the Behavior Therapist

Contents

SCIENCE

Some Reflections on the Stormy Marriage of Science, Would-Be Science, and "Pseudoscience"

Kirk Strosahl, *HeartMatters Consulting LLC, Portland, Oregon*

I AM A LONG-TIME READER OF, and occasional contributor to, *the Behavior Therapist*. I have been delighted to read several of the recent special issues in *tBT* addressing important questions and future trends in the field that will affect us all. First of all, I want to applaud the editorial staff for doing such a great service to all of us ABCT members.

A recent special issue of *tBT* (Codd, 2018b) dealt with the problem of "pseudo-scientific" therapies in clinical practice, with the bulk of the commentaries addressing the problem of resistance to the use of empirically supported therapies in community-based mental health practices (Codd, 2018a). I left the special series feeling uneasy about the rather black-and-white portrayal of these issues. I believe there are a variety of additional perspectives available to us that make these problems far less cut and dried than one might be led to believe. First, we need to remember that there is an important symbiotic relationship between "pseudoscience," in all of its many forms, and paradigmatic, mainstream science. One cannot have a healthy science without regular intrusions from the realm of "pseudoscientific" because, ultimately, most breakthrough innovations in science initially come from outside the established scientific paradigm.

ABCT — Election Results

Martin Antony, Ph.D.
President-Elect, 2018–2019

Shireen Rizvi, Ph.D.
Representative-at-Large and Liaison to Convention and Education Issues, 2018–2021

Sandra S. Pimentel, Ph.D.
Secretary Treasurer, 2019–2022

The changes to our mission statement and purposes were approved.
See our mission and bylaws at www.abct.org

INSTRUCTIONS *for* AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

■ Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.

■ Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.

■ Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.

■ Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: http://www.abct.org/Journals/?m=mJournal&fa=TBT): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Kate Wolitzky-Taylor, Ph.D., at **KBTaylor@mednet.ucla.edu.** Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

I also believe that pairing the issues of fringe clinicians using blatantly harmful therapies with the larger problem of resistance to using empirically supported treatments doesn't do justice to the latter problem. Unless we adopt a very broad definition of pseudoscience, these issues are pretty much unrelated. Lunatic fringe therapists not only don't respond to scientific opinion, they don't respond to any opinion other than one that agrees with their viewpoint. But the community therapists who are using untested treatments instead of empirically supported ones are not members of the lunatic fringe. Rather, they are from the mainstream of practicing mental health professionals and I doubt that they are inflicting harm on their clients. In fact, they may be using treatments that, when considered as a whole, might work as well as, or better than, our empirically supported ones. Indeed, what might end up popping out of the realm of untested treatments could be the next big clinical innovation that the CBT community is searching for.

My concern is that if we continue to treat these two issues as cut from the same cloth, we will stifle the development of creative solutions for the one problem over which we can exercise some control (i.e., the lack of application of empirically supported treatments in everyday clinical practice). I think most people would agree that our current approaches to addressing this problem have not worked, for highly predictable reasons that I will explain later. If something doesn't work over and over again, it is time to try something different, even if doing so puts us in a completely new terrain. An ossified, unhealthy scientific community is unable to do this and will actually move in the direction of greater rigidity and intolerance of the "nonbelievers." A flexible, healthy science sees this as an opportunity to incorporate potentially pseudoscientific ideas within a new, more robust scientific framework.

In this sense, the field of cognitive behavioral science is at an important crossroads. We can continue to excoriate community therapists for their seemingly "irrational" rejection of the CBT approaches that work, oh so well, in highly controlled efficacy studies, or we can adopt an attitude of curiosity about what is missing from CBT treatments that is causing them to lose the battle for the hearts and minds of community therapists.

The goal of this paper is to present a new framework for both understanding and overcoming the "resistance" by changing the product we are offering to the therapeutic community. In order to foster this type of change within the CBT community, we must first stop using problem-solving strategies that actually function as barriers to change. I will first briefly describe these barriers and then address them one by one in the remainder of this paper. At the end, I will offer some concrete suggestions on how we can make empirically supported CBT once again relevant to the average community clinician.

One barrier is our indiscriminately broad use of the term "pseudoscience." This term can not only be used to identify flagrantly harmful clinical practices, but also to dismiss a very wide range of clinical theories and approaches that we disagree with, or worse, to rally support for what amounts to a personal vendetta. A second barrier is the continued practice of treating the nonadoption of evidence-based treatments by community therapists as equivalent to them using pseudoscientific therapies. This assumption is not only highly unlikely, but adopting a stance of "you are either for us or against us" is not a very wise way to create systemic change, and will likely create more of the very resistance we are trying to eliminate. A final barrier is to use the mantle of science-based practice to invoke the privilege of evaluating new therapies as pseudoscientific simply on the basis of the "implausibility" of their underlying theories of suffering or proposed mechanisms of action. The claim that we can somehow determine in advance if a therapy is "valid" based upon its underlying assumptions is, in my view, both misguided and poses a direct threat to our scientific integrity.

First, a New Terminology Is Warranted!

The prefix *pseudo*, when used in the English language, is almost invariably an incendiary, judgmental term. There are "pseudo-seizures" in patients who are just pretending to have seizures but they really have mental health issues; there is "pseudo-dementia" in patients who are not really demented, but are just depressed. There are "pseudo-intellectuals," which is almost synonymous with the term "liberal" in conservative political commentaries. Then, there is the practice of "pseudoscience" by mental health clinicians who believe they are using scientifically supported therapies, while other clinical scientists adamantly dispute the scientific soundness of those therapies. When we hear the term *pseudo-science* used, it raises our blood pressure and makes us want to go out and stop those responsible. In typically human style, we then pair this conditioned fear/attack response with stories of the very worst examples of pseudoscientific practices (i.e., sexual orientation conversion therapies) and, voilà, it looks like there is an army of really malevolent community therapists out there.

How can taking this approach possibly be useful when applied to the problem of pseudoscientific practices and the generalized resistance to using empirically supported treatment practices? While it inflames the passions of card-carrying members of the science-based practice community, does it swing the attitudes and behavioral intentions of the typical community therapist? I think not. More likely, using a judgmental, finger-wagging approach will simply increase their resistance to using evidence-based practices.

