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CONVENTION REFLECTIONS | **ABCT Presidential Address: Defending Behavioral Science While Embracing Diversity in a Politicized Time: Examples from HIV and Behavioral Health**

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The authors declare no conflicts of interest.

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In his presidential address at the 59th Annual Association for Behavioral and Cognitive Therapy (ABCT) convention, 2025 ABCT president Dr. Steven A. Safren used the time and platform to address a timely and relevant topic to the field of cognitive and behavioral therapists: how behavioral scientists can embrace diversity, engage in advocacy, and learn from behavioral and health sciences to advance our field during a period in which science-based healthcare is being criticized, overlooked, and undercut.

Dr. Carolyn Becker introduced Dr. Safren. Dr. Becker highlighted Dr. Safren's impressive professional trajectory: noting he was a first-generation college student who started graduate school as one of the only openly "out" graduate students in his program. Dr. Safren completed his graduate studies at SUNY Albany and Temple University under the direction of Dr. Richard Heimberg, where his dissertation was focused on depression and hopelessness among sexual minority adolescents. Next, he completed his internship at Massachusetts General Hospital (MGH), where he worked with Dr. Michael Otto to develop a program of work focused (among other things) on improving treatment adherence among individuals with HIV, work which would provide the necessary groundwork for his role in the development of the medication adherence program "Life-Steps," which is similarly focused on individuals living with HIV. After spending 18 years at MGH, Dr. Safren accepted a position at the University of Miami and started a center for the study of HIV and mental health. Dr. Becker noted that over the course of his career, Dr. Safren has been a pioneer in the study of behavioral health, particularly among sexual and gender minority individuals, where his work has been instrumental in ensuring that evidence-based treatments are effective and available to populations that have historically been overlooked and underserved.

Dr. Safren started his address by noting that it has been a "very remarkable year" to be serving as president of ABCT. He stated that one of his primary aims as president this year has been to defend science. Dr. Safren echoed statements from the American Public Health Association, noting that "we are witnessing an unprecedented assault on the foundation of public health, science, and human aid." Dr. Safren also referenced a recent editorial he wrote in *the Behavior Therapist*, in which he stated that "we as clinical scientists may need to keep a watchful eye on the degree to which policies affect mental health, and the degree to which such policies are

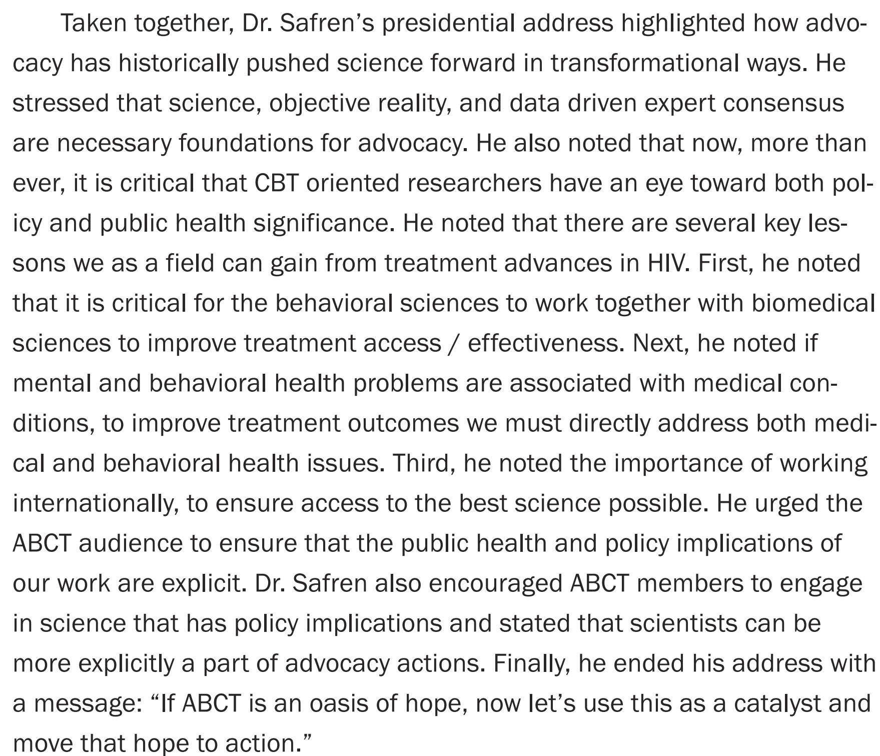
guided by psychological science." Dr. Safren then highlighted the thesis of his presidential address: that we have robust examples in history of how to combat and counteract misinformation in the health space, and we can look at strategies that have been employed in the past to successfully improve health and outcomes for the individuals we aim to serve in the present. In particular, Dr. Safren highlighted how health disparities are often associated with health misinformation, and that we can use evidence-based approaches to reduce such disparities. He stated that this approach has been particularly effective at increasing treatment access and adherence among individuals living with HIV, as well as individuals experiencing other health conditions.

Dr. Safren currently works in Miami, which is an HIV epicenter. He highlighted research demonstrating that there are several factors that can make treatment difficult to access for individuals with HIV. These factors include high levels of psychosocial syndemic problems, elevated trauma symptoms, social and educational barriers, incarceration, and health literacy / HIV stigma. Nonetheless, the field of HIV treatment has had tremendous success in linking advocacy and science. Indeed, although HIV was once considered a deadly diagnosis, by the mid-1990s, the availability of Highly Active Antiretroviral Therapy (HAART) helped move HIV from a terminal illness to a manageable chronic condition for most people living with HIV. Dr. Safren emphasized that health equity means putting resources in the places that need them the most, and that his work has largely been focused on increasing access / reducing barriers to treatment among individuals living with HIV. Critically, Dr. Safren highlighted that there has been a robust history of using advocacy to reduce health stigma associated with numerous health issues, including topics such as cancer and family planning.

Dr. Safren reminded the audience that the mission of ABCT is one of science and equal opportunity, and stated that ABCT's core values (science, quality, diversity, mentorship, and accountability) are consistent with this mission. Indeed, the theme of ABCT's 2025 conference was "Bridging the Divide: Promoting Rigorous Science and Inclusive Affirming Therapies," and the inaugural plenaries were consistent with this mission. Dr. Safren highlighted that ABCT itself has a history of and precedent for increasing its own ability to be inclusive and affirming for members. For example, in the 1960s and 1970s ABCT promoted therapies which attempted to change sexual orientation (i.e., conversion therapies); however, due to strong advocacy efforts over several decades, ABCT has dropped that support and has made strides to become more inclusive. These efforts include (but are not limited to) the establishment and support of the sexual and gender minority (SGM) SIG, the board and past President's apology statement for ABCT's support of conversion therapy, as well as a current ABCT board that is composed of a majority of members who identify as sexual and gender minorities. Dr. Safren notes that this is simply one aspect of how science and advocacy has been used within our professional organization to increase belonginess, improve access, reduce marginalization, and improve outcomes.

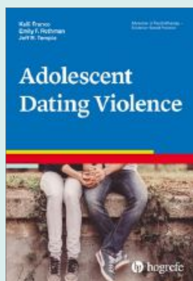
Dr. Safren also summarized how his own research in the realm of HIV treatment adherence has demonstrated how science can be used to improve treatment access. As aforementioned, Dr. Safren played a key role in

the development and implementation of the Life-Steps intervention. Life-Steps has been adapted domestically and globally and has been effective in maximizing adherence to PrEP and HAART medication. Notably, he highlighted international work that has been able to answer scientific questions which would not be able to be addressed in the United States alone. Dr. Safren also described recent work that has piloted using CBT to target both depression symptoms and treatment adherence. Additionally, his mentees and collaborators are currently working on projects designed to address mental health and health behavior change among often-overlooked populations including perinatal women with HIV, body image in sexual minority men with HIV, and individuals who use substances. The Life-Steps approach has also been extended to working to improve adherence among individuals with cancer, diabetes, and pain. Collectively, Dr. Safren noted that this body of work demonstrates how behavioral scientists can work with biomedical scientists to ensure effective treatments are being delivered to populations that need them.



Taken together, Dr. Safren's presidential address highlighted how advocacy has historically pushed science forward in transformational ways. He stressed that science, objective reality, and data driven expert consensus are necessary foundations for advocacy. He also noted that now, more than ever, it is critical that CBT oriented researchers have an eye toward both policy and public health significance. He noted that there are several key lessons we as a field can gain from treatment advances in HIV. First, he noted that it is critical for the behavioral sciences to work together with biomedical sciences to improve treatment access / effectiveness. Next, he noted if mental and behavioral health problems are associated with medical conditions, to improve treatment outcomes we must directly address both medical and behavioral health issues. Third, he noted the importance of working internationally, to ensure access to the best science possible. He urged the ABCT audience to ensure that the public health and policy implications of our work are explicit. Dr. Safren also encouraged ABCT members to engage in science that has policy implications and stated that scientists can be more explicitly a part of advocacy actions. Finally, he ended his address with a message: "If ABCT is an oasis of hope, now let's use this as a catalyst and move that hope to action." ■

A selection of upcoming titles are on the way, bringing fresh perspectives and timely insights.



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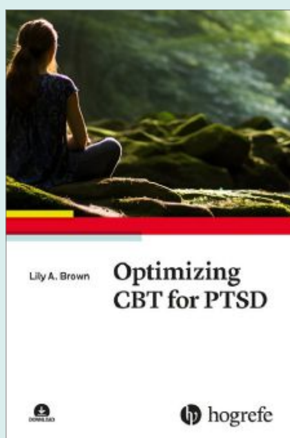

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CONVENTION REFLECTIONS | **Cautionary Tales and Food for Thought: Dr. Arthur M. Nezu's Lifetime Commitment to Growth Within the Mental Health Field**

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AT THIS YEAR'S ABCT CONVENTION, former ABCT president Dr. Arthur M. Nezu challenged his audience to rethink the way they conceptualize the mental health field. Through a series of narratives that he defines as "cautionary tales," this internationally known researcher and clinician highlighted several problems within contemporary psychology. He takes this one step further still by also offering "food for thought," or practical reflections on how the field might respond, urging professionals to navigate the future by reflecting on the past.

Dr. Nezu's opening cautionary tale centered on the integrity of psychological research, addressing issues such as predatory journals, article retraction, and delays in scientific progress. He effortlessly connected this to the burnout epidemic for psychology graduate students. Dr. Nezu uses his platform as a call to action to streamline research processes and improve self-care for budding clinicians. As the 2024 ABCT Lifetime Achievement Award recipient, Dr. Nezu encourages us to remember that "the most important thing is to never stop questioning," echoing Albert Einstein's famous words.

In order to abide by this idea, the field must remain humble. Dr. Nezu believes that this humility comes from critically evaluating behavioral and cognitive therapy (B&CT) to not only recognize its successes, but also to acknowledge its limitations. Research has shown that CBT and related therapies are not considered superior to other modalities for particular conditions. Additional studies have highlighted stagnant results over decades for certain diagnoses. Dropout rates, deterioration, nonresponse, and the development of new symptoms are some of the negative side effects of B&CT interventions often overlooked in the literature. In his own work, Dr. Nezu models intellectual curiosity by continuously seeking clearer definitions and applications of B&CT. He reminds us that although there is much to be proud of, there is always more work to be done.

