ABCT Association for Behavioral and Cognitive Therapies

the Behavior Therapist

ISSN 0278-8403 Volume 49, Issue 3 | April 2026

Editor: Gregory S. Chasson, Ph.D.

Editorial Board
Copyright Transfer
Submission Guidelines

> ORIGINAL RESEARCH

Exploring the Differences in Suicide Attempts and Nonsuicidal Self-Injury Among Individuals with Overcontrol and Loss-of-Control Eating Disorder Symptoms | 1
Tara S. Ramsay-Patel, Margaret T. Davis, Rebecca C. Kamody, Emily R. Weiss

> CLINICAL PRACTICE FORUM

The Unique Perils Presented by Artificial Intelligence for Individuals with Obsessive Compulsive Disorder | 21
Mary E. McNamara, Hannah C. Broos, Sarah C. Jessup, Jacob A. Nota, Jennie M. Kuckertz, Nathaniel Van Kirk, Martha J. Falkenstein

> OP-ED

Revisiting the Critical Appraisal of ACT and Functional Contextualism | 31
Josef Mattes

> ABCT MATTERS

- Update on Volunteering for ABCT | 51
- Volunteer Me | 53
- ABCT Career Center and Resources for Researchers | 54
- 11th WCCBT Congress - Information and Sessions | 55
- 2026 Leadership Election: Voting Now Open | 59
- Call for Fellows Applications | 60
- Call for Web Editor | 61
- Call for ABCT Champions Nominations | 62
- Call for Journal Reviewers | 63
- Webinars | 65

> THIS MONTH'S ADVERTISERS

- Praxis / New Harbinger | 20, 29
- RO DBT | 20
- Hogrefe | 30
- New Harbinger | 49, 50

PLUS

> ABCT Presidential Fireside Chat Announcements | 58
> Spotlight on a Researcher | 67

the Behavior Therapist
Published by the Association for Behavioral and Cognitive Therapies | 305 Seventh Avenue, New York, NY 10001
www.abct.org

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

the Behavior Therapist

Volume 49, Issue 3

ORIGINAL RESEARCH | **Exploring the Differences in Suicide Attempts and Nonsuicidal Self-Injury among Individuals with Overcontrol and Loss-of-Control Eating Disorder Symptoms**

Tara S. Ramsay-Patel
University College London

Margaret T. Davis
Yale University School of Medicine; Yale University; National Center for PTSD, VA CT Healthcare System

Rebecca C. Kamody, Emily R. Weiss
Yale University School of Medicine

The authors declare no conflicts of interest. This work was supported by National Institutes of Health [grant number R01MH 13172; Davis] and National Institute on Drug Abuse [grant number 5 T32 DA 22975-15; Weiss].This article was prepared using a limited access dataset obtained from the National Institute of Alcohol Abuse and Alcoholism (NIAAA). This article has not been reviewed or endorsed by NIAAA and does not necessarily represent the opinions of NIAAA, who is not responsible for the contents.

Correspondence to:
Tara Ramsay-Patel, University College London, Department of Psychology and Language Sciences
26 Bedford Way, London, WC1H 0AP, United Kingdom; email: tara.ramsay-patel@ucl.ac.uk

Keywords:
suicide, eating disorders, loss-of-control, self-injury, secondary analysis

ABSTRACT > *Eating disorders often co-occur with other high-risk behaviors, including suicide attempts (SA) and nonsuicidal self-injury (NSSI). Despite the clinical significance and complexity of SA and NSSI, our understanding of these behaviors within eating disorder populations remains limited. The current study conducted secondary analysis of data from the National Epidemiologic Survey on Alcohol and Related Conditions-III, examining the prevalence of SA and NSSI in 1,021 individuals exhibiting eating disorder symptoms. It was hypothesized that the prevalence of SA and NSSI would be higher in individuals with loss-of-control (LOC) eating disorder symptoms than those with overcontrol (OC) symptoms. In line with this hypothesis, findings indicated a significantly higher prevalence of SA and NSSI in individuals with LOC eating disorder symptoms than those with OC symptoms. These findings illustrate the complexities of SA and NSSI among individuals with eating disorder symptoms, highlighting the need to study symptom profiles rather than solely focusing on diagnostic categories. They also underscore a need for tailored interventions that address these high-risk behaviors, as well as future research that seeks to investigate the underlying factors contributing to this elevated risk.*

EATING DISORDERS ARE MENTAL HEALTH CONDITIONS characterized by severe and persistent disturbances in eating behaviors, and are associated with distressing thoughts and emotions (American Psychiatric Association [APA], 2013). These conditions include anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). AN is characterized by the extreme restriction of food intake, an intense fear of gaining weight, and a distorted view of weight. AN includes the restrictive subtype (AN-R) and the binge-eating / purging subtype (AN-BP). AN-R is marked by restriction of food intake without regular binge eating (i.e., repeated episodes of eating large amounts of food within discrete time periods, accompanied by a perceived loss-of-control) or compensatory behaviors (e.g., vomiting, exercise, fasting) to prevent weight gain. AN-BP includes restriction alongside episodes of binge eating and / or compensatory behaviors. BN involves episodes of binge eating followed by compensatory behaviors to prevent weight gain. BED features repeated binge eating episodes without the use of compensatory behaviors (American Psychiatric Association, 2013; World Health Organization [WHO], 2019).

Eating disorders are associated with high mortality rates (Plana-Ripoll et

al., 2022; Smink et al., 2012), significant physical and psychological comorbidities (Hudson et al., 2007), and a high likelihood of relapse and recurrence (Keel et al., 2005; Miskovic-Wheatley et al., 2023). There is also a well-established trend indicating increases in eating disorder severity, including at earlier ages (Auger et al., 2023), and especially in the aftermath of the coronavirus pandemic (Asch et al., 2021; Linardon et al., 2022). These evolving patterns suggest the need for a more nuanced understanding of how these life-threatening presentations develop and persist.

To advance our understanding of eating disorders in this way, it is important to consider the complexity of these conditions. Research that treats eating disorders as homogeneous groups, amalgamating symptoms into singular diagnoses, can obscure individual differences (Levinson et al., 2022). Arguably, a behaviorally based approach that divides eating disorder symptoms into those indicative of overcontrol versus loss-of-control may more effectively capture nuance and have clinical relevance (Westen & Harnden-Fischer, 2001; Wildes et al., 2011). Restrictive symptoms, such as those seen in AN and its restrictive subtype (AN-R), reflect overcontrol, whereas bingeing and purging symptoms, characteristic of AN-BP, BN, and BED, are more indicative of loss-of-control (APA, 2013; Farstad et al., 2016; Lavender et al., 2013). Recognizing that the subtypes within a single diagnosis (e.g., AN-R versus AN-BP) may reflect distinct overcontrol versus loss-of-control profiles underscores the value of examining symptom dimensions across diagnostic boundaries, rather than assuming that risk maps neatly onto categorical diagnoses.

Studying eating disorders on a dimensional spectrum, rather than relying solely on categorical diagnoses (e.g., AN versus BN), could offer deeper and more personalized insights into how different symptom profiles relate to prognosis and risk. For instance, this approach could be particularly valuable for understanding the pronounced co-occurrence of high-risk concerns, including suicide attempts (SA) and nonsuicidal self-injury (NSSI), with eating disorders. SA refers to when an individual harms themselves with the intention to die, and survives, while NSSI involves deliberately harming one's own body without the intent to die (e.g., through cutting and burning of the skin; Klonsky et al., 2014). Alarmingly, the prevalence of lifetime SA in individuals with eating disorders ranges from 15.7–44.1% (Udo et al., 2019), compared to 2.7% in the general population (Nock et al., 2008). Likewise, the prevalence of lifetime NSSI among those with eating disorders ranges from 21.8–32.7% (Cucchi et al., 2016), in comparison to 5.9% in the general population (Klonsky, 2011). SA and NSSI are also associated with more severe eating disorder symptomology (Gómez-Expósito et al., 2016) and suicide is a leading cause of death among individuals with eating disorders (A. R. Smith et al., 2018).

In support of taking this dimensional approach, there is some evidence suggesting that individuals with loss-of-control symptoms are at heightened risk of both SA and NSSI (Cucchi et al., 2016; Kostro et al., 2014), which may be due to elevated emotion dysregulation and impulsivity (Claes et al., 2015; Forcano et al., 2009; Muehlenkamp et al., 2012; Ross et al., 2009). However, it is critical to note that SA and NSSI are also highly prevalent in those with overcontrol presentations, with suicide being the second leading

cause of death in those with AN (A. R. Smith et al., 2018). Yet, research explicitly investigating the differences in the risk of SA and NSSI between individuals with overcontrol versus loss-of-control symptoms remains limited. Evidence also suggests that age and biological sex may influence the risk of SA and NSSI. For example, women are significantly more likely than men to endorse SA and / or NSSI (Bommersbach et al., 2022; Fox et al., 2018), but men are more likely to die by suicide (Canetto & Sakinofsky, 1998; Curtin, 2016). Further, while both SA and NSSI seem to decline from adolescence and young adulthood into adulthood (Moran et al., 2012; Wilkinson et al., 2022), risk increases again in older age (Conejero et al., 2018; Steele et al., 2018). A thorough understanding of these demographic factors is therefore important for understanding high-risk behaviors in individuals with overcontrol and loss-of-control symptoms.

Although the prevalence of SA and NSSI in the context of eating disorders has been documented, understanding of their relationship to diverse symptom profiles remains limited. Moreover, while SA and NSSI are distinct and independent phenomena, they are of interconnected clinical concern. In addition to direct associations with eating disorder symptom severity, both SA and NSSI serve as robust indicators of severe psychological distress and functional impairment, are associated with a risk of physical injury, and impose significant healthcare costs (e.g., Canner et al., 2018; Klonsky et al., 2016; Nock & Prinstein, 2004, 2005; Shepard et al., 2016; Sinclair et al., 2011). Given the significant risks associated with SA and NSSI, additional work is needed to help clarify the relationship between specific eating disorder symptom dimensions and the prevalence of SA and NSSI.

The present study aims to address this gap in the literature, examining the prevalence of SA and NSSI in individuals with overcontrol and loss-of-control eating disorder symptoms in a nationally representative population-based epidemiological dataset. This approach provides a broader understanding of SA and NSSI within a nonclinical sample, which are typically underrepresented in eating disorder research (Carrino et al., 2023). It was hypothesized that the prevalence of SA and NSSI would be higher in individuals with loss-of-control than overcontrol eating disorder symptoms. Given evidence that demographic factors (e.g., age, biological sex) may also influence SA and NSSI risk (Bommersbach et al., 2022; Conejero et al., 2018 Fox et al., 2018; Moran et al., 2012; Steele et al., 2018; Wilkinson et al., 2022), we also explored whether these factors differed between eating disorder symptom profiles.

Methods

Participants

Participants were part of the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III) study. NESARC-III is comprised of 36,309 noninstitutionalized U.S. civilians aged 18 to 90 years (Grant et al., 2014). For detailed information on participant demographics in the full NESARC-III sample, see Grant et al., (2015). Endorsement of eating disorder symptoms was required for inclusion in the present analyses. 1,021 participants (n = 305 for overcontrol symptoms; n = 716 for loss-of-control symptoms) were included because they endorsed the dichotomous restricting, bingeing, or

purging symptom variables. Given the present study's use of a nationally representative sample, rather than a clinical subset, all individuals who endorsed these variables were included. This approach ensured a robust dataset for exploratory analyses and a comprehensive understanding of nonclinical patterns.

Demographic Characteristics

Table 1 shows the full list of participant characteristics of the current sample, split as a function of eating disorder symptom expression.

Table 1. *Participant Characteristics*

	Overcontrol (OC) Symptoms (*n* = 305)	Loss-of-control (LOC) Symptoms (*n* = 716)
Age in Years: mean (SD)	44.26 (16.25)	42.15 (15.31)
Age Range in Years:	18-89	18-90
Biological Sex: % female	80.00	62.30
BMI: mean (SD)	24.13 (4.78)	31.57 (8.50)
Education Years: mean (SD)	10.63 (2.40)	9.79 (2.30)
Income Level: %		
< $25,000	28.90	39.80
$25,000-39,999	18.00	16.50
$40,000-69,999	22.70	20.90
≥$70,000	30.60	22.80
Ethnicity: %		
White	69.20	54.30
Black	4.60	20.50
American Indian / Alaska Native	0.30	1.80
Asian / Native Hawaiian / Other Pacific Islander	8.50	3.80
Hispanic	17.40	19.60

Procedure

NESARC-III is nationally representative of the US population (Grant et al., 2014) and was preregistered (ClinicalTrials.gov Identifier: NCT01273220). Data were collected between April 2012 and June 2013. Participants completed computer-assisted face-to-face personal interviews. NESARC-III employed a multistage probability sampling approach: (1) primary sampling units were composed of counties or groups of contiguous counties; (2) secondary sampling units comprised groups of census-defined blocks; (3) tertiary sampling units were households within these secondary units. Eligible adults were randomly selected from each household. NESARC-III oversampled non-Hispanic Black, Hispanic, and Asian household members, in comparison to non-Hispanic White household members (i.e., households with more than four eligible minority members had two respondents selected), to prevent underrepresentation and provide more comprehensive insights (Vaughan, 2017). NESARC-III had an overall response rate of 60.1% (Grant et al., 2016). The data was adjusted for nonresponse and weighted to represent the US population, aligning with the Bureau of the Census 2012 American Community Survey (Grant et al., 2014). As a nationally representative sample of the US population, this enhances the generalizability of NESARC-III's findings.

Design

This study is a secondary analysis of precollected, cross-sectional data from a population-based survey, NESARC-III. Data for NESARC-III were collected to provide a robust, publicly available, and nationally representative sample for conducting secondary analyses. This allows for the examination of various relationships in the general population, offering insights beyond those typically available in clinical samples. NESARC-III has been used for similar research into eating disorders, SA, and NSSI (Udo et al., 2019; Udo & Grilo, 2018, 2019; Vaughn et al., 2015).

Measures

Eating Disorder Symptoms

Eating disorder symptoms were measured using variables from The NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule-5 (AUDADIS-5; Grant et al., 2011). Three variables evaluated restricting symptoms, one examined bingeing symptoms, and six assessed purging symptoms. For example, participants were asked, *"When your weight was [participant's self-reported lowest weight]), did you restrict the amount of food you ate in order not to gain any weight even though other people thought you should?"* to assess restricting symptoms. Bingeing symptoms were assessed by the question, *"Have you ever eaten an unusually large amount of food within any 2-hour period, not including the holidays?"* To measure purging symptoms, participants were asked questions including: *"During any of those times when you were eating an unusually large amount of food, did you try to keep from gaining weight by vomiting, using enemas, laxatives, diuretics or other medicines, or by fasting, that is having no solid food, or exercising a lot?"* AUDADIS-5 is a structured diagnostic interview that assesses DSM-5 defined psychiatric disorders and their criteria, including eating disorders. The validity and reliability of AUDADIS-5 have been investigated through comparison with the Psychiatric Research Interview for Substance and Mental Disorders, DSM-5 version (Hasin et al., 1996). This revealed fair-to-moderate concordance (k = 0.24–0.72) for diagnostic criteria, and fair-to-excellent (ICC = 0.43–0.72) concordance for dimensional measures of substance use disorder (SUD), mood disorders, anxiety disorders, and post-traumatic stress disorder (PTSD) (Hasin et al., 2015; Hasin & Grant, 2015). Test–retest reliability of AUDADIS-5 in diagnosing specific disorders ranged from fair-to-excellent (k = 0.35–0.87) for SUD, mood disorders, anxiety disorders, PTSD, and personality disorders, and good-to-excellent reliability for dimensional measures (ICC = 0.50–0.85 ; Grant et al., 2015). Despite this demonstrated concordance and reliability for various psychiatric disorders, previous studies have not addressed the validity and reliability of AUDADIS-5 for eating disorders.

Lifetime SA

Lifetime SA was measured using a single question from the "Medical Conditions and Practices" assessment: "*In your entire life, did you ever attempt suicide?*" The use of a single item aligns with the offerings of NESARC-III and is consistent with past studies of SA using NESARC-III (e.g., Forrest et al., 2021; Udo et al., 2019).

Lifetime NSSI Engagement

Lifetime NSSI engagement was measured with a single item from the "Usual Feelings and Actions" assessment: "When you've been under a lot of stress, have you cut, burned, or scratched yourself on purpose?" The use of a single item aligns with the offerings of NESARC-III and is consistent with prior studies of NSSI using NESARC-III (e.g., Vaughn et al., 2015).

Creation of Overcontrol and Loss-of-Control Symptom Groups

Participants were stratified into two subgroups based on symptoms: overcontrol symptoms, and loss-of-control symptoms. For overcontrol symptoms, respondents were required to endorse any of the restricting symptoms only. For loss-of-control symptoms, respondents were required to report any of the bingeing and / or purging symptoms only. The criteria used to form the overcontrol and loss-of-control symptom groups are consistent with theoretical conceptualizations of eating disorder symptoms and previous research (Westen & Harnden-Fischer, 2001; Wildes et al., 2011).

Data Analysis

All statistical analyses were conducted using IBM SPSS Statistics (Version 29). All analyses used a two-tailed test with an alpha (α) level of $p < 0.05$.

Power Calculations

A priori power calculations were performed using G*Power (Faul et al., 2007) to determine the minimum sample size required for these analyses. For the preliminary analyses, the goal was to calculate the sample size required to achieve 95% power for detecting a medium effect (0.5; Cohen, 2013), at a significance level of α = .05. The results indicated that sample sizes of n = 145 for chi-square tests and n = 105 per group for independent samples t-tests. Consequently, n = 305 for individuals with overcontrol symptoms, and n = 716 for individuals with loss-of-control symptoms met these requirements.

Statistical Analyses

NESARC-III data is provided in a precleaned format. Where possible, NESARC-III used hot deck imputation to impute missing values (Grant et al., 2017). Analyses were performed to explore differences between individuals displaying overcontrol and loss-of-control symptoms using chi-square tests for SA, NSSI, and biological sex, and independent samples t-tests for age. To examine whether observed group differences in SA and NSSI remained after accounting for demographic factors, follow-up logistic regressions were conducted controlling for age and sex. An exploratory analysis of individuals endorsing both symptom types is presented in the supplementary materials.

Ethical Considerations

The Institutional Review Board of the National Institutes of Health and Westat Inc. provided ethical approval for the original data collection. Participants provided verbal informed consent, which was recorded electronically (Grant et al., 2016). This study was deemed exempt from a full IRB review under 45CFR46.104 by the Institutional Review Board of Yale University.

Results

Differences in Biological Sex and Age

Chi-square tests were conducted to assess group differences in biological sex (see Table 1). Of those with overcontrol symptoms, 80.00% identified as female, whereas for individuals with loss-of-control symptoms 62.30% identified as female. A significantly higher percentage of males endorsed loss-of-control symptoms versus overcontrol symptoms ($\chi^2 = 30.62$, $p < .001$). Independent sample *t*-tests were conducted to assess group differences in age (see Table 1). Individuals with overcontrol symptoms had a mean age of 44.26 years (SD = 16.25), while individuals endorsing loss-of-control symptoms were slightly younger on average, with a mean age of 42.15 years (SD = 15.31; $t(1019) = -1.98$, $p = .048$).

Differences in SA and NSSI

Chi-square tests were conducted to assess group differences in SA and NSSI. Individuals with loss-of-control symptoms exhibited a significantly higher prevalence of SA compared to those with overcontrol symptoms (Figure 1). 7.57% of individuals with overcontrol symptoms reported SA, compared to 15.08% of individuals with loss-of-control symptoms ($\chi^2(1) = 10.78$, $p = .001$). Similarly, individuals with loss-of-control symptoms exhibited a significantly higher prevalence of NSSI than those with overcontrol symptoms. 4.91% of individuals with overcontrol symptoms reported NSSI, compared to 9.78% of individuals with loss-of-control symptoms ($\chi^2(1) = 6.62$, $p = .010$). Follow-up logistic regressions demonstrated that differences remained significant after controlling for age (Z's = 5.43-9.70, *p*'s = .020–.002) and sex (Z's = 7.59–12.61 *p* 's = .006–< .001).

Additionally, exploratory analyses were conducted including individuals who reported both overcontrol and loss-of-control symptoms. Chi square tests examining NSSI and SA remained significant (*p* values .036–< .001). Individuals with combined symptom profiles had similar rates of NSSI (8.91%) to those with loss-of-control symptoms, but higher rates of SA (22.37%) than both groups. These results are displayed in Figure 2.

