also clarify precisely why it works and for which patients, thereby guiding more targeted, effective, and ethically transparent clinical practice.

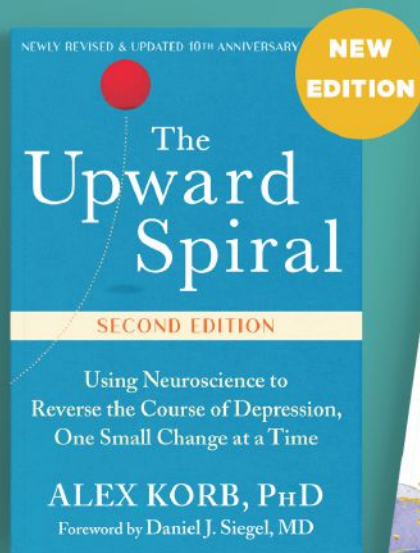
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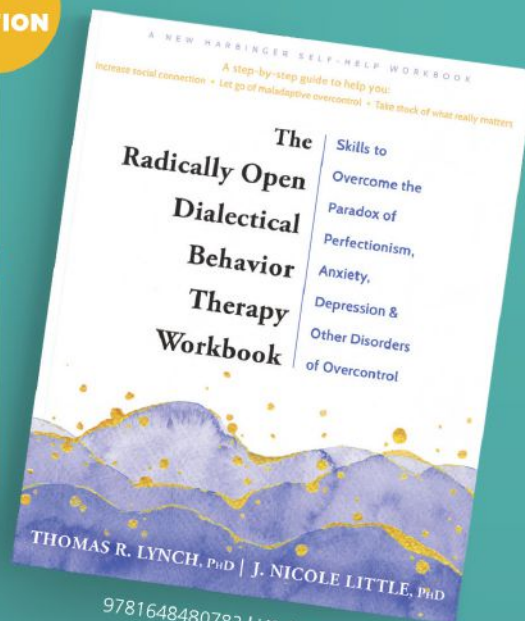
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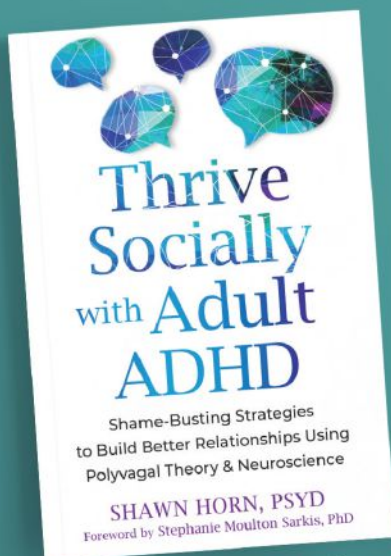


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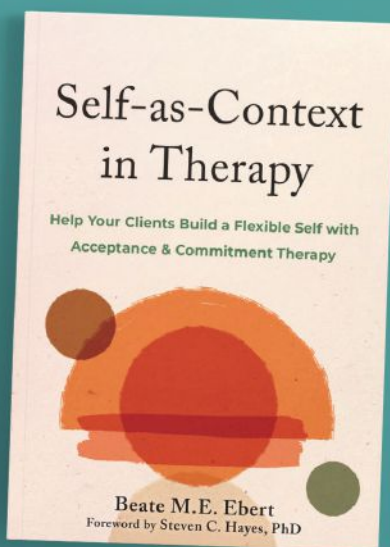


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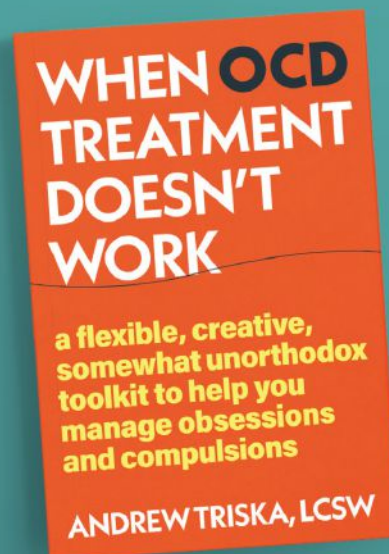
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Stay the Course and Continue Evolving



Dr. Carolyn Becker
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DEAR ABCT COLLEAGUES . . .

As we embark on the start of 2026, we want to take the time to reflect on some of the important milestones ABCT achieved this past year and discuss where we are headed. We also want to say thanks to you, the members, for your continued support of ABCT and our collective mission, which is more important than ever in these turbulent times.

The highlight of this past year was undoubtedly the recently concluded 2025 Annual Convention held in New Orleans. And what a time it was! It was great to see so many new members, first-time attendees, longtime colleagues, collaborators, and friends. Thanks to Immediate Past-President Dr. Steve Safran, the program chairs, and the entire convention planning committee, the theme of *Bridging the Divide* was evident across the entire program.

This year's Annual Convention saw approximately 3,200 registered attendees in New Orleans who came to participate in the following:

- 6 plenary presentations
- 286 oral papers presented in 41 sessions
- 80 symposia
- 4 spotlight research presentations
- 21 mini workshops
- 23 clinical round tables
- 37 panel discussions
- 5 research and professional development sessions
- 4 Clinical Grand Rounds
- 982 general posters
- 345 Special Interest Group Posters
- 40 exhibit booths
- 50+ Awards and Recognitions

Additionally, this year the convention saw new and exciting changes in its formatting with the addition of the speaker slide pre-convention upload requirement and Speaker Ready Room process, individual oral abstracts presentations, plenary talks, and the well-received inaugural Benefit Luncheon. All of this occurred in a spirit of respect, collegiality, and a recommitment to CBT science and clinical practice. Thank you to all who participated! To those of you who were unable to join us, we missed you and hope to see you in Baltimore at the 2026 convention.