In addition, as we have seen, charges of pseudoscience can, and have been, leveled at clinical scientists within the ACBT community. Once we take on the sacred role of defenders of the order against pseudoscience, the list of punishable transgressions can get so long and nebulous that few, if any, of us would get over that very high bar of scientific purity, including the defenders of the faith. Not many years ago, the founder of EMDR left ABCT in the context of repeated accusations of pseudoscientific practices. I'm not here to adjudicate those accusations, but it is interesting to note that EMDR is now listed on several credible registries as an empirically supported treatment for trauma-related conditions. Indeed, the history of science is full of examples in which today's pseudoscience is tomorrow's new science.

To say the least, I am very uneasy about the potential for manipulating the emotionally loaded tone that is generally associated with discussions about what to do about pseudoscientific therapies. Unchecked, it could breed an organization-wide in-tolerance of potentially beneficial (but untested) alternative and complementary therapeutic practices. This is the proverbial problem of "throwing the baby out with the bathwater." I don't think it is in our best interests to go down that path, and would instead like us to follow the lead of how a very similar issue is being dealt with in general medicine.

In the general medical community, a very significant percentage of physicians recommend untested supplements, special diets and/or other natural remedies for

common medical problems. They are taught to be tolerant of local cultural practices that run against the very precepts of allopathic medicine. Indeed, there is a huge industry devoted to providing physical manipulation procedures such as chiropractic care, acupuncture, or massage therapy. In many years of working side by side with general physicians, I've never once heard the term "pseudoscience" used to describe any of these largely untested approaches. The preferred term is "complementary and alternative medicine."

Many, if not most, complementary medicine practices have never been empirically verified, but they continue to be widely employed in the lay community, and there is a general tolerance for them in the medical community. Indeed, it is a very popular myth that general medicine has converted entirely to a science-based practice approach in which clinical evidence drives all medical decision making. A senior physician colleague once remarked that 50% of what he does with patients is based upon an educated guess. When I asked him what he meant by that, he stated somewhat cryptically, "I'm very well educated in medicine and I guess a lot, but these are educated guesses!" Accordingly, he did not feel it was appropriate for him to pass judgment on the utility of complementary or alternative medicine strategies. The takeaway is we don't have to agree with a clinical theory or practice to be tolerant of it. In most cases, we can let the patient be the final judge of whether to use these approaches. Following the lead of medicine, I would suggest we replace the term "pseudoscience" with a more tolerant and respectful term, "complementary and alternative mental health practices."

The Health of Clinical Science Depends Upon "Would-Be Science and Pseudoscience"

The fact that the subjects of resistance of practicing psychologists to using empirically supported treatments and flagrantly harmful pseudoscientific therapies were discussed side by side in the special issue could result in the conclusion that, if a therapist is not delivering an empirically supported treatment, then by definition that therapist must be engaging in pseudoscientific practices.

This assumption not only strains the imagination, but it creates a disparaging, stereotypic image of the typical community therapist as intellectually underpowered, gullible to misinformation, cultish and

unable to tell what is working and what is not working with clients. To assume that the second or third best treatment in the community (that hasn't gone through an RCT) has little or no clinical benefit just defies common sense. For over 30 years, I have trained therapists of all disciplinary backgrounds via direct practice shadowing and I can count on one hand the number of therapists that I thought were clueless and posed a danger to their clients. The vast majority of therapists seem open to new ideas and approaches, and are very much focused on helping their clients.

This vast army of clinicians, most of them master's-level trained social workers, marital and family therapists, and mental health counselors, are practicing in a realm I call "would-be science." Many of the preferred clinical approaches used by the clinicians *would be* evidence based if someone were to go out and conduct the needed clinical research to demonstrate clinical efficacy. Unfortunately, these practitioner communities do not come from a tradition that values confirmatory clinical research and typically do not have the academic infrastructures needed to systematically test their new treatment approaches. Consequently, the empirical data is not coming out of the master's-level mental health disciplines, which collectively far outnumber psychologists in the mental health workforce. In addition, research into alternative therapeutic approaches is not coming out of the highly silo-oriented psychotherapy research community, consisting mainly of psychologists and psychiatrists. The result is that potentially innovative clinical approaches get overlooked or lost, or worse, labeled as pseudoscientific practices. Treatment developments in the would-be science sector are major contributors to the evolution of psychotherapeutic approaches. Instead of taking an intolerant stance toward these new ideas, we should welcome them and bring then into the research system for evaluation and dissemination.

As an example, there is a brief treatment approach called Solution-Focused Brief Therapy (SFBT; deShazer, 1986) that has gained widespread adoption throughout the mental health community, both in the United States and abroad. When I conduct clinical training workshops, I routinely ask participants to raise their hands if they have been exposed to SFBT readings and trainings and/or CBT readings and trainings. Typically, many, if not more, community therapists will indicate exposure to and training in SFBT than in CBT. However,

SFBT is currently not listed as an empirically supported treatment on any credible registry. Despite this "limitation," SFBT has probably had more impact on mental health practice habits in the community setting than all of the empirically supported CBTs combined.

The truth be known, I've integrated many SFBT principles into my own clinical practice, and, indeed, several of them show up in the Acceptance and Commitment Therapy model. As a community practitioner for most of my career, I've had to constantly adapt my clinical practice to keep getting better at what I do. Some of these adaptations come from clinical evidence; some don't. That is the reality of evolving a clinical practice over the course of one's career. I aspire to be evidence based when I have the luxury of doing so, and in the other 75% of the cases I have to draw ideas from anywhere I can.

Just like big galaxies attract and swallow up smaller ones that get too close, the scientific mainstream routinely cannibalizes clinical innovations developed in the realm of would-be science. In the early 1990s, who would have thought that acceptance and mindfulness interventions were anything other than a "New Age" fad, practiced by hippie clinicians who had smoked too much pot? The problem we must come to grips with is that many ground-breaking clinical innovations come from the fuzzy regions of seemingly radical ideas and untested interventions. Attempting to stomp out these variations in the name of eradicating what we judge to be "pseudoscience" will only damage the long-term interests of the field.