Discussion

Overall, the results of this study suggest that the prevalence of SA and NSSI is significantly higher among individuals with loss-of-control eating disorder symptoms than overcontrol symptoms. This finding aligns with previous work demonstrating a heightened risk of SA and NSSI in individuals exhibiting loss-of-control symptoms compared to those with overcontrol symptom profiles (Cucchi et al., 2016; Kostro et al., 2014). Several potential explanations could account for this increased risk. First, preexisting characteristics (e.g., personality traits) may predispose individuals with loss-of-control symptoms to SA and NSSI. Alternatively, the presence of loss-of-control symptoms may directly increase the likelihood of SA and NSSI. Finally, other factors may elevate the risk of both loss-of-control symptoms and SA and NSSI, and there may be a bidirectional causal influence between loss-of-control symptoms and SA and NSSI, with both presentations mutually increasing the likelihood of each other.

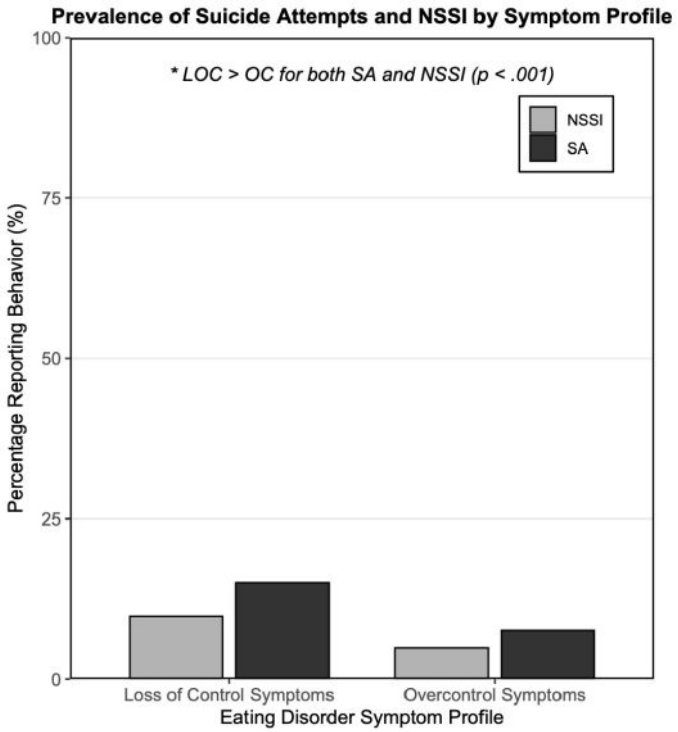


Figure 1. *Group Differences in Prevalence of SA and NSSI Among Individuals with Loss-of-Control Eating Disorder vs. Overcontrol Symptoms*

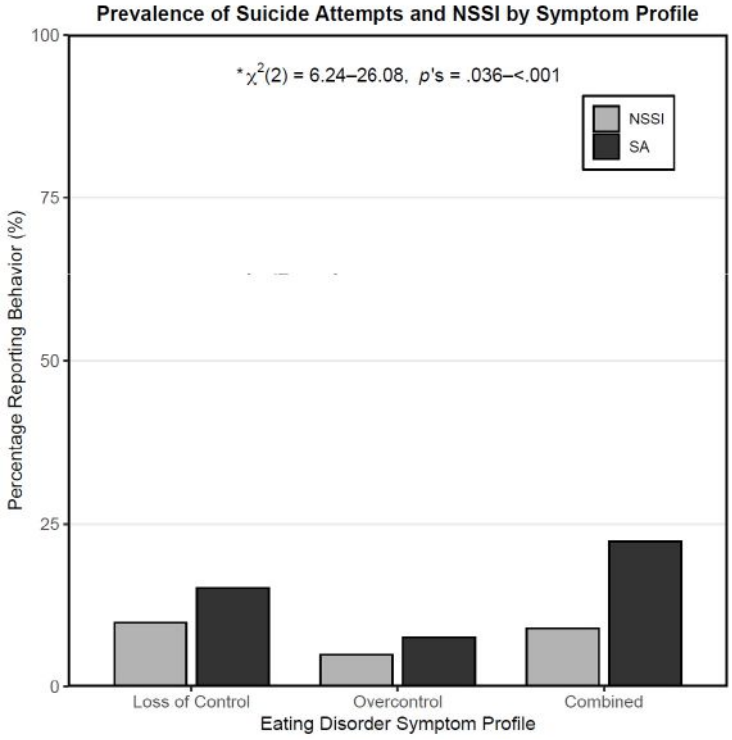


Figure 2. *Analysis of Exploratory Analyses Conducted Including Individuals Who Reported Both Overcontrol and Loss-of-Control Symptoms*

In terms of specific individual differences that may be implicated in these processes, those with loss-of-control symptoms may exhibit an elevated risk of SA and NSSI due to factors such as emotion dysregulation and impulsivity. Past research has highlighted that individuals with loss-of-control symptoms show elevated levels of emotion dysregulation and impulsivity when compared to those with overcontrol symptoms (Claes et al.,

2015; Forcano et al., 2009; Lavender & Mitchell, 2015; Muehlenkamp et al., 2012; Ross et al., 2009). Emotion dysregulation, in particular, is a central feature of etiological models and theories of SA and NSSI (e.g., Chapman et al., 2006; Joiner, 2005; Klonsky & May, 2015; Nock et al., 2008; Nock & Prinstein, 2004; Van Orden et al., 2010) including among individuals with eating disorders specifically (Pisetsky et al., 2017; Svirko & Hawton, 2007). Evidence consistently highlights that NSSI is both a consequence of emotion regulation difficulties and functions as a maladaptive strategy for (temporarily) alleviating negative affect (McKenzie & Gross, 2014; Nock, 2010; Wolff et al., 2019). Relatedly, individuals who report SAs typically experience elevated levels of emotion dysregulation (Anestis et al., 2014; Baer et al., 2022; Pisani et al., 2013; Rajappa et al., 2012). A substantial body of research also indicates that individuals with eating disorders and a history of SA and NSSI exhibit higher levels of emotion dysregulation compared to those with eating disorders but no history of these behaviors (Gómez-Expósito et al., 2016; Rania et al., 2021; Smith et al., 2018; Vieira et al., 2021)

Individuals with loss-of-control symptoms have also demonstrated higher levels of impulsivity than those with overcontrol symptoms (Claes et al., 2015; Westen & Harnden-Fischer, 2001; Wonderlich et al., 2005). Impulsivity, and especially negative urgency (the tendency to act rashly while experiencing negative emotions), appears to play a critical role in the risk for SA and NSSI (Liu et al., 2017; Lockwood et al., 2017, 2020), including among those with eating disorders (Claes et al., 2015; Vieira et al., 2021).

However, it is crucial to acknowledge that levels of SA and NSSI were still high amongst individuals with overcontrol symptoms, underscoring that SA and NSSI span the eating disorder spectrum (A. R. Smith et al., 2018). This may also be attributable to similar risk factors as those experienced by individuals with loss-of-control symptoms (e.g., emotion dysregulation and impulsivity). It could also reflect risk factors specific to overcontrol symptom presentation. For example, restrictive eating may be a painful behavior associated with an acquired capability for NSSI and SA. Acquired capability refers to the habituation to physiological pain and a diminished fear of death that arises from exposure to painful experiences, such as restrictive eating. This process can enhance an individual's propensity to engage in NSSI and SA, and is considered a requirement for a lethal SA (Holm-Denoma et al., 2008; Joiner, 2005; Selby et al., 2010; Van Orden et al., 2010)

Further studies are needed to identify the mediators of the relationship between eating symptoms and SA and NSSI, particularly, the ways in which specific factors may differentially contribute to risk among presentations characterized by overcontrol versus loss-of-control symptoms. Identifying and understanding these mechanisms would provide critical insights into potential targets for intervention, ultimately contributing to the development of more effective, tailored treatments aimed at reducing SA and NSSI in this high-risk population.

A significantly higher percentage of males endorsed loss-of-control symptoms relative to overcontrol symptoms. Given that females are more likely than males to report SA and NSSI (Bommersbach et al., 2022; Fox et al., 2018), this sex difference could partially contribute to the observed dif-

ferences in SA and NSSI between groups. However, follow-up logistic regression analyses indicated that group differences in SA and NSSI remained significant after controlling for sex. Individuals with overcontrol symptoms also had a slightly higher mean age (*M* = 44.26 years, *SD* = 16.25) compared to those endorsing loss-of-control symptoms (*M* = 42.15 years, *SD* = 15.31). This difference is modest, and the large standard deviations suggest a wide age range within each group and therefore considerable overlap between the two groups. Further, both mean ages fall within middle adulthood. If on average, one group was situated within a higher-risk developmental period for SA and NSSI, such as adolescence, young adulthood, or much later in life, age might be a plausible explanation for group differences (Conejero et al., 2018; Moran et al., 2012; Steele et al., 2018; Wilkinson et al., 2022). However, given that both groups were within the 4th decade of life on average, we believe it is unlikely that this age difference accounts for differences in SA and NSSI. Relatedly, observed differences in NSSI and SA remained significant when controlling for age in exploratory follow-up analyses.

The current study exhibits several notable strengths. Firstly, by using data from NESARC-III, this study captures a nationally representative, community-based sample rather than a clinical sample. Much of the existing research on eating disorders has relied on clinical samples (Carrino et al., 2023), despite the fact that the majority of those exhibiting eating disorder symptoms do not access treatment (Hart et al., 2011) and clinical samples often differ from nonclinical samples. For instance, clinical samples display greater symptom severity, a higher prevalence of comorbidities, and underrepresentation of racial / ethnicity minorities (Carrino et al., 2023). By using a nonclinical sample, the present study captures a broader spectrum of eating disorder symptomatology, ranging from individuals who may not meet full diagnostic criteria (i.e., subthreshold cases) to those who would. This enhances the generalizability of the findings to the wider population, beyond those just engaged in treatment or identified through clinical pathways.

The present study also included both male and female participants. Males are consistently underrepresented in eating disorder research, with less than 1% of studies specifically focusing on males. As a result, most findings may not accurately apply to males (Murray et al., 2017). Despite this, a significant proportion of males report experiencing eating disorder symptoms (Calzo et al., 2016; Mangweth-Matzek et al., 2016), rates of eating disorders are increasing more rapidly in males than females, and there is no discernible difference in symptom severity between males and females (Bentley et al., 2015; Mitchison et al., 2013; Mitchison & Mond, 2015). Males are also generally found to be at a higher risk of dying by suicide (Canetto & Sakinofsky, 1998; Curtin, 2016). Including males in the present study therefore enhances the field's understanding of SA and NSSI within an important, underrepresented group and strengthens the generalizability of these findings. Finally, NESARC-III is the largest epidemiological survey to assess psychiatric disorders using a nationally representative sample of US adults (Grant et al., 2014). Using a large sample facilitated the study of SA, which is typically challenging to investigate due to its low

base-rate (Mann et al., 2021), and ensured the current study possessed sufficient statistical power to detect any effects, had they been present.

Several limitations also warrant consideration. A methodological limitation arises from the use of AUDADIS-5 to assess eating disorder symptoms within NESARC-III. While AUDADIS-5's validity and reliability have been established for other psychiatric conditions (Grant et al., 2015; Hasin et al., 2015; Hasin & Grant, 2015), they have not been assessed for eating disorders specifically. This limits our understanding of the symptom profiles assessed in the current study (e.g., in terms of clinical severity; generalizability to clinical populations). It is essential that future research seeks to replicate these findings utilizing measures designed to assess eating disorders. The cross-sectional nature of NESARC-III also limits the ability to draw definitive conclusions about temporal relationships (Rindfleisch et al., 2008). SA and NSSI may have occurred at any point in time, making it difficult to establish whether these behaviors preceded or followed the onset of eating disorder symptoms. This precludes our understanding of whether preexisting characteristics predispose individuals with eating disorder symptoms to SA and NSSI, eating disorder symptoms directly increase the risk of SA and NSSI, other shared factors concurrently elevate the risk of both loss-of-control symptoms and SA and NSSI, or if a bidirectional influence leads to eating disorder symptoms and SA and NSSI. Longitudinal studies are needed to clarify the direction and causality of these relationships.

Clinicians should be especially vigilant in monitoring for signs of SA and NSSI in individuals with LOC symptoms, as this group appears to be at elevated risk. Tailored treatment approaches that address specific symptom profiles and underlying evidence-based risk factors could improve outcomes . . .

The findings of this study highlight important clinical implications for the prevention, detection, and treatment of SA and NSSI in individuals with eating disorder symptoms, particularly among those exhibiting loss-of-control symptoms. Clinicians should be especially vigilant in monitoring for signs of SA and NSSI in individuals with LOC symptoms, as this group appears to be at elevated risk. Tailored treatment approaches that address specific symptom profiles and underlying evidence-based risk factors could improve outcomes (e.g., addressing factors such as emotion regulation and impulsivity). One viable option is Dialectical Behavior Therapy (DBT), a form of psychotherapy designed to equip individuals with the skills to more effectively regulate emotions and tolerate distress (Linehan, 1993; Linehan & Wilks, 2015). DBT has shown promise in addressing eating disorder symptoms, SA, NSSI, emotion dysregulation, and impulsivity (Bankoff et al., 2012; Cavicchioli et al., 2023; Kothgassner et al., 2021; McCauley et al.,

2018; Neacsiu et al., 2014; Neacsiu et al., 2014). More broadly, these findings underscore the value of examining eating disorder symptoms dimensionally rather than strictly categorically. By identifying differences in SA and NSSI prevalence across overcontrol and loss-of-control symptom profiles, which cut across diagnostic boundaries, the results suggest that risk may be closely tied to behavioral patterns, rather than to diagnostic labels alone. For example, individuals with AN-BP may share more in common with those diagnosed with BN or BED in terms of SA and NSSI risk (Foulon et al., 2007; Sesboüé et al., 2025). This supports calls within the field to adopt approaches that better capture clinical heterogeneity and inform targeted interventions.

Future research should focus on using longitudinal data to gain a deeper understanding of the causal relationships between overcontrol and loss-of-control symptoms, and the risk of SA and NSSI. Furthermore, it is essential to investigate the underlying mechanisms that drive the high rates of SA and NSSI in individuals with loss-of-control and overcontrol symptoms, including specifically exploring why loss-of-control symptoms may be linked to higher risks of these behaviors. Although the primary aim of this study was to examine relative differences in SA and NSSI prevalence between overcontrol and loss-of-control symptom profiles*,* rather than to estimate current population-level incidence, future research should replicate these findings using more recent data to account for shifts in eating disorder, SA, and NSSI prevalence and presentation over time (Asch et al., 2021; Bommersbach et al., 2024; Linardon et al., 2022). It is also important to acknowledge that many individuals present with both overcontrol and loss-of-control symptoms, either simultaneously or as a progression over time (Milos et al., 2005; Serra et al., 2022; Tozzi et al., 2005).

Participants who endorsed both overcontrol and loss-of-control symptoms were excluded from our primary analyses. This decision was based on the structure of the NESARC-III dataset, which assesses lifetime symptom endorsement without temporal specificity, making it unclear whether these behaviors occurred concurrently or sequentially. To preserve interpretability and allow clearer comparisons between distinct symptom profiles, main analyses focused on participants who endorsed only overcontrol or only loss-of-control symptoms. However, exploratory, follow-up analyses including individuals with combined symptom profiles indicated that those who displayed a combination of overcontrol and loss-of-control symptoms over their lifetime may have higher rates of SA relative to the other two groups. Yet, as noted above, the lack of temporal specificity in the data prohibits firm conclusions about the combined impact of these symptom profiles on SA risk. These findings, along with the overcontrol or only loss-of-control symptom coexistence, highlight the need for research that considers their interaction and cumulative impact on SA and NSSI risk.

Relatedly, while the present study aimed to provide a broad, descriptive understanding of these behaviors across dimensional symptom patterns, rather than to model specific predictors or mechanisms, future studies should account for the high rates of comorbidity between eating disorders and other disorders (e.g., Brewerton et al., 2024, found that 76.4% of their eating disorder sample had a comorbid mood disorder).

These conditions may interact with eating disorder symptoms to influence risk for SA and NSSI.

In conclusion, this study underscores the elevated prevalence of SA and NSSI among individuals with eating disorder symptoms, with significantly higher levels of SA and NSSI among those with loss-of-control symptoms compared to those with overcontrol symptoms. These results align with existing literature, emphasizing the importance of recognizing the heterogeneous nature of eating disorders and the value of taking a transdiagnostic approach by studying specific symptom profiles. Future research is needed to further elucidate the mechanisms driving the elevated risk of SA and NSSI observed in individuals with loss-of-control symptoms. Clinically, these insights point towards the need for tailored interventions that address the specific needs of this high-risk group. Ultimately, understanding the complex dynamics between eating disorder symptoms, SA, and NSSI is crucial for improving treatment outcomes and represents a promising opportunity for advancing eating disorder research.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Anestis, M. D., Kleiman, E. M., Lavender, J. M., Tull, M. T., & Gratz, K. L. (2014). The pursuit of death versus escape from negative affect: An examination of the nature of the relationship between emotion dysregulation and both suicidal behavior and non-suicidal self-injury. *Comprehensive Psychiatry*, *55*(8), 1820–1830. https://doi.org/10.1016/j.comppsych.2014.07.007

Asch, D. A., Buresh, J., Allison, K. C., Islam, N., Sheils, N. E., Doshi, J. A., & Werner, R. M. (2021). Trends in US Patients Receiving Care for Eating Disorders and Other Common Behavioral Health Conditions Before and During the COVID-19 Pandemic. *JAMA Network Open*, *4*(11), e2134913. https://doi.org/10.1001/jamanetworkopen.2021.34913

Auger, N., Steiger, H., Luu, T. M., Chadi, N., Low, N., Bilodeau-Bertrand, M., Healy-Profitós, J., Ayoub, A., Brousseau, É., & Israël, M. (2023). Shifting age of child eating disorder hospitalizations during the Covid-19 pandemic. *Journal of Child Psychology and Psychiatry*, *64*(8), 1176–1184. https://doi.org/10.1111/jcpp.13800

Baer, M. M., Spitzen, T. L., Richmond, J. R., Tull, M. T., & Gratz, K. L. (2022). Associations of interpersonal and intrapersonal emotion regulation strategies to suicidal ideation and suicide attempts. *Journal of Contextual Behavioral Science*, *24*, 1–9. https://doi.org/10.1016/j.jcbs.2022.02.003

Bankoff, S. M., Karpel, M. G., Forbes, H. E., & Pantalone, D. W. (2012). A Systematic Review of Dialectical Behavior Therapy for the Treatment of Eating Disorders. *Eating Disorders*, *20*(3), 196–215. https://doi.org/10.1080/10640266.2012.668478

Bentley, C., Gratwick-Sarll, K., Harrison, C., & Mond, J. (2015). Sex differences in psychosocial impairment associated with eating disorder features in adolescents: A school-based study. *International Journal of Eating Disorders*, *48*(6), 633–640. https://doi.org/10.1002/eat.22396

Bommersbach, T. J., Olfson, M., & Rhee, T. G. (2024). National trends in emergency department visits for suicide attempts and intentional self-harm. *American Journal of Psychiatry*, *181*(8), 741-752.

Bommersbach, T. J., Rosenheck, R. A., Petrakis, I. L., & Rhee, T. G. (2022). Why are women more likely to attempt suicide than men? Analysis of lifetime suicide attempts among US adults in a nationally representative sample. *Journal of Affective Disorders*, *311*, 157–164. https://doi.org/10.1016/j.jad.2022.05.096

Brewerton, T. D., Gavidia, I., Suro, G., & Perlman, M. M. (2024). Associations between major depressive and bipolar disorders and eating disorder, PTSD, and comorbid symptom severity in eating disorder patients. *European Eating Dis-*

orders Review, *32*(2), 188-200.

Calzo, J. P., Horton, N. J., Sonneville, K. R., Swanson, S. A., Crosby, R. D., Micali, N., Eddy, K. T., & Field, A. E. (2016). Male Eating Disorder Symptom Patterns and Health Correlates From 13 to 26 Years of Age. *Journal of the American Academy of Child & Adolescent Psychiatry*, *55*(8), 693-700.e2. https://doi.org/10.1016/j.jaac.2016.05.011

Canetto, S. S., & Sakinofsky, I. (1998). The Gender Paradox in Suicide. *Suicide and Life-Threatening Behavior*, *28*(1), 1–23. https://doi.org/10.1111/j.1943-278X.1998.tb00622.x

Canner, J. K., Giuliano, K., Selvarajah, S., Hammond, E. R., & Schneider, E. B. (2018). Emergency department visits for attempted suicide and self harm in the USA: 2006–2013. *Epidemiology and Psychiatric Sciences*, *27*(1), 94–102. https://doi.org/10.1017/S2045796016000871

Carrino, E. A., Flatt, R. E., Pawar, P. S., Sanzari, C. M., Tregarthen, J. P., Argue, S., Thornton, L. M., Bulik, C. M., & Watson, H. J. (2023). Sociodemographic and clinical characteristics of treated and untreated adults with bulimia nervosa or binge-eating disorder recruited for a large-scale research study. *Journal of Eating Disorders*, *11*(1), 126. https://doi.org/10.1186/s40337-023-00846-4

Cavicchioli, M., Movalli, M., Bruni, A., Terragni, R., Maria Elena, G., Borgia, E., Begarani, M., & Ogliari, A. (2023). The Initial Efficacy of Stand-Alone DBT Skills Training for Treating Impulsivity Among Individuals With Alcohol and Other Substance Use Disorders. *Behavior Therapy*, *54*(5), 809–822. https://doi.org/10.1016/j.beth.2023.02.006

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy*, *44*(3), 371–394. https://doi.org/10.1016/j.brat.2005.03.005

Claes, L., Islam, M. A., Fagundo, A. B., Jimenez-Murcia, S., Granero, R., Agüera, Z., Rossi, E., Menchón, J. M., & Fernández-Aranda, F. (2015). The Relationship between Non-Suicidal Self-Injury and the UPPS-P Impulsivity Facets in Eating Disorders and Healthy Controls. *PLOS ONE*, *10*(5), e0126083. https://doi.org/10.1371/journal.pone.0126083

Cohen, J. (2013). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). Routledge.