Despite the success of our recent convention, we must acknowledge the fact that mental health research and practice in the U.S. is still facing some stiff

headwinds. The current U.S. government is alarmingly untethered from an understanding of the public health implications of ignoring evidence-based science. As such ABCT will continue to be firmly ensconced in our values and will remain an oasis of hope for our members, even in an environment that is unfriendly to science, higher education, and many facets of clinical practice. Our Board, committees, and staff will continue to look for ways to support our members and the important work you all do. Please know that we are also hard at work identifying ways that ABCT can support all members across the entire year, even if you cannot attend the convention.

We also want to take this time to highlight the fact that ABCT has been and will remain in, for the near future, a time of transition. This is a naturally occurring cycle that all organizations should go through periodically. Importantly, this is a phase of organizational development that optimally occurs across several presidential terms, as it has for ABCT, and represents a collective effort by many people. Our transition is not over, and thus one theme this year will be that we are staying the course set by our recent Past Presidents and Boards.

For ABCT, the current phase of transition was sparked both by efforts to become a bigger and more welcoming tent to a broader membership and by a change in our executive leadership. We realize that many facets of our transition are invisible to many members so we wanted to share some of what has been going on behind the scenes. For instance, over the last 18 months, we have started to usher in some much-needed changes that will help ABCT evolve and grow to better serve our members. Some of these necessary changes involved instituting governance best practices including improved training for Board members, developments in continuing education, alterations to Convention (as noted above), better use of technology, changes in staffing structure, centralized SIG dues collection, creating a fundraising and development infrastructure, and enhanced member support and member benefits. Much work remains to be done. For instance, this year we will be upgrading our membership database, which will allow us to better serve members and assist committees in their tasks. In summary, ABCT will continue to move forward in our evolution AND remain true to our values and build on the strengths and past successes of our organization.

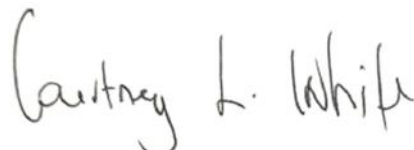
We look forward to what lies ahead in the coming months, including a key partnership between ABCT and the World Confederation of Cognitive and Behavioural Therapies (WCCBT) to host the 11th World Confederation of Cognitive and Behavioural Therapies Congress in San Francisco in June 2026.

Stay tuned to hear more from the ABCT Board of Directors and leadership in the coming months, including announcements about a few Presidential Fireside Chats to be held in the Spring and Summer of 2026.

Until then, take care.



CAROLYN BECKER, PH.D., ABPP
ABCT President



COURTNEY L. WHITE, PH.D., CAE
CEO, ABCT

To spotlight the extraordinary work of our ABCT membership, we are highlighting the work of recently admitted ABCT Fellows. Fellow status is the highest level of membership in ABCT, and we hope that many members aspire to demonstrate their outstanding and sustained accomplishments in at least one of the areas of eligibility: Clinical practice; Education and training; Advocacy/policy/public education; Dissemination and implementation; Research; and Diversity, equity, and inclusion.

Adrian Aguilera, Ph.D., is the Chancellor's Professor in the School of Social Welfare and Computational Precision Health at University of California, Berkeley and the Department of Psychiatry and Behavioral Sciences at University of California, San Francisco. At UC Berkeley, Dr. Aguilera directs the Digital Health Equity and Access Lab (dHEAL). He is trained as a clinical psychologist and is an expert in cognitive and behavioral approaches to treating depression and anxiety. His research is focused on utilizing mobile phone technologies and data science to implement mental health interventions to address health disparities in low-income and marginalized populations. He leads work in innovative digital health interventions that are designed with and for underserved communities and conducts pragmatic, real-world implementations in public sector and community-based settings. He partners with community organizations to leverage capacity and conduct research that is relevant to their needs. He has extensive formal training in implementation science, community-based research methods and integrating cultural sensitivity all while developing innovative digital technology-based interventions.



Below is an interview conducted with Dr. Adrian Aguilera.

FELLOW > Dr. Adrian Aguilera

Can you tell us about what made you apply for Fellow status at ABCT?

I applied for Fellow status because I wanted to become a more integral part of ABCT and contribute my perspective to the organization. ABCT has long been a professional home where I have grown as a researcher and clinician, and I saw the Fellow application as an opportunity to reflect on my contributions, deepen my engagement, and help advance the society's mission. Preparing the application also allowed me to take stock of the impact of my work across research, clinical practice, training, and advocacy for equity in behavioral health.

Becoming a Fellow means that you have distinguished yourself in a variety of areas that can include dissemination, clinical service, research, training, program development, policy/advocacy and advancing diversity, equity and inclusion. If you had to identify three professional accomplishments of which you are most proud, what would they be?

First, I am proud of disseminating CBT training to broad audiences including community clinicians and Spanish-speaking providers. For over a decade, I led Spanish-language CBT groups at the San Francisco General Hospital where I trained numerous clinicians, particularly social workers, in CBT methods. I also developed an online "CBT for Spanish Speakers" training video and led a federally funded workforce training program, the Center of Excellence in Behavioral Health Equity (COEBHE), which recruits and trains behavioral health workers and researchers to deliver evidence-based practice for underserved populations.