One way ABCT members could facilitate the bi-directional flow of ideas and treatment technology is to get much more interested in examining those complementary and alternative treatment approaches (which community therapists are already using), with reference to existing CBT approaches. Instead of sequestering ourselves in research silos where we only test our favorite CBT treatment against our second favorite CBT treatment, we need to seek out, engage complementary treatment approaches, and test them. For example, since we are so up in arms about Thought Field Therapy (TFT), how about organizing an honest clinical trial comparing a CBT and a TFT approach with a particular clinical problem? Instead of allowing the SFBT approach, which is full of behavioral principles, to appear to be the antithesis of the CBT approach, what if some researcher compared SFBT to a CBT, and tested a

ESSENTIAL RESOURCES
for YOUR PRACTICE
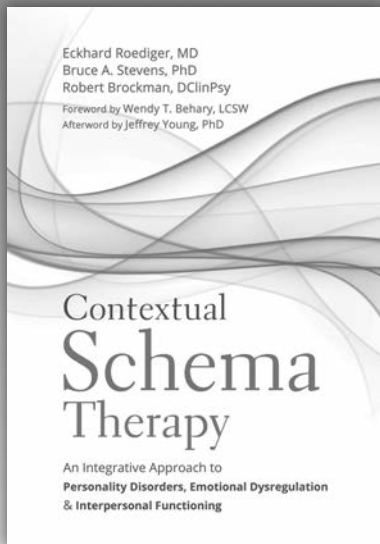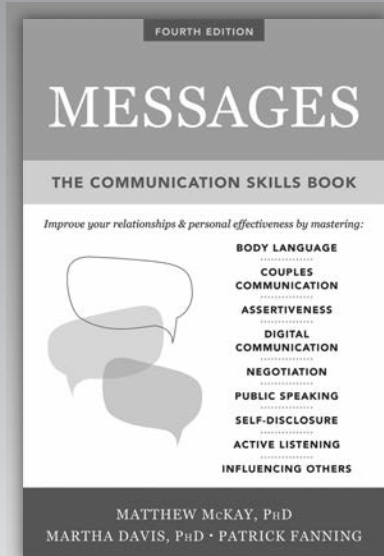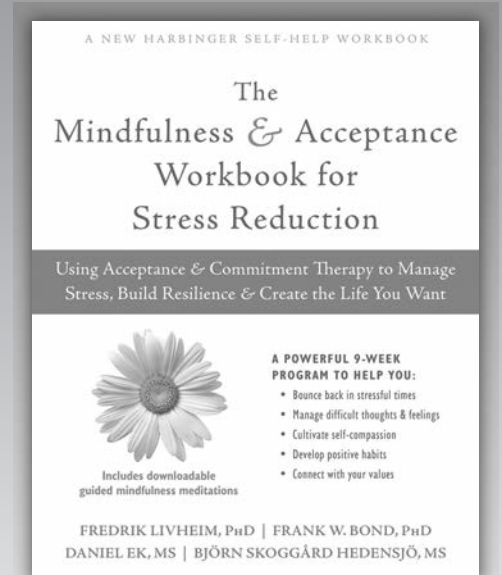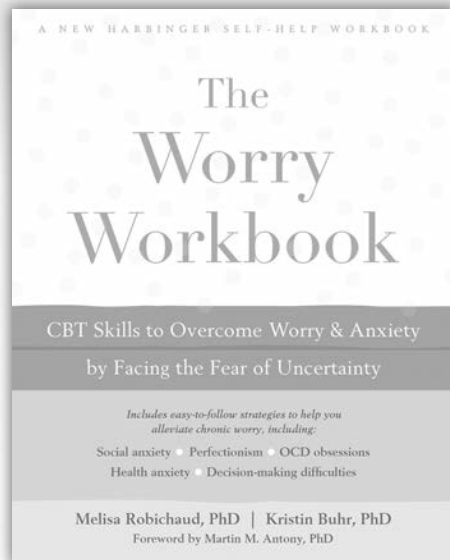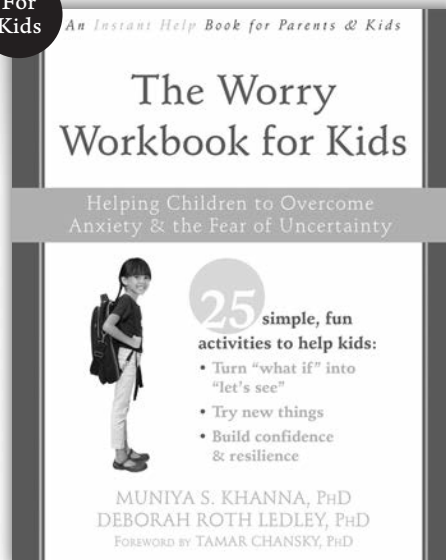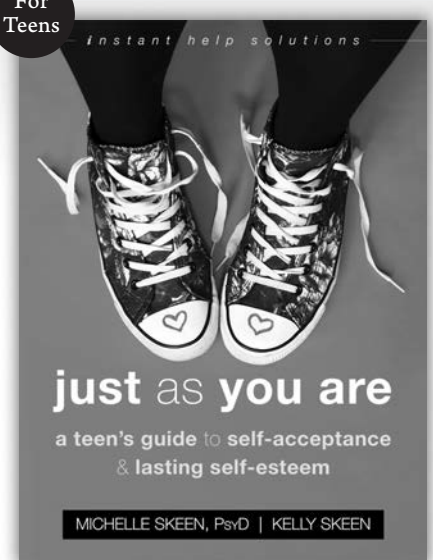
newharbingerpublications
1-800-748-6273 | newharbinger.com

Quick Tips *for* THERAPISTS Sign up today! Visit: **newharbinger.com/quicktips**

Learn more about evidence-based continuing education and training with PRAXIS praxiscet.com

package combining the two approaches? We will never win hearts and minds by taking an "either-or" approach in the discussion about the use of empirically supported treatments in community practice; we must take a "both-and" approach instead.

The Treatment Uptake Problem

The term I will use in this paper to describe the general level of willingness of clients and therapists to receive, and deliver, an empirically supported treatment is "treatment uptake." It doesn't matter how efficacious a cognitive behavioral treatment is shown to be in research. If clients refuse to participate in treatment or a high percentage drop out, it is not an effective treatment at the level of community practice. A therapist working on a clinical team can't afford to have a high percentage of clients refuse a treatment or drop out after treatment is initiated. Clients that refuse a treatment have to be reassigned to another therapist, while therapy dropouts will re-present for care and require a significant amount of "rework."