Conejero, I., Olié, E., Courtet, P., & Calati, R. (2018). Suicide in older adults: Current perspectives. *Clinical Interventions in Aging*, *Volume 13*, 691–699. https://doi.org/10.2147/CIA.S130670

Cucchi, A., Ryan, D., Konstantakopoulos, G., Stroumpa, S., Kaçar, A. Ş., Renshaw, S., Landau, S., & Kravariti, E. (2016). Lifetime prevalence of non-suicidal self-injury in patients with eating disorders: A systematic review and meta-analysis. *Psychological Medicine*, *46*(7), 1345–1358. https://doi.org/10.1017/S0033291716000027

Curtin, S. C. (2016). *Suicide Rates for Females and Males by Race and Ethnicity: United States, 1999 and 2014*. https://www.cdc.gov/nchs/data/hestat/suicide/rates_1999_2017.htm

Farstad, S. M., McGeown, L. M., & Von Ranson, K. M. (2016). Eating disorders and personality, 2004–2016: A systematic review and meta-analysis. *Clinical Psychology Review*, *46*, 91–105. https://doi.org/10.1016/j.cpr.2016.04.005

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*(2), 175–191. https://doi.org/10.3758/BF03193146

Forcano, L., Fernández-Aranda, F., Álvarez-Moya, E., Bulik, C., Granero, R., Gratacòs, M., Jiménez-Murcia, S., Krug, I., Mercader, J. M., Riesco, N., Saus, E., Santamaría, J. J., & Estivill, X. (2009). Suicide attempts in bulimia nervosa: Personality and psychopathological correlates. *European Psychiatry*, *24*(2), 91–97. https://doi.org/10.1016/j.eurpsy.2008.10.002

Forrest, L. N., Grilo, C. M., & Udo, T. (2021). Suicide attempts among people with eating disorders and adverse childhood experiences: Results from a nationally representative sample of adults. *International Journal of Eating Disorders*, *54*(3), 326–335. https://doi.org/10.1002/eat.23457

Foulon, C., Guelfi, J. D., Kipman, A., Adès, J., Romo, L., Houdeyer, K., … & Gorwood, P. (2007). Switching to the bingeing/purging subtype of anorexia nervosa is frequently associated with suicidal attempts. *European Psychiatry*, *22*(8), 513-519.

Fox, K. R., Millner, A. J., Mukerji, C. E., & Nock, M. K. (2018). Examining the role of sex in self-injurious thoughts and behaviors. *Clinical Psychology Review*, *66*, 3–11. https://doi.org/10.1016/j.cpr.2017.09.009

Gómez-Expósito, A., Wolz, I., Fagundo, A. B., Granero, R., Steward, T., Jiménez-Murcia, S., Agüera, Z., & Fernández-Aranda, F. (2016). Correlates of Non-suicidal Self-Injury and Suicide Attempts in Bulimic Spectrum Disorders. *Frontiers in Psychology*, *7*. https://doi.org/10.3389/fpsyg.2016.01244

Grant, B. F., Chu, A., Sigman, R., Amsbary, M., Kali, J., Sugawara, Y., Jiao, R., Ren, W., & Goldstein, R. (2014). *Sources and accuracy statement: National Epidemiologic Survey on alcohol and related conditions-III (NESARC-III)*. National Institute on Alcohol Abuse and Alcoholism (NIAAA). http://www.niaaa.nih.gov/sites/default/files/NESARC_Final_Report_FINAL_1_8_15.pdf

Grant, B. F., Goldstein, R. B., Chou, S. P., Saha, T. D., Ruan, W. J., Huang, B., Smith, S. M., Zhang, H., Jung, J., Pickering, R. P., Aivadyan, C., Greenstein, E., & Hasin, D. S. (2011). *The alcohol use disorder and associated disabilities interview schedule-diagnostic and statistical manual of mental disorders, version (AUDADIS-5)*. National Institute on Alcohol Abuse and Alcoholism.

Grant, B. F., Goldstein, R. B., Smith, S. M., Jung, J., Zhang, H., Chou, S. P., Pickering, R. P., Ruan, W. J., Huang, B., Saha, T. D., Aivadyan, C., Greenstein, E., & Hasin, D. S. (2015). The Alcohol Use Disorder and Associated Disabilities Interview Schedule-5 (AUDADIS-5): Reliability of substance use and psychiatric disorder modules in a general population sample. *Drug and Alcohol Dependence*, *148*, 27–33. https://doi.org/10.1016/j.drugalcdep.2014.11.026

Grant, B. F., Saha, T. D., Ruan, W. J., Goldstein, R. B., Chou, S. P., Jung, J., Zhang, H., Smith, S. M., Pickering, R. P., Huang, B., & Hasin, D. S. (2016). Epidemiology of *DSM-5* drug use disorder: Results from the national epidemiologic survey on alcohol and related conditions–III. *JAMA Psychiatry*, *73*(1), 39. https://doi.org/10.1001/jamapsychiatry.2015.2132

Hart, L. M., Granillo, M. T., Jorm, A. F., & Paxton, S. J. (2011). Unmet need for treatment in the eating disorders: A systematic review of eating disorder specific treatment seeking among community cases. *Clinical Psychology Review*, *31*(5), 727–735. https://doi.org/10.1016/j.cpr.2011.03.004

Hasin, D. S., & Grant, B. F. (2015). The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Waves 1 and 2: Review and summary of findings. *Social Psychiatry and Psychiatric Epidemiology*, *50*(11), 1609–1640. https://doi.org/10.1007/s00127-015-1088-0

Hasin, D. S., Shmulewitz, D., Stohl, M., Greenstein, E., Aivadyan, C., Morita, K., Saha, T., Aharonovich, E., Jung, J., Zhang, H., Nunes, E. V., & Grant, B. F. (2015). Procedural validity of the AUDADIS-5 depression, anxiety and post-traumatic stress disorder modules: Substance abusers and others in the general population. *Drug and Alcohol Dependence*, *152*, 246–256. https://doi.org/10.1016/j.drugalcdep.2015.03.027

Hasin, D. S., Trautman, K. D., Miele, G. M., Samet, S., Smith, M., & Endicott, J. (1996). Psychiatric Research Interview for Substance and Mental Disorders (PRISM): Reliability for substance abusers. *American Journal of Psychiatry*, *153*(9), 1195–1201.

Holm-Denoma, J. M., Witte, T. K., Gordon, K. H., Herzog, D. B., Franko, D. L., Fichter, M., Quadflieg, N., & Joiner, T. E. (2008). Deaths by suicide among individuals with anorexia as arbiters between competing explanations of the anorexia–suicide link. *Journal of Affective Disorders*, *107*(1–3), 231–236. https://doi.org/10.1016/j.jad.2007.07.029

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*(3), 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

Joiner. (2005). *Why people die by suicide*. Harvard University Press.

Keel, P. K., Dorer, D. J., Franko, D. L., Jackson, S. C., & Herzog, D. B. (2005). Postremission Predictors of Relapse in Women With Eating Disorders. *American Journal of Psychiatry*, *162*(12), 2263–2268. https://doi.org/10.1176/appi.ajp.162.12.2263

Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: Prevalence, sociodemographics, topography and functions. *Psychological Medicine*, *41*(9), 1981–1986. https://doi.org/10.1017/S0033291710002497

Klonsky, E. D., & May, A. M. (2015). The Three-Step Theory (3ST): A New Theory

of Suicide Rooted in the "Ideation-to-Action" Framework. *International Journal of Cognitive Therapy*, *8*(2), 114–129. https://doi.org/10.1521/ijct.2015.8.2.114

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology*, *12*(1), 307-330. https://doi.org/10.1146/annurev-clinpsy-021815-093204

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal Self-Injury: What We Know, and What We Need to Know. *The Canadian Journal of Psychiatry*, *59*(11), 565–568. https://doi.org/10.1177/070674371405901101

Kostro, K., Lerman, J. B., & Attia, E. (2014). The current status of suicide and self-injury in eating disorders: A narrative review. *Journal of Eating Disorders*, *2*(1), 19. https://doi.org/10.1186/s40337-014-0019-x

Kothgassner, O. D., Goreis, A., Robinson, K., Huscsava, M. M., Schmahl, C., & Plener, P. L. (2021). Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation: A systematic review and meta-analysis. *Psychological Medicine*, *51*(7), 1057–1067. https://doi.org/10.1017/S0033291721001355

Lavender, J. M., & Mitchell, J. E. (2015). Eating Disorders and Their Relationship to Impulsivity. *Current Treatment Options in Psychiatry*, *2*(4), 394–401. https://doi.org/10.1007/s40501-015-0061-6

Lavender, J. M., Wonderlich, S. A., Crosby, R. D., Engel, S. G., Mitchell, J. E., Crow, S. J., Peterson, C. B., & Le Grange, D. (2013). Personality-based subtypes of anorexia nervosa: Examining validity and utility using baseline clinical variables and ecological momentary assessment. *Behaviour Research and Therapy*, *51*(8), 512–517. https://doi.org/10.1016/j.brat.2013.05.007

Levinson, C. A., Hunt, R. A., Christian, C., Williams, B. M., Keshishian, A. C., Vanzhula, I. A., & Ralph-Nearman, C. (2022). Longitudinal group and individual networks of eating disorder symptoms in individuals diagnosed with an eating disorder. *Journal of Psychopathology and Clinical Science*, *131*(1), 58. https://doi.org/10.1037/abn0000727

Linardon, J., Messer, M., Rodgers, R. F., & Fuller-Tyszkiewicz, M. (2022). A systematic scoping review of research on COVID -19 impacts on eating disorders: A critical appraisal of the evidence and recommendations for the field. *International Journal of Eating Disorders*, *55*(1), 3–38. https://doi.org/10.1002/eat.23640

Linehan. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. Guilford press.

Linehan, M. M., & Wilks, C. R. (2015). The Course and Evolution of Dialectical Behavior Therapy. *American Journal of Psychotherapy*, *69*(2), 97–110. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97

Liu, R. T., Trout, Z. M., Hernandez, E. M., Cheek, S. M., & Gerlus, N. (2017). A behavioral and cognitive neuroscience perspective on impulsivity, suicide, and non-suicidal self-injury: Meta-analysis and recommendations for future research. *Neuroscience & Biobehavioral Reviews*, *83*, 440–450. https://doi.org/10.1016/j.neubiorev.2017.09.019

Lockwood, J., Daley, D., Townsend, E., & Sayal, K. (2017). Impulsivity and self-harm in adolescence: A systematic review. *European Child & Adolescent Psychiatry*, *26*(4), 387–402. https://doi.org/10.1007/s00787-016-0915-5

Lockwood, J., Townsend, E., Daley, D., & Sayal, K. (2020). Impulsivity as a predictor of self-harm onset and maintenance in young adolescents: A longitudinal prospective study. *Journal of Affective Disorders*, *274*, 583–592. https://doi.org/10.1016/j.jad.2020.05.021

Mangweth-Matzek, B., Kummer, K. K., & Pope, H. G. (2016). Eating disorder symptoms in middle-aged and older men. *International Journal of Eating Disorders*, *49*(10), 953–957. https://doi.org/10.1002/eat.22550

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving suicide prevention through evidence-based strategies: A systematic review. *American Journal of Psychiatry*, *178*(7), 611–624. https://doi.org/10.1176/appi.ajp.2020.20060864

McCauley, E., Berk, M. S., Asarnow, J. R., Adrian, M., Cohen, J., Korslund, K., Avina, C., Hughes, J., Harned, M., Gallop, R., & Linehan, M. M. (2018). Efficacy of Dialectical Behavior Therapy for Adolescents at High Risk for Suicide: A Randomized Clinical Trial. *JAMA Psychiatry*, *75*(8), 777. https://doi.org/10.1001/jamapsychiatry.2018.1109

McKenzie, K. C., & Gross, J. J. (2014). Nonsuicidal Self-Injury: An Emotion Regulation Perspective. *Psychopathology*, *47*(4), 207–219. https://doi.org/10.1159/000358097

Milos, G., Spindler, A., Schnyder, U., & Fairburn, C. G. (2005). Instability of eating disorder diagnoses: Prospective study. *British Journal of Psychiatry*, *187*(6), 573–578. https://doi.org/10.1192/bjp.187.6.573

Miskovic-Wheatley, J., Bryant, E., Ong, S. H., Vatter, S., Le, A., National Eating Disorder Research Consortium, Aouad, P., Barakat, S., Boakes, R., Brennan, L., Bryant, E., Byrne, S., Caldwell, B., Calvert, S., Carroll, B., Castle, D., Caterson, I., Chelius, B., Chiem, L., … Maguire, S. (2023). Eating disorder outcomes: Findings from a rapid review of over a decade of research. *Journal of Eating Disorders*, *11*(1), 85. https://doi.org/10.1186/s40337-023-00801-3

Mitchison, D., & Mond, J. (2015). Epidemiology of eating disorders, eating disordered behaviour, and body image disturbance in males: A narrative review. *Journal of Eating Disorders*, *3*(1), 20. https://doi.org/10.1186/s40337-015-0058-y

Mitchison, D., Mond, J., Slewa-Younan, S., & Hay, P. (2013). Sex differences in health-related quality of life impairment associated with eating disorder features: A general population study. *International Journal of Eating Disorders*, *46*(4), 375–380. https://doi.org/10.1002/eat.22097

Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J. B., & Patton, G. C. (2012). The natural history of self-harm from adolescence to young adulthood: A population-based cohort study. *The Lancet*, *379*(9812), 236–243. https://doi.org/10.1016/S0140-6736(11)61141-0

Muehlenkamp, J. J., Peat, C. M., Claes, L., & Smits, D. (2012). Self-Injury and Disordered Eating: Expressing Emotion Dysregulation Through the Body. *Suicide and Life-Threatening Behavior*, *42*(4), 416–425. https://doi.org/10.1111/j.1943-278X.2012.00100.x

Murray, S. B., Nagata, J. M., Griffiths, S., Calzo, J. P., Brown, T. A., Mitchison, D., Blashill, A. J., & Mond, J. M. (2017). The enigma of male eating disorders: A critical review and synthesis. *Clinical Psychology Review*, *57*, 1–11. https://doi.org/10.1016/j.cpr.2017.08.001

Neacsiu, A. D., Bohus, M., & Linehan, M. M. (2014). Dialectical Behavior Therapy: An Intervention for Emotion Dysregulation, in J. Gross (ed.), *Handbook of Emotion Regulation* (2nd ed., pp. 491-507). The Guilford Press.

Neacsiu, A. D., Eberle, J. W., Kramer, R., Wiesmann, T., & Linehan, M. M. (2014). Dialectical behavior therapy skills for transdiagnostic emotion dysregulation: A pilot randomized controlled trial. *Behaviour Research and Therapy*, *59*, 40–51. https://doi.org/10.1016/j.brat.2014.05.005

Nock, M. K. (2010). Self-Injury. *Annual Review of Clinical Psychology*, *6*(1), 339–363. https://doi.org/10.1146/annurev.clinpsy.121208.131258

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., Bruffaerts, R., Chiu, W. T., De Girolamo, G., Gluzman, S., De Graaf, R., Gureje, O., Haro, J. M., Huang, Y., Karam, E., Kessler, R. C., Lepine, J. P., Levinson, D., Medina-Mora, M. E., … Williams, D. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *British Journal of Psychiatry*, *192*(2), 98–105. https://doi.org/10.1192/bjp.bp.107.040113

Nock, M. K., & Prinstein, M. J. (2004). A Functional Approach to the Assessment of Self-Mutilative Behavior. *Journal of Consulting and Clinical Psychology*, *72*(5), 885–890. https://doi.org/10.1037/0022-006X.72.5.885

Nock, M. K., & Prinstein, M. J. (2005). Contextual Features and Behavioral Functions of Self-Mutilation Among Adolescents. *Journal of Abnormal Psychology*, *114*(1), 140–146. https://doi.org/10.1037/0021-843X.114.1.140

Pisani, A. R., Wyman, P. A., Petrova, M., Schmeelk-Cone, K., Goldston, D. B., Xia, Y., & Gould, M. S. (2013). Emotion Regulation Difficulties, Youth–Adult Relationships, and Suicide Attempts Among High School Students in Underserved Communities. *Journal of Youth and Adolescence*, *42*(6), 807–820. https://doi.org/10.1007/s10964-012-9884-2

Pisetsky, E. M., Haynos, A. F., Lavender, J. M., Crow, S. J., & Peterson, C. B. (2017). Associations between emotion regulation difficulties, eating disorder symptoms, non-suicidal self-injury, and suicide attempts in a heterogeneous eating disorder sample. *Comprehensive Psychiatry*, *73*, 143–150. https://doi.org/10.1016/j.comppsych.2016.11.012

Plana-Ripoll, O., Dreier, J. W., Momen, N. C., Prior, A., Weye, N., Mortensen, P. B., Pedersen, C. B., Iburg, K. M., Christensen, M. K., Laursen, T. M., Agerbo, E., Ped-

ersen, M. G., Brandt, J., Frohn, L. M., Geels, C., Christensen, J. H., & McGrath, J. J. (2022). Analysis of mortality metrics associated with a comprehensive range of disorders in Denmark, 2000 to 2018: A population-based cohort study. *PLOS Medicine*, *19*(6), e1004023. https://doi.org/10.1371/journal.pmed.1004023

Rajappa, K., Gallagher, M., & Miranda, R. (2012). Emotion Dysregulation and Vulnerability to Suicidal Ideation and Attempts. *Cognitive Therapy and Research*, *36*(6), 833–839. https://doi.org/10.1007/s10608-011-9419-2

Rania, M., Monell, E., Sjölander, A., & Bulik, C. M. (2021). Emotion dysregulation and suicidality in eating disorders. *International Journal of Eating Disorders*, *54*(3), 313–325. https://doi.org/10.1002/eat.23410

Rindfleisch, A., Malter, A. J., Ganesan, S., & Moorman, C. (2008). Cross-Sectional versus Longitudinal Survey Research: Concepts, Findings, and Guidelines. *Journal of Marketing Research*, *45*(3), 261–279. https://doi.org/10.1509/jmkr.45.3.261

Ross, S., Heath, N. L., & Toste, J. R. (2009). Non-suicidal self-injury and eating pathology in high school students. *American Journal of Orthopsychiatry*, *79*(1), 83–92. https://doi.org/10.1037/a0014826

Selby, E. A., Smith, A. R., Bulik, C. M., Olmsted, M. P., Thornton, L., McFarlane, T. L., Berrettini, W. H., Brandt, H. A., Crawford, S., Fichter, M. M., Halmi, K. A., Jacoby, G. E., Johnson, C. L., Jones, I., Kaplan, A. S., Mitchell, J. E., Nutzinger, D. O., Strober, M., Treasure, J., … Joiner, T. E. (2010). Habitual starvation and provocative behaviors: Two potential routes to extreme suicidal behavior in anorexia nervosa. *Behaviour Research and Therapy*, *48*(7), 634–645. https://doi.org/10.1016/j.brat.2010.03.016

Serra, R., Di Nicolantonio, C., Di Febo, R., De Crescenzo, F., Vanderlinden, J., Vrieze, E., Bruffaerts, R., Loriedo, C., Pasquini, M., & Tarsitani, L. (2022). The transition from restrictive anorexia nervosa to binging and purging: A systematic review and meta-analysis. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *27*(3), 857–865. https://doi.org/10.1007/s40519-021-01226-0

Sesboüé, S., Grandclerc, S., Moro, M. R., Godart, N., & Blanchet, C. (2025). Non-suicidal self-injury and anorexia nervosa: A systematic scoping. *Eating Disorders*, *12*, 14. https://doi.org/10.1016/j.encep.2024.11.017

Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A., & Silverman, M. M. (2016). Suicide and Suicidal Attempts in the United States: Costs and Policy Implications. *Suicide and Life-Threatening Behavior*, *46*(3), 352–362. https://doi.org/10.1111/sltb.12225

Sinclair, J. M. A., Gray, A., Rivero-Arias, O., Saunders, K. E. A., & Hawton, K. (2011). Healthcare and social services resource use and costs of self-harm patients. *Social Psychiatry and Psychiatric Epidemiology*, *46*(4), 263–271. https://doi.org/10.1007/s00127-010-0183-5