Second, I am proud of integrating digital innovation with a focus on reducing disparities in access to mental health care. My research pioneered the use of text messaging as an adjunct to CBT, demonstrating its effectiveness in doubling attendance and influencing how technology is now integrated with human support. This work has been supported by federal grants, including a Career Development award (K23) and two large research grants (R01s) from the National Institutes of Health (NIH). In my current R01, I am training community supporters to assist Spanish-speaking users of a CBT app, combining digital delivery with community engagement.

Finally, I am proud of my role as one of the founding members of the Technology and Behavior Change Special Interest Group (SIG) at ABCT. This community has provided a space for collaboration and innovation at the intersection of technology and behavioral science. I was honored to receive the SIG's Mid-career Award, which affirmed the impact of my work and the recognition of peers in the field.

Can you tell us a bit about your pathway to becoming a professional? Who were your greatest influences during your training and in the early stages of your career?

As the first in my family to graduate from college, I relied heavily on academic mentors to guide my path. At Stanford University, I worked in a cultural psychology research lab, where I was encouraged by then-graduate student Victoria Plaut to pursue graduate training. In my clinical psychology doctoral program at the University of California, Los Angeles (UCLA), I worked with Steven López, who modeled a rigorous and thoughtful approach to conceptualizing, defining, and measuring culture in research on Latino mental health.

The most significant influence on my research trajectory was my postdoctoral mentor, Ricardo Muñoz, who instilled in me a focus on innovation to maximize the reach of CBT interventions. He encouraged me to think big, not be constrained by traditional models, and always keep equity at the center of intervention design. These mentors, along with many others, provided the foundation for the work I now lead in the Digital Health Equity and Access Lab, where our projects are community-centered and co-developed in low-resource settings.

What advice would you have to someone who may be considering a similar career trajectory to your own?

I encourage trainees and early career professionals to start by identifying their internal sense of purpose—the motivation that drives their work—and let that guide their professional decisions. Once you have that foundation, seek creative and interdisciplinary ways to frame and study the issues you care about. Some of my most meaningful insights have come from integrating perspectives across psychology, social work, public health, and computer science, among others. When we step outside of our own discipline or specific field of study, we have more to learn from new ways of approaching problems. I've realized that I have significant clinical and community knowledge, but others have technical skills that I lack. Combining forces allows for greater impacts.

I also strongly recommend building supportive mentoring relationships. Throughout my career, I have benefited enormously from guidance, and I now

prioritize mentoring graduate students, junior faculty, and trainees, many from historically underrepresented backgrounds. Finding mentors who share your values and then paying that forward by supporting others is an essential part of building a sustainable and meaningful career.

Hindsight being 20/20, are there things that you would do differently during your career if you had the opportunity for a “do over?”

I wish I would have developed confidence in myself and my abilities, earlier. During training, I often focused on the areas where I was less strong than my colleagues and made broad conclusions about my abilities. This linear sense of “worst to best” was not helpful and most importantly not accurate. I later learned to identify and value my own specific strengths and realized that there are various ways to be successful and have positive impact. As I gained confidence in my ability to generate impactful ideas and communicate them, I realized that I could build on those and work with others with complementary skills and abilities.

What advice would you have for someone considering applying for Fellowship status at ABCT?

Although acceptance is never guaranteed, the application process itself can be transformative. Reflecting on accomplishments and one’s place in the field provides clarity on future directions and confidence in the contributions already made. For me, preparing the application also spurred conversations with colleagues and mentors, which deepened my connections within the field. Regardless of the outcome, I believe the process is well worth undertaking as part of one’s professional growth.

Finally, as an esteemed Fellow, we would welcome your opinions about ABCT:

I have been a member of ABCT for over 15 years. Over that time, the organization has provided invaluable opportunities to connect with colleagues, stay current with cutting-edge methods, and share my work with a community committed to evidence-based practice.

The services I find most valuable are the Annual Convention and the network of Special Interest Groups, both of which foster collaboration and innovation. Looking forward, I hope ABCT continues to expand and diversify its membership by more fully engaging adjacent professions such as social work, counseling, marriage and family therapy, and others delivering mental health services. These groups provide the majority of mental health services in the United States, and their deeper inclusion will strengthen our collective ability to disseminate evidence-based cognitive and behavioral interventions. By broadening our reach and building structural supports for workforce diversity, ABCT can continue to lead in shaping the future of mental health practice. ■

Highlighting our 2025-2027 Change Leaders

THE ABCT CHANGE LEADERS PROGRAM is an initiative aimed at engaging early advanced students and career professionals in a two-year, leadership development activity with assigned sponsors while ABCT takes active steps to broaden and improve the diversity, equity, inclusion, access, and justice focus of its work. The ABCT Board recognizes that important structural change in our organization should come from an intersectional and collaborative process with diverse members, including those who may not feel represented by current or historic board membership.

The ABCT Change Leaders Program has its own designated staff and Board liaisons to the program to help facilitate this effort. This unique leadership program aims to expose participants to the structure and activities of ABCT through interactions with program directors, the Board, and other leadership groups in an effort to demystify how ABCT operates. This knowledge then will be used by Change Leaders, working collaboratively with existing leadership, to make a difference at a systems level within and beyond ABCT.

Join us in welcoming the newest cohort of ABCT change leaders as we enter the new year, and look forward to their contributions in the term to come.