The same caveat applies to therapists. A treatment could be 100% effective when delivered by a highly trained research therapist, but if no community therapist is willing to use it, it is not effective in clinical practice. Obviously, there are a whole host of reasons why community-based therapists are "resistant" to using empirically supported treatments (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). Up to now, the dominant assumption is that this resistance is somehow "misguided," i.e., there is nothing wrong with the treatment packages we are asking therapists to use; it is just that they inexplicably refuse to use them. This rationale creates a finger-pointing mentality in which the clinical scientist is "right" and the community therapist is "wrong." We scientists can then study the irrational beliefs of community therapists and publish a bunch of papers about possible fixes. What is generally lost in this process is the possibility that community therapists are seeing something about how empirically supported treatments play out in practice that we, the treatment development and research community, have failed to recognize.

As a first step toward developing a new strategic approach to the problem of treatment uptake, I would suggest we stop using the term "resistance" and remind ourselves of the famous CBT adage: "Resistance is a failure on the part of the therapist, not the client." The problem of treatment uptake is not a failure on the part of community therapists to "see the light" of evidence-based practice, it is a failure on the part of the scientific community to deliver a "product" that is acceptable to most therapists and their clients.

As the example of widespread adoption of the SBFT approach demonstrates, community-based therapists will adopt treatment approaches that meet certain "end user" requirements. While SBFT does have some treatment package elements, it is really a transdiagnostic approach that is relatively easy to learn and implement in practice. The basic principles of SFBT readily generalize across different clinical problems and can be used up and down the scale of symptom severity and chronicity. So, with a limited amount of continuing education expense, a therapist can deliver basic SFBT with a modicum of fidelity and impact. The founders of the SFBT approach were practicing clinicians who were "tuned in" to the harsh realities of community practice in the early years of managed behavioral health care. They were thus able to "sell" the SFBT approach as a solution to those practice realities (i.e., increasing pressure to see more clients and to get treatment accomplished in fewer and fewer sessions).

Within the CBT treatment development community, I have not seen the same kind of attention given to the preferences and practice-based realities of the community therapist, nor to the treatment preferences of prospective clients. I am not aware of any empirically supported CBT that, as a core part of the initial treatment development process, utilized consumer focus groups of practicing therapists likely to deliver the treatment in naturalistic settings, as well as clients likely to be the recipients of those treatments. Without receiving such input from the "end users" at the design and development stage of a new treatment, the likelihood of a "poor fit" with the realities of community practice or client preferences is a near certainty. Indeed, Steven C. Hayes described the current generation of manual-based empirically supported therapies as a "gold-plated Cadillac," meaning that they are not scalable to community practice contexts (Arch, 2018). It is worth describing some of the challenges that community-based therapists face when considering whether or not to employ an empirically supported CBT:

1. With the uncontrolled proliferation of manual-based therapies, there are too many treatment packages that must be learned through specialized and expensive postdegree training.

2. The interventions used in empirically supported treatments are disorder specific, and may not readily generalize to treatment of other conditions.

3. Empirically supported treatment packages are complex, labor-intensive and expensive to deliver, often in resource-starved environments where there are significant systemic constraints on the amount of services that can be delivered to one client.

4. The intellectual and emotional "wear and tear" associated with delivering these complex treatments creates pervasive problems with professional burnout.

5. Managed care precertifications rarely authorize the number of sessions needed to execute the full empirically supported treatment protocol, creating an immediate need to "bootstrap" the protocol, without any guidance on how to do so.

6. Due to the inconvenience of attending therapy, it is hard to convince the typical client to participate in 12 to 16 sessions of therapy.

7. It is particularly hard to keep attending therapy when the client must first come out of pocket to meet insurance deductibles and then make co-payments on a session-by-session basis.

8. The therapy refusal and dropout rate is very high, particularly in the most invasive exposure-based treatment packages.

9. There are few low-intensity versions of most empirically supported treatment packages, resulting in a one-size-fits-all approach to clients with varying levels of chronicity and symptom severity.

10. The length of treatment creates major issues with "through put" in a clinical practice, resulting in long wait times for new clients.

This list is not meant to be exhaustive; it is meant to demonstrate that the concerns of community therapists are not "irrational" at all. These are graduate-trained professionals who must integrate a variety of treatment modalities and interventions into a workable clinical practice in which they will see 100 to 200 new patients per year.
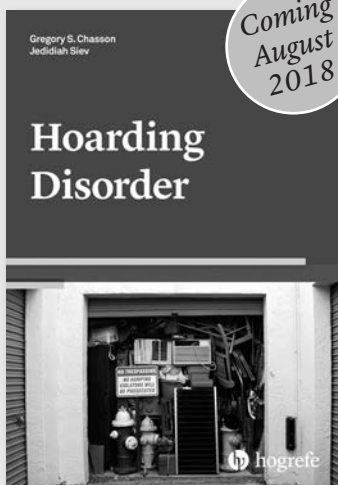
What If the Treatment Uptake Problem Was Solved?

There is a very well-known SFBT technique called the "miracle question" that might apply here: What if a miracle happened and the problem of treatment uptake, at least on the part of community therapists, suddenly disappeared? What would that new world of clinical practice look like? Fortunately, that miracle did happen in the United Kingdom with the initiation of a program called Improving Access to Psychological Therapies (IAPT; Clark et. al., 2009). The British government made the decision to invest the equivalent of $1.2 billion annually into the delivery of empirically supported therapies for mood and anxiety disorders to citizenry all across England. The IAPT program is a social investment in mental health treatment conducted on a scale never seen before in the history of the mental health industry.

A rigorous, competency-based training program in various empirically supported treatments is required to assure the practice readiness of "high-intensity" EST therapists, most of whom are licensed psychologists. These are self-selected therapists who have "bought into" the virtues of empirically supported therapies and then elect to receive focused, competency-based training in how to deliver them. In short, this is not a group of shoddily trained community therapists; they are excellently prepared to do the work of delivering high-quality therapy. These trained specialists have been deployed throughout general practice clinics in England. And to top the miracle off, all of the clients seen in the IAPT program provide outcome measures of depression and anxiety before and after treatment, and at every treatment session.

Miracle or Nightmare?