Smink, F. R. E., Van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of Eating Disorders: Incidence, Prevalence and Mortality Rates. *Current Psychiatry Reports*, *14*(4), 406–414. https://doi.org/10.1007/s11920-012-0282-y

Smith, A., Forrest, L., & Velkoff, E. (2018). Out of touch: Interoceptive deficits are elevated in suicide attempters with eating disorders. *Eating Disorders*, *26*(1), 52–65. https://doi.org/10.1080/10640266.2018.1418243

Smith, A. R., Zuromski, K. L., & Dodd, D. R. (2018). Eating disorders and suicidality: What we know, what we don't know, and suggestions for future research. *Current Opinion in Psychology*, *22*, 63–67. https://doi.org/10.1016/j.copsyc.2017.08.023

Steele, I. H., Thrower, N., Noroian, P., & Saleh, F. M. (2018). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, assessment & management. *Journal of Forensic Sciences*, *63*(1), 162–171. https://doi.org/10.1111/1556-4029.13519

Svirko, E., & Hawton, K. (2007). Self-Injurious Behavior and Eating Disorders: The Extent and Nature of the Association. *Suicide and Life-Threatening Behavior*, *37*(4), 409–421. https://doi.org/10.1521/suli.2007.37.4.409

Tozzi, F., Thornton, L. M., Klump, K. L., Fichter, M. M., Halmi, K. A., Kaplan, A. S., Strober, M., Woodside, D. B., Crow, S., Mitchell, J., Rotondo, A., Mauri, M., Cassano, G., Keel, P., Plotnicov, K. H., Pollice, C., Lilenfeld, L. R., Berrettini, W. H., Bulik, C. M., & Kaye, W. H. (2005). Symptom Fluctuation in Eating Disorders: Correlates of Diagnostic Crossover. *American Journal of Psychiatry*, *162*(4), 732–740. https://doi.org/10.1176/appi.ajp.162.4.732

Udo, T., Bitley, S., & Grilo, C. M. (2019). Suicide attempts in US adults with lifetime DSM-5 eating disorders. *BMC Medicine*, *17*(1), 120. https://doi.org/10.1186/s12916-019-1352-3

Udo, T., & Grilo, C. M. (2018). Prevalence and Correlates of DSM-5–Defined Eating Disorders in a Nationally Representative Sample of U.S. Adults. *Biological Psychiatry*, *84*(5), 345–354. https://doi.org/10.1016/j.biopsych.2018.03.014

Udo, T., & Grilo, C. M. (2019). Psychiatric and medical correlates of *DSM-5* eating disorders in a nationally representative sample of adults in the United States. *International Journal of Eating Disorders*, *52*(1), 42–50. https://doi.org/10.1002/eat.23004

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

Vaughan, R. (2017). Oversampling in Health Surveys: Why, When, and How? *American Journal of Public Health*, *107*(8), 1214–1215. https://doi.org/10.2105/AJPH.2017.303910

Vaughn, M. G., Salas-Wright, C. P., DeLisi, M., & Larson, M. (2015). Deliberate self-harm and the nexus of violence, victimization, and mental health problems in the United States. *Psychiatry Research*, *225*(3), 588–595. https://doi.org/10.1016/j.psychres.2014.11.041

Vieira, A. I., Moreira, C. S., Rodrigues, T. F., Brandão, I., Timóteo, S., Nunes, P., & Gonçalves, S. (2021). Nonsuicidal self-injury, difficulties in emotion regulation, negative urgency, and childhood invalidation: A study with outpatients with eating disorders. *Journal of Clinical Psychology*, *77*(3), 607–628. https://doi.org/10.1002/jclp.23038

Westen, D., & Harnden-Fischer, J. (2001). Personality Profiles in Eating Disorders: Rethinking the Distinction Between Axis I and Axis II. *American Journal of Psychiatry*, *158*(4), 547–562. https://doi.org/10.1176/appi.ajp.158.4.547

Wildes, J. E., Marcus, M. D., Crosby, R. D., Ringham, R. M., Dapelo, M. M., Gaskill, J. A., & Forbush, K. T. (2011). The clinical utility of personality subtypes in patients with anorexia nervosa. *Journal of Consulting and Clinical Psychology*, *79*(5), 665–674. https://doi.org/10.1037/a0024597

Wilkinson, P. O., Qiu, T., Jesmont, C., Neufeld, S. A. S., Kaur, S. P., Jones, P. B., & Goodyer, I. M. (2022). Age and gender effects on non-suicidal self-injury, and their interplay with psychological distress. *Journal of Affective Disorders*, *306*, 240–245. https://doi.org/10.1016/j.jad.2022.03.021

Wolff, J. C., Thompson, E., Thomas, S. A., Nesi, J., Bettis, A. H., Ransford, B., Scopelliti, K., Frazier, E. A., & Liu, R. T. (2019). Emotion dysregulation and non-suicidal self-injury: A systematic review and meta-analysis. *European Psychiatry*, *59*, 25–36. https://doi.org/10.1016/j.eurpsy.2019.03.004

Wonderlich, S. A., Crosby, R. D., Joiner, T., Peterson, C. B., Bardone-Cone, A., Klein, M., Crow, S., Mitchell, J. E., Le Grange, D., Steiger, H., Kolden, G., Johnson, F., & Vrshek, S. (2005). Personality subtyping and bulimia nervosa: Psychopathological and genetic correlates. *Psychological Medicine*, *35*(5), 649–657. https://doi.org/10.1017/S0033291704004234

World Health Organization. (2019). *International Statistical Classification of Diseases and related health problems:* (Vol. 3). World Health Organization.

CLINICAL PRACTICE FORUM |

The Unique Perils Presented by Artificial Intelligence for Individuals with Obsessive Compulsive Disorder

Mary E. McNamara, Hannah C. Broos
McLean Hospital; Harvard Medical School

Sarah C. Jessup
McLean Hospital; Vanderbilt University Medical Center

Jacob A. Nota, Jennie M. Kuckertz, Nathaniel Van Kirk, Martha J. Falkenstein
McLean Hospital; Harvard Medical School

ABSTRACT > *While the advent of artificial intelligence (AI) has led to new discoveries and efficiencies in healthcare, it has also brought new challenges. For individuals with obsessive compulsive disorder (OCD) who may struggle with checking and reassurance-seeking behaviors, the accessibility of generative AI tools can be particularly problematic. In this Clinical Practice Forum article, we review the necessity of blocking reassurance-seeking, as well as the ways in which AI poses challenges to successful treatment of OCD. Finally, we offer recommendations for clinicians to consider when working with patients with OCD.*

The authors declare no conflicts of interest. This project was supported by a Pope-Hintz Fellowship at McLean Hospital awarded to Mary McNamara. Martha Falkenstein's time was supported by a grant from the National Institute of Mental Health (K23MH126193). Jennie Kuckertz contributed to the preparation of this manuscript while supported by a grant from the National Institute of Mental Health (1R01MH135899).

Correspondence to:
Mary E. McNamara, PhD, 115 Mill Street, Mailstop 207, Belmont, MA 02474; email: mmcnamara14@mgb.org

Keywords:
obsessive-compulsive disorder, artificial intelligence, exposure and response prevention

THE EXPLOSION OF ARTIFICIAL INTELLIGENCE (AI) TOOLS IN RECENT YEARS has led to incredible advancements in science and medicine. This potential extends to the field of mental health; for example, it may positively impact the speed with which obsessive compulsive disorder (OCD) is diagnosed as well as the quality of OCD treatment (for a review, see J. Kim et al., 2025). However, the speed with which AI practices are being adopted in healthcare requires careful attention not only to the opportunities presented by the tools' usage, but also the associated pitfalls (e.g., Kim et al., 2023). Here we review pitfalls of AI use for OCD treatment in particular, based on our clinical experience as therapists who treat this disorder, as well as very early emerging research on AI. We also provide initial recommendations for clinicians on assessing and treating OCD in an environment where AI use is increasingly widespread.

The point of exposure and response prevention (ERP)—the gold-standard treatment for OCD (Ferrando & Selai, 2021)—is to intentionally lean into uncertainty when exposed to a trigger or to one's obsessive thoughts, while refraining from compulsions such as reassurance seeking which function to lessen uncertainty (Gillihan et al., 2012). Theoretical models of OCD suggest that obsessions and compulsions are functionally related, such that compulsions serve to neutralize anxiety and distress associated with obsessions (Conelea et al., 2012; Starcevic et al., 2011). Evidence suggests that engaging in compulsions strengthens the cycle of OCD and leads to increased symptoms (Starcevic et al., 2011). Therefore, during ERP, patients learn to tolerate distress without engaging in these behaviors (Hezel & Simpson, 2019). While patients are often "exposed" to triggers in their daily lives, ERP is therapeutically helpful specifically because of the response prevention piece whereby patients work to resist rituals.

Reassurance-seeking is a common compulsive behavior in OCD, defined as repeatedly and excessively seeking information about a perceived threat (Parrish & Radomsky, 2010). Many individuals with OCD become trapped in obsessive-compulsive cycles where they engage in reassurance-seeking that

is maintained by momentary increases in perceived certainty about a given threat and associated reductions in their anxiety and distress related to a specific situation (Kobori et al., 2012; Starcevic et al., 2012). Reassurance-seeking has been consistently linked with OCD symptom severity and is thought to serve as a neutralization behavior or compulsion (Haciomeroglu, 2020; Starcevic et al., 2012). Individuals with OCD often seek reassurance from various sources, including family and friends, media, the internet, and other online sources (Parsons et al., 2025; Parsons & Alden, 2022).

Reassurance is targeted in treatment both by encouraging the patient to refrain from asking for it, as well as modifying the responses that individuals with OCD receive when they engage in this compulsion. When reassurance seeking from loved ones is present—which is the case for up to 92% of adult and 98% of child patients with OCD (Sperling et al., 2025)—families are educated around how accommodation of rituals or providing reassurance is iatrogenic for the individual with OCD. For example, parents or romantic partners may feel they are helping the patient to move on or "think logically" by providing reassurance about their fears. The therapist can help illustrate that while reassurance may appear to temporarily relieve suffering, it only serves to perpetuate and worsen OCD symptoms in the long term. In collaboration with the patient, the therapist will help empower families to resist giving reassurance and share other ways to help respond in these moments (Lebowitz et al., 2014; Thompson-Hollands et al., 2015). This partnering with the family often is essential to successful treatment, as it helps families resist participating in rituals that ultimately maintain OCD symptoms.

. . . parents or romantic partners may feel they are helping the patient to move on or "think logically" by providing reassurance about their fears. The therapist can help illustrate that while reassurance may appear to temporarily relieve suffering, it only serves to perpetuate and worsen OCD . . .

However, there is another source of reassurance that proves much more challenging to block than that from well-intentioned family members: AI. Among the biggest pitfalls are generative AI tools such as ChatGPT, Gemini, and DeepSeek, which are increasingly being used as lightning-fast sources of reassurance for individuals with OCD. Not only do these sources provide reassurance with just a few clicks of the keyboard, but they are also indefatigable: there is no limit to how many times you can ask ChatGPT the same question, and unlike a human, its patience does not wear thin. Whereas a loved one or patient may begin to set boundaries around reassurance-seeking, generative AI continues to provide on-demand support. This is often a relief to many individuals suffering with OCD—at last, a way to reduce some anxiety without any of the social costs that so often come with compulsions. Although no research has directly ex-

amined the pitfalls of generative AI in OCD treatment, clinicians have anecdotally noted a sharp increase in the use of generative AI for reassurance-seeking purposes and several nonempirical blogs have highlighted the ways in which AI can be detrimental to OCD treatment (e.g., Ciochon, 2025; Harwerth, 2025; Samuel, 2025; Taneia Surles, 2025). Patients have long used the internet as a way to seek reassurance, but AI tools particularly intensify existing ways of seeking reassurance; while searching the internet requires the user to sift through various pages and sometimes conflicting information (e.g., an inherently more uncertain process), AI more directly answers queries and summarizes information in a way that presents as less ambiguous (Amer & Elboghdadly, 2024).

Indeed, generative AI models pose several unique characteristics that are uniquely problematic for the maintenance and treatment of OCD symptoms. First, generative AI models are highly accessible. Unlike loved ones or treatment providers, AI is always available and can be accessed at all hours of the day without limits. Second, as a news article from the *Washington Post* (De Vynck & Merrill, 2025) highlights, the tone of AI responses are often sycophantic, and models validate rather than challenge the user (Cheng et al., 2025). Generative AI is designed to be helpful, often providing "safe" or "soothing" answers (Ciochon, 2025) that reinforce obsessional thinking and compulsive behaviors. Finally, generative AI draws on questionable sources of data, often misciting references from existing literature, and these models are susceptible to the spread of information or disinformation (Graf et al., 2024; Monteith et al., 2024). OCD treatment is nuanced and requires a trained provider to examine and highlight the underlying functions of covert behaviors, which at this stage can be—and often are—missed by generative AI models.

Prior to the 1970s, the prognosis for someone with OCD was incredibly poor (National Collaborating Centre for Mental Health [UK], 2006). The advent of ERP drastically changed outcomes for individuals with OCD, especially the new understanding of the necessity for blocking nearly all rituals for symptom improvement. Meanwhile, new, AI-based technology can be used in both adaptive and maladaptive ways, creating more insidious methods of ritualizing. In our experience as practicing clinicians and OCD researchers, patients may misuse generative AI in ways which can serve to worsen their OCD, due to elements of these tools that are especially unhelpful for people with OCD. We review these below.

Gives Direct Reassurance

Perhaps the most obvious way patients might seek reassurance is through direct "conversation" with tools like ChatGPT and Gemini. Patients might input questions such as "Can I get rabies from touching something a dog also touched?" Often, these tools will give strong and unequivocal reassurance—in the response below, note the bolded statements (bolded emphasis given by ChatGPT): *"That's a really understandable concern—rabies is a scary disease, so it's normal to worry. But yes, I can reassure you confidently:* ***you are safe in this situation****. Even* ***if the dog wasn't vaccinated,*** *you* ***cannot get rabies just by touching something the dog touched ...*** *If you'd like, you can tell me exactly what kind of contact you had (for example, what*

object you touched and whether you had any open wounds), and I'll double-check—but from what you've said so far, ***you're completely safe and don't need rabies shots.****"*

Promotes Excessive Engagement with Obsessions

Because the algorithms in generative AI validate the user, these tools often unknowingly collude with OCD in generating reasons why the feared outcome may occur. Consider prompts such as "Is it considered cheating if I told my coworker I liked her dress?" In instances like these, ChatGPT will often give some straightforward reassurance, but will also prompt the user with follow-up questions like, "*Would you like to tell me exactly what you said and how your relationship is set up? That could help me give you a more tailored answer.*" As a result, the user can quickly become tangled in a never-ending series of clarifying questions in an attempt to gain certainty about their feared outcome (e.g., that they cheated). In essence, while generative AI tools are trying to aid the user in getting more and more clarity in their answer, unfortunately, the algorithms are aiding the person in obsessing further and deeper. While evidence-based treatment for OCD often focuses on giving less power to intrusive thoughts and worries, the use of AI tools does the opposite, sending the message that these thoughts are important, have meaning, and should be explored further.

Provides Ritual Justification

AI tools may also unknowingly aid the user in generating reasons why additional ritualizing might be justified. We often refer to these reasons for ritualizing as permission-giving statements. To illustrate, a patient who is concerned he may be poisoned after eating on a glass table that was cleaned earlier in the day may ask ChatGPT, "Can you die if you accidentally eat trace amounts of Windex?" ChatGPT reassures the patient that a trace amount won't cause harm, and asks clarifying questions about how much they ingested. If the patient—as many patients with OCD do—begins to express doubt in their memory and says they are unsure if it was only a trace amount, ChatGPT validates the patient's anxiety and encourages them to take action: "*That's completely understandable—and it's good that you're asking rather than ignoring it. Here's what's important: If you're not sure how much Windex you might have ingested, the safest thing you can do right now is call Poison Control (U.S. number: 1-800-222-1222) or your country's equivalent.*"

Delivers Immediate Response

One strategy in ERP involves postponing the ritual with the intention of helping the person build the strength to resist ritualizing entirely over time. For individuals who obsess about health concerns and ritualize via frequent trips to the doctor, this would include postponing these visits. However, our experience is that more and more patients are turning to generative AI to ask questions without any sort of postponement. While frequent trips to the doctor or emergency room often have social, occupational, and financial costs that may slow or disincentivize this ritual, using AI tools have little to none. It is

important to re-emphasize that from a symptom maintenance standpoint, all rituals function the same—even a "less costly" ritual in terms of external consequences will still have the mechanistic consequence of maintaining the OCD cycle.

Allows Picture Uploading

Many AI tools now include the option to upload pictures, which can become a novel means by which patients engage in checking. Individuals with health-related anxieties seem especially vulnerable to this, and may upload pictures of perceived ailments repeatedly asking whether the area looks to be improving or worsening. For individuals with moral scrupulosity, screenshots of text messages, emails, and social media posts can be analyzed to determine whether anything offensive was said. Patients who are preoccupied with avoiding upsetting others can use AI to analyze the tone of conversation partners over text in an attempt to gain certainty about whether the sender is irritated.

Feeds Perfectionism

In our experience, patients who struggle with academic perfectionism and "not-just-right" experiences are especially vulnerable to the use of AI tools for ritualizing. Patients may struggle with moving on from reading a sentence as they check to ensure they understood it comprehensively, or struggle to write fluidly without finding the perfect word or making the sentence sound perfectly eloquent. We find patients often struggle with asking AI tools repeatedly to help them find the perfect word at the expense of producing much if any text. They might also feed in their reading material to the algorithm as an additional check that they are comprehending everything "correctly," which usually results in a cycle of rereading and rechecking with the tool. Additionally, while asking generative AI to write an entire assignment is less common, feeding these tools written paragraphs and asking for them to be made more "eloquent" or "academic" is not unusual. These all undermine the process of ERP as they reduce uncertainty around having made a mistake or submitting a suboptimal product.

Using to Write Imaginal Scripts

We have experienced patients increasingly using AI to generate imaginal exposure scripts. At first glance, the idea that patients might use AI to write imaginal scripts may not seem problematic. Generative AI can produce creative scripts, which the patient can then practice reading as part of their exposure. However, this can be problematic for several reasons. At worst, asking AI to write the script can be a means of avoiding engaging with content that is distressing while supporting the patient's incorrect belief that they are "doing exposure." For example, we have heard patients report to their therapist that they did an imaginal exposure, only to find out that they asked ChatGPT to generate a script that they did not actually read. At best, while using AI might result in descriptive scripts, outsourcing the writing process may undermine the effectiveness of the imaginal exposure. To this

point, emerging research shows that using generative AI reduces feelings of psychological ownership over the produced work (Draxler et al., 2024; Kim et al., 2025). A recent study out of MIT found that essays written with AI tools decreased both the user's sense of ownership about the essay, as well as decreased learning outcomes (e.g., memory; Kosmyna et al., 2025). As a result, the authors also suggest that using AI may result in shallow learning and memory encoding. Certainly, additional research in this area is needed to understand how the use of AI may affect learning and engagement with the content of therapy, including ERP. Nevertheless, this preliminary work gives us pause about using AI tools to facilitate imaginal scripts.

Using AI Instead of—Or to Contradict—A Therapist

Lastly, we have experienced patients using AI tools for support in lieu of finding a therapist or reaching out to their care team. When asked about why they use AI tools, patients will report "it makes me feel better" or "it helps reduce my anxiety." Unfortunately, in OCD these are most often affective signals that reassurance or some other ritual has been completed. Sometimes, patients have also checked the advice given by their treatment team against ChatGPT. In the Windex example given above, when told that the user's therapist advised them not to call Poison Control, ChatGPT discourages following the therapist's advice (bolded emphasis by ChatGPT): *"Your **therapist** is trained for mental health care, but **not for poison or toxic exposure,** so this situation is outside their **area of expertise**."* While this is understandable from a public health perspective, it highlights the unique challenges that individuals and treatment teams for OCD face with generative AI tools. Importantly, we are referring to the way individuals may use standard generative AI tools (e.g., Gemini, Claude, etc.) for therapeutic purposes or support, not AI therapy chatbots. We do not yet have data or clinical experience to speak to how therapeutic-specific AI may or may not work for individuals with OCD, but encourage this as a focus of future research. Initial research also shows that clinician-generated exposure hierarchies are still superior to ones generated by AI (Bernstein et al., 2025), suggesting there is work to be done before AI is patient-ready for OCD.