DR. YVETTE BEAN received a Bachelor of Arts in Psychology from Elon University. She then went on to receive a Master of Arts with an emphasis in Clinical Psychology from Towson University. Dr. Bean received a Doctor of Philosophy in Educational (School) Psychology from the University of Georgia. Her dissertation examined cultural differences in face processing and emotion recognition and its implications for autism assessment and treatment. She completed an internship at the Kennedy Krieger Institute providing behavioral treatment for children with severe problem behaviors and training for parents of children with developmental disabilities. She then completed a two-year post-doctoral fellowship at Kennedy Krieger's Center for Autism Services, Science and Innovation (CASSI). Dr. Bean is currently working as a staff psychologist at CASSI where she provides autism assessments and treatment. She is licensed in the state of Maryland and a board-certified behavior analyst (BCBA). She has a passion for providing culturally informed care and is thrilled to be a part of the 2025-2027 Change Leaders Cohort.



BHARAT BHARAT is a 4th year doctoral student in the Health Track of the Clinical Psychology Ph.D. program at the University of Miami (UM), under the mentorship of Dr. Steven Safren.

His research interests include LGBTQ+ mental health, resilience, intersectionality, implementation science, and developing new interventions aimed at preventing HIV and bolstering resilience in marginalized communities, especially for queer people of color.

He is currently a member of the American Psychological Association's (APA) Advocacy Coordinating Committee, helping evaluate and shape advocacy priorities that impact psychologists across research, public interest, health service psychology, and clinical practice. At state level, he is the co-chair of the Collaborative Problem-Solving Group and serves on the Social Justice and the Diversity and Cultural Competence Committees within the Florida Psychological Association.



WENDY CHU, PhD (she/her/hers) is a Postdoctoral Fellow in the Mood, Anxiety, ADHD Collaborative Care for Equity (MAACC-E) Program at Lurie Children's Hospital of Chicago. She received her Ph.D. in Clinical-Community Psychology at the University of South Carolina and completed her pre-doctoral clinical internship at the University of Illinois Chicago Department of Psychiatry.

Informed by her experiences with intersectional identities, Dr. Chu's research aims to improve the cultural responsiveness of mental health services for marginalized youth and families through community-engaged approaches. Her work integrates principles from clinical science, community

psychology, and implementation science.

Beyond her scholarship, Dr. Chu is actively involved in service and leadership efforts aimed at advancing mental health equity. She looks forward to serving as an ABCT Change Leader to help ensure ABCT inspires current and future scholars, clinicians, and community members to conduct culturally responsive research, practice, and policy that advances behavioral and cognitive therapies.



JOSH DESON (they/them) is a clinical and research postdoctoral fellow at Yale Medicine within the Yale Gender Program. They earned their Ph.D. in clinical psychology in 2025 from Fordham University's Clinical Psychology Doctoral Program, where they also received their M.A. in clinical psychology in 2021. They completed their clinical internship at the Yale School of Medicine and Yale-New Haven Health hospital's Clinical Psychology Internship Program. At this clinical fellowship they conducted clinical work with LGBTQ patients and their families within the Yale Gender Program. Josh earned their B.A. in psychology, specializing in health and development, from Stanford University in 2017.

Josh's primary research interests include investigating gender minority stress and resilience factors and how they interact with daily emotion regulation experiences and nonsuicidal self-injury (NSSI) in gender-diverse youth and young adults. They also are interested in research examining strengths and protective factors regarding LGBTQ youth and young adult suicide prevention.

Josh approaches clinical work from a systems- and trauma-informed, gender-affirming, and evidence-based perspective. Their approach is rooted in cognitive-behavioral and third-wave therapies, and centers family-oriented treatment as appropriate. Josh has worked in various clinical settings, including pediatric LGBTQ clinics, college counseling centers, private practice settings, inpatient hospitals, and severe mental illness units in a forensic jail setting. From their previous work, Josh has developed a clinical approach emphasizing authenticity, cultural humility, harm reduction, and working collaboratively with youth and families to foster radical healing and hope.



DR. C. DANIELLE GREEN is a licensed clinical psychologist and Assistant Professor at Cincinnati Children's Hospital Medical Center. Focusing on Black youth with ADHD, she works alongside families to understand how they navigate the condition across home, school, and community systems while co-creating culturally competent interventions and expanding access through implementation in nontraditional spaces. Through this work, Dr. Green amplifies the voices of Black youth with ADHD and their families, advocating for equity and positive transformation in ADHD service delivery.



DR. CHRISTIN MUJICA (she/her/ella) is recent graduate of University of Arkansas' Clinical Psychology PhD program. She is first-generation Venezuelan-American, a mom to a wonderful daughter, and identifies as a scientist-practitioner-activist.

Her research interest are related to understanding and addressing the impact of racism on the mental health of People of Color with a growing focus on perinatal populations. Dr. Mujica is currently a NIDA T32 Postdoctoral Fellow at the Medical University of South Carolina where she is focused on the treatment of co-occurring PTSD and SUD in perinatal populations.

At the core of who Christin is, and deeply tied to her values, is a commitment to helping transform the organizations and institutions she is a part of. She strives to leave them better than she found them, extending a hand to those who will come after her and ensuring they enter a more welcoming, supportive space.



ELAINE RUIZ, PhD, is a bilingual (Spanish/English) licensed clinical psychologist currently serving children and families at the adolescent medical psychiatric inpatient unit at Hasbro Children's Hospital/Brown University Health. She completed her PhD in clinical psychology at the University of Rhode Island, and her predoctoral residency at the University of California Los Angeles in the Child and Adolescent Acute Care Track. Upon earning her doctorate, she completed her postdoctoral fellowship at the New England Center for OCD and Anxiety in Boston, MA, where she specialized in providing individualized evidence-based care incorporating Exposure and Response Prevention and Acceptance and Commitment Therapy for children and young

adults experiencing anxiety and obsessive-compulsive related disorders.