Dr. Nezu's "food for thought" was presented in a way that appeals to both developing and seasoned clinicians alike, as he encouraged the adoption of a lifelong learning mindset. He highlighted therapist competence and the therapeutic alliance as central to improving treatment outcomes, asserting that more personalized and multidisciplinary care can decrease individual dropout rates. Grounded in critical thinking, Dr. Nezu's professional philosophy underscores the importance of examining both the strengths and weaknesses of B&CT. Intentional evaluation of B&CT's successes and shortcomings can increase clinical competence and improve client outcomes, consequently increasing accessibility to B&CT.

The title *Lifetime Achievement* is more than fitting for Dr. Nezu's award, as his career exemplifies continuous growth, reflection, and care. He concluded with a powerful message: "You can't solve a problem if you ignore its existence." While clinicians often motivate clients to confront difficult realities, Dr. Nezu encourages us as clinicians to do the same. Dr. Nezu's talk serves as a reminder that meaningful progress in the mental health field begins with a willingness to confront challenges with curiosity, humility, and purpose. ■

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Convention Reflections |

Adapting Evidence-Based Trauma Treatments Across Cultural Contexts: Lessons from Dr. Debra Kaysen's ABCT Plenary

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Dr. Debra Kaysen delivered the opening plenary address at the 59th Annual ABCT Convention (2025) in New Orleans, Louisiana. A licensed clinical psychologist and Professor of Psychiatry and Behavioral Sciences at Stanford University, her work has been highly influential in shaping how trauma and posttraumatic stress are understood and treated, particularly among minoritized and diverse populations. Her research, funded by agencies including NIDA, NIAAA, NIHD, the Department of Defense, PCORI, and USAID, has resulted in more than 200 peer-reviewed publications and has informed public policy, clinical training, and service delivery nationwide. Widely recognized as a leader and mentor in the field, Dr. Kaysen previously served as President of the International Society for Traumatic Stress Studies, where she emphasized collaborative, equitable approaches to trauma research and care.

In the introduction to her plenary, Dr. Kaysen framed her talk around a central question facing the field: how can evidence-based interventions be meaningfully brought to cultural contexts and communities that have historically had limited access to them? Dr. Kaysen started by highlighting a well-documented concern in the academic literature: that many widely used evidence-based treatments were developed in "WEIRD" countries (Western, Educated, Industrialized, Rich, and Democratic), contexts that do not reflect the global majority of individuals affected by trauma (Henrich et al., 2010). She reviewed disparities in trauma exposure, PTSD chronicity, and access to care, emphasizing that in low- and middle-income countries, most individuals with PTSD receive little to no mental health treatment (Koenen et al., 2017). From this foundation, she articulated a clear mismatch between the cultural contexts in which treatments are developed and the settings where the greatest need for care exists. Dr. Kaysen defined culture as a socially transmitted system of shared meaning and noted that it is intersectional, varies within groups, shapes the therapeutic relationship, and is frequently oversimplified in clinical analyses. She then addressed a central tension in the field between strict adherence to the original treatment and the develop-

> ... a well-documented concern in the academic literature: that many widely used evidence-based treatments were developed in "WEIRD" countries (Western, Educated, Industrialized, Rich, and Democratic), contexts that do not reflect the global majority of individuals affected by trauma ...

ment of entirely new, culturally specific interventions. This framing set the stage for her explanation of adaptation, which was defined as the inclusion of systematic cultural and contextual shifts that preserve essential treatment elements while improving fit with clients' values and lived experiences. Dr. Kaysen then transitioned to sharing case examples illustrating this approach.

Case Example 1: Implementation of Cognitive Processing Therapy by Community Health Workers in the Democratic Republic of Congo

Dr. Kaysen began her first case example by orienting the audience to the setting of the Democratic Republic of Congo (DRC), a large and culturally diverse country that has been profoundly impacted by the African World War, with approximately 250 languages spoken and minimal mental health infrastructure or formal training systems. Against this backdrop, Dr. Kaysen outlined the core components of Cognitive Processing Therapy (CPT), a cognitive-based, gold-standard intervention for PTSD (Resick & Schnicke, 1992). At its core, CPT aims to reduce PTSD symptoms by helping individuals examine and modify the beliefs and language they use to understand traumatic experiences.

Dr. Kaysen then described the cultural and contextual adaptations required to implement CPT in the DRC. Some of the cultural challenges that arose involved the delivery language, the historical absence of talk therapy, the longstanding stigma surrounding sexual assault, and culturally specific beliefs about the meaning and interpretation of trauma. Contextual differences, as Dr. Kaysen stated, were arguably more significant. These involved the delivery by paraprofessionals, the setting of "listening houses," the level of literacy, and the treatment timing to account for women's farming responsibilities. The adaptation process occurred in multiple stages. Prior to implementation, the CPT manual was simplified to remove clinical jargon and to emphasize behavioral descriptions, and then cultural and contextual adaptations were made collaboratively in the field with clinicians. Dr. Kaysen highlighted several specific modifications, including changes to language and beliefs used in treatment. For example, rather than using the term "Socratic dialogue," clinicians employed a fishing metaphor: instead of catching fish for someone, the goal is to teach them how to fish. More extensive contextual changes were also required, including shifting training from didactic to practice-based formats, adapting materials for lower literacy levels by incorporating naturally occurring cues, and scheduling sessions around market days to improve attendance.

Dr. Kaysen concluded this case example by reviewing the implementation outcomes and comparing CPT with treatment as usual, which consisted of individual support, mediation, and referral services. CPT demonstrated stronger outcomes, with participants in villages using CPT showing 15 times higher odds of no longer meeting criteria for PTSD or depression (Bass et al., 2013). These gains were sustained over time; at 5-year follow-up, the majority of participants remained below clinical thresholds, and relapse rates were approximately 20%, comparable to trials conducted in the United States (Bass et al., 2022).

Case Example 2: Healing Seasons

Shifting to a markedly different context, Dr. Kaysen next described work conducted with a Native American tribe in the Pacific Northwest. She began by situating the historical and structural context of the community, which has been profoundly affected by the legacy of Native American boarding schools. In these schools, children were systematically removed from their homes, punished for speaking their language of origin or engaging in spiritual practices, and subjected to cultural erasure. These historical harms continue to reverberate through ongoing poverty, discrimination, and collective trauma. Importantly, this clinical intervention was initiated by the community itself, with the goal of addressing the widespread trauma affecting community members. As such, the work involved not only adaptation of the intervention, but also a community-partnered process to determine which intervention would be most appropriate. The overarching aim of the initiative was that effective treatment of PTSD would also lead to broader benefits, including reductions in substance use and high-risk sexual behavior.

The intervention selected was Narrative Exposure Therapy, an approach that relies on tactile and symbolic elements to construct trauma narratives, using stones to represent traumatic experiences and flowers to signify positive events. Unlike CPT, Narrative Exposure Therapy was originally developed for use in conflict settings and non-Western cultural contexts (Schauer et al., 2020). Nevertheless, several key cultural considerations required careful attention, including historical trauma, spirituality, the legacy of linguistic and cultural oppression, and the deeply interconnected nature of the community. Contextual factors also shaped implementation, as treatment was delivered across two settings, a community mental health center and tribal clinic, both characterized by high poverty and limited access to transportation.

Using a different adaptation framework than in the prior case example, Dr. Kaysen distinguished between surface-level adaptations, which address observable features of a population, and deep adaptations, which modify intervention components to reflect culturally specific meanings and experiences. Surface-level adaptations included incorporating more culturally relevant examples, opening sessions with client-led spiritual practices or rituals, and providing gift bags containing tribe-specific objects. A key deep adaptation involved explicitly addressing historical trauma within the therapeutic narrative, such as including a stone representing the first time a participant learned about their community's historical trauma. In terms of outcomes, both treatment conditions, Narrative Exposure Therapy and a comparison intervention combining motivational interviewing and CBT skills, were equally effective in reducing PTSD symptoms (Pearson et al., 2025). Notably, however, Narrative Exposure Therapy demonstrated superior outcomes for alcohol and drug use compared to the alternative substance use treatment (Pearson et al., 2025).

Case Example 3: Islamic Trauma Healing: Integrating Faith and Science

The third and final case example presented by Dr. Kaysen was situated in Somalia. As with the prior examples, she began by orienting the audience to key contextual factors shaping mental health needs in the region. Somalia has experienced decades of armed conflict, mass displacement, and climate-related crises, resulting in high levels of trauma exposure alongside extremely limited access to formal mental health care. Mental illness is highly stigmatized, further reducing the likelihood that individuals will seek or receive treatment. Similar to the second case example, this collaboration was initiated by the community itself, reflecting a locally driven effort to address trauma-related distress. Primary cultural considerations included language, stigma surrounding mental illness, and the central role of Islam in Somali identity and daily life. Key contextual factors included delivery by lay leaders, implementation within mosques, flexibility across multiple settings, and the need for an intervention that could be learned and delivered with minimal training.

Unlike the previous two case examples, this project integrated Islamic teachings directly with principles drawn from evidence-based trauma interventions. Dr. Kaysen described several culturally grounded elements of the intervention, including opening sessions with a supplication, using religious stories involving trauma to illustrate principles of cognitive restructuring, and addressing stigma by inviting participants to share trauma memories with God rather than framing disclosure solely within a clinical model. The intervention was designed to be highly flexible, allowing for both group and individual delivery, leadership by trained lay providers, and implementation within religious spaces. Training requirements were minimal, with providers able to learn the intervention in approximately 6 hours.

Dr. Kaysen concluded by reviewing early outcome data, which demonstrated significant improvements over time compared to a waitlist control condition. Large effect sizes were observed for PTSD symptoms, with medium effect sizes for depression (Zoellner et al., 2024). As Dr. Kaysen emphasized, this case represents a particularly strong example of intervention cocreation rather than adaptation.

Conclusion

Dr. Kaysen concluded her plenary by synthesizing key lessons drawn from the three case examples. Across settings, she emphasized that when the core elements of evidence-based interventions are preserved, cultural adaptation can meaningfully increase treatment fit, reduce dropout, and maintain clinical effectiveness. She underscored that all clinical work occurs within multicultural contexts, requiring clinicians and researchers to thoughtfully consider how cultural factors shape engagement and therapeutic processes. Dr. Kaysen also highlighted the importance of openly addressing culture in treatment, including acknowledging historical trauma and potential mistrust rooted in past harms experienced by marginalized communities. When approached carefully, adaptations can enhance relevance without compromising treatment integrity.

Dr. Kaysen ended by outlining key implications for the field and future directions, including the need for greater clarity regarding the extent of

necessary adaptation, improved identification of core therapeutic components, and more systematic methods for coding and evaluating adaptations. Developing a deeper understanding of which modifications improve cultural fit and outcomes will be essential for advancing equitable, effective mental health care across diverse settings.

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CONVENTION REFLECTIONS | **Invited Plenary: "Intervening on the Emotional Moment With Those in Distress": Reflections on Dr. Douglas Mennin's Invited Address**

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The authors declare no conflicts of interest.