Because of the laudable decision to make all IAPT data freely accessible in the public domain, we now have access to the world's largest database of mental health outcomes related to the provision of empirically supported treatments in community practice. Here are some of the major results from the 2015–2016 data set (NHS Digital, 2016):

- Number of total program referrals: 1,179,328.
- Number of patients refusing entry into treatment: 225,806 (19% of eligible).
- Number of nonattending patients (failed to show for first appointment or dropped out of therapy: 416,391 (35% of eligible).
- Percentage of cases that were classified as noncases at treatment initiation (spontaneous remission during the waiting period): 46,736 (5% of eligible).
- Remaining patients with "case status" at initiation of treatment who completed treatment: 490,395 (41.5% of eligible).
- Overall average percentage of patients demonstrating reliable change: 227,052 (46.3 %).
- Percentage of patients from "more deprived" populations demonstrating reliable change (35%).

If we factor in rates of treatment refusal, spontaneous remission during the waiting period, therapy dropouts, and treatment nonresponders, the overall success rate of empirically supported CBT is 19%. This net effectiveness figure does not include clients who initially respond to therapy, but subsequently relapse. This means that out of 100 clients presenting with panic disorder (as but one example), the probability of any one of them entering into, completing, and benefiting from an empirically supported treatment is about 1 out of 5.

Moreover, the costs associated with such a high attrition and relatively low success rate are staggering. The average cost to deliver a full-length CBT in IAPT was estimated to be approximately $3,800 (Radkrahishnan et al., 2013). With respect to the emotional "wear and tear" associated with delivering evidence-based CBT, 68% of IAPT therapists showed clear indications of emotional exhaustion, and reported that they objectified their clients more and experienced a lowered sense of personal accomplishment. These are the three core signs of professional burnout (Steele, McDonald, Schroder, Mellnor-Clark, 2015), and we know that high levels of burnout are associated with lower client satisfaction, job switching, resignation, and early retirement.

The results of IAPT clearly show that treatment refusal and dropping out of therapy are by far the biggest threats to the scalability and community effectiveness of empirically supported treatments. The likelihood is that community therapists who have toyed with the use of empirically supported CBT have run into these problems when applying them to consecutive new clients. Unlike efficacy studies, which use ornate screening procedures to select the most motivated clients, a community clinician does not have that luxury. The reality is that long, complicated treatments make considerable demands on clients who may already be struggling with depleted emotional, financial, or social resources. The dropout rates observed in the IAPT program are not an anomaly. Therapy dropouts are actually a significant problem even in CBT efficacy studies, averaging about 25% (Ong, Lee, & Twohig, 2018). Indeed, a recent study of early and late dropouts among suicidal and self-harming adolescents undergoing DBT showed that 45% of clients failed to complete the treatment (Germain et. al., 2018).

Accordingly, we need to develop and test treatments that are much more palatable for the average client. For example, consider that we have developed an alternative treatment that is only 35% effective, but has a 5% treatment refusal rate and a 10% dropout rate. This alternative treatment has a net effectiveness of 30%, and would have a bigger impact on the overall community of need than a typical empirically supported CBT with much higher rates of treatment refusal and therapy dropout.

The second sobering result of IAPT regards the actual effectiveness of empirically supported treatments when they are delivered to completion. Even when available treatment resources are immense, as in the IAPT program, and even when therapists get special training, empirically supported treatments don't seem to perform nearly as well in applied practice settings as they do in efficacy studies. It is thus likely that estimates of the clinical efficacy of empirically supported treatments are significantly inflated. It is common to observe a large "voltage drop" when an evidence-based treatment is disseminated en masse into the community (Chambers, Glasgow, & Strange, 2013). This loss of efficacy, especially if it happens with the first few clients seen by a community therapist, is likely to make that therapist more skeptical about the real value of using empirically supported CBTs.

Some Practical Strategies for Improving Treatment Uptake

Not being one to yell fire in a theatre without also bringing an oversized fire extinguisher along with me, I would like to offer three very practical suggestions for improving the likelihood of uptake of CBT by therapists and clients.

Briefer Is Better

The most commonsense change we should make to current empirically supported treatments is to shorten their length, perhaps by as much as 50%. The average number of therapy session attended in the United States is between 4 and 6, depending upon the database studied. The modal number of therapy sessions attended in America is 1 (Gibbons et al., 2011; Harnett, O'Donovon, & Lambert, 2010). There are some indications in the clinical research literature that shorter treatment packages might result in lower initial refusal rates and therapy dropout rates (Katon et al., 1996; Sledge, Moras, Hartley, & Levine, 1990). In any event, shorter treatment protocols are more likely to be "in synch" with the utilization trends just described.

Indeed, we are already seeing promising research developments in this regard. Prominent members of the CBT research community have raised our awareness of the need to redesign empirically supported treatments to be more in synch with the needs of both community therapists and the clients they serve (Wolitzky-Taylor et. al., 2015). There also have been some groundbreaking research efforts to examine the effectiveness of briefer versions of CBT. For example, Cigrang and colleagues reported a wide variety of positive clinical benefits from a brief version of Cognitive Processing Therapy (CPT) delivered to primary care patients suffering from combat-related PTSD (Cigrang et al., 2015). In addition to resulting in significantly reduced PTSD symptoms, another noteworthy finding was high levels of treatment acceptance among active-duty clients, who indicated that they otherwise would not have sought mental health care for their problems. Cully and colleagues examined a brief CBT protocol (bCBT) for treating depression and anxiety in medical patients with comorbid health problems (Cully et al., 2017). The bCBT approach, consisting of 4 contacts spread over a 4-month period, produced favorable clinical outcomes in 63% of patients treated, as well as significant improvements in self-reported functional status.

While many of the early studies of brief CBT were conducted in primary care settings, there is now a growing interest in designing and testing brief CBT in "mainstream" psychotherapy research community. For example, Wolitzky-Taylor and colleagues reported very impressive results of a 7-session integrated anxiety treatment

---

---

targeting clients with comorbid substance abuse (Wolitzky-Taylor et. al., 2018). Otto and associates (2012) developed and demonstrated the clinical benefits of a 5-session CBT protocol for panic disorder. In summary, it does appear that the wheels of change are going to move us in the direction of briefer, and more scalable, forms of empirically supported CBT. This science is desperately needed as we move into the era of integrating behavioral approaches within a variety of community health and social service settings.