Elaine has a diverse background helping youth and families both in outpatient and inpatient clinical settings. Her clinical interests involve utilizing evidence-based practices to address the unique needs of children, adolescents, and young adults experiencing acute mental health conditions. Furthermore, as a scientist-practitioner, Elaine is also invested in research. Elaine's research interests include increasing access to mental health care for historically marginalized communities, adapting evidence-based practices to better serve Latinx immigrants, understanding differences in risk and protective factors of anxiety, and developing culturally sensitive prevention and intervention efforts for Latinx individuals experiencing anxiety.



DR. ZOE R. SMITH (she/her) is an assistant professor in the clinical psychology program at the University of Denver. She is the director of the Advancing Community-Centered Interventions (ACCTION) Team, a licensed child and adolescent psychologist, and an activist for radical change and liberation.

Dr. Smith focuses on developing and providing culturally responsive assessments and interventions for neurodiverse and trauma-exposed Black and/or Latiné youth. The ACCTION Team examines trauma at multiple levels including discrimination, racism, developmental trauma disorder, community violence, etc., and how trauma effects the mental health of young people and their families. We use community-based participatory action research methods to partner with young people and their families.



ARADHANA (ARA) SRINAGESH (she/her), is a Clinical Psychology PhD candidate at the University of Rhode Island and a pre-doctoral psychology resident at Rutgers University Behavioral Health Care (UBHC) at Piscataway.

Her research focuses on the influences of social and geographic contexts on an individual's substance-related behaviors and how adaptive interventions can support behavior change for a specific person and within social contexts. Additionally, she is interested in how person- and momentary-level factors influence substance-related behaviors among Asian Indian diaspora.

She identifies as a first-generation immigrant, and these experiences have shaped her commitment to education, equity, and social justice.

Notably, she co-founded Psychin' Out, a global grassroots community of aspiring and current psychology trainees.



ZACHARY (ZACH) WILDE served as an active-duty Marine from 2013 to 2017, where he developed a strong commitment to leadership, resilience, and mental health. Following his honorable discharge, he earned his bachelor's degree at Washington State University, researching adolescent risk and resilience, adversity, and infant temperament. He later continued this work at the University of Idaho's Stress and Coping Lab, studying stress and barriers to mental health care in rural communities.

In 2020, Zach began doctoral training in clinical psychology at the University of Southern Mississippi. His clinical focus is in pediatric and health psychology, providing evidence-based interventions for trauma, internalizing disorders, and health behavior change. He works with patients and families coping with chronic illness, medical complications, neurodevelopmental disorders, and adversity, emphasizing culturally responsive, strengths-based care that fosters resilience, well-being, and health equity.

His research examines the intersection of adversity, physical health, and positive psychology, with a focus on how adaptive traits and health behaviors protect at-risk populations. He employs physiological assessments—including electroencephalography, actigraphy, and biomarkers of stress—to study biopsychosocial processes. His long-term goal is to integrate research on health, equity, and protective factors with clinical practice to inform interventions that reduce disparities and promote positive functioning.

Zach completed his predoctoral internship at the Greater Hartford Internship Consortium in Connecticut and is now a postdoctoral fellow at Mayo Clinic.

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DR. DONTE BERNARD
University of Missouri



DR. JILL EHRENREICH-MAY
University of Miami

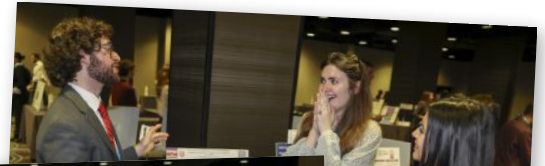
CONVENTION SNAPSHOTS



↑ For more photos of this year's awards ceremony and awardees, visit www.abct.org/membership/abct-awards

We're thrilled to have seen so many of you at this year's **ABCT Convention in New Orleans!**

From presidential addresses to plenaries, fantastic posters and presentations, and an incredible showing of both student and professional work, our members truly make our organization the incredible community that it is.



This year also featured our inaugural **ABCT Benefit Luncheon**, a wonderful showcase of local food, live music and dance, auctions and fundraising, and a chance for devoted networking and friendly connection amongst our members.

We look forward to seeing you next year in Baltimore, MD, for our 60th Convention!

60th Annual Convention

NOVEMBER 12-15, 2026

HILTON BALTIMORE INNER HARBOR & BALTIMORE CONVENTION CENTER

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 Alexa Angelosponta, at 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.

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 Samantha Busa, at 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.

AMASS (Advanced Methodology and Statistics Seminars)

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 Qimin Liu, at amass@abct.org.

Submission deadline: February 10, 2026 at 3:00 a.m. EST

Submissions will be accepted through the online submission portal, which will open after January 2, 2026. 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.”

For more information or to answer any questions
before you submit your abstract, reach out to meetings@abct.org

Call for Award Nominations

To be presented at the 60th Annual Convention in Baltimore, MD
Awards & Recognition Chair: Anne M. Donnelly, Psy.D.

The ABCT Awards and Recognition Committee is pleased to announce the 2026 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.

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. Raymond DiGiuseppe, 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, 2026 | [NOMINATION FORM](#)

Outstanding Clinical Supervisor

This award is 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 doctoral-level supervisor.