Recommendations for Clinicians

Given that AI tools are here to stay, we offer several suggestions for how clinicians can best equip themselves to help their patients struggling with OCD. First, careful assessment in intake sessions about what forms of AI clients use, how frequently, and how they are used functionally is important. Note that patients might not recognize that they are using AI for reassurance, especially in the early stages of treatment, and careful inquiry is needed on the part of the clinician to understand how the use of these tools is operating functionally for the individual. This assessment, of course, should continue throughout the course of treatment, rather than ending during the assessment session. This may become especially important when other sources of reassurance become less available as family members and loved ones reduce reassurance as described above. Next, it is important to provide thorough psychoeducation on OCD and the necessity of leaning into uncertainty, as well as to explain the ways in which AI

use can undermine this. This step can help patients to understand why "chatting" is contraindicated for their recovery and help empower them to resist. For therapists who incorporate Acceptance and Commitment Therapy (ACT) into their practice, initiating a conversation about values can be helpful at this stage. As with time spent on any compulsion, time and energy given to using AI means less time spent meaningfully engaging with loved ones or hobbies. For the patient who really struggles to resist using ChatGPT on their own, the therapist and patient may collaboratively decide that the next best course of action is to block websites that are unhelpful to their recovery on their phone and computer. And while Google now provides an AI overview automatically when you complete a Google search, workarounds exist to remove this from your webpage.

Conclusion

Although the benefits of generative AI in clinical care (e.g., personalized treatment plans, enhanced efficiency, improved diagnostic accuracy) have sparked considerable and understandable enthusiasm, researchers and clinicians alike have highlighted the importance of exercising caution when implementing AI in clinical care. In the case of OCD, generative AI frequently serves as a low-cost, highly accessible reassurance-seeking tool that validates the individual's concerns. As a result, using generative AI often functions as a compulsion that ultimately maintains symptoms for those with OCD. Despite the detrimental effects of generative AI reported and observed by OCD clinicians and the increased traction such tools are gaining in popular media, no empirical research to date has examined the perils of generative AI use in the context of OCD treatment. Research is needed to better understand the frequency of AI use for reassurance-seeking purposes, the full extent to which AI use detrimentally affects those with OCD, as well as other unique potential pitfalls of this tool in the treatment of OCD.

REFERENCES

Amer, E., & Elboghdadly, T. (2024). The end of the search engine era and the rise of generative AI: A paradigm shift in information retrieval. *2024 International Mobile, Intelligent, and Ubiquitous Computing Conference (MIUCC)*, 374–379.

Bernstein, E. E., Jaroszewski, A. C., Jacoby, R. J., Bailen, N. H., Ragan, J., Usmani, A., & Wilhelm, S. (2025). Feasibility of using ChatGPT to generate exposure hierarchies for treating obsessive-compulsive disorder. *Behavior Therapy*, *56*(4), 680–688.

Cheng, M., Lee, C., Khadpe, P., Yu, S., Han, D., & Jurafsky, D. (2025). Sycophantic AI decreases prosocial intentions and promotes dependence. In *arXiv [cs.CY]*. arXiv. http://arxiv.org/abs/2510.01395

Ciochon, T. (2025, September 16). *Always Available, Never Enough: How AI Can Fuel OCD Reassurance-Seeking*. Empowered Connections Counseling. https://www.empoweredconnectionscounseling.com/blog/2025/9/16/always-available-never-enough-how-ai-can-fuel-ocd-reassurance-seeking

Conelea, C. A., Freeman, J. B., & Garcia, A. M. (2012). Integrating behavioral theory with OCD assessment using the Y-BOCS/CY-BOCS symptom checklist. *Journal of Obsessive-Compulsive and Related Disorders*, *1*(2), 112–118.

De Vynck, G., & Merrill, J. B. (2025, November 12). We analyzed 47,000 ChatGPT conversations. Here's what people really use it for. *The Washington Post*. https://www.washingtonpost.com/technology/2025/11/12/how-people-use-chatgpt-data/

Draxler, F., Werner, A., Lehmann, F., Hoppe, M., Schmidt, A., Buschek, D., &

Welsch, R. (2024). The AI ghostwriter effect: When users do not perceive ownership of AI-generated text but self-declare as authors. *ACM Transactions on Computer-Human Interaction: A Publication of the Association for Computing Machinery*, *31*(2), 1–40.

Ferrando, C., & Selai, C. (2021). A systematic review and meta-analysis on the effectiveness of exposure and response prevention therapy in the treatment of Obsessive-Compulsive Disorder. *Journal of Obsessive-Compulsive and Related Disorders*, *31*(100684), 100684.

Gillihan, S. J., Williams, M. T., Malcoun, E., Yadin, E., & Foa, E. B. (2012). Common pitfalls in exposure and response prevention (EX/RP) for OCD. *Journal of Obsessive-Compulsive and Related Disorders*, *1*(4), 251–257.

Graf, E. M., McKinney, J. A., Dye, A. B., Lin, L., & Sanchez-Ramos, L. (2024). Exploring the limits of artificial intelligence for referencing scientific articles. *American Journal of Perinatology*, *41*(15), 2072–2081.

Haciomeroglu, B. (2020). The role of reassurance seeking in obsessive compulsive disorder: the associations between reassurance seeking, dysfunctional beliefs, negative emotions, and obsessive- compulsive symptoms. *BMC Psychiatry*, *20*(1), 356.

Hezel, D. M., & Simpson, H. B. (2019). Exposure and response prevention for obsessive-compulsive disorder: A review and new directions. *Indian Journal of Psychiatry*, *61*(Suppl 1), S85–S92.

arwerth, J. (2025, April 26). *How Artificial Intelligence is Making Your OCD Worse — OCD & Anxiety Recovery*. OCD & Anxiety Recovery | Dallas & Houston. https://wetreatocd.com/blog/artificial-intelligence-ocd

Kim, H.-J., Han, S., & Hong, J.-W. (2025). That's my AI-content: Exploring psychological ownership and posting intentions of AI-generated content on social media. *International Journal of Human-Computer Interaction*, 1–21.

Kim, J., Cai, Z. R., Chen, M. L., Simard, J. F., & Linos, E. (2023). Assessing biases in medical decisions via clinician and AI chatbot responses to patient vignettes. *JAMA Network Open*, *6*(10), e2338050.

Kim, J., Pacheco, J. P. G., Golden, A., Aboujaoude, E., van Roessel, P., Gandhi, A., Mukunda, P., Avanesyan, T., Xue, H., Adeli, E., Kim, J. P., Saggar, M., Stirman, S. W., Kuhn, E., Supekar, K., Pohl, K. M., & Rodriguez, C. I. (2025). Artificial intelligence in obsessive-compulsive disorder: A systematic review. *Current Treatment Options in Psychiatry*, *12*(1), 23.

Kobori, O., Salkovskis, P. M., Read, J., Lounes, N., & Wong, V. (2012). A qualitative study of the investigation of reassurance seeking in obsessive–compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, *1*(1), 25–32.

Kosmyna, N., Hauptmann, E., Yuan, Y. T., Situ, J., Liao, X.-H., Beresnitzky, A. V., Braunstein, I., & Maes, P. (2025). Your brain on ChatGPT: Accumulation of cognitive debt when using an AI assistant for essay writing task. In *arXiv [cs.AI]*. arXiv. http://arxiv.org/abs/2506.08872

Lebowitz, E. R., Omer, H., Hermes, H., & Scahill, L. (2014). Parent training for childhood anxiety disorders: The SPACE program. *Cognitive and Behavioral Practice*, *21*(4), 456–469.

Monteith, S., Glenn, T., Geddes, J. R., Whybrow, P. C., Achtyes, E., & Bauer, M. (2024). Artificial intelligence and increasing misinformation. *The British Journal of Psychiatry*, *224*(2), 33–35.

National Collaborating Centre for Mental Health (UK). (2006). In *Obsessive-Compulsive Disorder: Core Interventions in the Treatment of Obsessive-Compulsive Disorder and Body Dysmorphic Disorder*. British Psychological Society (UK).

Parrish, C. L., & Radomsky, A. S. (2010). Why do people seek reassurance and check repeatedly? An investigation of factors involved in compulsive behavior in OCD and depression. *Journal of Anxiety Disorders*, *24*(2), 211–222.

Parsons, C. A., & Alden, L. E. (2022). Online reassurance-seeking and relationships with obsessive-compulsive symptoms, shame, and fear of self. *Journal of Obsessive-Compulsive and Related Disorders*, *33*(100714), 100714.

Parsons, C. A., Kim, H. J., Singh, S., Lkhagva, T., Wang, J., & Alden, L. E. (2025). Covert or connected: Motivations for online and interpersonal reassurance-seeking in OCD. *Journal of Anxiety Disorders*, *115*(103057), 103057.

Samuel, S. (2025, June 25). *ChatGPT and OCD are a dangerous combo*. Vox. https://www.vox.com/future-perfect/417644/ai-chatgpt-ocd-obsessive-compulsive-disorder-chatbots

Sperling, J. B., Stark, A. M., Woodson, O., Tung, E. S., Falkenstein, M. J., & Kuckertz, J. M. (2025). Family accommodation of OCD and anxiety symptoms across the lifespan. *The Behavior Therapist*, *48*(6), 676–694.

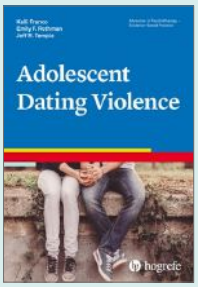
Starcevic, V., Berle, D., Brakoulias, V., Sammut, P., Moses, K., Milicevic, D., & Hannan, A. (2011). Functions of compulsions in obsessive-compulsive disorder. *The Australian and New Zealand Journal of Psychiatry*, *45*(6), 449–457.

Starcevic, V., Berle, D., Brakoulias, V., Sammut, P., Moses, K., Milicevic, D., & Hannan, A. (2012). Interpersonal reassurance seeking in obsessive-compulsive disorder and its relationship with checking compulsions. *Psychiatry Research*, *200*(2-3), 560–567.

Taneia Surles, M. P. H. (2025, July 30). *Can ChatGPT make OCD worse? What people with OCD need to know*. NOCD. https://www.treatmyocd.com/blog/chatgpt-ocd-reassurance-seeking

Thompson-Hollands, J., Abramovitch, A., Tompson, M. C., & Barlow, D. H. (2015). A randomized clinical trial of a brief family intervention to reduce accommodation in obsessive-compulsive disorder: a preliminary study. *Behavior Therapy*, *46*(2), 218–229.

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

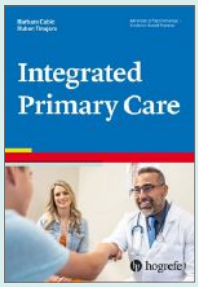


Adolescent Dating Violence

Advances in Psychotherapy – Evidence-Based Practice - Volume 56

K. Franco/E. Rothman/J. Temple

ISBN 978-0-88937-419-5
Also available as eBook

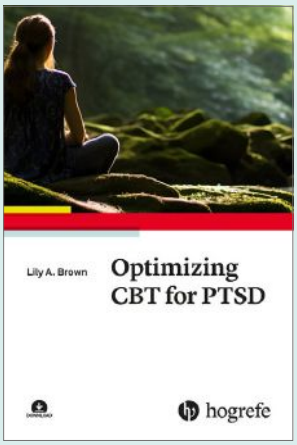


Integrated Primary Care

Advances in Psychotherapy – Evidence-Based Practice - Volume 57

B. Cubic/R. Tinajero

ISBN 978-0-88937-610-6
Also available as eBook



Optimizing CBT for PTSD

L. Brown
ISBN 978-0-88937-669-4
2026, viii/170 pages

A critical text for leveraging cognitive behavioral therapy (CBT) in patients experiencing PTSD.

In this comprehensive volume, Lily Brown offers concise, evidence-based guidance on how to leverage CBT for patients experiencing PTSD. She analyzes common challenges clinicians face when attempting to adhere to treatment manuals and proposes solutions that practitioners can offer to enhance patient outcomes.

www.hogrefe.com/apt

hogrefe

OP-ED | # Revisiting the Critical Appraisal of ACT and Functional Contextualism

Josef Mattes
Private practice; University of Vienna

ABSTRACT > *This paper discusses the relationship between Acceptance and Commitment Therapy (ACT) and truth. In a recent special issue of the journal Behavior Therapy, this relationship was characterized as unusual and problematic by one of the editors (among several other perceived problems with ACT), which was denied in a reply paper by ACT proponents. The reply was based on the fact that, for the philosophy of science behind ACT, there is an a priori choice of a particular variant of what ACT proponents refer to as a "truth criterion." The present paper argues that this reply appears unconvincing: Not only is the alleged "truth criterion" not a criterion for truth in the usual sense of the word, it does not even seem pragmatic in the way understood by ACT proponents themselves. Specifically, it is not "adequate to the challenges of the human condition" under a reasonable understanding of that condition: It arguably carries serious risks, without offsetting benefits either in psychotherapy or concerning the human condition more generally.*

The author declares no conflicts of interest. The author would like to express gratitude to two reviewers of this journal for their careful reading of the manuscript, and interesting as well as helpful comments. Some edits within the text were made by the author using ChatGPT.

Correspondence to:
Josef Mattes; email: research@jmattes.at

Keywords:
functional contextualism, acceptance and commitment therapy, process-based therapy, truth, pro-social

Background

A recent issue of the journal *Behavior Therapy* contained a special section entitled "A Critical Appraisal of Acceptance and Commitment Therapy" (McKay & O'Donohue, 2023). In their introduction, the editors called for methodological improvements as well as for a commitment to more traditional values associated with science. In their view, Acceptance and Commitment Therapy (ACT) research suffers from serious measurement problems and problematic research designs, as well as problematic conceptualization and possibly practice of values and ethics. For example, these editors claimed that among the 900 RCTs listed on contextualscience.org there are no reports of studies of ACT failing to show positive outcomes (p. 930). One paper criticized the scientific status of ACT from a philosophy of science point of view, making a number of highly critical claims regarding its metascience, the constructs employed and their measurement, its account of values, and the quality of its research (O'Donohue, 2023)

Many of those raised issues have been answered (and some acknowledged as valid) in the response paper by Hayes et al. (2023), but that response also accuses several of the critical papers in the aforementioned special issue of fundamental misunderstandings, and of painting so dark a picture of ACT that it would threaten genuine conversation if true (p. 1038).

Considerable parts of the response by Hayes et al. (2023) seem convincing. For example, the critics' claim that there are no reports of studies of ACT failing to show positive outcomes was easily refuted, by pointing to contextualscience.org/negative_findings. Nevertheless, the present paper argues that there is a least one major point where the response is inadequate: the reply to the critique in O'Donohue (2023) of the metascientific perspective advanced by ACT proponents. Specifically, according to O'Donohue, "the

metascientific perspective advanced by ACT proponents […] is none too clear, is not well-developed or well-argued, has a substantial Machiavellian component, and is not to be influenced by any mainstream perspective from the philosophy of science" (p. 957). Furthermore, he claimed that:

> ACT's philosophy of science is unusual and problematic in its views on accountability, truth, and rationality […]. Truth, knowledge, and what exists are rendered as matters that are up to the individual and their goals (p. 959).

The present paper concentrates on the last issue raised by O'Donohue. It argues that ACT's philosophy of science indeed has a highly problematic view on truth—not only as usually understood, but problematic even by its own standards.

Outline of the Paper

The first section of the present paper briefly recalls some necessary background on ACT (and its philosophy in general), pragmatism, and truth. This is followed by a section discussing the relationship between truth, usefulness, and the "pragmatic truth criterion" alleged by ACT proponents. The latter is shown to differ from the pragmatism of William James in particular (despite ACT proponents claiming to be in James's tradition), given that it is based on a restricted concept of usefulness. This "local" version of usefulness also turns out to be the main point that makes the proclaimed "pragmatic truth criterion" problematic. Therefore, in most of the present paper, the philosophy advanced by ACT proponents will be referred to as "myopic pragmatism." The two sections that follow thereafter explain the problem; the first arguing that myopic pragmatism carries serious risks (relative to a publicly stated goal of ACT proponents themselves), and the second explaining that there do not seem to be offsetting benefits, either in psychotherapy or more generally. The final discussion explores how this myopic aspect could be removed without endangering the philosophical bases in pragmatism, behaviorism, functionalism, or evolutionary thinking (all of which the present author agrees with).

ACT, Philosophy, Truth

ACT and Philosophy

ACT is one of the many therapies in the so-called third wave of cognitive-behavioral therapies (CBT), though a notable point of difference from other third-wave CBTs can be found in the ways in which ACT's practice is strongly rooted in Skinner's radical behaviorism, rather than in cognitive theories. In ACT, it is posited that unnecessary suffering occurs when psychological rigidity prevents adaption to internal or external contexts, which in turn is assumed to result from verbal / cognitive processes leading to cognitive entanglement and experiential avoidance, thereby narrowing behavioral repertoires (Hayes, Strosahl & Wilson, 2012; p. 64). Thus:

> The ultimate goal of ACT is to bring verbal cognitive processes under better contextual control and to have the client spend more time in contact with the positive consequences of his or her actions immediately in the present as part of a valued life path (p. 65).

Or, in other words:

> […] the ultimate goals of ACT are to undermine the hegemony of

> human language and bring our clients and ourselves back into broader contact with knowledge—including intuition, inspiration, and simple awareness of the world (p. 26).

To achieve this, ACT interventions try to enhance six specific flexibility processes, usually depicted in the form of a hexagon referred to as the "hexaflex" (p. 63). Recently, this was developed into a more general model – Process-Based Therapy (PBT; Hayes & Hofmann, 2018). The ambition in this is to go beyond treating mental illness (a concept that is rejected) to achieve a broad agenda of behavioral change built on a more universally applicable set of principles (Hayes & King, 2024; p. 2).

According to Hayes et al. (2023), in addition to the concept of psychological flexibility, ACT has bases in relational frame theory (RFT, a behavioral theory of human language), contextual behavioral science (CBS, a general form of behavioral science), and functional contextualism (a particular philosophy of science that is claimed to be especially of relevance to psychology and behavioral science). CBS is taken to be of such importance within ACT, in fact, that the main organization behind ACT is called the "Association for Contextual Behavioral Science" (ACBS), and its journal the *Journal of Contextual Behavioral Science* (JCBS). It should be noted that the crucial term "contextualism" here is meant to be synonymous with "pragmatism" (e.g., Hayes et al., 2023; p. 1040).

ACT and Pragmatism(s)

When calling a philosophy "pragmatism," it is crucial to specify what is meant by the term, as there are many versions of pragmatic philosophy. C. S. Peirce (1878) is usually considered the founder of pragmatism, and William James its most important popularizer; other important names include John Dewey, Willard V.O. Quine, Hilary Putnam, Richard Rorty, Nicholas Rescher, Stephen Stich, Susan Haack, Robert Brandom, Cheryl Misak, Sami Pihlström, among others. These figures did not always agree; that there are huge differences between them can be seen in Peirce later referring to his *own* philosophy as "pragmaticism," a term that he hoped would be saved from "kidnappers." Another telling example is the heavy criticism of Rorty's philosophy by other pragmatists: it was referred to as "vulgar pragmatism" by Susan Haack (1995), as "narcissistic pragmatism" by Jeffrey Stout (2007), and as "solipsism with a 'we' instead of an 'I'" by Hilary Putnam (1992).

History teaches that these are not purely intellectual differences. Problematic interpretations of "pragmatism" are possible and can have serious practical implications, at least when one leaves the narrow domain of mental health and embraces a broader agenda. This should not be a surprise; after all, an attitude of "what works is true" might seem to some not too dissimilar from "might is right." Consistent with this, in the 1920s it was noted that "[f]ascism has come to mean to the popular imagination [the] application of pragmatism to politics" (Elliott, 1926; p. 164). Mussolini, in particular, held a well-known admiration for a form of pragmatism (Pihlström, 2021; p. 13). This does not, of course, mean that pragmatist philosophies in general are problematic (indeed, the present author considers himself a pragmatist); but it does show that one needs to be careful regarding how specific forms of pragmatism might be more or less susceptible to unintended problematic misin-

terpretation, or other potential adverse consequences of their propagation.

In view of this clear importance to distinguish between different pragmatisms, it is significant that the "contextualism" in CBS and functional contextualism is specifically meant to refer to pragmatism "in the tradition of W. James (1907)" (Hayes, Pistorello & Levin, 2012; p. 979); that is, his book *Pragmatism* (1907)—and, presumably, also the book that James explicitly called a sequel to it: *The Meaning of Truth – A Sequel to Pragmatism* (published in 1909, the year before James died – so most likely containing his mature views). Before discussing these, the next section outlines the view on truth propagated by proponents of ACT.