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DR. DOUGLAS MENNIN currently serves as faculty and the Director of Clinical Training in Columbia University's clinical psychology program. There, he has provided training in assessment, diagnosis, and treatment of anxiety and mood-related disorders. Beyond his clinical training, Dr. Mennin has engaged in research aiming to better understand the ways in which providers improve emotion-regulation skills and reduce chronic and in-the-moment distress experienced by those with mood and anxiety-related conditions. He is an expert in the treatment of chronic mood- and anxiety-related concerns. Through the tenure of his career, Dr. Mennin has published over 150 peer-reviewed manuscripts and continues to engage in research to better understand the etiology and maintenance of chronic distress and negative thinking. His work has included the codevelopment, with Dr. David Fresco, of Emotion Regulation Therapy, a treatment which seeks to assist individuals in best managing and treating experiences of chronic distress. Dr. Mennin was invited to present on his Emotion Regulation Therapy work at the 2025 Association for Behavioral and Cognitive Therapies Annual Convention in New Orleans, Louisiana.

Dr. Mennin began his invited plenary by outlining the patient experience of chronic distress, first by defining emotional distress as "holding pain" or frequently reflecting on and coming back to negative thoughts or experiences by means of rumination, worry or self-criticism. This internal, cognitive experience is also related to an internal, neurobiological experience resulting in the psychophysiological arousal experienced during distress. Although modern treatments have proven efficacious in treating disorders associated with chronic emotional distress (e.g., Major Depressive Disorder, Generalized Anxiety Disorder), patients experiencing these refractory symptoms associated with chronic distress may be less responsive to treatment (Borkovec & Ruscio, 2001; Mennin & Fresco, 2014). To address this, Dr. Mennin emphasized the importance of the "moment in," or the timepoint that is best for improving adaptive skills and coping among those who are experiencing some degree of distress. Through orienting toward "moment in" intervention, Dr. Mennin outlined a model of distressing moments which explains how emotional experiences may, over time, snowball, growing in magnitude and longer-term consequences (e.g., experiences of prolonged, chronic distress). As a means of managing these experiences of reoccurring distress, he outlined the mechanisms by which Emotion Regulation Therapy (ERT; Mennin & Fresco, 2024) seeks to instill change by means of enhanced internal observation and metacognitive skills (e.g., decentering, or seeing the mind from a different perspective) to create a life of fulfilled values and increased agency. Different than, and yet derived from and grounded in, traditional Cognitive Behavioral Therapies (CBT), ERT seeks to unify what we know from affective

science and what we know about therapies that work (e.g., skills training, exposures, mindfulness) to provide more targeted care for individuals experiencing chronic distress (Applebaum et al., 2022; Renna, et al., 2017). Throughout his talk, Dr. Mennin discussed several recent research findings from his team, which provide promising support for ERTs ability to treat target elements of his outlined model of distressing moments to reduce client distress. A number of the findings described during Dr. Mennin's address have not yet been published, providing a cutting-edge summary of his work on ERT.

Dr. Mennin's review of the extant literature on ERT began with support for the overall efficacy of the intervention. Dr. Mennin presented data from a 2018 study in which participants with Generalized Anxiety Disorder and / or comorbid Major Depressive Disorder received 20 sessions of ERT (Mennin et al., 2018). When compared to a waitlist control, ERT demonstrated clinically meaningful improvements across multiple clinical domains, including reductions in worry, rumination, and functional impairment, as well as improvements in general quality of life. ERT aims to treat cognitive and affective symptoms of distress states—termed negative self-referential processes (e.g., worry and rumination; Northoff, 2007)—which reduce one's ability to engage in goal- and value-congruent behaviors. This control-comparison trial evidenced ERT's ability to meaningfully reduce these core constructs while improving adaptive coping skills taught through ERT, including decentering and mindfulness. Moreover, the improvements demonstrated within the ERT condition were medium to large effects that were subsequently maintained over a 9-month follow-up period.

Following this, Dr. Mennin presented on a uniquely adapted version of ERT for caregivers of individuals with cancer (ERT-C; Applebaum, et al., 2022). As caregivers of individuals with cancer experience a multitude of psychosocial stressors (e.g., Askari et al., 2012), ERT was identified as a potential intervention which may alleviate prolonged chronic distress and increase in-the-moment distress management skills. Within this trial, ERT-C was compared to Cognitive Behavioral Therapy for Caregivers (CBT-C). When delivered across 8 sessions, ERT-C was associated with similar reductions in caregiver distress, including reductions in worry, rumination, anxiety, and burden, as well as improvements in quality of life. Moreover, it appears that these reductions in distress had direct benefits to those they cared for, as patients with cancer also saw improvements in emotional and physical well-being. Uniquely, this adaptation of ERT was not specific to a particular psychological diagnosis, proving some initial support regarding ERT's efficacy in reducing distress in a transdiagnostic fashion.

In an effort aimed at better understanding the optimal number of sessions or "dose" of ERT, Dr. Menning discussed a subsequent trial among patients reporting an anxiety or mood disorder characterized by frequent perseverative thoughts (Renna et al., 2023). Renna and colleagues (2023) compared the effects of 8-session and 16-session ERT on a key feature of internalizing disorders: perseverative worry. Results of the study indicated large effect size reductions in perseverative worry among both the 8- and 16-session treatment groups, including throughout a 2-year follow-up period. Of note, however, at 2-year follow-up, participants in the 16-session version of

ERT reported more pronounced reductions in perseverative worry compared to participants in the 8-session version. Taken together, these initial trials demonstrate that ERT is an intervention which may be effective across varying populations and that it may be effective when delivered at small (8-session) doses; however, as ERT aims to target those core constructs associated with negative self-referential processes such as perseverative worry, longer formats (e.g., 16-session) may be more appropriate for making the most meaningful, sustained changes on these core constructs.

Following Dr. Mennin's discussion of completed research, he provided insight regarding some ongoing or recently completed work that he and his team have been conducting to better understand the manner in which mechanisms of ERT result in improved clinical outcomes. As decentering (i.e., the ability to engage in self-observation on one's own thoughts and feelings) is a key adaptive coping mechanism developed within ERT, Dr. Mennin presented on unpublished work by his colleagues and team (Mennin, 2025) to evaluate the role of decentering on clinical outcomes. Preliminary results demonstrated that the development of decentering skills as an adaptive coping mechanism was a more pronounced mediator between treatment and caregiver distress in ERT-C compared to CBT-C. Further evidencing the profound impact of decentering on client outcomes, preliminary findings from Dr. Mennin and his team (Mennin, 2025) demonstrated significant differences in effect sizes between 8-session and 16-session ERT for those with anxiety and mood disorders. Specifically, in the 16-session version of ERT, there was a larger effect of increased decentering on reduced rumination, as compared with 8-session ERT. As ERT aims to target characteristics of chronic distress, these analyses demonstrated that working on in-the-moment skills such as decentering for longer periods of time may result in greater symptom reduction, such as rumination, in the long-term. Dr. Mennin also presented preliminary results from time-lagged analyses examining the temporal relationship between decentering, worry, and rumination. Findings from this unpublished work indicated that improvements in decentering typically preceded reductions in worry and rumination, suggesting that the development of the skill of decentering may be a key mechanism through which ERT reduces perseverative negative thought patterns (Mennin, 2025). As ERT is proposed to reduce chronic, enduring maladaptive coping strategies (negative perseverative thinking), these results suggest ERT can target mechanisms which reduce distress by improving regulatory capabilities through skill development.

Beyond examining the core mechanisms at work in ERT, Dr. Mennin outlined the importance of considering contextual factors in relation to the experience of distress. Understanding the contexts within which clients live and experience the world influence is critical to the client's ability to engage in emotion regulation skills (Bonanno & Burton, 2013). To address patient-environment concerns, ERT has been developed such that it may be flexibly adapted to different populations, such that it may be personalized while maintaining its core components. For example, in their RCT which utilized ERT-C, the ERT manual was shared with caregivers and feedback was solicited to adapt examples and terminology to better reflect the needs and experiences of caregivers of cancer patients. Providing further evidence in support of the adapt-

ability of ERT, Dr. Mennin discussed a modification of ERT for delivery during the COVID-19 pandemic, though that work is not yet published (Mennin, 2025). Within this iteration of ERT, flexible session structure was offered, such that individuals received either one or two sessions per week, and digital applications were adapted and employed to assist individuals developing and using their learned skills in moments before, during, and after distressing events.

Taken together, the evidence presented provided strong support for the emergent ERT framework. ERT appears to be promising intervention for reducing distress, particularly among populations which may experience more chronic and enduring psychopathology linked to rumination and perseverative worry. Given the initial success of ERT, it will be critical to continue to expand upon the extant literature as Dr. Mennin and colleagues establish the evidence base and work to disseminate their intervention. In doing so, a few key areas of development seem critical to establishing ERT, as well as identifying *when* and *for whom* ERT will be most helpful.

First, while Drs. Mennin and Fresco have led a number of trials of ERT, further support for the efficacy of ERT would be strongly supported by independent replication of ERT trials by other researchers. Such evidence would require the commitment of independent researchers to adapt and implement ERT in their own work, conducting further randomized trials in new settings. Successful independent trials would lend additional support for the efficacy and transportability of ERT.

Second, expanding the empirical foundation of ERT to new populations and diagnostic categories may help to answer "for whom" ERT will be helpful. Emotion regulation processes are central to a number of diagnostic categories and psychological disorders. To date, the bulk of the extant ERT literature appears focused on anxiety and depressive disorders. Given the central role of emotional regulation in the presentation of suicidal thoughts and behaviors (e.g., Colmenero-Navarrete et al., 2022), as well as other diagnoses, such as Posttraumatic Stress Disorder (e.g., McLean & Foa, 2017), future research should seek to examine the potential impacts of ERT across a broader range of clinical presentations. Similarly, the extent to which ERT may be an efficacious intervention for psychopathology among children and adolescents is also an area for critical expansion, as early intervention on childhood emotion regulation skills may have the potential to impact life-long symptom trajectories and psychopathology.

Third, given the number of efficacious treatments for anxiety and depression, such as CBT (Cuijpers et al., 2016), Behavioral Activation Therapy (Stein et al., 2021), and Acceptance and Commitment Therapy (Bai et al., 2020), among others, a crucial question for the development of ERT is whether ERT should be used as a front-line treatment, may be better held for use with specific presentations of internalizing psychopathology, or might be useful for those who show less than ideal responses to other forms of treatment (i.e., what might be termed "treatment resistant" depression, in the broadest sense of the term). Larger funded clinical trials utilizing rerandomization models for treatment nonresponders, allowing for examination of moderation of treatment effects, or even the use of SMART trial designs may help elucidate the circumstances, populations, or presentations for which ERT is most effective.

On the whole, ERT appears to be a promising intervention supported by

multiple randomized trials conducted by Drs. Mennin and Fresco. Dr. Mennin's ABCT address laid out the empirical evidence in systematic fasion, making a strong argument for the inclusion of ERT in clinicians' intervention repertoires. As with any emerging intervention, there are numerous empirical questions that could be asked to refine and optimize the targeting of the intervention. Despite these questions, the evidence presented by Dr. Mennin offers insight into this promising treatment model.