Client-Powered Stepped-Care Options

Stepped care involves structuring a treatment approach so that it can be delivered via a set of low-intensity to high-intensity intervention packages. The goal is to use the least amount of treatment resources needed to help any individual client, while retaining the ability to "step up" the level of treatment intensity if the client fails to benefit from a lower level of care. The notion of using stepped levels of care is by no means new to the mental health community. Unutzer and colleagues have studied a stepped care model called "collaborative care" in the primary care context for close to two decades, showing

positive benefits of this approach with a range of mental health conditions (Unutzer et al., 2002). Indeed, the IAPT program employs a stepped-care approach involving the assignment of clients to either a "low-intensity" (primarily therapist guided or unguided self-help treatment) or "high-intensity" (full-length empirically supported CBT) treatment. IAPT clients can either be stepped up from low-intensity to high-intensity care or stepped down to the low-intensity care approach (Clark et al., 2009).

The problem, as I see it, is that collaborative care and IAPT are "therapist centric" stepped-care models in which the client is "assigned" to a level of care, based upon the therapist's determination of what treatment the client "needs." The client is not "asked" what level of care he or she would prefer. Asking the client to choose his or her preferred level of care is what I call "client-powered stepped care," and adopting this approach is completely consistent with the evolving emphasis on patient centeredness in mental health care (Croghan & Brown, 2010; Hensley, 2012). The more clients are allowed to take control of their treatment, the more likely they are to com-

plete it, leading to lower rates of treatment refusal and therapy dropouts and greater levels of participation in treatment.

The emphasis on giving clients a range of acceptable treatment options will place some new demands on treatment researchers. We no longer need just one treatment protocol for a particular problem; we will need to present clients with a menu of evidence-based treatment options. Thus, there might be a 2-session, 6-session, and 16-session version of the same empirically supported CBT, each of which has been studied and determined to be of acceptable effectiveness. New clients would thus be allowed to choose the treatment intensity level that fits their preferences. Clients that end up not responding to a lower-intensity treatment could be stepped up to a higher-intensity treatment. Since the client has "bought in" to the treatment process via the low-intensity option, there is far less likelihood that the client will suddenly drop out of the high-intensity treatment.

Strengths-Based Transdiagnostic Models

The problem of therapist treatment uptake would be significantly reduced if the overall number of empirically supported treatments was fewer and more similar than different in their basic design. This argues for moving away from disorder-specific treatment protocols and moving towards more integrative, principle-based approaches that readily generalize from one clinical problem to another. Again, the idea of developing treatment approaches that can be applied across a range of conditions has been percolating in the CBT community for several years. ACT and the Unified Protocol for Emotional Disorders are two of the more prominent examples of this emerging movement toward clinical parsimony (Barlow et al., 2011; Hayes, Strosahl, & Wilson, 2011).

In addition to focusing the new generation of CBT treatments around a much smaller set of underlying behavioral principles, we need to actively identify, integrate, and repackage promising complementary and alternative treatment approaches and principles, such as SFBT. This would allow us to promote empirically supported intervention principles (rather than treatment packages) that include some elements of other popular therapeutic approaches within a behavioral framework. One notable shift in philosophy is to focus treatment on improving existing client strengths, rather than on eliminating signs and symptoms of pathology. It is much easier to engage clients by talking about what is going right with them, as opposed to focusing on what is wrong with them. I think transdiagnostic behavioral principles would fit into this shift of focus very easily. As Hayes and Hofmann (2018) stress, returning to the transdiagnostic principles of CBT might lead to a product that is more acceptable to community therapists and clients alike. Indeed, a recent meta-analysis suggested that ACT, a transdiagnostic approach, resulted in a significantly lower rate of therapy dropouts compared with traditional CBT approaches (Ong et al., 2018).

The Art of Living in Glass Houses

We are getting ahead of the data when we choose to reject complementary and alternative therapies a priori, because their theoretical assumptions seem implausible to us. Galileo's theory that the earth orbited the sun, not vice versa, was rejected as implausible and even heretical by the leading scientists of his day. He was eventually put to death for refusing to recant his blatant pseudoscientific beliefs.

So, if we are going to get into the practice of rejecting things like energy fields, or vortices, as scientifically implausible and therefore a priori as forms of pseudoscience, consider this: Most everything we deal with in psychotherapy cannot be seen. Thoughts can't be seen; emotions can't be seen; impulses can't be seen; memories can't be seen; physical sensations can't be seen. Our clients can only make verbal reports of them, and we can watch them react and behave in various ways as they make these reports. How is this reality different than a person talking about having an "energy field all around me" or "feeling wired into the universe through this vortex" or talking about "karma" in a particularly painful life situation? Indeed, the most powerful forces in the universe are energy fields of various kinds, invisible to the naked eye. Call me a product of New Age thinking, but I believe it is far too early to summarily reject alternative accounts of how the human universe works. And anytime I'm in the vicinity of Sedona, Arizona, I always make a point of taking a long vortex hike, because I love the feeling of that ancient spiritual energy washing over me.

In closing this article, I'm reminded of the old saying: "People that live in glass houses shouldn't throw stones." We should spend our time and energy, not on chastising community therapists for failing to adopt our favorite treatment approaches, but rather on getting our own house in order. If we adopt a broad definition of pseudoscientific practices, then the CBT community is probably engaging in some of them. I believe we are overstating the case for both the effectiveness of empirically supported CBT and the superiority of CBT to other untested, but highly popular, alternative and complementary treatment approaches. In truth, we have only demonstrated that evidence-based treatments can positively affect symptoms of distress, but their impacts on broader and potentially more important aspects of daily functioning, personal growth, and development and quality of life, are largely unknown. We, for the most part, have been unable to scientifically validate the mechanisms of change underlying most of our treatments. And we continue to downplay the criticisms of our treatments by the professionals responsible for delivering them and the clients destined to receive them. Addressing these shortcomings, and developing truly scalable treatments for widespread application in the communities we serve, should keep us plenty busy for the next decade or so. By then, the pseudoscientific practices of today may have already become accepted mainstream science!

References

Arch, J. (2018). A conversation with Steve Hayes and Stephan Hofmann about process based CBT. *the Behavior Therapist, 41*, 81-83.

Barlow, D., Farchione, T., Fairholme, C., Ellard, K., Boisseau, C., Allen, L. & Ehrenreich-May, J. (2011). *The unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide*. New York: Oxford University Press.