ACT and Truth

The literature on ACT, CBS, and functional contextualism is replete with references to a supposed "pragmatic truth criterion," which claims that truth is defined by usefulness (workability, achieving a goal one has) in a local sense. For example:

- Handbook of CBS: "For contextualism, *the truth criterion is 'successful working'*" (Biglan & Hayes, 2016; p. 44, emphasis added)
- ACBS website: "ACT emphasizes *workability as a truth criterion*, and chosen values as the necessary precursor to the assessment of workability because values specify the criteria for the application of workability" (contextualscience.org/philosophical_roots, accessed 2024; emphasis added).
- PBT book: "*Truth is* [...] the extent to which a particular analysis occasions '*successful working*' or is considered 'viable'" (Hayes & Hofmann, 2018; p. 29, emphasis added)
- Introductory article in JCBS (Hayes, Barnes-Holmes & Wilson, 2012): truth is a matter of workability and defending the validity of ultimate purposes is a fool's errand (p. 4).
- ACT book (Hayes et al., 2012a): "*Truth [...] is defined* [!] *by* whether a particular activity (or set of activities) helped *achieve a stated goal*" (p. 31; emphasis added).
- "In all [!] forms of contextualism and in ACT, <u>what is true is what works</u>. <u>Truth</u> of this sort <u>is always local</u> and pragmatic. <u>*Your* truth may not be *mine*</u> if we have different goals" (p. 33; italics in original, underlining added)

In light of this, it should not come as a surprise that O'Donohue concluded that the philosophy behind ACT has a problematic view on truth, in that truth is up to individuals and their goals. As McKay and O'Donohue (2023) put it, "ACT's metascience does not directly share the usual scientific norms of a commitment to truth, transparency, and accuracy," but rather "if the goal is to persuade or to pursue some personal reward, then functional contextualism simply evaluates the behavior on whether it helps the person achieve this chosen goal" (p. 931).

Nevertheless, Hayes et al. in their reply paper called these conclusions "grotesque misunderstandings" (Hayes et al., 2023; p. 1042). They did so because, according to them, even though goals in ACT are personally chosen, the goals of functional contextualism are prechosen; therefore, the goals of the philosophy of science behind ACT are not up to the individual (p. 1043).

For example, the passage from the handbook of CBS cited above continues as follows:

> For contextualism, the truth criterion is "successful working." That is, a contextual analysis is held to be true or valid if it helps you to achieve some goal. *The goal for functional contextualism, by declaration, is prediction and influence with precision, scope, and depth* (Biglan & Hayes, 2016; p. 44; emphasis added).

While this may be so, the rest of this paper argues that this does not invalidate the above critiques of functional contextualism and CBS. Specifically, the following points will be argued: The alleged pragmatic truth criterion neither captures the usual notion of truth, nor is it compatible with pragmatic truth as understood by William James (1907, 1909). Not only that, it is not even pragmatic by its own standards: it is likely to be harmful with respect to the publicly stated goal of CBS, and of little if any benefit. Furthermore, the fact that functional contextualism refers to the specific goal of "prediction and influence with precision, scope, and depth" does not automatically mitigate any of the problems just listed.

Truth, Usefulness, Myopia

Truth and Usefulness

When US president George Bush claimed in 2003 that Iraq possessed weapons of mass destruction, this seems to have been useful for him: he was able to start the war he wanted, and there seem to have been no adverse consequences for him. But there were no such weapons; so this claim, while it worked for him, was not *true* (in the regular sense of the word). The North Korean government's claims that there are no famines in its country may help keep it in power, but this does not stop people there from starving in large numbers (Fahy, 2015; p. 20). In the twentieth century, in all major wars the aggressors claimed victimhood (Snyder, 2010; p. 399); for example, in 1939, Nazi Germany pretended that Poland had attacked it, and that in starting a war it was only "shooting back." Today there is a war of aggression being waged in Europe, again involving claims of self-defense of a great power against a much smaller neighbor. Whether such a claim turns out to be useful for the one making it is clearly not the same question as whether it is true.

One can easily multiply these examples: usefulness and truth of a statement are quite different. Crucially, in the examples presented here, they are not only different in an abstract sense, but in a pragmatic way: the difference between truth and usefulness is often "a difference that makes a difference," as pragmatists like to say.[1]

Myopic Pragmatism

The above examples concern what one may call a myopic version of pragmatism, where the concern is exclusively with achieving a specific goal. In contrast, William James, while stating that "the true" is only the expedient in the way of thinking, clarified immediately: "expedient in almost any fashion, and

[1] As William James (1907) put it, "the pragmatic method is primarily a method of settling metaphysical disputes that otherwise might be interminable. [...] If no practical difference whatever can be traced, then the alternatives mean practically the same thing, and all dispute is idle." Surely it is not idle to ask whether a claim that a war was started in self-defence is true, or only useful for the person speaking.

expedient in the long run and on the whole, *of course*; for what meets expediently all the experience in sight won't necessarily meet all farther experiences equally satisfactorily," (James, 1909 / 2010; p. 6, emphasis added). Later in the book he added: "When we spoke of the meaning of ideas consisting "in their 'practical' consequences" [...] particular consequences can perfectly well be of a theoretic nature" (James, 1909 / 2010; pp. 153, 156) and "I apprehended no exclusively subjectivistic reading of my meaning. My mind was so filled with the notion of objective reference that I never dreamed that my hearers would let go of it" (James, 1909 / 2010; p. 172). Indeed, he even noted that "*the name 'pragmatism,' with its suggestions of action, has been an unfortunate choice*" (James, 1909 / 2010; p. 139, emphasis added).

Whether this results in a viable view on truth (in the regular sense of the word), and whether James was consistent in this, are questions that need not be discussed here. What is important is the stark contrast with ACT proponents' claim that "truth" is defined by workability in a local sense, and subjective. Henceforth, this latter claim will be referred to as "myopic pragmatic truth (criterion)," and functional contextualism as "myopic pragmatism," since neither functional or contextual thinking nor pragmatic philosophy imply the myopic version advanced under the heading of "functional contextualism" (see the Discussion section at the end of the paper).

Clearly, the myopic pragmatic truth criterion does not correspond to the usual notion of truth. To this, it could conceivably be answered that myopic pragmatists might not assert it because it is true in the usual sense, but because they find it useful to do so (thus "true" according to the way they use the word). The next two sections of this paper argue that, at least with regard to the publicly stated goal of CBS, this seems unlikely.

Myopic Pragmatic "Truth": Likely Harm

CBS and the Human Condition

According to the proponents of ACT, usefulness must be evaluated with regard to a specific, publicly announced goal (Hayes, 1993; p. 16). For CBS, the stated goal is "to create a behavioral science more adequate to the challenges of the human condition."[2] It seems hard to imagine someone disagreeing with this goal. It seems equally hard to evaluate whether something is useful for approaching this goal, as long as it is not spelled out how one views the human condition. On a plausible view of (an important aspect of) the human condition, proclaiming the myopic pragmatic truth criterion seems inconsistent with the above goal, as will be argued next.

Truth and the Human Condition

Does (ab-)use of the word "truth" matter? That might seem a strange ques-

[2] This goal is proclaimed both in the title, and the very first paragraph, of the article that introduced CBS. (Hayes, Barnes-Holmes & Wilson, 2012c) Note that this seems prima facie to be a different goal from prediction-and-influence with precision, scope, and depth. Nevertheless, proponents of functional contextualism and CBS seem to believe that these goals are effectively the same. For example, Biglan & Hayes (2016, p. 37) claimed that "following the functional contextualist strategy makes it more likely that the behavioral sciences will contribute to the improvement of human well-being." One of the purposes of the present paper is to raise doubts about this (at least as long as these goals are commingled with myopic "truth").

tion in the age of alternative facts and post-truth: at the time of writing, problems with the global climate are worsening, political polarization is increasing within and between nations, and there seems to be a re-emerging tendency for leaders of great powers to resort to violence in achieving their goals. To many (including the present author) these appear to be among the major current challenges of the human condition. Yet it seems highly implausible to blame any of these, or similar issues, on people paying too much attention on whether their beliefs are true in the usual sense of the word. On the contrary, lack of concern with truth—indifference to how things really are—is what the famous moral philosopher Harry Frankfurt (2005) referred to as "bullshit" (p. 33) and saw as one of the most salient features of our culture (p. 1). The term is now widely used both in psychology and philosophy.[3] The difference between bullshit and lying is laid out as the following:

> Someone who lies and someone who tells the truth are playing on opposite sides, so to speak, in the same game. Each responds to the facts as he understands them, although the response of the one is guided by the authority of the truth, while the response of the other defies that authority and refuses to meet its demands. The bullshitter ignores these demands altogether. He does not reject the authority of the truth, as the liar does, and oppose himself to it. He pays no attention to it at all. By virtue of this, bullshit is a greater enemy of the truth than lies are (Frankfurt, 2005; p. 61).

Unfortunately, myopic pragmatism appears to align with Frankfurt's characterization of discourse that is indifferent to questions of truth in the usual sense of the word. Indeed, one of the main figures in functional contextualism proclaimed already in the title of a paper (that was approvingly quoted several times by myopic pragmatists) that he sees "[n]o place for reality and truth" (Barnes-Holmes, 2000).

Why Reality and Truth Need a Place

Missionary Zeal

> Those outside of the CBS community are sometimes worried about its expansive goals and enthusiasm. […] Skinner provided an example: he was but a fledgling animal researcher when he wrote his utopian novel *Walden Two* (1948). That might seem arrogant or even frightening, but it is neither (Hayes, Strosahl, & Wilson, 2012; p. 373).

Maybe one should be worried because of *Walden Two*. More precisely, because of what Skinner wrote in his 1976 preface to *Walden Two*, entitled "*Walden Two* Revisited": "China may be closer to the solutions I have been talking about." This is relevant in the present context: in his paper "*Why Contextual Behavioral Science Exists*," Steven Hayes (2016; p. 10)—the main developer of ACT and the related philosophies—explained his interest in Skinner's work as relating to his utopian vision and missionary zeal. Indeed, *Walden Two* had led Hayes to become a behaviorist in the first place (Hayes, 2015; p. xx), as he thought that *Walden Two* was a blueprint for a world with more human cooperation, better child rearing, healthier environments, and more satisfying workplaces (Hayes, 2019; p. 50). Laudable goals, to be sure. Unfortunately, this does not seem to describe today's China, let alone that of 1976.

[3] A search for "bullshit" on Semantic Scholar gave 142 results in psychology and 239 results in philosophy.

Indeed, Skinner wrote the above in the very year in which the communist party leader Mao Zedong died, under whose rule dozens of millions had died through starvation, persecution, prison labor, and mass executions (Fenby, 2008; Yang, 2012). To be fair, Skinner may (or may not) have backtracked somewhat by continuing after the above quote with noting that a Communist revolution in America is hard to imagine (*not* that it would be undesirable) and referring to Lenin(!) for the question of how much suffering one can (*not* how much one may) impose on those now living for the (presumed!) benefit of those in the future.

Whatever Skinner's exact views on this may have been, many intellectuals did support Maoism (Lovell, 2019). This holds despite the fact that they must have known (*if they had bothered to compare their opinions with reality*)[4] that many facets of Maoism were horrible: Dozens of millions starving during the so-called "great leap forward" into the Great Chinese Famine (Yang, 2012); the vicious power struggle of the decade before 1976, euphemistically referred to as "cultural revolution"; the Maoist *Khmer Rouge* in Cambodia massacring more than a quarter of the population within under 4 years (Cruvellier, 2014); various Maoist terrorist movements (Lovell, 2019), among which the *Sendero Luminoso* ("shining path [of Mao Zedong ideas]") in Perú stood out both through its brutality and through the cowardice of its leader (a philosophy professor) when he was captured; to name just a few.

Nevertheless, there seems to be no reason to assume that those who supported Maoism were not well-intended; it seems more likely that they were blinded to the consequences by their *enthusiasm* (compare also the discussion in the eponymous subsection later in the present paper). This illustrates that, if you care about doing good, truth and reality are not optional: you have to make sure that it works as intended.

How Do You Know? An important problem, while mostly ignored in CBS and functional contextualism, was recognized at least once: The question "how do you know that it works?" is very tricky one to answer for the functional contextualist (Hayes, 1997; p. 40). The answer proposed in Hayes (1997) is that this involves "nonverbal knowing." Whether this makes sense in the simple examples given therein (e.g., "a person 'knows' that they have been hit and they 'know' that it hurts; if the person was given a way to avoid being hit the person would 'know' that the hitting had stopped"; p. 42) will be left aside here. But it surely does not do to judge all matters this way: it is science that shows us that "nonverbal knowledge" is often wrong, and therefore far from always reliable. That the earth is stationary seems just as obvious as the sensation of hurt when being hit; meanwhile, the idea that humans evolved from other animals is counter-intuitive to an extent that many still deny it, to name just a few examples (Hossenfelder, 2022; Sapolsky, 2023; Skinner, 1971). Our decisions are not nearly as free as we feel—if they are at all. If functional contextualism is to be a philosophy of science, it owes us a more detailed account of how science is meant to work without

[4] As for example already Aron (1955) noted, "La Chine de Mao Tse-toung, en cette fin d'année 1954, a pris la succession de la Yougoslavie de Tito. Plus vaste, plus mystérieuse que le pays du David balkanique, elle va réaliser enfin le vrai communisme. Comme personne ne déchiffre les caractères de l'écriture, que les visites se limitent à quelques villes et quelques usines, *l'enthousiasme des voyageurs n'est guère menacé par le contact du réel.*" [emphasis added]

pointing to "facts" (Hayes, 1997; p. 40, in scare quotes in the original), beyond the general claim that there is a meaningful link between verbal and nonverbal repertoires[5] (p. 41).

Enthusiasm. To evaluate whether a stated goal is approached, one needs to recourse precisely to what is disavowed (i.e., comparison with reality). Basing this evaluation exclusively on some unspecified "nonverbal knowing" is problematic, as we have seen. There are at least two more reasons why such enthusiasm may be detrimental to the human condition. First, by proclaiming the supposed myopic pragmatic truth criterion, one likely contributes to the overall disregard for truth in society. Second, to be convinced that one is working for the common good is no proof that one actually *is*. A full discussion of these is unfortunately beyond the scope of this paper; nevertheless the following provides a brief sketch.

Concerning the first problem, one can point to evidence of contagion in disregard for truth: For example, information about the dishonesty of other people increases dishonesty, as confirmed by a recent meta-analysis (Gerlach et al., 2019). Lack of respect for truth also spilled over from postmodernism to right-wing politics (McIntyre, 2018; chapter 6). This possible contagion should be of concern even for those who believe that the appeal to precision, scope, and depth suffices to prevent problematic behaviors by CBS adherents themselves.[6]

Concerning the second problem, pretty much everyone feels righteous; human biases in general, the bias blind spot in particular (Pronin & Hazel, 2023; Pronin et al., 2002), and group think (Bénabou, 2013) make it extremely difficult to be sure that one is "on the right side." This includes even the most extreme cases: as already mentioned, the historian Timothy Snyder noted that "[n]o major war or act of mass killing in the twentieth century began without the aggressors or perpetrators first claiming innocence and victimhood" (2010; p. 399). Even the Nazis thought they were on the morally good side: "the road to Auschwitz was paved with righteousness" (Koonz, 2003; p. 3). As the philosopher Moeller (2009; p. 31) succinctly observed: "*actions performed self-righteously always feel right to the self that performs them*."[7]

It may be that "[e]nthusiasm is a force for good if it is kept linked to science values" (Hayes, Strosahl, & Wilson, 2012; p. 373), but when you are under the spell of a strong emotion (e.g., enthusiasm—the word itself deriving from the Greek for "divine obsession") you are in a bad position to check whether you and those you align with are indeed keeping up scientific values. Even more so if you start with a blanket disavowal of "verbal knowing," as in "it is ultimately impossible to justify knowledge claims by pointing to 'facts' that fit in with the claim" (Hayes, 1997; p. 40).

---

[5] One may also ask why myopic pragmatists would care about science in the first place, if they believe that progress in science is not real, as for example Monestès & Villatte (2015; p. 211) claimed.

[6] It is also important to keep in mind that allegiances are flexible: who you consider favourably may join the other side in the future. For example, early in his political career, Mussolini was a leader of the Italian socialist party. It is also worth remembering that from 2001 to 2009, Donald Trump was a member of the Democratic party.

[7] Furthermore, hypocrisy is a huge problem, much bigger than is widely assumed (Batson, 2015).

Prediction, Influence, Ethics

The above considerations point to serious problems with publicly proclaiming that local usefulness is a truth criterion, as myopic pragmatist do. Importantly, these are independent of whether or not one simultaneously states for oneself a specific goal.

Furthermore, O'Donohue accused the metascientific perspective behind ACT with having a substantial "Machiavellian" component: if values are only evaluated as to whether they work for the individual, then, he argued, one can promote behavior that is selfish and possibly harmful and destructive to others. Refering to Machiavelli, he observed in addition that this may be even more workable if hidden behind a facade of virtue. This he distinguished from that which he took to be conventional pragmatism, which is additionally concerned with whether something works for others affected by the act or for society as a whole (O'Donohue, 2023; p. 965).

Hayes et al. (2023) tried to answer this charge of a possibly Machiavellian understanding by asserting that the pragmatic criterion "does *not* mean that any scientific purpose or 'goal' is legitimate within functional contextualism" (p. 1042). They invite the reader to imagine a manipulative scientist whose goal is to become powerful in the academic world, and claim that "[b]y definition, if someone pursues such a goal as the anchor for their science, that is very different from pursuing 'prediction-and-influence with precision, scope, and depth,' so this is not functional contextualism" (p. 1043). Further, they claim that, empirically, these two goals are incompatible (p. 1044).

To the present author, the empirical claim seems implausible, and the alleged theoretical incompatibility seems far from clear as well: how can you intentionally become powerful in the academic world, unless by predicting and influencing others' behavior?

Neither claim provides a careful argument and / or empirical data. To the present author, the empirical claim seems implausible, and the alleged theoretical incompatibility seems far from clear as well: how can you intentionally become powerful in the academic world, unless by predicting and influencing others' behavior? Using only a limited number of analytic concepts that apply to a range of cases and that cohere with established science (i.e., predicting and influencing with precision, scope, and depth) seems in no way incompatible with becoming powerful in academia either (maybe "depth" implies that one will be found out in the long run, but the long run is something that myopic pragmatism by definition disregards; recall that "In all [!] forms of contextualism and in ACT, what is true is what works. Truth of this sort is always local [...]" [Hayes et al., 2012; p. 33]). Thus, the example offered by Hayes et al. does not appear to establish the intended distinction. In particular, the empirical claim is not substantiated, and the proposed theo-

retical incompatibility remains insufficiently specified and unargued.

Fortunately, being *compatible* with undesirable behavior need not in itself be a problem. The crucial question is whether something is *conducive* to such behavior (by oneself, or in society more generally). The argument of the present paper is that while pragmatic thinking *per se* does not seem to be, myopic pragmatism may well be—even if probably unintentionally. At the very least, to avoid it one needs to compare the intended effects of one's actions with what happens in reality. Enthusiasm alone is not enough—whether within science or concerning society at large.

Myopic Pragmatic "Truth": Offsetting Benefits?

Assuming one agrees that proclaiming myopic pragmatic "truth" is seriously problematic, might there be important benefits that outweigh those risks? In this section, possible benefits related to psychotherapy will be discussed first, then possible benefits to the human condition more generally.

Psychotherapy

If it is posited that suffering arises "when people so strongly believe the literal contents of their mind that they become *fused* with their cognitions" (Hayes, Strosahl, & Wilson, 2012; p. 20), doesn't it follow that it is unavoidable to redefine truth to reduce suffering, at least in the area of mental health? Not necessarily. Note that the problem arises when people *strongly* believe the literal contents of their mind. The issue is not *whether* you believe that your thoughts are more-or-less true, but *how certain* you are about having the complete truth and nothing but the truth. Thus it should not come as a surprise that other approaches, including Meta-Cognitive Therapy and various mindfulness-based interventions, arrived at ideas very similar to defusion in ACT— all without subscribing to the myopic pragmatic "truth" criterion, as far as the present author knows. As Hayes et al. (2022; p. 2) noted: "the so-called 'third wave' could never have happened based on ACT alone—it took DBT, MBCT, FAP, BA, MCT, CFT,[8] and many more." Indeed, similar ideas can already be found in ancient Greek (and Buddhist, of course) philosophy, as explained in Mattes (2022).

Moreover, Hayes et al. (2023; p. 1037) themselves admitted that "a process-based approach is emerging from many corners of CBT," so there is no reason to assume that the idiosyncratic use of the word "truth" in myopic pragmatism is relevant to it. Regarding the recent idionomic approach advocated in Hayes et al. (2023), the situation seems no different: behavior analytic concepts were, in the main, already idionomic (Hayes et al., 2022; p. 9), and the CBS community was "awakened" (Hayes et al., 2023; p. 1049) to problems inherent in standard psychometrics only by Molenaar (2004), a paper in which none of the terms "function," "contextual," or "pragmatism" appear. In sum, myopic pragmatic truth is not necessary for an idionomic approach, for PBT or for ACT. Tellingly, in the most recent survey of the history of ACT and CBS, the word "truth" did not appear at all (Hayes & King, 2024).

Nurturing and Prosocial

[8] The acronyms refer to Dialectical Behavioral Therapy, Mindfulness Based Cognitive Therapy, Functional Analytic Psychotherapy, Behavioral Activation, Meta-Cognitive Therapy, and Compassion Focused Therapy, respectively.