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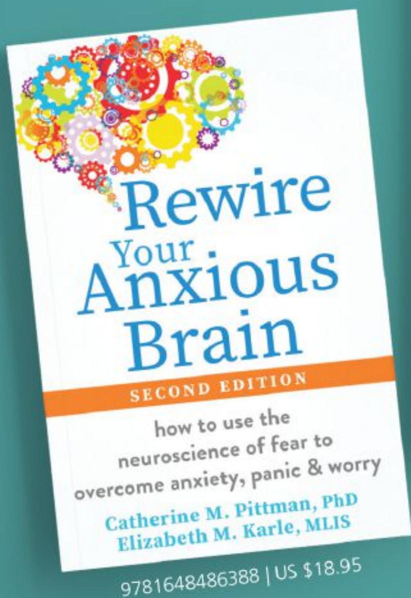

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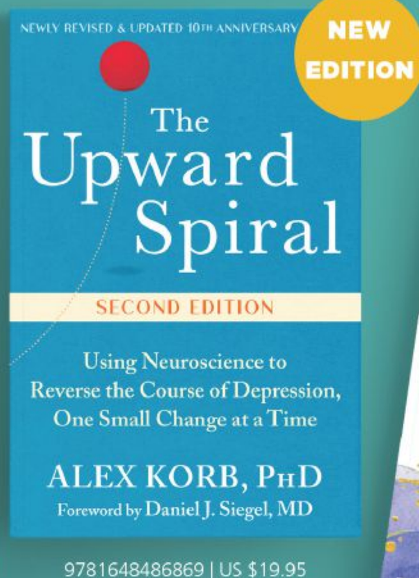

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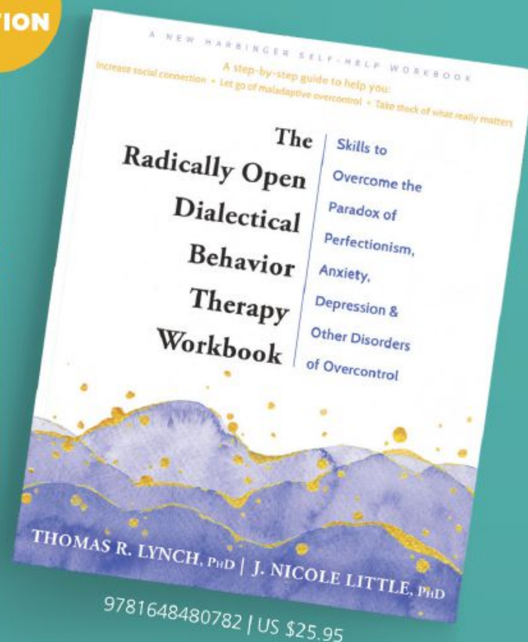

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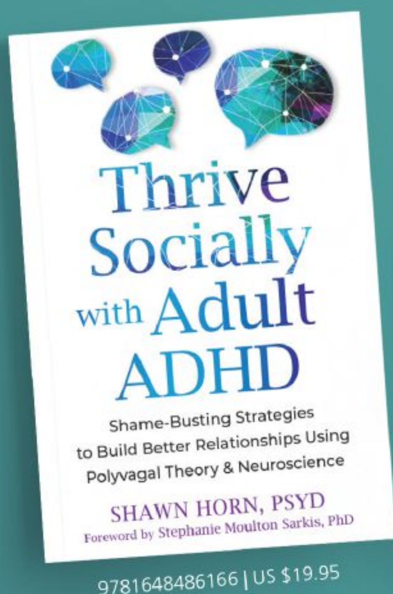

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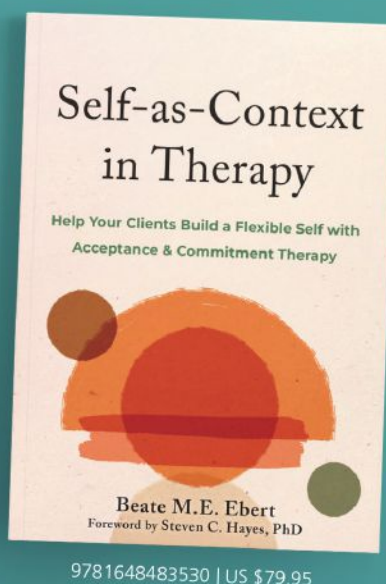

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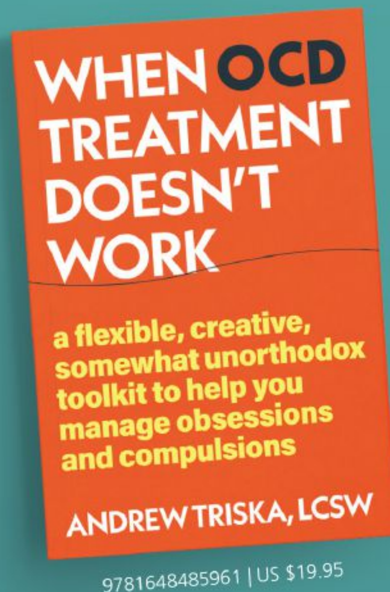

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CONVENTION REFLECTIONS |

"A Multi-Disciplinary Approach to the Study of Social Policies and Mental Health Disparities: Insights from Stigma Research": Reflections on Dr. Mark L. Hatzenbuehler's Invited Address

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Clinical science has long focused on understanding and addressing factors at individual and interpersonal levels to reduce mental distress and decrease disparities among minoritized populations. Although important, this focus is insufficient for mitigating mental health difficulties as it overlooks the impacts of the broader, sociopolitical environment in which a person exists. This was one of the primary takeaways of the invited address delivered by Dr. Mark L. Hatzenbuehler at ABCT's 59th Annual Convention. Dr. Hatzenbuehler is a Professor of Psychology and the director of the Biopsychosocial Effects of Stigma (BEST) lab at Harvard University. Dr. Hatzenbuehler has received several honors and awards for his contribution to the field including being an Elected Fellow of the Academy of Behavioral Medicine Research. His research, focused on examining the biopsychosocial mechanisms contributing to mental health difficulties among minoritized groups, has been funded by institutes including the National Institutes of Health, the Centers for Disease Control and Prevention, the William T. Grant Foundation, and the Robert Wood Johnson Foundation.

Dr. Hatzenbuehler began his address by providing an overview of the current state of the literature on stigma and mental health. In his overview, Dr. Hatzenbuehler stressed that stigma should be understood as a multidimensional construct that manifests at individual (i.e., within person), interpersonal (i.e., within interactions), and broader, structural levels. He defined structural stigma as "societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and well-being of the stigmatized." Although there is a robust body of literature linking individual- and interpersonal-level stigma with mental health difficulties, research on the impacts of structural stigma is much more limited. This gap may be at least in part due to the limitations of traditional psychological research. Questions about the mental health impacts of differential exposure to structural stigma are difficult to address using gold-standard clinical research methods such as randomized control trials due to challenges with feasibility and ethicality. In response to these challenges, Dr. Hatzenbuehler highlighted the exciting opportunity for innovative interdisciplinary collaboration that research on structural stigma presents, drawing from fields such as sociology, public health, and political science that have a much longer history of exploring macro-level factors. Dr. Hatzenbuehler suggested several approaches for using interdisciplinary methods to measure the impacts of structural stigma on mental health. He also shared examples from his own novel and impactful research program illustrating the adverse effects of exposure to structural stigma on the mental health of minoritized or marginalized groups.

Structural-level stigma is dynamic and responsive to broader sociopolitical forces. This is particularly salient in the current moment, given rapid and consequential shifts in public policy, institutional practice, and legal protections for minoritized groups. Dr. Hatzenbuehler recommended that scholars capitalize on these ongoing changes to demonstrate the adverse mental health impacts of increasing structural stigma among minoritized populations. Dr. Hatzenbuehler shared an example in which he and other members of his research group used advanced, quasi-experimental designs to examine the impacts of changing state-level policies to permit the denial of services to same-sex couples (Raifman et al., 2018). Results showed that among sexual minority adults (i.e., adults who identified as gay, lesbian, bisexual, or not sure of their sexual orientation), those who lived in a state that implemented laws permitting the denial of services to same-sex couples experienced a 46% relative increase in mental distress compared to sexual minority adults living in control states that did not implement such laws. These findings were specific to sexual minority individuals and did not extend to heterosexual adults. Importantly, the study demonstrated that short-term increases in structural stigma are associated with short-term increases in mental distress, specifically among stigmatized groups, likely contributing to mental health inequities.

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In addition to measuring the adverse impacts of increasing structural stigma on mental health, Dr. Hatzenbuehler also raised a question about whether decreased exposure to structural stigma leads to positive mental health outcomes. Dr. Hatzenbuehler pointed out that although such a question seems simple, it is difficult to address as it requires longitudinal measurements of mental health that have occurred in tandem with a social context that has had pronounced reductions in structural stigma, reflected in social policy. Thus, researchers may need to look outside of the United States to find areas that meet these requirements. Dr. Hatzenbuehler shared that from 2005 to 2015, Sweden implemented significant policy change increasing the legal recognition and rights of sexual minority groups. Using data from the Swedish National Public Health Survey, he and his team demonstrated that the implementation of these policies, subsequently reducing structural stigma exposure, was associated with significant reductions in mental distress among sexual minority adults (Hatzenbuehler et al., 2018). Moreover, they showed that the previous disparity in mental distress between heterosexual adults and sexual minority adults was eliminated within

the same 10-year period. These findings are particularly promising as they illustrate that mental health disparities are not inevitable or permanent. Instead, they are malleable and responsive to changes in the sociopolitical environment.

Finally, Dr. Hatzenbuehler recommended that researchers examine temporal variations in structural stigma by following participants as they move into and out of areas with differing levels of structural stigma. Drawing from tools used by economists to examine associations between neighborhood mobility and child development (e.g., Chetty et al., 2016), Pachankis and colleagues (2021) examined mental health outcomes among European sexual minority adults who moved from countries with higher structural stigma, characterized by the criminalization, protection, and recognition of sexual minorities, to countries with lower structural stigma. Findings indicated that exposure to structural stigma in the country of origin was associated with proximal mental health outcomes; however, these impacts appeared to fade over time. Among sexual minority men who moved from their country of origin more recently (i.e., within 4 years), the country of origin's level structural stigma was significantly associated with depressive symptoms. This association was no longer significant among sexual minority men who had moved 5 years earlier or more. Like the previous study, such findings suggest that the negative mental health impacts of structural stigma are not permanent and may be alleviated when individuals relocate to more affirming, less stigmatizing environments.

The work presented by Dr. Hatzenbuehler illustrated how clinical scientists, in collaboration with scholars from other disciplines, can use advanced, rigorous, and innovative approaches to understand the impacts of structural stigma on the mental health of stigmatized populations. His work demonstrated that exposure to structural stigma does indeed have deleterious impacts on the mental health of minoritized groups. Importantly, his work also demonstrated that the negative impacts of structural stigma are neither unavoidable nor permanent. Instead, structural stigma can be seen as a malleable social determinant of health whose impacts can be reduced through the implementation of macro-level change and by supporting individuals living in high-stigma contexts as they seek affirmation in proximal or distal environments.