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, 2026 | [NOMINATION FORM](#)

Outstanding Clinician

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Robert Leahy, 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 Clinician" in the subject line.

NOMINATION DEADLINE: MARCH 3, 2026 | [NOMINATION FORM](#)

Outstanding Mentor

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

NOMINATION DEADLINE: MARCH 3, 2026 | [NOMINATION FORM](#)

Sobell Innovative Addictions Research Award

The award is given to an individual who, through the performance of one or more research studies, has developed a novel and very innovative (1) program of research or (2) assessment or analytic tool or method that advances the understanding and/or treatment of addictions. The emphasis is on behavioral and/or cognitive research or research methods that have yielded exceptional breakthroughs in knowledge. The recipient receives \$1,500 and a plaque. Candidates must be current members of ABCT and are eligible for the award regardless of career stage. Candidates may self-nominate or be nominated by others who need not be members of ABCT. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Sobell Research Award" in the subject line.

NOMINATION DEADLINE: MARCH 3, 2026 | [NOMINATION FORM](#)

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 receive \$1,000 and a certificate. Please use the nomination form 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, 2026 | [NOMINATION FORM](#)

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, 2026 | [NOMINATION FORM](#)

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 Connie and Steve Ballmer and the Ballmer Institute; Community Behavioral Health and The Evidence-Based Practice and Innovation Center, Philadelphia; and Natalie Dallard, Evidence-Based Practice and Innovation Center. 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, 2026 | [NOMINATION FORM](#)

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, 2026 | [NOMINATION FORM](#)

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, 2026 | [NOMINATION FORM](#)

President's New Researcher Award

ABCT's 2025-26 President, Carolyn Becker, Ph.D., invites submissions for the 48th 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, 2026 | [NOMINATION FORM](#)

Student Dissertation Awards

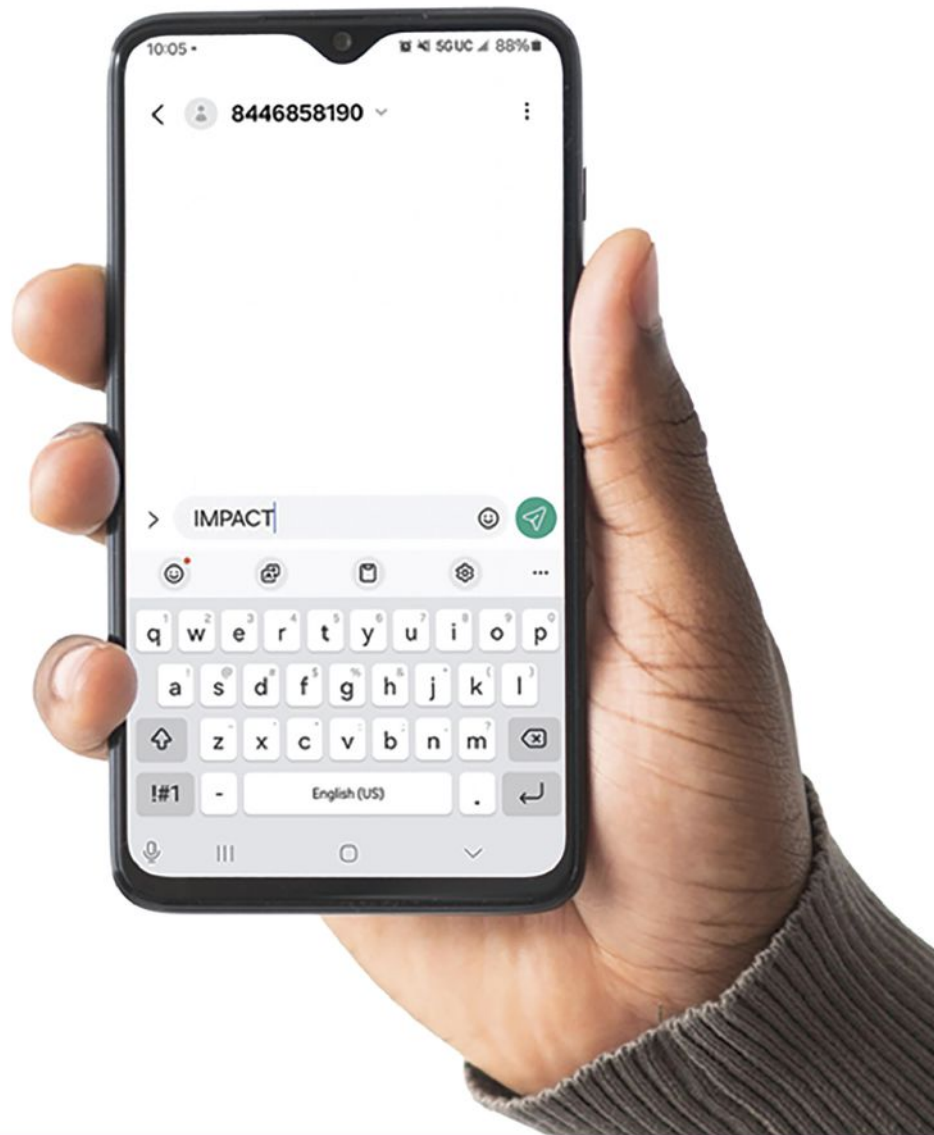
- Virginia A. Roswell Student Dissertation Award (\$1,000)
- Leonard Krasner Student Dissertation Award (\$1,000)
- John R. Z. Abela Student Dissertation Award (\$500)

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 2026. Proposals with at least 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, 2026 | [NOMINATION FORM](#)

TEXT-TO-GIVE! TO DONATE TO THE ABCT STRATEGIC IMPACT FUND, TEXT “IMPACT” TO 844-685-8190

To auto-fill the details above, scan this QR code with your smartphone



NOTE! This campaign only runs through January 2026

The key submission dates and deadlines are as follows:

OPEN NOW – Full Call for Papers Opens

Symposia, Panel Discussions, Clinical Roundtables, Open Papers, and poster presentations.