Biglan (2015) promised a science of human behavior that can improve our lives, by creating nurturing environments that lead to societies that are happier and healthier, with the thinking of the author being guided by functional contextualism (p. 14). Similarly, Atkins et al. (2019) aimed to further human thriving by improving the ability to get along and cooperate with others, employing ACT's psychological flexibility model to implement interventions. Does this prove that the alleged myopic pragmatic truth criterion has beneficial effects?

Not that the present author could see: neither the expression "pragmatic truth" nor "truth criterion" appeared in either of these two books. Biglan did write, "what we say about the world is better thought of as talk that may be useful for some purpose, rather than truth with a capital T" (p. 5), and "words are not seen as *definitive* descriptions of the way the world is, but as ideas that may be useful" (p. 37, emphasis added), but such statements are far from claiming that truth is defined by local usefulness, as myopic pragmatism would claim.

On the other hand, as Atkins et al. (2019) noted, fostering trust is important, since a lack of trust can interfere with cooperation (p. 64), in particular when conflict runs high (p. 67). But why would one trust the statements of someone who is merely interested in achieving their goals[9], rather than communicating on a shared basis? Of course, just because someone claims to tell the truth this need not mean they are not lying. But at least they can be held accountable when the lie is revealed, while the myopic pragmatist can point out never to have claimed to tell things as they are. Because of truth default, the human tendency to believe (Gilbert et al., 1993), others may overlook this in the short run and take the myopic pragmatist to be interested in and responsive to truth in the usual sense. Nevertheless, in the long run this seems likely to be detrimental to the overall level of trust and well-being in society. But even if we assume that myopic pragmatists themselves do stick to the truth (despite their publicly stated disregard for the usual notion of truth), already the repeated proclamation of myopic "truth" will tend to contribute to the general devaluing of truth and corrosion of trust, which in turn is highly problematic:

Trust is a central source of well-being in a society. When individuals feel that they can trust others, cooperative interactions become more likely, making a group of individuals able to enjoy better outcomes than the sum of individual stand-alone efforts would achieve. Opportunistic and dishonest behavior hinders trust by generating negative feedback to trusting behavior (Georgantzis et al., 2022).

Discussion

Dogmatism

According to Hayes et al. (2023; p. 1042), one of the seminal papers in the development of functional contextualism was Hayes (1993). The latter paper pointed to the importance of avoiding dogmatism, defined as "cognitive claims that go beyond the cognitive evidence" (p. 17). It even referred to dogmatism as the common error of contextualism (pragmatism). In particular, William James was accused of being dogmatic in not explicitly specifying one

[9] Whatever these may be—they may publicly state goals, but these are again just speech acts which under this logic serve a goal possibly different from telling things as they are.

goal. But in this, Hayes implicitly assumed that James had to subscribe to myopic pragmatism—a dogmatic assumption on the part of Hayes: while providing several quotes relating to truth from James (1907 / 2010), he neglected to mention James's emphasis on the whole and the long run, which is seen not only in his book dedicated to the concept of truth (James, 1909 / 2010), but also already in statements including that truth needs to adapt life "to the reality's whole setting" (James 1907 / 2010; chapter 6). In addition, since it is asserted that goals and assumptions must be *verbally* stated (Hayes 1993, p. 16), this implies that nonverbal knowing (Hayes, 1997), even though it may be necessarily involved in myopic pragmatic truth (Biglan & Hayes, 2016; p. 49), does not help avoiding dogmatism.

The notion that pragmatism is in danger of veering in the direction of dogmatism, in particular with respect to its view on truth, was already noted over a century ago:

> [A]s regards the fundamental questions of philosophy—especially […] the nature of truth—pragmatism is absolutely dogmatic. The hypothesis that pragmatism is erroneous is not allowed to enter for the pragmatic competition; however well it may work, it is not to be entertained. To 'turn your back resolutely and once for all' upon the philosophy of others may be heroic or praiseworthy, but it is not undogmatic or open-minded. (Russell, 1908 / 2020)

False Dichotomies

Another point where myopic pragmatism is dogmatic is in setting up false dichotomies. One of these is between scientific theories, which can be evaluated, and philosophical assumptions, about which no discussion is allowed ("assumptions are pre-analytic"; Hayes et al., 2023; p. 1041). This presupposes a clear separation between science and philosophy. But no less a pragmatic philosopher than Willard Van Orman Quine noted that there is no sharp dichotomy between "science" and other naturalistic epistemic enterprises including naturalistic philosophy:

> The boundary between naturalistic philosophy and the rest of science is just a vague matter of degree. (Quine, 1995; 257)

> [S]cience is not a substitute for common sense, but an extension of it. The quest for knowledge is properly an effort to broaden and deepen the knowledge which the man in the street already enjoys, in moderation, in relation to the common place things around him. (Quine, 1997; 229)

Of course, the myopic pragmatist may, for whatever reason, find it useful to claim that there *is* such a dichotomy, but this claim would be dogmatic unless it is well-argued. Notably, such an argument would presumably involve the results of empirical claims on the consequences of positing such a dichotomy, therefore involving empirical analysis. This shows that the philosophical assumptions underlying a scientific analysis cannot be perfectly insulated from scientific analysis proper, in contrast to what, for example, Hayes et al. (2023; p. 1043) would demand. There is also no inherent contradiction in using the results of an analysis to iteratively adjust the assumptions underlying the analysis. For example, if analysis shows one's assumptions to be contradictory, or a goal to be

hopeless, it would seem reasonable to reconsider one's assumptions and / or goals. Consistent with this, the pragmatic philosopher Nicholas Rescher (2016; p. 123) pointed out that "a pragmatism that is consistent, coherent, and self-sustaining will not just proceed pragmatically with respect to achieving unevaluated ends and purposes."

Consequences

Myopic pragmatists sometimes try to argue that pragmatism and / or behaviorisms and / or evolutionary thinking imply the myopic pragmatic truth criterion. Stopping to assert the latter would then seem to have the consequence that one has to give up some or all of the former. Fortunately, the arguments advanced to show that myopic pragmatic truth is implied by these more general assumptions are, as far as the present author is aware of them, flawed. Here is a brief discussion of some of them:

Barnes-Holmes (2000; p. 199) claimed that because the verbal behavior of a scientist is part of a single behavioral stream, this implies that it "does not *refer* or *correspond* to an external reality" (original emphasis). Instead, it supposedly only matters whether one states verbally that a previous verbal behavior led to achieving a verbally stated goal. To his credit, he noted that "behavioral pragmatism may appear somewhat 'autistic' in its emphasis on the personal goals of a single pragmatist," but claimed that this is avoided if one adopts the goal of getting others to agree. There are a number of serious problems with that approach. First, even if this would be possible, one would only end up with "solipsism with a 'we' instead of an 'I'" (as Putnam [1992; ix] put it with regard to Rorty). Second, how does one know if others agree? If it is just a matter of discrimination within the one behavioral stream, as Barnes-Holmes states, this takes us back to ordinary solipsism; if not, then it requires correctly perceiving an external reality. Finally, the whole argument is based on setting up a false dichotomy between realism (that supposedly posits an "immutable, absolute, and final" truth) versus no reality and truth at all. But realism only means "that *despite the role that minds play in the creation of various entities*, there is still something about those entities—*some aspect of their nature*—that *is mind-independent*" (Miller, 2022; p. 9, emphasis added). There is room for a middle way between naive realism and the blanket denial of any place for reality and truth (compare, for example, the pragmatic realism of Legg and Sant'Anna [2024]).

Hayes et al. (2023; p. 1044) referred to Hoffman (2019), who claimed that "evolution hid the truth from our eyes" so that we do not have only a limited, partial, more-or-less biased view of reality, but supposedly "[w]e see *none* of reality as it is." Yet, despite Hoffman's claim to the contrary, his theory is self-defeating (Bagwell, 2023), and Berke et al. (2022) pointed to additional problems with the scientific argument.[10] The latter found in simulations that, as the need for flexible goals increases, inflexible perceptual systems become more veridical. This is of particular interest, as it shows that *truthfulness can add to workability*, in contrast to the dogmatically repeated assertion that "claiming that

[10] See also Mattes (in press) for an overview and further arguments against Hoffamn's claim.

something works 'because it is real' adds nothing to workability"[11] (e.g., Biglan and Hayes, 2016; p. 49).

Hayes and Long (2013; p. 19) claimed that "the realist agenda" is inconsistent with a functional approach. This inconsistency supposedly arises because "selectivist accounts make unnecessary the work of providing guidance about *how one would know when* a truth-as-correspondence relation has been established" (original emphasis).[12] Remarkably, Hayes and Long (2013) neglected to refer to Hayes (1997), with its insight that the question "how do you know that it works?" *does* need an answer (even if the answer to the question suggested in that paper is flawed, as argued above). Not that a better understanding of the "how" needs to be a goal in itself, but any scientifically respectable form of pragmatism needs *justified* beliefs *that* it works, which seems hard to come by without at least some grasp on a "how" that goes beyond a vague reference to some unexplained non-verbal way of knowing.

Conclusion

The present paper criticized one specific aspect of the philosophy advanced by ACT proponents: its problematically "local" and subjective version of pragmatism with its myopic "truth" criterion. The latter was argued to be questionable in particular from the standpoint of adequacy for the challenges of the human condition, a goal that CBS itself proclaims. Restricting to the realm of psychotherapy, even if at this time the proponents of ACT follow appropriate scientific practices (which is the case, as far as the present author is aware), the question inevitably arises how robust this commitment is. By the inner logic of myopic pragmatism, to follow scientific practices is motivated by the belief that it is useful in a local sense (see above section "ACT and Truth"). But this raises the question of what will happen if and when the results of applying scientific method do not align with the chosen goal. Therefore, scientific claims made by ACT proponents may require more scrutiny from the scientific community than is customary, as long as they consider local usefulness the criterion for truth.

On the other hand, myopic pragmatism is implied by *none* of pragmatism, behaviorism, functionalism, or evolutionary thinking, nor by the publicly stated goals of CBS or of functional contextualism. This raises the question why the myopic truth criterion is proclaimed. The discussion in the "Dogmatism" section above suggested an explanation.

What does all this mean in practice? This author suggests we remind ourselves that the ultimate goal of ACT is "to undermine the hegemony of human language and bring our clients and ourselves back into broader contact with knowledge—including intuition, inspiration, and simple awareness of the world" (Hayes, Strosahl & Wilson, 2012; p. 26). In this sense, we know very well that truth and local usefulness are dif-

[11] The present author has yet to see an argument for this claim. It certainly is not entailed by pragmatism. On the contrary, James (1909/2010; p. 12) wrote "I try to refute the slanderous charge that we deny real existence, I will say here again, for the sake of emphasis, that the existence of the object, whenever the idea asserts it 'truly,' is the only reason, in innumerable cases, why the idea does work successfully, if it work at all."

[12] In contrast, Shields (2023) argued that "our best pragmatist account of truth may well be a version of the correspondence theory."

ferent concepts: the belief that one first needs a philosophical definition of truth is just one of the cases where the hegemony of language misleads us. Further, we might want to remind ourselves of the danger of false dichotomies, not least that lying between an immutable, absolute, and final truth on the one hand, and no reality and truth on the other. Taking this into account in our practical work with our clients, dropping the pretence that truth and local usefulness are the same is unlikely to interfere with our ability to help clients towards defusing from rigidly held narrow beliefs. Concerning the ambition to create a science more adequate to the challenges of the human condition, broader knowledge appears to be even more important: being in contact only with perceived positive consequences of one's actions seems problematic, as responsible action requires that one also faces up to any negative consequences thereof. We need to ensure (as well as we can) that our beliefs, our assertions, and our actions have overall positive consequences on reality.

REFERENCES

Aron, R. (1955). *L'Opium des Intellectuels*. Calmann-Lévy.

Atkins, P. W., Wilson, D. S. & Hayes, S. C. (2019). *Prosocial: Using Evolutionary Science to Build Productive, Equitable, and Collaborative Groups*. New Harbinger Publications.

Bagwell, J. (2023). Debunking interface theory: Why Hoffman's skepticism (really) is self-defeating. *Synthese, 201:25*.

Barnes-Holmes, D. (2000). Behavioral pragmatism: No place for reality and truth. *The Behavior Analyst, 23*, 191-202.

Batson, C. D. (2015). *What's Wrong With Morality? A Social-Psychological Perspective*. Oxford University Press.

Bénabou, R. (2013). Groupthink: collective delusions in organizations and markets. *The Review of Economic Studies, 80*, 429-462.

Berke, M., Walter-Terrill, R., Jara-Ettinger, J. & Scholl, B. (2022). Flexible goals require that inflexible perceptual systems produce veridical representations: implications for realism as revealed by evolutionary simulations. *Cognitive Science, 46: e13195*.

Biglan, A. (2015). *The Nurture Effect: How the Science of Human Behavior Can Improve Our Lives*. New Harbinger Publications.

Biglan, A. & Hayes, S. C. (2016). Functional Contextualism and Contextual Behavioral Science. In R. D. Zettle, S. C. Hayes, D. Barnes-Holmes & A. Biglan (Eds.), *The Wiley handbook of contextual behavioral science* (pp. 37-61). John Wiley & Sons, Ltd.

Cruvellier, T. (2014). *The Master of Confessions: The Making of a Khmer Rouge Torturer*. Ecco.

Elliott, W. Y. (1926). Mussolini, prophet of the pragmatic era in politics. *Political Science Quarterly, 41*, 161-192.

Fahy, S. (2015). *Marching Through Suffering: Loss and Survival in North Korea*. Columbia University Press.

Fenby, J. (2008). *Modern China. The Fall and Rise of a Great Power, 1850 to the Present*. Ecco.

Frankfurt, H. G. (2005). *On Bullshit*. Princeton University Press.

Georgantzis, N., Jaber-Lopez, T. & Rodriguez-Lara, I. (2022). Editorial: Economic Games, (Dis)honesty and Trust. *Frontiers in Psychology, 13*.

Gerlach, P. , Teodorescu, K. & Hertwig, R. (2019). The truth about lies: A meta-analysis on dishonest behavior. *Psychological Bulletin, 145*, 1-44.

Gilbert, D. T., Tafarodi R. W. & Malone, P. S. (1993). You can't not believe everything you read. *Journal of Personality and Social Psychology, 65*, 221-233.

Haack, S. (1995). Vulgar Pragmatism: An Unedifying Prospect. In H. J. Saatkamp

(Ed.), *Rorty & Pragmatism: The philosopher responds to his critics* (pp. 126-153). Vanderbilt UP.

Hayes, S. C. (1984). Making sense of spirituality. *Behaviorism, 12*, 99-110.

Hayes, S. C. (1993). Analytic goals and the varieties of scientific contextualism. In S.C.Hayes, L.J.Hayes, H.W.Reese & T.R.Sarbin (Ed.), *Varieties of Scientific Contextualism* (pp. 11-27). Routledge. Reprinted in Hayes (2015, 100–116).

Hayes, S. C. (1997). Behavioral epistemology includes nonverbal knowing. In L. J. Hayes & P. M. Ghezzi (Ed.), *Investigations in behavioral epistemology*) (pp. 35-43). Reno, NV: Context Press. Reprinted in Hayes (2015, 143–152).

Hayes, S. C. (2015). *The act in context: The canonical papers of Steven C. Hayes*. Routledge.

Hayes, S. C. (2016). Why Contextual Behavioral Science Exists. In R. D. Zettle, S. C. Hayes, D. Barnes-Holmes & A. Biglan (Eds.), *The Wiley handbook of contextual behavioral science* (pp. 9-16). John Wiley & Sons, Ltd.

Hayes, S. C. (2019). *A Liberated Mind: How to pivot toward what matters*. Penguin.

Hayes, S. C., Barnes-Holmes, D. & Wilson, K. G. (2012). Contextual Behavioral Science: Creating a science more adequate to the challenge of the human condition. *Journal of Contextual Behavioral Science, 1*, 1 - 16.

Hayes, S. C., Ciarrochi, J., Hofmann, S. G., Chin, F. & Sahdra, B. (2022). Evolving an idionomic approach to processes of change: Towards a unified personalized science of human improvement. *Behavior Research and Therapy, 156*, 104155.

Hayes, S. C. & Hofmann, S. G. (2018). *Process-based CBT: The science and core clinical competencies of cognitive behavioral therapy*. New Harbinger Publications.

Hayes, S. C., Hofmann, S. G. & Ciarrochi, J. (2023). The idionomic future of cognitive behavioral therapy: what stands out from criticisms of ACT development. *Behavior Therapy, 54*, 1036-1063.

Hayes, S. C. & King, G. A. (2024). Acceptance and commitment therapy: What the history of ACT and the first 1,000 randomized controlled trials reveal. *Journal of Contextual Behavioral Science, 33*, 100809.

Hayes, S. C. & Long, D. M. (2013). Contextual Behavioral Science, Evolution, and Scientific Epistemology. In Dymond Simon & B. Roche (Ed.), *Advances in Relational Frame Theory: Research and Application* (pp. 5-25). Context Press.

Hayes, S. C., Pistorello, J. & Levin, M. E. (2012). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, 40*, 976-1002.

Hayes, S. C., Strosahl, K. D. & Wilson, K. G. (2012). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change* (2nd ed.). Guilford Press.

Herbert, J. D., & Padovani, F. (2015). Breaking the ontology taboo: Reply to Monestès and Villatte. *Journal of Contextual Behavioral Science*, 4, 235–236. https://doi.org/http://dx.doi.org/10.1016/j.jcbs.2015.10.004

Hoffman, D. D. (2019). *The Case Against Reality: Why Evolution Hid the Truth from Our Eyes*. W.W. Norton & Co.

Hossenfelder, S. (2022). *Existential Physics: a Scientist's Guide to Life's Biggest Questions*. Viking.

James, W. (1907/2010). *Pragmatism: A new name for some old ways of thinking*. The Floating Press.

James, W. (1909/2010). *The Meaning of Truth: A Sequel to 'Pragmatism'*. The Floating Press.

Koonz, C. (2003). *The Nazi Conscience*. The Belknap Press.

Legg, C. & Sant'Anna, A. (2024). Pragmatic realism: towards a reconciliation of enactivism and realism. *Phenomenology and the Cognitive Sciences, 24*, 213—230.

Lovell, J. (2019). *Maoism: a global history*. Knopf.

Mattes, J. (2022). ACTing as a Pyrrhonist. *International Journal for the Study of Skepticism, 12*, 101-125.

Mattes, J. (in press). The case against The Case Against Reality. *Biological Theory*.

McIntyre, L. C. (2018). *Post-truth*. MIT Press.

McKay, D. & O'Donohue, W. (2023). Conceptual, Psychometric, Methodological

and Value Problems in Acceptance and Commitment Therapy: Introduction to the Special Section, “A Critical Appraisal of Acceptance and Commitment Therapy”. *Behavior Therapy, 54*, 929-938. https://doi.org/10.1016/j.beth.2023.07.004

Miller, J. T. M. (2022). *Metaphysical Realism and Anti-Realism*. Cambridge University Press.

Moeller, H.-G. (2009). *The Moral Fool: a Case for Amorality*. Columbia University Press.

Molenaar, P. C. M. (2004). A manifesto on psychology as idiographic science: bringing the person back into scientific psychology, this time forever. *Measurement: Interdisciplinary Research and Perspectives, 2*, 201-218.

Monestès, J.-L. & Villatte, M. (2015). Humans are the selection criterion in psychological science, not “reality”: A reply to Herbert and Padovani. *Journal of Contextual Behavioral Science, 4*, 210 - 211.

O’Donohue, W. (2023). The scientific status of acceptance and commitment therapy: An analysis from the philosophy of science. *Behavior Therapy, 54*, 956-970.

Peirce, C. S. (1878). How to make our ideas clear [Illustrations of the logic of science, second paper]. *Popular Science Monthly, 12*, 286-302.

Pihlström, S. (2021). *Pragmatist Truth in the Post-Truth Age: Sincerity, Normativity, and Humanism*. Cambridge University Press.

Pronin, E. & Hazel, L. (2023). Humans” bias blind spot and its societal significance. *Current Directions in Psychological Science, 32*, 402—409.

Pronin, E., Lin, D. Y. & Ross, L. (2002). The bias blind spot: perceptions of bias in self versus others. *Personality and Social Psychology Bulletin, 28*, 369-381.

Putnam, H. (1992). *Realism with a Human Face*. Harvard University Press.

Quine, W. (1995). Naturalism; or, living within one’s means. *Dialectica, 49*, 251-263.

Quine, W. V. (1997). The scope and language of science. In W. V. Quine (Ed.), *The Ways of Paradox and other Essays* (Revised and enlarged edition. The original text appeared in the British Journal for the Philosophy of Science, 1957.) (pp. 228-245). Harvard University Press.

Rescher, N. (2016). *Pragmatism in Philosophical Inquiry: theoretical considerations and case studies*. Springer.