Findings from Dr. Hatzenbuehler's work lay the groundwork for future efforts to mitigate disparities and improve mental health outcomes among minoritized groups using macro- and micro-level interventions. Dr. Hatzenbuehler stressed the importance of translating research findings into public policy and encouraged clinical scientists to advocate for evidence-based policies aimed at reducing structural stigma using both quantitative and qualitative data. He noted that as clinical scholars and practitioners, we have the unique ability to amplify the stories of our patients, participants, and communities. By collaborating with storytellers (e.g., journalists), we can present compelling narratives about the negative impacts of structural stigma on day-to-day living and well-being. Such narratives may in turn convince policymakers who may otherwise remain unconvinced by quantitative evidence.

Dr. Hatzenbuehler also acknowledged that, although policy change is im-

portant, this change can be slow and may be subject to reversal as sociopolitical dynamics shift. Therefore, it is also important to adapt individual-level interventions to ensure that they are effective for minoritized individuals living in high-stigma social contexts. Research suggests that the efficacy of mental health interventions is significantly reduced among individuals living in high-stigma contexts (Price et al., 2021). As Dr. Hatzenbuehler notes, this worrying finding indicates that such interventions may be least effective among the populations for whom they are most vital. Although researchers have already begun to develop interventions specifically for minoritized individuals living in high-stigma contexts (e.g., Project ESTEEM; Pachankis et al., 2019), additional research is needed.

Most importantly, Dr. Hatzenbuehler's work demonstrated that solely addressing stigma at individual- and interpersonal-levels using traditional psychological research methods is insufficient for mitigating health disparities among minoritized groups. Effective efforts must also include multidimensional, multidisciplinary examinations of structural-level factors, addressing the root causes of mental health disparities, and complementing individual-level efforts with systemic change. Looking forward, as the sociopolitical landscape continues to evolve in unpredictable ways that often increase structural stigma, these coordinated, multipronged approaches can equip scholars and practitioners to serve as advocates, promoting well-being among minoritized groups and fostering positive, lasting change.

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CONVENTION REFLECTIONS |

"State of the Science and Emerging Research on Gender Affirmative Medical Care for Transgender Youth:" Reflections on Dr. Diane Chen's Invited Plenary

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GENDER-AFFIRMING MEDICAL CARE HAS BECOME A FOCAL POINT of political discourse and legislation in the United States in recent years (Garcia Gutiérrez et al., 2024; Lee et al., 2024), despite strong consensus among medical organizations and experts that such care is critical to the well-being of transgender and gender diverse (TGD) youth. Amid legislative efforts to restrict access to this care, clinicians, advocates, and researchers are charged with countering misinformation with available scientific evidence. Against this backdrop, Dr. Diane Chen's invited plenary "State of the Science and Emerging Research on Gender Affirmative Medical Care for Transgender Youth" at the 2025 ABCT convention provides a timely overview of current scientific knowledge on this topic. Dr. Chen is a Professor of Psychiatry and Behavioral Sciences, Pediatrics, and Medical Social Sciences at Northwestern University, Feinberg School of Medicine, and the Behavioral Health Director for Adolescent and Young Adult Medicine at Ann & Robert H. Lurie Children's Hospital. She is also the founding psychologist for Lurie Children's Gender Development Program and Supportive Program for a Range of Urogenital Traits (SPROUT).

Dr. Chen began her talk by reviewing key terminology and highlighting the psychosocial challenges faced by TGD youth. TGD youth are individuals whose gender identity differs from their sex assigned at birth. Many of these individuals experience gender dysphoria (clinically significant distress associated with the incongruence between their gender and their sex assigned at birth) and may use a range of strategies and services for gender affirmation, including social transition, hormone treatment, and surgical intervention. Although TGD youth make up a small percentage of the overall population, Dr. Chen noted a growing trend in TGD youth seeking gender-affirming medical treatment, such as hormone replacement therapy, to address gender dysphoria and related mental health concerns. To this end, Dr. Chen highlighted the disproportionate mental health burden experienced by TGD youth relative to their cisgender peers, with research showing they are at substantially elevated risk for poorer psychiatric outcomes including depression, anxiety, and suicidality (Reisner et al., 2015).

Gender-affirming medical treatment aims to support the well-being of TGD youth by aligning their gender presentation and / or physical body with their gender identity (Lee & Rosenthal, 2023). Importantly, Dr. Chen underscored that not all TGD youth seek medical intervention. For those that do, Dr. Chen discussed how treatment is guided by evidence-based clinical practice guidelines and encompasses a spectrum of reversible, partially revers-

ible, and irreversible interventions (Coleman et al., 2022; Hembree et al., 2017). Specifically, reversible gonadotropin-releasing hormone agonists prevent the development of secondary sex characteristics that are not aligned with a person's gender identity. Partially reversable hormone replacement therapy (exogenously administered testosterone and estrogen) induces several changes, such as the development of secondary sex characteristics that are aligned with a person's gender identity. Some of these changes are reversible with cessation of treatment (e.g., body fat redistribution), while others are not (e.g., breast development, voice deepening). Irreversible gender-affirming surgeries, such as feminizing and masculinizing surgeries, are offered when a person has reached legal adulthood. Dr. Chen emphasized the importance of a personalized approach to intervention selection that takes into consideration the person's age, development stage, and unique embodiment goals.

Numerous studies have examined the impact of gender-affirming care on TGD youth (Weixel et al., 2025). Dr. Chen reviewed findings from available longitudinal studies that investigated the impact of gender-affirming hormone treatment on psychosocial outcomes in TGD youth (Achille et al., 2020; Allen et al., 2019; Allen et al., 2025; Chen et al., 2023; Chelliah et al., 2024; Kuper et al., 2020; Olson-Kennedy et al., 2025; Tordoff et al., 2022). Overall, these studies suggest that gender-affirming care is associated with positive psychosocial outcomes in TGD youth, including reductions in depression, anxiety, and suicidality, and improvements in life satisfaction and positive affect. Dr. Chen also highlighted several limitations of this body of work, noting that studies are limited by small sample sizes, a reliance on standard of care clinical data, relevantly short follow-up periods, and a primary focus on internalizing symptoms with less attention on externalizing symptoms. Several studies also combined individuals receiving puberty blockers with those receiving hormone treatments, which may obscure meaningful differences in outcomes between these treatments. Studies are also limited by a focus on average changes in psychosocial outcomes over time, which may not capture meaningful heterogeneity in treatment responses. Dr. Chen presented findings from her research showing significant variation around average changes in psychosocial outcomes, suggesting there may be distinct subgroups of TGD youth with varying outcomes (Chen et al., 2023). Collectively, the current body of research consistently highlights that gender affirming care has potential to improve psychosocial well-being in TGD youth, but also points to a need for methodologically rigorous longitudinal studies to understand the impact of gender-affirming treatments on both internalizing and externalizing symptoms, and identify factors that predict unique symptom trajectories in youth receiving gender-affirming treatments.

Accordingly, Dr. Chen and colleagues utilized data from the Trans Youth Care United States Study to characterize trajectories of internalizing and externalizing symptoms over a 4-year period in TGD youth receiving hormone replacement therapy (Chen et al., 2024). Results indicated that most youth showed favorable symptom trajectories, characterized by persistently low or declining internalizing and externalizing symptoms, whereas a minority had less favorable trajectories marked by persistently high internalizing and externalizing symptoms, despite hormone treatment. Youth with more favorable

symptom trajectories had lower levels of loneliness, less gender minority stress, higher parental acceptance, and higher emotional support at baseline. These findings align with broader literature demonstrating the benefit of gender-affirming treatment for psychosocial functioning and underscores the importance of an affirming social environment in promoting favorable psychosocial outcomes for TGD youth (Singh & Lopez, 2025). In addition, they indicate that a subgroup of TGD youth has poorer psychosocial outcomes and may benefit from additional therapeutic support. In other words, findings should not be taken to mean that gender-affirming care is not beneficial for some TGD youth, but rather likely reflect the reality that TGD youth are whole people with psychosocial needs beyond those addressed by gender-affirming care alone. Finally, Dr. Chen highlighted that a subset of these youth began hormone treatment with better psychosocial functioning and maintained it throughout the course of the study, showing no change in internalizing or externalizing symptoms over time. Hence, she poses this question: should improvement in psychosocial outcomes be used as a metric for evaluating the success of gender-affirming treatments, particularly given that these treatments were not intended to target these outcomes?

In sum, Dr. Chen provided a thoughtful synthesis of current scientific evidence on gender-affirming medical care for TGD youth. Current research indicates that gender-affirming care significantly improves the mental health and well-being of many TGD youth. However, ongoing research is needed to address limitations of existing studies and further advance the evidence base. As Dr. Chen emphasized, clinical care for TGD youth should be firmly rooted in scientific evidence and compassion. With this approach, we can continue to support the health and well-being of these individuals, which is becoming increasingly more important as political and legislative efforts target their rights.

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CONVENTION REFLECTIONS | **“Evaluating a Family-Focused Intervention to Support Palestinian Parents and Adolescents”: Reflections on Laura Miller-Graff’s Invited Plenary**

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LAURA MILLER-GRAFF, PH.D., IS A PROFESSOR OF PSYCHOLOGY AND peace studies and director at the William J. Shaw Center for Children and Families, a faculty fellow at the Kellog Institute for International Studies, and the director of the Building Resilience After Violence Exposure (BRAVE) Research Lab at the University of Notre Dame. Her research focuses on the development and evaluation of psychological interventions for children and families who have been exposed to chronic violence and trauma. Her invited plenary talk, titled “Evaluating a Family-Focused Intervention to Support Palestinian Parents and Adolescents” focused on her team’s work to create a culturally and contextually informed intervention aimed at aiding Palestinian families living in Gaza and the West Bank as they navigate a life filled with frequent exposure to violence.

The presentation began with providing context for the intervention. Dr. Miller-Graff highlighted two key points: the macro-context of Palestinians during the occupation of the West Bank and Gaza, which has led to frequent exposure to violence and trauma, and the substantial variation in experiences related to the occupation and the Gaza War due to geospatial and time factors. According to a study published in 2013 (Haj-Yahia et al.), more than 90% of youth living in East Jerusalem or the West Bank have witnessed community violence, with 82.0% experiencing the violence directly. Since the Gaza War began, Palestinians in the West Bank have experienced high rates of displacement and acute increases in deaths and violence-related injuries (UN OCHA, 2025). Prior to the Gaza war, Palestinians living in Gaza already experienced frequent airstrikes, land incursions, and mass violence against protestors. Since October 7, 2023, incidences of violence have escalated dramatically. An estimated 67,173 people, almost a third of whom were children, have been killed (Palestinian Health Ministry, 2025, as reported by Reuters, 2025) and almost all children have been displaced, with many reporting lacking safety and basic needs (Hamad et al., 2024).

Dr. Miller-Graff then began to discuss the theoretical underpinnings of her team’s intervention, Promoting Positive Family Futures (PPFF). She highlighted the Social Ecological Theory as a framework for understanding how large-scale sociopolitical violence caused by the occupation and war can lead to violence at the community and family level (Boxer & Sloan-Power, 2013; Dubow et al., 2009) and that this exposure can lead to poorer health and well-being for Palestinian adolescents and families (Dubow et al., 2009; Miller-Graff & Cummings, 2017; Veronese et al., 2022). This also means that resilience can be evident at many different system levels (Ungar, 2012). Emotional Security Theory provides one avenue for developing resilience at the family level, and pilot research in Gaza has shown that better family system functioning is related to improved child adjustment outcomes (Maloney et al.,

2022). Thus, PPFF aims to address individual, family, and community factors.