Chambers, D., Glasgow, R., & Strange, K. (2013). The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation Science, 8*, 117. doi: org/10.1186/1748-5908-8-117.

Cigrang, J., Rauch, S., Mintz, J., Brundige, A., Avila, L., Bryan, C., Goodie, J., & Peterson, A., (2015). Treatment of active duty military with PTSD in primary care: A follow-up report. *Journal of Anxiety Disorders, 36*, 110-114. doi: 10.1016/j.janxdis.2015.10.003

Clark, D., Layard, R., Smithies, R,, Richards, D., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behavior Research and Therapy, 47*, 910–920. doi:

10.1371/journal.pone.0062873

Codd, R. (2018a). Pseudoscience in mental health treatments: What remedies are available? *the Behavior Therapist, 41*, 1-3.

Codd, R. (Ed.). (2018b). Pseudoscience in mental health [Special issue]. *the Behavior Therapist, 41*(1).

Croghan, T. & Brown, J. (2010). *Integrating mental health treatment into the patient centered medical home.* (Prepared by Mathematica Policy Research under Contract No. HHSA290200900 019I TO2.) AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality.

Cully, J., Stanley, M., Petersen, N., Hundt, N., Kauth, M., Naik, A., Sorocco, K., Sansgiry, S., Zeno, D., & Kunik, M. (2017). Delivery of brief cognitive behavioral therapy for medically ill patients in primary care: A pragmatic randomized clinical trial. *Journal of General Internal Medicine, 32*, 1014-1024. doi.org/10.1007/s11606-017-4101-3

deShazer, S. (1986). Brief therapy: Focused solution development. *Family Process, 25*, 207-221. doi: 10.1111/j.1545-5300.1986.00207.x

Germain, M., Corcoran, V., Wheeler, L., DeMann, J., Peros, O., Bahguna, T., & Miller, A. (2018). Risk factors for early and late dropout from Dialectical Behavior Therapy for suicidal adolescents. *the Behavior Therapist, 41*, 69-81.

Gibbons, M., Rothbard, A., Farris, K., Stirman, S., Thompson, S., Scott, K., & Crits-Christoph, P. (2011). Changes in psychotherapy utilization among consumers of services for major depressive disorder in the community mental health system. *Administration and Policy in Mental Health, 38*(6), 495–503. doi: org/10.1007/s10488-011-0336-1

Harnett, P., O'Donovan, A., & Lambert, M. (2010). The dose effect relationship is psychotherapy: Implications for social policy. *The Clinical Psychologist, 14*, 39-44. doi: 10.1080/13284207.2010.500309

Hayes, S., & Hofmann, S. (2018). (Eds.). *Process-based CBT: Core clinical competencies in evidence-based treatment.* Oakland, CA: Context Press / New Harbinger.

Hayes, S., Strosahl, K. & Wilson, K. (2011). *Acceptance and commitment therapy: The process and practice of mindful change.* New York: Guilford Press.

Hensley, M. (2012). Patient-centered care and psychiatric rehabilitation: What's the connection? *International Journal of Psychosocial Rehabilitation, 17*, 135-141.

Katon, W., Robinson, P. Von Korff, M., Lin, E., Bush, T., Ludman, E., & Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry, 53*, 924-932. doi:10.1001/archpsyc.1996.01830100072009

Lilienfeld, S., Ritschel, A., Lynn, S., Cautin, R., & Latzman, R. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review, 33*, 883–900. doi: org/10.1016/j.cpr.2012.09.008

National Health Service, Digital Reports, (2016). *Psychological therapies: Annual report on the use of IAPT services—England, 2015-2016.* http://content.digital.nhs.uk/pubs/psycther1516

Ong, C. W., Lee, E. B., & Twohig, M. P. (2018). A meta-analysis of dropout rates in acceptance and commitment therapy. *Behaviour Research and Therapy, 104*, 14-33. https: doi.org/10.1016/j.brat.2018.02.004

Otto, M., Tolin, D., Nations, K., Utschig, A., Rothbaum, B., Hofman, S., & Smits, J. (2012). Five sessions and counting: Considering ultra-brief treatment for panic disorder. *Depression and Anxiety, 29*, 465-470. doi: 10.1002/da.21910

Radkrahishnan, R., Hammond, G., Jones, P., Watson, A., McMillan-Shields, F., & LaFortune, S. (2013). Costs of the Improving Access to Psychological Therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected primary care trusts in the East of England. *Behavior Research and Therapy, 51*, 37-45. doi: org/10.1016%2Fj.brat.2012.10.001

Sledge, W., Moras, K., Hartley, D., & Levine, M. (1990). Effect of time-limited psychotherapy on patient dropout rates. *American Journal of Psychiatry, 147*, 1341–1347. doi: org/10.1176/ajp.147.10.1341

Steele, C., McDonald, J., Schroder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: Burnout in therapists working within Improving Access to Psychological Therapies services. *Journal of Mental Health, 24*, 33-37. doi: 10.3109/09638237.2014.971145.

Unutzer, J., Katon, W., Callahan, C., Williams, J., Hunkeler, E., Harpole, L., . . . Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *Journal of the American Medical Association, 288*, 2836-45.

Wolitzky-Taylor, K., Krull, J., Rawson, R., Roy-Byrne, P. Ries, R., & Craske, M. (2018). Randomized clinical trial evaluating the preliminary effectiveness of an integrated anxiety disorder treatment in substance use disorder specialty clinics. *Journal of Consulting and Clinical Psychology. 86*. 81-88. 10.1037/ccp0000276.

Wolitzky-Taylor, K., Zimmermann, M., Arch, J., De Guzman, E., & Lagomasino, I. (2015). Has evidence-based psychosocial treatment for anxiety disorders permeated usual care in community mental health settings? *Behaviour Research and Therapy, 72*. doi: 10.1016/j.brat.2015.06.010.