12th January 2026 – Main Call for Papers Closes

Information will be available on the website (www.wccbt2026.org) including the electronic submission procedures, Congress tracks and examples of different presentation formats.

Information on Invited Address speakers as well as Post-Congress Workshops available by October 2025. The full final program will be available prior to the Congress on the website. The program of In-Congress workshops will also be available in advance of the Congress so that delegates are able to pre-book these when registering for the Congress online.

Scientific Program - June 25–28, 2026

The World Confederation of Cognitive and Behavioural Therapies (WCCBT) is a global multidisciplinary organization dedicated to the promotion of evidence-based cognitive behavioral strategies designed to evaluate, prevent, and treat mental conditions and illnesses. ABCT is a member of WCCBT. **The WCCBT 2026 Congress will take place in San Francisco, California, from Thursday, June 25 to Saturday, June 27. Post-Congress workshops will be held on Sunday, June 28.** San Francisco has a rich history of innovative psychological research in areas including CBT, neuroscience, mental health disparities, and health services for underserved populations. **The theme of the 2026 Congress is “Health for All: Affirming, Equitable, and Sustainable CBT.”** This theme emphasizes WCCBT’s aim to promote mental and physical health for individuals worldwide through cognitivebehavioral approaches that affirm personal agency, resilience, and identities; meet individual needs while also reducing health disparities at the population level; and are sustainable in their intended settings. The Scientific Committee will especially encourage submissions that target the 2026 Congress theme.

The Congress will cover, among many others, the following areas:

- Aging and lifespan psychology
- Anxiety disorders
- Artificial intelligence and technology-based interventions
- Basic processes and experimental psychopathology
- Behavioral medicine, chronic illness, and integrated primary care
- Child and adolescent mental health
- Conflict, disasters, and trauma- and stressor-related disorders
- Dissemination and implementation science
- Family- and caregiver-based interventions
- Feeding and eating disorders
- Interventions and care delivery models in the context of resource limitations
- LGBTQIA+
- Mood disorders and suicidality
- Neurodevelopmental and autism spectrum disorders
- Obsessive-compulsive and related disorders
- Personality disorders
- Positive psychology and resilience
- Promoting diversity, equity, inclusion and reducing stigma
- Psychedelic-assisted interventions
- Schizophrenia spectrum and other psychotic disorders
- School-based interventions
- Sexual wellbeing and / or partnership concerns
- Sports and performance-related interventions
- Substance use
- Training, supervision, and credentialing
- Transdiagnostic and therapeutic processes

Get Involved

in the ABCT Community



Speakers' Bureau

Use our Speakers Bureau to help find experts on topics, such as PTSD, anxiety, suicide, and more; or to locate people who could speak to your school or organization either about CBT or about careers in the field.

Search or update your own listing [here!](#)

Volunteer Me

Volunteer Me is a year-round portal that allows members to indicate interest in serving on an ABCT committee. ABCT members looking to volunteer within the organization should consider joining one or more of our very active and vibrant committees. Learn more about each committee. **Visit the Volunteer Me portal here!***

** Please note that your indication of interest does not automatically add you to a committee.*

- Academic Training and Education Standards Committee
- AMASS Committee
- Awards and Recognition Committee
- Behavioral Health Equity Committee
- Clinical Directory & Referral Committee
- Continuing Education Committee
- Dissemination, Implementation, and Community Engagement Committee
- Fellows Committee
- Fundraising and Development Committee
- History Council
- Institutes Committee
- International Associates Committee
- Leadership & Elections Committee
- Local Arrangements Committee
- Master Clinician Seminar Committee
- Membership Committee
- Program Committee
- Public Education and Media Dissemination Committee
- Publications Committee
- Research & Professional Development Committee
- Research Facilitation Committee
- Self-Help Book Recommendations Committee
- SIG Committee
- Social Networking Media Committee
- Student Membership Committee
- Technology Committee
- Web Committee
- Workshops Committee
- World Congress Scientific Program Committee

ABCT Elections

Nominations Now Open!

Nominations for ABCT's 2025 Leadership elections are NOW OPEN. This is an exciting opportunity for members interested in ABCT governance and leadership.

The nomination form can be accessed at:
services.abct.org/i4a/forms/index.cfm?id=88

OPEN LEADERSHIP POSITIONS:

President-Elect (2026-27) - Serves as the official spokesperson of ABCT and presides over the Board of Directors and all governance activities of the organization.

Representative-at-Large (2026-29) - Liaison to Membership Programs. Board Liaison in charge of supporting and overseeing the work of several committees under the membership programs portfolio.