Program development for this intervention was also guided by care gaps identified by community partners in the West Bank and Gaza. Specifically, there was a notable gap in care that focused on family systems. Community partners also reported a lack of treatments that universally addressed mental health rather than specific psychopathology. A pilot study for this type of program was conducted from 2017 to 2018, with a sample of 21 families across three treatment groups. Treatment was designed to consist of five group sessions with the whole family (both parents and the adolescent) and two in-home sessions (one with parents only, one with the whole family). Sessions focused on emotional security, social ecological models of resilience, conflict resolution, cognitive restructuring, and emotion regulation strategies. Findings suggested feasibility and potential for effectiveness, including reported decreases in maternal depression, higher parental security, increases in adolescent-rated family security and relational resilience, reduced behavior difficulties, and increased adolescent prosocial behaviors. However, no fathers engaged in any sessions, despite initial reported enthusiasm for the intervention. When asked, these fathers reported it was important for them to be strong for their families in the face of adversity, and they worried their role as protectors may be diminished if they expressed vulnerability in front of their wives and children. The local counselors also suggested that the intervention would benefit from an additional trust-building session to address initial hesitancy to engage in a psychotherapeutic intervention. Based on this feedback, the team developed an eight-session protocol that included an initial trust-building session and created an independent fathers' group that ran in parallel with the adolescent and mother group. The father then joined his family for the two at-home sessions. A subsequent randomized control trial (RCT) conducted in Gaza in 2019–2020 using the revised protocol led to almost 100% paternal engagement (Miller-Graff & Cummings, 2022). Mothers and fathers in PPFF reported increased emotion regulation posttreatment and fathers reported lower posttreatment depression compared to treatment as usual (TAU; 25-session, child-only, psychosocial program). Changes in parental emotion regulation also led to indirect effects on adolescent adjustment in the PPFF group (Miller-Graff & Cummings, 2022).

Dr. Miller-Graff and her collaborators are currently running an RCT with a planned enrollment of 300 Palestinian adolescents and their parents comparing PPFF to TAU, a 16-session, adolescent-only group therapy. Measures are collected at baseline, posttest, 6 months, and 1 year posttreatment and include both surveys and observational assessments. Data collection ran from September to October 2023 in Gaza and December 2023 to present in the West Bank. The study currently has 297 families enrolled with ongoing assessments at posttest, 6 months, and 1 year. Preliminary results suggest improvements in adolescent mental health across both interventions but statistically significant differences between groups in changes in parental mental health symptoms, with parental depression symptoms and paternal well-being improving significantly more in the PPFF group. On family problem-solving tasks, families in PPFF demonstrated both more constructive and destructive behaviors, but they were also more likely to solve the identified problem compared to TAU at 6 months. This may indicate increased approach rather than avoidant

behaviors, although Dr. Miller-Graff cautioned this is based on a small sample size and that they are waiting for additional data for 6-month follow-up assessments. PPFF parents were also less likely to use destructive behaviors and were more likely to solve the identified problem compared to TAU parents during a marital problem-solving task at posttreatment. PPFF also outperformed TAU on every feasibility, accessibility, perceived benefits, and perceived skill gain indicators.

Overall, results from these studies suggest PPFF confers better improvement in parental mental health symptoms and family functioning while providing equivalent to marginally better outcomes for adolescents in fewer sessions than TAU. Families also report a very clear preference for PPFF, and fidelity checks suggest that the intervention is easy to implement. Moving forward, Dr. Miller-Graff and her colleagues are looking for ways to create locally sustainable training and supervision models, disseminate the intervention manual, and apply the protocol to other conflict-affected settings. For example, one of Dr. Miller-Graff's co-investigators, Mark Cummings, is beginning work alongside colleagues to see how this intervention may be applied in Ukraine.

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CONVENTION REFLECTIONS | **"Responding to Mass Trauma: Adapting Evidence-Based Treatments to Scale in Israel After October 7": Reflections on Dr. Jonathan Huppert's Invited Plenary Address**

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In his invited plenary address at the 59th Annual ABCT Convention, Dr. Jonathan Huppert presented strategies and preliminary outcomes of disseminating evidence-based treatments following a mass trauma event in Israel on October 7th. Dr. Huppert is a Professor of Psychology and the Helen and Sam Beber Chair of Clinical Psychology at The Hebrew University of Jerusalem. Dr. Huppert has over 25 years of experience in studying and treating posttraumatic stress disorder (PTSD), anxiety, and other commonly comorbid disorders. Most recently, Dr. Huppert established The Center for Trauma Recovery at The Hebrew University and has continued to contribute to the dissemination of evidence-based interventions throughout Israel.

Dr. Huppert began his plenary address by conveying the need for evidence-based treatments in Israel, even prior to the mass trauma event on October 7. A brief historical overview of the state of the Israeli public mental health system was presented, and Dr. Huppert noted that individuals seeking mental health treatment often experience extended wait times and limited treatment options. Furthermore, the psychotherapy options in Israel have been predominantly psychodynamic, stemming from Freud's influence in establishing the mental health system in Israel. The primary difficulty, as explained by Dr. Huppert, has been the lack of standardized mental health practices in Israel, which he has aimed to address by prioritizing the incorporation of evidence-based assessments and treatments. This aim was further expanded following the mass trauma event on October 7, 2023.

Increasing Access to Psychological Treatments (IAPT) Pilot in Israel

Largely influenced by Dr. David Clark's Talking Therapies Program (formerly Increasing Access to Psychological Treatments; IAPT), Dr. Huppert launched an adapted pilot project in Israel. The primary components of this program include routine outcome monitoring (assessment of symptoms, functioning, and therapeutic alliance), incorporating evidence-based practice of cognitive behavior therapy (CBT), use of a stepped care model, and implementation of concurrent training and supervision. From the preliminary cohorts, Dr. Huppert emphasized the importance of routine feedback from the therapists and cultivating a culture of CBT evidence-based treatment acceptance and dissemination in each clinic. After receiving feedback from clinicians in early 2023 requesting further training for treating PTSD, Dr. Huppert had planned to disseminate Cognitive Processing Therapy (CPT) to clinicians. However, the planned phases of dissemination were disrupted following a mass trauma event on Israel on October 7, 2023.

Responding to Mass Trauma: Program Adaptations

Showcasing the large-scale need for available treatment options, estimations of trauma exposure in Israel were included in Dr. Huppert's address. Roughly 200,000 individuals were estimated to be directly exposed to trauma (military, first responders, and casualties), with an additional 200,000 individuals estimated to be indirectly exposed to trauma (family members and evacuees). Alongside those directly and indirectly exposed, Dr. Huppert explained that the country as a whole—approximately 9 million individuals—experienced a national trauma. As a result, new cases of PTSD, anxiety, and depression were expected to significantly rise, further taxing an already burdened system.

To accommodate the anticipated increase in individuals seeking mental health treatment following trauma exposure, Dr. Huppert and his team established The Center for Trauma Recovery at The Hebrew University. The program's primary aims are to increase the accessibility of evidence-based trauma focused mental health treatments, advance the standard of evidence-based care in professionals through training and supervision, and to leverage technology to reach individuals at a larger scale. Based on the American Psychological Association's Guidelines for the treatment of PTSD and in consultation with experts in the field, Dr. Huppert and his team selected four first-line psychotherapy interventions to train clinicians in: Prolonged Exposure Therapy, Cognitive Processing Therapy, Written Exposure Therapy, and Trauma-Focused CBT for children and adolescents. As of the invited address, over 5,000 clinicians had participated in trainings dedicated to the treatment of psychological trauma at the Center for Trauma Recovery in collaboration with the STRONG STAR Training Initiative and Cognetica.

Based on the American Psychological Association's Guidelines for the treatment of PTSD and in consultation with experts in the field, Dr. Huppert and his team selected four first-line psychotherapy interventions to train clinicians in: Prolonged Exposure Therapy, Cognitive Processing Therapy, Written Exposure Therapy, and Trauma-Focused CBT for children and adolescents.

In addition to increases in individuals seeking treatment for PTSD since October 7, there has also been a documented rise in the number of new cases for individuals experiencing trauma-related comorbidities, such as grief, general distress, anxiety, and depression. In an effort to address these conditions, The Center for Trauma Recovery incorporated four additional psychological interventions into their training in 2024, to include:

Unified Protocol, Interpersonal Psychotherapy, Prolonged Grief Therapy, and Multimodal Grief Therapy for children and adolescents. In total, the Center for Trauma Recovery now includes training in eight different interventions for mental health clinicians across Israel. Evidence-based mental health treatment training includes a 3- to 4-day workshop and 20 sessions of ongoing small group consultation supervision following the completion of the training workshop. An additional feature of this training program is the use of multi-tiered consultation supervision, where supervising consultants receive support from Dr. Huppert and other experts in the field. In the last 2 years, Dr. Huppert and his team have trained over 350 therapists in delivering evidence-based mental health treatments. Findings from this effort have demonstrated that clinicians who complete training endorse greater confidence in the use of evidence-based protocols for PTSD and trauma-related conditions and increased implementation of evidence-based mental health assessments and treatments with their community patients.

PTSD Treatment Outcomes in Israel

Dr. Huppert also addressed PTSD treatment outcomes in Israel, noting positive effect sizes have been observed in trauma-exposed individuals being treated with evidence-based interventions, such as Written Exposure Therapy and Cognitive Processing Therapy. As has been shown in the literature, similar overall reductions in PTSD symptoms as measured by the PCL-5 have been observed among individuals treated with Written Exposure Therapy and Cognitive Processing Therapy. Interestingly, results have found that Written Exposure Therapy has demonstrated a more rapid reduction in PTSD symptom severity, thus highlighting the utility of this brief evidence-based intervention. Moreover, Dr. Huppert stated that roughly half of the individuals treated with Written Exposure Therapy experience a clinically significant reduction in symptoms. One important note about the presented data was that the observed treatment effects may be distorted by ongoing psychological trauma exposures in Israel. This trend may explain the difference in observed treatment effects in the sample compared to the literature. That is, the large effect sizes commonly observed in published trauma-focused psychotherapy studies include samples where individuals seek treatment following trauma exposure, whereas the presented data included individuals with continued trauma exposure. This trend highlights the potential need for adapted evidence-based psychological treatments to accommodate individuals who are experiencing ongoing trauma exposure.

Dr. Huppert also shared that Written Exposure Therapy was reported to be easier to learn and administer as compared to CPT among new mental health therapists. Therefore, future directions for large scale, mass trauma exposure response should prioritize training of this treatment.

Reaching Individuals at Scale

An additional aim of Dr. Huppert and his team was to develop a digital application to provide support for trauma-exposed individuals who may not have access to traditional, synchronous modalities of care. Based on the

principles of Cognitive Processing Therapy, this self-help application includes 120 micro-learning modules featuring 2–5-minute videos. So far, 3 participants have utilized the digital application, and pilot data from these individuals have yielded promising results. The team has also recently received funding to support a larger clinical trial examining this digital application among individuals receiving care from Sheba Hospital. The trial will enroll 130 participants with PTSD over the next two years.