Russell, B. (1908/2020). William James’s Conception of Truth. In W. James & D. Olin (Eds.), *William James: Pragmatism, in focus* (2020). (Reprinted from the Albany Review, January 1908, where it appeared under the title ‘Transatlantic “truth” ‘). Routledge.

Sapolsky, R. M. (2023). *Determined: A Science of Life Without Free Will*. Penguin Press.

Shields, M. (2023). Truth from the agent point of view. *The Philosophical Quarterly*, 73, 1205–1225.

Skinner, B. F. (1948). *Walden Two*. (Reprinted 2005). Hackett Publishing.

Skinner, B. F. (1971). *Beyond Freedom and Dignity* (Reprinted 1976). Penguin Books.

Snyder, T. (2010). *Bloodlands: Europe between Hitler and Stalin*. Basic Books.

Stout, J. (2007). On Our Interest in Getting Things Right: Pragmatism Without Narcissism. In C. Misak (Ed.), *New Pragmatists* (pp. 7-31). Oxford University Press.

Yang, J. (2012). *Tombstone: The Great Chinese Famine 1958-1962*. Farrar, Straus and Giroux.

Update on Volunteering for ABCT:

Giving Thanks for Your ABCT Volunteer Efforts

We want to start this communication by recognizing and thanking the many hundreds of volunteers who currently, or in the past, have given their time and expertise to help grow this organization and advance ABCT's mission. As with most membership-based nonprofit associations, ABCT operates largely on a volunteer-based ecosystem. Few membership associations have enough permanent staff to manage all the work of the organization. In fact, many nonprofit organizations, particularly in their formative stages, rely almost exclusively on volunteerism for their governance, administrative and day-to-day operations. As membership associations grow and mature within their field or industry, most will necessarily evolve to hire professional staffers. Nonetheless, the work of its volunteer members will always remain indispensable, as volunteers are the heart and soul of a professional membership society or association. We recognize and thank all of you who have given your time serving in ABCT governance, leadership, committees, SIGs, taskforces, mentorship, or in any other way in support of our mission. ABCT does not exist without you!

We also wanted to take a moment to talk more generally about volunteerism and recent changes that have been initiated to make it easier for more members to volunteer and to bring ABCT up to best practices. To start, volunteerism in a nonprofit membership association context involves individual members offering their time, skills, and energy to support the organization's mission. Volunteerism is more than just "helping out"—it is a structured and intentional contribution aligned both with the individual's values and the organization's goals. Volunteerism is a part of the essential infrastructure that enables membership organizations such as ABCT to operate, connect, and create lasting impact.

Last year, we initiated a process of creating uniform procedures under which all committees of ABCT will operate. Moving forward, all ABCT committees will operate on term limits with a staggered rotation policy, so all committee members do not rotate off at the same time. The term limits are also intended to bring new members and ideas into the committees, as well as relieve members who have been serving for extended periods of time. Each committee was also asked to create or update their charge (purpose), as well as create annual benchmarks. Working with the chairs and coordinators, committees will also be asked to submit at least two reports to the ABCT Board each year. This way the Board can gauge the effectiveness of the committee in carrying out its charge, as well as identify ways to better assist each committee—if necessary—as they work to fulfill the mission-driven strategic objectives of the organization.

We also created an association-wide online portal called ***Volunteer Me***, where any member of ABCT can volunteer their service. All ABCT committees

are listed on the Volunteer Me portal with a short description of their charges. Volunteers may select the committee of their choice, to be considered, as well as submit a brief statement of interest. Chairs, staff, and leadership will vet the submissions and chairs will usually make the final recommendations as to whom they believe would be the best match for the committee's work. Each spring we will conduct our annual "Call for Volunteers" in April and May, with the goal of seeking new volunteers to keep committees current and fully populated. The committee year mirrors the Board and fiscal year, which runs from November to November. Please be on the lookout for the 2026 Call for Volunteers notice and plan to submit your name via the Volunteer Me portal if interested in serving.

Mutually Beneficial

Volunteerism, while important to the association, must also operate in a context where it's mutually beneficial. The member association benefits through member-donated time, skills, perspectives, and community support that advance its mission. The volunteers benefit through personal or professional growth such as skills development (e.g., leadership, communication, technical abilities), networking and community connection, resume or CV building, access to other experts in the field, and gaining experience relevant to career goals. There are also collective goals that benefit both the association and the volunteers such as helping to shape the field, giving back to the profession, and expanding the influence of the organization. Volunteer roles must also match the individual's interests, skills, or aspirations while meeting organizational needs.

In recent years there have been some declining trends in volunteerism across the board in North America. Some of this may be attributed to structural shifts such as economic pressures, or time fragmentations. The pandemic likely also affected this, as it did so many other aspects of life. However, there is some evidence that the decline may be reversing, according to the Initiative for Strategic Volunteer Engagement think tank. Importantly, associations across the board still maintain that the need for volunteers remains just as high as ever. We realize that ABCT is lucky to have so many members who are willing to contribute to our collective vision to broadly improve mental health for all using evidence-based interventions.

At their core, nonprofits organizations such as ABCT exist to serve communities and causes, and volunteers help make that possible. Here at ABCT we thank you and look forward to your continued service and investment in the future of ABCT. We believe that ABCT has and can continue to truly make this world a better place. We are grateful for your efforts to make that happen!

Courtney L. White, PhD, CAE
CEO, ABCT

Carolyn Becker, PhD, ABPP
President, ABCT

Volunteer Me | abct.org

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

Visit the Volunteer Me portal here!

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

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

Career Center

ABCT JOB BANK is the premier electronic recruitment resource for the industry. Here, employers and recruiters can access the most qualified talent pool with relevant work experience to fulfill staffing needs.

Whether an employer or a job-seeker, we'll help find the connection that's right for you, quickly and easily!

Get started today at:
abct.org/for-professionals/job-bank

Featured Jobs

Associate/Full Professor in Digital Health
Indiana University - Indianapolis | Indianapolis, Indiana
The Fairbanks School of Public Health and the School of Science Department of Psychology at IU Indianapolis invite applications for a tenured associate or full professor position in the digital health...
Posted - April 2, 2026 | Apply Now | Save job

Inaugural Psychiatry Residency Associate Program Director | MUSC Health Florence, SC
MUSC Health | Florence, South Carolina
The Medical University of South Carolina (MUSC) and MUSC Health Florence are seeking an outstanding candidate for the role of Residency Associate Program Director, to assist in leading and growing a n...
Posted - March 31, 2026 | Apply Now | Save job

Adolescent and Family Addiction Psychologist - Open Academic Rank
Emory University School of Medicine | Atlanta, Georgia
The Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine is seeking a full-time psychologist to join its outpatient faculty, open academic rank. The ideal candidate...
Posted - March 17, 2026 | Apply Now | Save job

Professional Development in Research
Selected tBT Articles Related to Professional Development in Research.

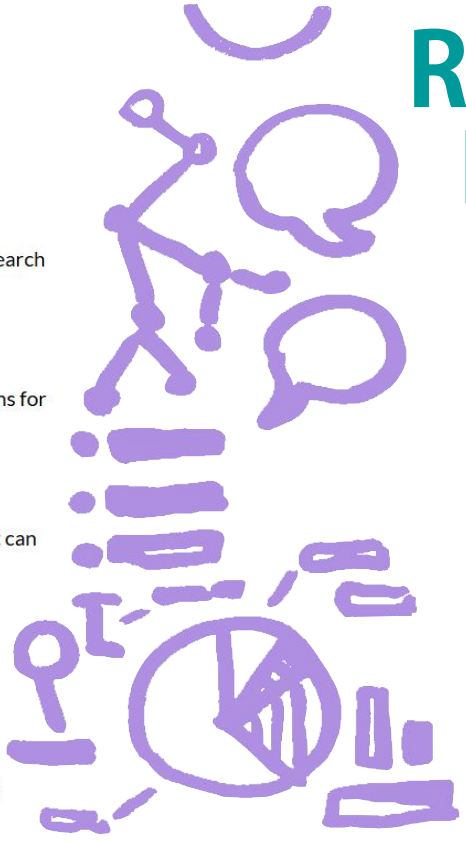
Research Method Spotlights
A curated collection of resources on different research methods relevant to the ABCT community.

Statistical Software & Resources
A list of third party statistical tools and applications for those doing CBT research.

Data Collection Tools
A list of data collection tools and applications that can be helpful for those doing CBT research.

Government Funding Agencies
Links to Government Funding Agencies

Grant Resources
The process of grant writing can be daunting for a professional at any stage of their career.



Resources for Researchers

ABCT is constantly evaluating how to best serve the research community.

Please take advantage of the growing number of helpful resources for researchers available at:

abct.org/for-professionals/research-resources

ELEVENTH WORLD CONFEDERATION OF COGNITIVE AND BEHAVIOURAL THERAPIES CONGRESS

MARRIOTT MARQUIS SAN FRANCISCO | 25TH - 28TH JUNE 2026

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 topics and sessions:

- 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

Ticketed Sessions

The Friendship Bench: Lessons From A Thousand Grandmothers | Dixon Chibanda, London School of Hygiene and Tropical Medicine & University of Zimbabwe

The Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents: Clinical Lessons from Global Successes in Modification and Implementation | Jill Ehrenreich-May, University of Miami

Existential Concerns and Cognitive-Behavioral Procedures: Managing Death, Isolation, Identity, Freedom and the Search for Meaning | Ross Menzies, University of Technology Sydney

CBT for ADHD in Adults – Basics and Beyond | Steve Safren, University of Miami

Cognitive-Behavioural Approaches for People with Complex Presentations of Psychosis | Gillian Haddock, University of Manchester

OCD Unlocked: Evidence-Based CBT Strategies for Immediate Impact | Lata McGinn, Yeshiva University

Context Matters: Cognitive and Behavioral Intervention with At-Risk Populations in the Global South | Silvia Helena Koller, Universidade Federal do Rio Grande

Exposure Therapy for Eating and Weight Disorders: Evidence, Practice, and Challenges | Anita Jansen, Maastricht University

Evidence Based Management of Intimate Partner Violence Against Women | Marta Rondon, Universidad San Martin de Porres and Instituto Nacional Materno Perinatal

Designing Real-Time Research: Practical Approaches to Ecological Momentary Assessment | Kirsty Clark, Vanderbilt University

An Evidence-Based Approach to Treating Fears of Recurrence and Disease Progression In Chronic Physical Conditions | Louise Sharpe, The University of Sydney

Using the Implementation Research Logic Model (IRLM) to Effectively Implement EBTs in Your Organization | Justin Smith, University of Utah

Positive Affect Treatment for Depression, Anxiety and Anhedonia | Michelle Craske, University of California, Los Angeles

Understanding and Treating Addiction | John Kelly, Harvard Medical School

A 4-Stage Model of Socratic Dialogue to Improve Therapy Effectiveness | Christine Padesky, Center for Cognitive Therapy – Huntington Beach

Parent-Child Interaction Therapy (PCIT): An Empirically Supported Approach for Young Children and Their Caregivers | Melanie Nelson, PCIT International Association

The Case Formulation Approach to Cognitive Behavior Therapy | Jacqueline Persons, Oakland Cognitive Behavior Therapy Center and University of California, Berkeley

A Process-Based Approach to Evidence-Based Practice | Steven Hayes, University of Nevada, Reno

The Single-Session Consultation: An Introductory Clinical Workshop | Jessica Schleider, Northwestern University

Gain Without Pain: Practical CBT Skills for Perfectionism | Roz Shafran, University College London

Body Project Eating Disorder Prevention Program: Evidence-Base, Intervention Theory, and Implementation | Eric Stice, Stanford University

CBT Perspective on Grief Counseling: Assessment and Intervention | Jianping Wang, Beijing Normal University

Master Clinicians Sessions

ACT Skills for Perfectionism: A Process-based, Compassionate, and Flexible Approach for High-Achieving, Perfectionistic, and Striving Behaviors | Patricia Zurita Ona

Comparative Psychopathology: A New Framework for Understanding Psychological Disorders and Strengthening Cognitive-Behavioral Therapy Through Broader Behavioral Science | Daniel Marston

Less Avoiding, More Doing: An Acceptance and Commitment Therapy Workshop for Chronic "Later-ers" | Patricia Zurita Ona

Positive Affect Treatment for Depression and Anxiety | Alicia Meuret

Preventive Cognitive Therapy for Depression: An Evidence-based Approach to Reduce Relapse Risk: Why and How | Claudi Bockting

Why Your Patients Really Don't Get Better | Jeffrey Lazarus

In-Congress Workshops

Adapting and Expanding Your CBT Skills for Working with Misophonia | M. Zachary Rosenthal, Marta Siepsiak, Jane Gregory, Grace Heppes

CBT Adaptations for Affirming Care for Transgender and Gender Diverse Clients | Debra Hope, Nathan Woodruff, Melissa Hunt

Cognitive Behavioral Therapy for Nightmares | Kristi Pruiksma, Kelsi Gerwell

Cognitive Behavioral Therapy of Repetitive Negative Thinking | Kadir Ozdel, Ercan Altinoz, Mehmet Hakan Turkcapar

Cognitive-Behavior Therapy for Adult ADHD: An Implementation-Focused Approach | Russell Ramsay

Cognitive-Behavioral Therapy to Help Suicidal Patients Choose to Live (With an Extra Spotlight on Vulnerable Populations, Including Refugees, Sexual Minorities) | Cory Newman

Culturally Adapting CBT for Asian Heritage Populations: An Evidence-based Approach | Wei-Chin Hwang

Dialectical Behavior Therapy (DBT)-Informed Treatment for Psychosis | Maggie Mullen

Empirically-supported Assessment and Treatment of Functional Impairments in Executive Function and Organizational Skills in ADHD and Related Disorders in Children and Teens | Richard Gallagher, Jenelle Nissley-Tsiopinis

Extending Access to Care for Youth with Selective Mutism: Helping All Children Find Their Voice | Jami Furr, Aileen Herrera

Failing Better. Encouraging Adoption of CBT by Non-psychologist Professionals Through a Competency-focused Approach | James Hambrick

How to Think Like Socrates: From Socratic Questioning to Stoicism to Modern CBT | Scott Waltman

Integrating Mindfulness with Clinical Precision: Strategic Practice Selection in CBT | Noga Zerubavel, Terri Messman

Mapping Change: A Workshop on Precision Therapy Through Transtheoretical Case Conceptualization and Treatment Planning | Connor Adams, Natasha Hansen, Rachel Weiler

Metacognitive Therapy for Health Anxiety | Robin Bailey

Mindfulness Intervention for Emotional Distress | Xinghua Liu, Yanjuan Li

Personalising CBT Interventions Using Modular Approaches | Sophie Bennett, Roz Shafran

Providing Evidence-based Assessment and Treatment of Patients with Severe Obesity Across Settings | Larissa McGarrity, Hannah Farnsworth

Quality CBT Without Borders: Implementing WCCBT's Global Training Standards | Mehmet Sungur, Jacquie Cohen, Andrea Ashbaugh, Firdaus Mukhtar

Representation in CBT: A Framework for Clinical and Systemic Practice | Faithful Odusote

Resilience for Trauma-Informed Professionals: Protecting Clinicians and Researchers from the Effects of Exposure to Secondary Traumatic Stress | Patricia Kerig

Respond with CARE™ (Child-Adult Relationship Enhancement) After Disasters: The Agents of Change in Reducing Risk and Promoting Resilience in Youth | Robin Gurwitch, Jami Furr

Stepping up Our Game: Improving Use of Exposure Therapy for Eating Disorders | Carolyn Becker, Glenn Waller

Supervision Essentials for Cognitive-behavioral Therapy: Training Clinicians to Excel in CBT Conceptualization, Interventions, and Therapeutic Relationship Skills | Cory Newman

Task-sharing Lay Health Worker Training and Supervision of Cognitive and Behavioural Therapies in Africa. Lessons from Zimbabwe | Melanie Abas, Concilia Tarisai Bere, Conall O'Cleirigh, Elizabeth Powers, Amelia Stanton, Jane Fusire, Sheila Marezva, Oline Chivere

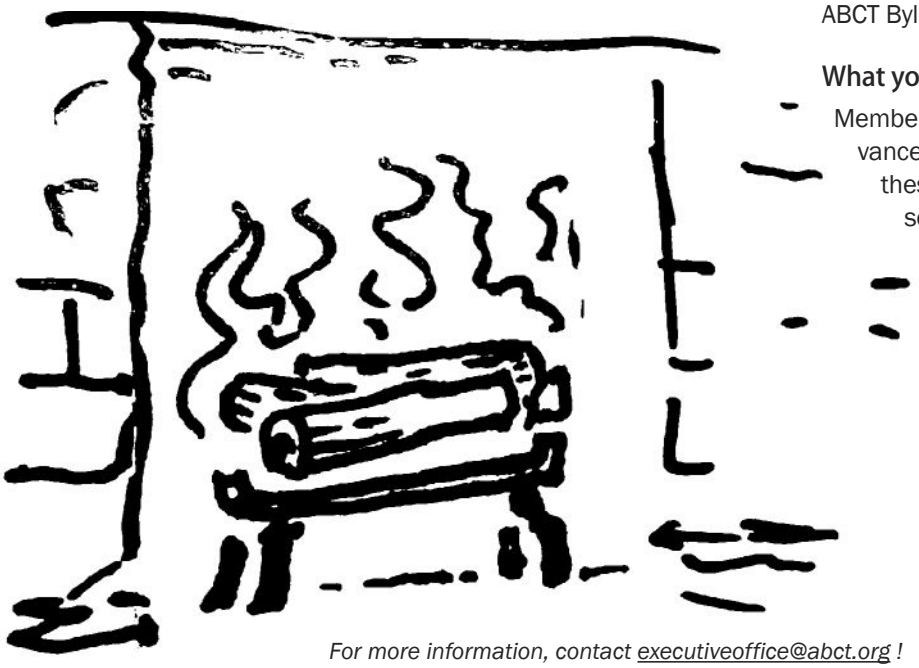
TEAM-CBT for Shame and Anxiety: A Blueprint for Helping Your Patients Heal | Jill Levitt, David Burns

Upskilling CBT Skills to Work with Older Adults: Key Differences from Standard Practice | Viviana Wuthrich

11TH ANNUAL WORLD CONFEDERATION OF COGNITIVE AND BEHAVIOURAL THERAPIES CONGRESS

MARRIOTT MARQUIS SAN FRANCISCO | 25TH - 28TH JUNE 2026

ABCT Presidential Fireside Chats *with* Dr. Carolyn Becker



For more information, contact executiveoffice@abct.org !

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
(Recording Available Here)

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

ABCT Elections

Voting for this year's elections is now open!

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 opened
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.

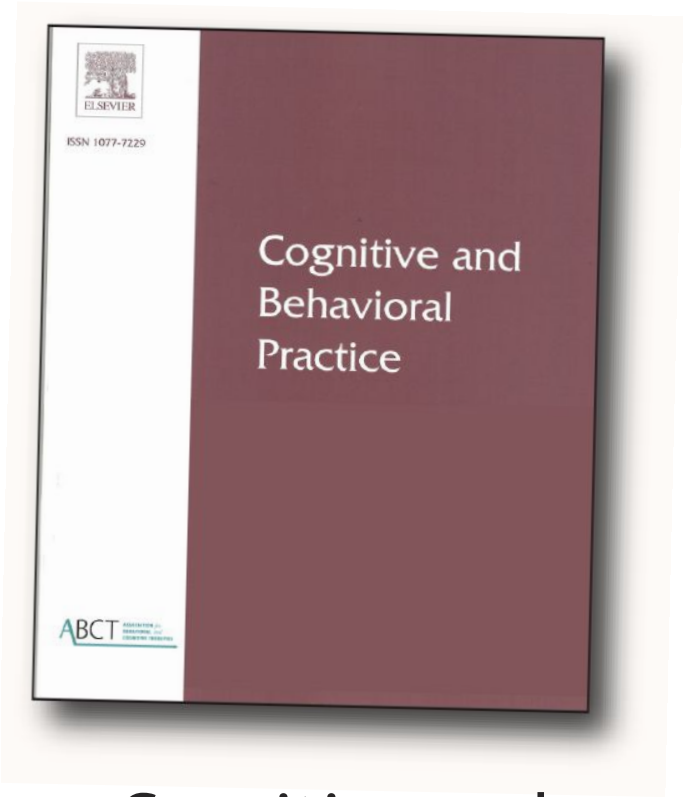
Volunteer

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

April 24th — Wendy Wild | Using the CTRS-R in CBT Training and Supervision

May 15th — Jessica Peters | A Practical Introduction to Assessment and Treatment of Premenstrual Mood Disorders

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

+ more!

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

www.elearning.abct.org


SPOTLIGHT ON A RESEARCHER
PRESENTED BY ABCT'S
RESEARCH FACILITATION 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
Winners will be
featured on
ABCT's website,
social media, & at
the Convention
Award Ceremony
Nominate
yourself or
someone else!
Submissions Due
https://forms.gle/FBfyfQHq7iQ88tnh8