GENERAL TIMELINE:

Mon Feb 2 - Nomination period closes
Wed, Apr 1 - Voting portal opens
Thurs, Apr 30 - Voting portal closes
Fri, May 15 - Winners announced to membership

Call for Applications: Fellows

Fellows Status for 2026

ABCT FELLOW STATUS IS AWARDED TO FULL MEMBERS WHO ARE RECOGNIZED BY A GROUP OF THEIR PEERS FOR DISTINGUISHED, OUTSTANDING, AND SUSTAINED ACCOMPLISHMENTS THAT ARE ABOVE AND BEYOND THE EXPECTATIONS OF THEIR EXISTING PROFESSIONAL ROLE. Because members' career paths come with unique opportunities, the committee is sensitive to the environment in which the applicant has functioned, and we weigh the contributions against the scope of the applicant's current or primary career.

Multiple Routes to ABCT Fellow Status

ABCT offers 6 areas of consideration for Fellowship status, with only one area necessary for selection: (a) clinical practice; (b) education and training; (c) advocacy/policy/public education; (d) dissemination/implementation; (e) research; and (f) diversity, equity, and inclusion. Applicants for fellowship will be asked to endorse the area(s) in which they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow, and focusing on one area of outstanding and sustained effort is an effective strategy for the required self-statement and emphases by letter writers. What guides the committee's decision making is determining if an applicant has made outstanding, sustained contributions that go beyond their work role expectations.

Who is Eligible to Apply for Fellow Status? (a) Full membership in ABCT for at least 10 years (not necessarily continuous); (b) Terminal graduate degree (doctorate or masters according to discipline) relevant to behavioral and cognitive therapies or related area(s); and (c) at least 15 years of professional experience following completion of requirements for graduation. Two letters of reference are required; one should be from an existing ABCT Fellow. If the latter requirement is a barrier to applying, please contact the Chair of the Fellows committee at fellows@abct.org, who will then assist in determining how best to handle this request. The Committee encourages qualified and diverse applicants to apply.

Potential Fellow applicants, as well as their letter writers, must describe the applicant's specific contributions that are outstanding and sustained.

To aid in writing these letters, the Fellows committee prepared Guidelines for Applicants and Letter Writers for how to write fellow status contributions, available here: www.abct.org/Members/?m=mMembers&fa=Fellow. While these guidelines provide examples of what the Fellows committee considers outstanding, sustained contributions, they are far from exhaustive.

Deadline for Fellow Status Applications: July 1, 2026, is the deadline for both applicants and letter writers to submit their materials. Applicants will be notified of the decision on their application by mid-October 2026. For more information, please visit the Fellowship application page here: www.abct.org/Members/?m=mMembers&fa=Fellow

APPLICATION DEADLINE: July 1, 2026

ABCT Fellows Committee

Matthew Skinta, Ph.D., Chair

Deborah Dobson, Ph.D.

Jeff Goodie, Ph.D.

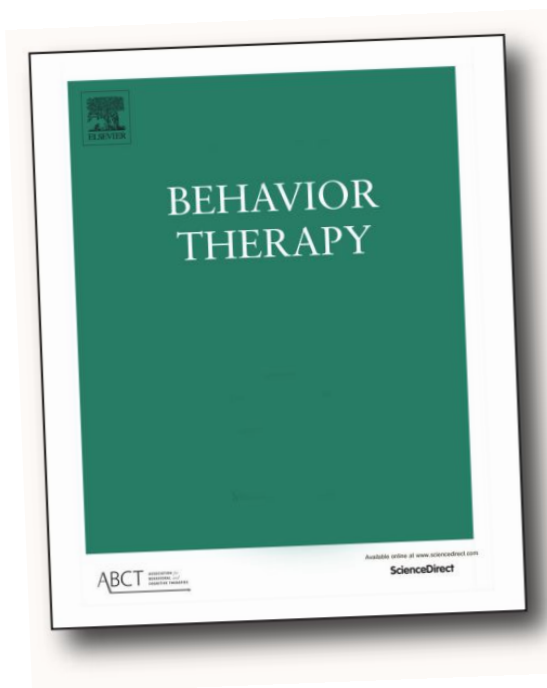
Volunteer

To Review for Our Journals

We are looking to expand our reviewer pool for two journals.

Please click the links below to access each journal's respective volunteer forms.

Here is a chance to **give back** to the field, **be involved** in our community of editors, **engage with authors** about topics on which you are an expert, and help to **maintain the integrity of science and advance the field!**



**BEHAVIOR
THERAPY**
(click here)



***the Behavior
Therapist***
(click here)

Webinars

elearning.abct.org

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

upcoming

Jonathan Huppert | Live Webinar January 15 - Challenges and Opportunities in Disseminating Evidence-based Treatments in the Face of Mass Trauma: Israel as a Case Example

Anne Marie Albano | Live Webinar January 28 - Anxiety, Adolescents, and Parents on the Pathway to Adulthood

recorded

Jeffrey Cohen | Doing Affirmative Cognitive Behavior Therapy with LGBTQ+ Young People

Ken Carswell | An Introduction to WHO's Psychological Interventions Implementation Manual

Anne Marie Albano | Examining the Caregivers' Role in Trauma-focused CBT for Youth: Modeling the Work and Values of Dr. Mary Cover Jones

Brian Pilecki | Introduction to Psychedelic Assisted Therapy for CBT Clinicians

Jeremiah Weinstock | An Overview to Gambling Disorder and Its Treatment

Betsy Stade and Shannon Wiltsey Stirman | AI Applications for Training and Therapy: Emerging Technologies and Ethical Considerations

+ more!

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

www.elearning.abct.org



SPOTLIGHT ON A RESEARCHER

PRESENTED BY ABCT'S
RESEARCH FACILITATION COMMITTEE

Recognizing Excellence in

1. Early Career Research
2. Mid-Career Research
3. Health Disparities Research

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