Further accomplishing the goal of reaching trauma-exposed individuals at scale, Dr. Huppert and his team have translated *Making Meaning of Difficult Experiences*, a self-help book written by Dr. Shelia Rauch and Dr. Rothbaum, into Hebrew and are currently working on an Arabic translation. Dr. Huppert and his team have also collaborated with the largest podcast in Israel and are releasing eight episodes on evidence-based treatments for trauma and PTSD. The podcast has reached over 20,000 individuals so far.

Finally, in collaboration with the Israeli Ministry of Health and the four Health Maintenance Organizations (HMOs) of Israel, Dr. Huppert and his team have been instrumental in increasing access to psychoeducation and evidence-based mental health treatments throughout Israel. Dr. Huppert and his team have promoted a comprehensive change within the mental health care system by targeting training and consultation supervision for individual mental health therapists and mental health clinics, as well as increasing reach for trauma exposed individuals through the use of digital health applications and the translation of self-help books. Reoccurring themes throughout Dr. Huppert's address included the importance of patient and clinician feedback in the treatment and dissemination process, the value of ongoing supervision and support for clinicians treating trauma-exposed patients, and the necessity of collaboration of subject matter experts from across the world. Altogether, Dr. Huppert's talk showcases a gold standard approach for the dissemination and implementation of evidence-based mental health treatments following recurring exposure to large scale, mass trauma events.

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Spotlight on a Research Method

The Resource Guide below is the first installment in a *Spotlight on a Research Method* series created by ABCT's Research Facilitation Committee. This series is not an endorsement, but meant to highlight various methodologies in our field.

The Spotlight on a Research Method *series is designed to provide a curated collection of resources on different research methods relevant to the ABCT community. Below you will find a brief overview of the topic, introductory / foundational resources, exemplar studies employing the method, toolkits and trainings, and funding mechanisms.*

Community-Based Participatory Research: A Resource Guide

What is CBPR and Why it Matters

Community-based participatory research (CBPR) is a collaborative research approach that equitably involves researchers, community members, and other stakeholders throughout the research process, recognizing the unique strengths and knowledge each brings (Collins et al., 2018). CBPR aims to combine knowledge and action to create positive and lasting social change by addressing health disparities and promoting health equity (Collins et al., 2018; Xia et al., 2016). CBPR has specific core principles that distinguish it from other research approaches, including equity in partnership, colearning among all partners, shared power in decision-making, reciprocity, and mutual benefit (Wallerstein et al., 2010).

CBPR is important for several key reasons. First, CBPR bridges the gap between science and practice by engaging communities as cocreators of knowledge rather than merely study participants (Rosa et al., 2025; Wallerstein et al., 2010). This approach ensures research is culturally appropriate, actionable, and directly relevant to community needs. Second, CBPR addresses power imbalances inherent in traditional research by promoting equitable distribution of power and resources between researchers and community members (Wallerstein et al., 2010). Communities that have historically been excluded from research, particularly racially and ethnically minoritized populations, become equal partners in defining research questions, study design, data collection, analysis, and dissemination (Collins et al., 2018). Third, CBPR produces more sustainable and effective interventions through trust-based partnerships that build community capacity, sustain collaborative efforts, and drive systemic transformations (Wallerstein et al., 2020). Lastly, CBPR enhances research rigor and innovation by incorporating community theories and local knowledge into the research process, leading to a deeper understanding of factors influencing health and illness (Wallerstein et al., 2010), which is particularly valuable when adapting interventions for underserved populations.

Table 1. A compendium of resources on community-based participatory research.

Section	Resources

Foundational Texts and Introductory Papers	• Wallerstein, N., Duran, B., Oetzel, J. G., & Minkler, M. (2017). Community-based participatory research for health equity (3rd edition). Wiley. ISBN: 978-1-119-25885-8
	    • *Note: 2nd edition (2008) can be found for free download via Google Scholar.*
	• Hacker, K. (2013). Community-based participatory research. SAGE Publications, Inc. ISBN: 978-1-452-20581-6
	• Collins et al. (2018). Community-based participatory research (CBPR): Towards equitable involvement of community in psychology research. *American Psychologist*, *73*(7), 884-898. https://doi.org/10.1037/amp0000167
	    • *Provides an introductory overview on this research approach and discusses its defining principles, implementation within psychology research, its advantages, and potential ethical challenges. A case study is also provided.*
	• Cargo, M., & Mercer, S. L. (2008). The value and challenges of participatory research: strengthening its practice. *Annual Review of Public Health*, *29*(1), 325-350. https://doi.org/10.1146/annurev.publhealth.29.091307.083824
	    • *Provides an integrative practice framework and structured process for developing, implementing, maintaining, and evaluating partnerships within participatory studies. A review of key challenges and added value of participatory research is also provided.*

Exemplar Studies and Deeper Dives	• Bogic et al. (2023). "Keep up the messages, sometimes it was a lifesaver": Effects of cultural adaptation on a suicide prevention clinical trial in American Indian/Alaska Native communities. *Behaviour Research and Therapy, 166*, 104333. https://doi.org//10.1016/j.brat.2023.104333
	    • *Describes how focus groups and interviews with American Indian / Alaska Native community members were used to improve acceptability and responsiveness of a culturally adapted suicide prevention intervention and its evaluation within a clinical trial.*
	• Asnaani et al. (2022). Utilizing community partnerships to devise a framework for cultural adaptations to evidence-based mental health practice in diverse communities. *Cognitive and Behavioral Practice*, *29*(4), 831-845. https://doi.org/10.1016/j.cbpra.2022.06.006
	    • *Outlines how community-engaged clinicians and researchers can create culturally-responsive, evidence-based treatment frameworks within community mental health settings in partnerships with communities of color. Describes a mixed-methods approach to developing such a community-engaged collaboration.*
	• Okamoto et al. (2020). The implementation of a culturally grounded, school-based, drug prevention curriculum in rural Hawaiʻi. *Journal of Community Psychology*, *48*(4), 1085-1099. https://doi.org/10.1002/jcop.22222
	    • *Describes how a community-based participatory research approach was used in developing a culturally grounded, school-based, drug prevention curriculum. Qualitative data from educational stakeholders were used to guide the approach to implementation and ensure feasibility.*
	• Cacari-Stone et al. (2014). The promise of community-based participatory research for health equity: A conceptual model for bridging evidence with policy. *American Journal of Public Health*, *104*(9), 1615-1623. https://doi.org/10.2105/AJPH.2014.301961
	    • *Includes 2 case study examples demonstrating connections among CBPR contexts and processes, policymaking processes and strategies, and outcomes.*
	• Lucero et al. (2018). Development of a mixed methods investigation of process and outcomes of community-based participatory research. *Journal of Mixed Methods Research*, *12*(1), 55-74 .https://doi.org/10.1177/1558689816633309
	    • *A mixed methods study on CBPR practices that facilitate effective community partnerships. Results illustrate how the integration of qualitative and quantitative approaches enhanced understanding of the way trust and governance function within CBPR partnerships.*

	• Chou, T., & Frazier, S. L. (2018). Supporting ethical practice in community-engaged research with 4R: Respond, Record, Reflect, and Revise. *Ethics & Behavior*, *30*(5), 311-325. https://doi.org/10.1080/10508422.2019.1645665 • *Provides a more in-depth framework for ethical practice to support CBPR with vulnerable and historically disenfranchised groups. The authors discuss the ethical principles of beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity.*

Toolkits and Trainings	• **Patient-Centered Outcomes Research Institute (PCORI) Engagement Resources**
	  • *Extensive resources for conducting patient-engaged research, including resources on successful engagement practices, building stakeholder research teams, engaging with research partners on data analysis, a literature database, and much more.*
	• **Community Engaged Research Resource List:**
	  • *Google Sheet that contains a number of different toolkits, courses, and other resources related to CBPR and community-engaged research more broadly.*
	• **Toolkit for Community Engaged Substance Use Research**
	  • Toolkit, webinars, and examples resources for engaging in community-based substance use research and community-informed research priorities.
	• **University of New Mexico, Centre for Participatory Research**
	  • Tools for strategic planning, survey instruments, facilitation guides, and an in-depth e-book on principles of community engagement.
	• **Free Online Trainings:**
	  • **Detroit Urban Research Centre:** Online Course on CBPR: A Partnership Approach for Public Health
	  • **University of Rochester Medical Centre:** Community-Based Participatory Research Training

Funding Mechanisms	**United States** • Patient-Centered Outcomes Research Institute (explicitly requires patient / community engagement) • National Institute on Minority Health and Health Disparities (often has CBPR-focused R01s, R21s, R34s) • National Center for Complementary and Integrative Health (supports participatory and community-engaged work with underserved groups) • Substance Abuse and Mental Health Services Administration (community-engaged mental health programs) • Health Resources and Services Administration (community-based health workforce and support) • Robert Wood Johnson Foundation (participatory health equity initiatives) • Agency for Healthcare Research and Quality (community-engaged health services research) **Canada / International** • Canadian Institutes of Health Research (many grants increasingly call for the inclusion of community members in research projects, either as knowledge users or within strategic partnerships) • Wellcome Trust (advocates for community engagement within research projects)

Note: A version of this guide will be made available on ABCT's Research Resources webpage.

REFERENCES

Collins, S. E., Clifasefi, S. L., Stanton, J., The Leap Advisory Board, Straits, K. J. E., Gil-Kashiwabara, …Wallerstein, N. (2018). Community-based participatory research (CBPR): Toward equitable involvement of community in psychology research. *American Psychologist, 73*(7), 884–898. https://doi.org/10.1037/amp0000167

Rosa, W. E., Santos, J., Agbeko, A. E., Barksdale, C. L., Carvajal, S., Dillard, D.,... Pérez-Stable, E. J. (2025). Community-based participatory research: A lifeline to achieve people-centered care. *Frontiers in Public Health, 13*, Article 1693459. https://doi.org/10.3389/fpubh.2025.1693459

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(Suppl 1), S40–S46. https://doi.org/10.2105/AJPH.2009.184036

Wallerstein, N., Oetzel, J. G., Sanchez-Youngman, S., Boursaw, B., Dickson, E., Kastelic, S., … Duran, B. (2020). Engage for Equity: A long-term study of community-based participatory research and community-engaged research practices and outcomes. *Health Education & Behavior, 47*(3), 380–390. https://doi.org/10.1177/1090198119897075

Xia, R., Stone, J. R., Hoffman, J. E., & Klappa, S. G. (2016). Promoting community health and eliminating health disparities through community-based participatory research. *Physical Therapy, 96*(3), 410–417. https://doi.org/10.2522/ptj.20140529

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

Information on Invited Address speakers as well as Congress Workshops is now available. 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. **Some workshops will be held on Sunday, June 28.**

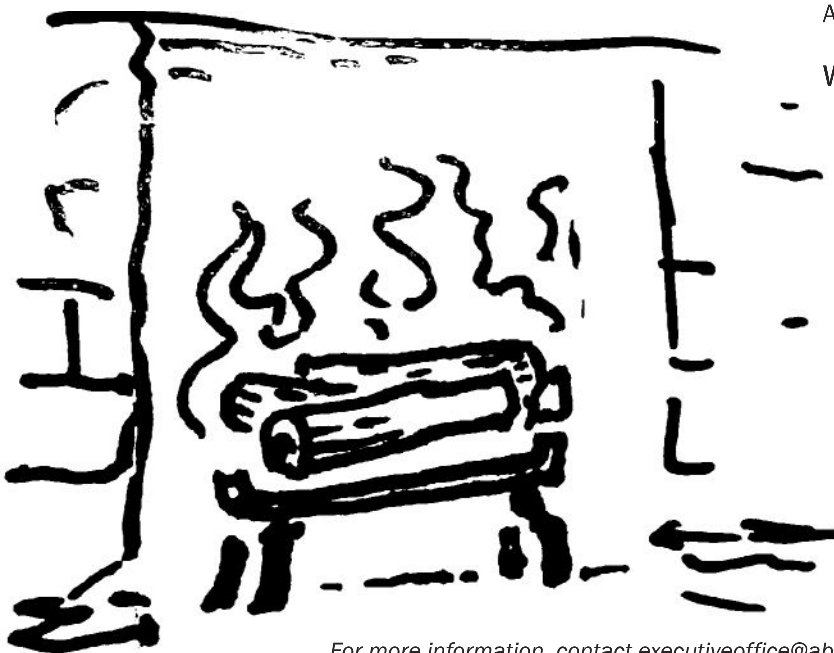
Scientific Program - June 25–28, 2026

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

ABCT Presidential Fireside Chats *with* Dr. Carolyn Becker



As part of ABCT's commitment to transparency and accountability, we will hold several member-engagement virtual meetings with the president throughout this year. These online meetings will be open to the entire membership and will see the president responding to questions from a moderator as well as the audience, on matters of organizational importance. The first meeting will focus largely on ABCT Bylaws updates and Board expansion.

What you need to know:

Members are encouraged to submit questions in advance, and we will try to respond to as many of these questions as possible. We will also take some questions live and in real time from members of the online audience. The event will be recorded so if you are unable to attend in real time, you'll have an opportunity to view the recording later. Capacity is limited so please register early once the meetings links are distributed.

The Fireside Chats are scheduled for :

Fireside Chat #1
Thurs., March 12, 2:00-3:30 pm ET
(Register Here)

Fireside Chat #2
Thurs., May 14, 2:00-3:30 pm ET.

For more information, contact executiveoffice@abct.org !

ABCT Elections

Voting opens soon!

Voting for this year's elections is just a few weeks away!

Familiarize yourself with the positions below, and be prepared to VOTE in April!

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:

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., ABPP, Chair

Deborah Dobson. Ph.D.
Jeff Goodie, Ph.D., ABPP
Meghan McDevitt-Murphy, Ph.D.
Art Nezu, Ph.D., ABPP
David Moscovitch, Ph.D.
Gail Steketee, Ph.D.

Call for Web Editor

ABCT is seeking its next Web Editor for a 3-year term (starting in January 2027).

The position is funded with an honorarium. The role principally involves developing content for the website, encouraging user engagement and interest, and reviewing the site and navigational structure to ensure it remains best suited to our audiences.

Technological knowledge is less essential, and the Web Editor is not expected to post to the site or otherwise take on the function of a web master.

Web Page Mission Statement

The website serves a central function as the public face of ABCT. As such, it has core functions linked to the mission and goals of the organization: facilitating the appropriate utilization and growth of CBT and serving as a resource and information source for matters related to CBT.

Information and resources are directed toward three groups:

- Members
- Nonmember Professionals
- Consumers

In striving to ensure this platform continues to be a trusted foundational resource for all of our constituents, the Web Editor may liaise with associate editors, journal editors, committees, and SIGs for content, which may include:

- Recent research findings
- CBT in the news
- Diagnosis-specific information
- Efficacy information
- Training
- The “feel” of cognitive-behavioral treatment
- Resources for professionals, students, help-seeking public, media
- CBT curricula

How to Apply:

A vision statement is due by June 12, 2026.

Please contact Stephanie Schwartz, Director of Publications (sschwartz@abct.org), for more information and for the vision statement guidelines.

We look forward to receiving your inquiries!

Call for Nominations

Champions of Evidence-Based Interventions

Deadline: April 15, 2026

This award recognizes outstanding individuals who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT. The primary goals of this award are:

1. *To "find, connect, and celebrate" (Knudsen et al., 2019) our partners and others invested in promoting evidence-based practice. Examples include community partners and colleagues, allies, advocates, and people with lived experience, among others.*
2. *Increase ABCT members' awareness of the champion role and ways to identify and engage with champions.*
3. *Broaden engagement of community partners in dissemination and implementation of evidence-based practices and foster relationships with ABCT and its members.*
4. *Build on the influence of champions to promote the mission of ABCT.*

Potential Candidates

Nominees should demonstrate the characteristics of champions, broadly construed, as recognized in the implementation science literature (see Knudsen et al., 2019, for examples relevant to ABCT: www.abct.org/docs/PastIssue/42n1.pdf). Champions are those individuals who support, facilitate, diffuse, or implement the core assets of evidence-based interventions. Champions' efforts expand the scope and impact of evidence-based interventions beyond the reach of researchers alone. They are "change agents," differentiating themselves from others by their visionary quality, enthusiasm, and willingness to risk their reputation for change. Ideal candidates should have demonstrated the following:

(a) communicating a vision and impact of evidence-based psychological interventions;

(b) going above and beyond in their efforts to relentlessly promote innovation;

(c) actively leading positive social change; and

(d) making a substantive impact.

Given the emphasis of the Champions award, research faculty, government employees who serve as program officers, funders, and others in similar roles whose work duties inherently include a focus on the promotion of evidence-based practice and conducting or funding of research on evidence-based practices are not typically a strong fit for this award. Individuals who have been previously recognized as Champions are also not eligible for the award again unless they are nominated for activities that differ substantially from those for which they were already recognized. Both members and nonmembers of ABCT are eligible.

Recognition and Engagement

The Champions Program is our chance to show gratitude for important on-the-ground work. Nominees will be reviewed in May by the Dissemination Implementation and Community Engagement Committee (DICEC), and the DICEC's selection of awardees will be forwarded to the ABCT Board of Directors for approval. Recipients' names and photographs will be posted on the ABCT website, along with their accomplishments as champions. Champions will also have their registration fees for the ABCT Annual Convention waived; at the convention, they will be honored at the program-wide Award Ceremony, and invited to participate in a "Champions Panel" where they will be further honored and have the opportunity to share their wisdom with other convention attendees. Additionally, Champions will be invited to engage in an advisory capacity with the DICEC.

How to Nominate

Email your nomination to champions@abct.org (link to nomination form is on the Champions web page) by **April 15, 2025**. Be sure to include "Champions Nomination" in the subject line.

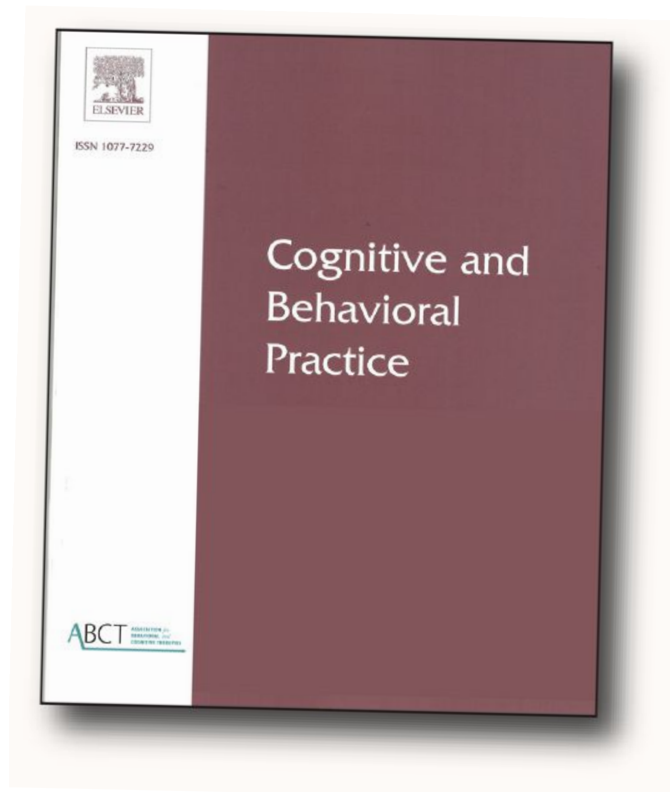
Volunteer

To Review for *Cognitive and Behavioral Practice*

We are looking to expand our reviewer pool for our journal.

Please click the link below to access the volunteer form!

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!**



Cognitive and Behavioral Practice

(click here)

Update Your Clinical Directory Profile!

Let potential clients and your ABCT colleagues reach you.
A complete and accurate Clinical Directory profile listing will help ensure robust connections among you, the help-seeking public, and colleagues seeking referrals.

The best—and only—way is to ***update your Clinical Directory listing*** now, in ***4 easy steps***:

1. Log in at services.abct.org/i4a/ams/profile
2. Click "Edit Your Profile"
3. Click "Contact Info" to update important details of your listing[SS1]
4. Navigate to the "Addresses" section and click the "Clinical Directory 1" tab, then input your address. Even if your address is the same as your mailing address, it still needs to be entered with the Clinical Directory 1 type.

Tips to maximize your listing:

- Add demographics/population served: Listing demographics of the population you work with helps define your practice and prevents having to redirect potential clients.
- Add specialties/languages: Pinpoint the distinctive features of what your practice offers.
- Practice Philosophy: Use clear, jargon-free language that resonates with clients.
- Add your photo (for expanded listings only—see below): Foster a sense of interest and connection.

For an annual fee of $50, you can ***enhance your Find a Therapist Directory listing***. With this expanded option, not only will your name come first in any searches that capture your listing, but it will include these features:

- Expanded Clinical Directory features:
- Your listing appears first in searches
- Your headshot appears with your listing
- Multiple practice locations can be included
- Potential clients can view the insurance(s) you accept
- Your listing includes a link to your website

Questions about updating your listing?
Contact membership@abct.org

Need a more in-depth explanation?
Follow our expanded step-by-step guide, linked here!

Webinars

elearning.abct.org

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

upcoming **Stay tuned for upcoming webinar announcements!**

recorded

Kate McHugh | Treating Co-Occurring Anxiety and Opioid Misuse

Anne Marie Albano | Anxiety, Adolescents, and Parents on the Pathway to Adulthood

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

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

+ more!

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

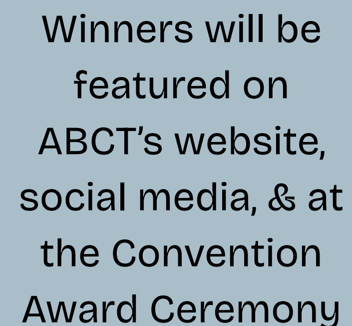
www.elearning.abct.org

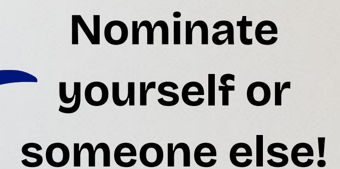
PRESENTED BY ABCT'S
RESEARCH FACILITATION COMMITEE

Every Spring we look for an ...

Outstanding Researcher Focused on Health Disparities and/or Marginalized Groups

- **Any career stage**
- **Current ABCT Member**
- **Doing Work Reflecting ABCT Values/Mission**





Submissions Due

https://forms.gle/FBfyfQHq7iQ88tnh8