· · ·

Correspondence to Kirk Strosahl, Ph.D., 1327 SE Tacoma St. 322, Portland, OR 97202; kirk@mtnviewconsulting.com

A B C T   P I O N E E R S   S E R I E S

www.abct.org ABCT > FOR MEMBERS > CBT PIONEERS
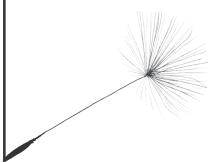
Explore
ABCT's growing CBT Pioneers series: Interviews with CBT's influential thinkers, researchers, and practitioners—

David Barlow

David Burns

Phil Kendall

Judith Beck

Esther Deblinger

Steven C. Hayes

Art Nezu & Christine Maguth Nezu

The Application of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders to Chronic Pain

John D. Otis, *VA Boston Healthcare System and Boston University*

CHRONIC PAIN IS CURRENTLY one of the most common, impairing, and costliest conditions reported in the American adult population, affecting more people than heart disease, cancer, and diabetes combined; about 100 million American adults suffer daily from functional impairment, disability, and distress caused by chronic pain and its sequelae (Institute of Medicine, 2011; Kroenke, 2003). Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. When pain persists for longer than 3 months it is considered chronic pain (IASP, 2011). The experience of chronic pain can be caused by many factors, including diseases, accidents, violence and trauma, or normal degenerative changes that occur with age.

Chronic pain is one of the most frequent reasons that people seek health care. National statistics indicate that approximately 55% of individuals in the United States have experienced some level of pain in the last month, with at least 11% reporting chronic pain (Nahin, 2015). A more recent survey conducted by the U.S. Centers for Disease Control and Prevention indicated that 19.6% of adults endorsed having "pain most days or every day" for the past 6 months (Quickstats, 2017). The national costs of pain are astounding—ranging from $560 to $635 billion per year when considering annual health care costs and costs associated with lower productivity (Gaskin & Richard, 2012). In the VA healthcare system, almost 50% of patients in primary care endorse experiencing pain on a regular basis (Kerns, Otis, Rosenberg, & Reid, 2003). Chronic pain is also a significant problem among recent military returnees, with 44% of soldiers returning from deployment reporting chronic pain (Toblin, Quartana, Riviere, Walper, & Hoge, 2014).

Although many people are able to adaptively cope with pain, for some people the experience of pain contributes to functional disability, emotional distress, and reduced quality of life. Chronic pain can impact every aspect of a person's life, including their work, recreational activities, relationships, and feelings of independence. Thus, understanding factors that maintain or contribute to the experience of pain is a critical topic of research. In fact, in 2011, the National Institute of Health enlisted the Institute of Medicine to assess the state of the science regarding pain research, care, and education, as pain is currently considered one of our nation's greatest public health challenges. While research has made tremendous strides in understanding the psychological, biological, and cognitive underpinnings of pain, many gaps still persist in our knowledge of pain and efficacious treatments for pain. Further, many challenges persist in the field. Perhaps now more than ever, there is a pressing need to expand the "reach" of our current treatments so that they can help more people, and there is a critical need to optimize the treatments that do exist so that patients show greater functional improvement. The field is greatly in need of novel psychological treatments that have the potential to more efficiently help diverse populations of patients with pain return to healthier physical and emotional functioning.

The Comorbidity Between Chronic Pain and Emotional Disorders

One of the clinical challenges often faced by therapists when providing psychological treatment for chronic pain is the high rate of comorbidity between pain and emotional disorders such as anxiety and depression. Rates of depression in samples of chronic pain patients are estimated to be 50% (Elliott, Renier, & Palcher, 2003) while anxiety is estimated to be high as 45% (Kroenke et al., 2013; Staerkle et al., 2004). As the frequency, intensity, and duration of pain increases so too does the likelihood of the presence of an emotional disorder (Bair, Robinson, Katon, & Kroenke, 2003). Research indicates that patients with chronic pain and emotional disorders experience significantly greater pain severity, pain-related disability, and impairments in health-related quality of life. In addition, the presence of an emotional disorder can contribute to poorer pain treatment outcomes including functional limitations, impaired social functioning, higher unemployment, and reduced treatment satisfaction (Bair et al., 2003; Bair, Wu, Damush, Sutherland, & Kroenke, 2008).

Vlaeyen and Linton (2000) proposed a cognitive behavioral fear-avoidance model to illustrate the process by which thoughts and emotions contribute to the experience of pain. According to this model, when a person interprets acute pain (i.e., pain lasting less than 3 months) as nonthreatening they are more likely to maintain their engagement in everyday activities and experience recovery. However, when pain is interpreted as threatening, a process called "catastrophizing," this interpretation may contribute to pain-related fear, anxiety, and avoidance of activities, as well as increased guarding behaviors (e.g., grimacing, bracing, and rubbing the pain location), and hypervigilance to bodily sensations. Catastrophic beliefs may include thoughts such as, "This is never going to get better," or negative views including, "I'm worthless to my family because I can't work." When this pattern of thinking persists, feelings of depressed mood may increase. As pain and depressive symptoms continue, patients may withdraw or avoid doing everyday activities due to fear and anxiety over the possibility of further injury or increased pain. In this way, avoidance may also contribute to increased disability and depressive symptoms. As the person becomes more depressed and inactive, fear and avoidance increase, and pain may be perceived as more intense. With continued inactivity, their muscles may become weaker, they may begin to gain weight, and their overall physical conditioning may decline. Thus, this cognitive behavioral fear-avoidance model has served to demonstrate the potential influences of avoidance and catastrophizing on the development and maintenance of chronic pain, and has guided the development and refinement of cognitive and behavioral treatments for chronic pain (Flink, Boersma, & Linton, 2013; Racine et al., 2016; Ramirez-Maestre, Esteve, Ruiz-Parraga, Gomez-Perez, & Lopez-Martinez, 2016).

There is also accumulating evidence that pain and emotional disorders share common neurobiological pathways (Bar et al., 2007; Wiech & Tracy, 2009). Studies have found correlations between brain responses involved during catastrophizing and in the modulation of pain, including the dorsolateral prefrontal, insula, and anterior cingulate cortices (Seminowicz & Davis, 2006). Experimental studies of pain have found that inducing a depressed mood state and negative pain-specific cognitions is associated with increased pain unpleasantness and increased activity in the prefrontal cortex, subgenual anterior cingulate cortex, and hippocampus (Berna et al., 2010). Evidence of overlapping structures involved in pain and cognitions may explain how the presence of an emotional disorder may impact processing of painful stimuli.

The high rates of comorbidity between pain and emotional disorders is a risk factor for the abuse of opiates and other substances. Every day, more than 90 Americans die after overdosing on opioids, including prescription pain relievers, heroin, and synthetic opioids such as fen-

tanyl (Rudd, Seth, David, & Scholl, 2016). Studies have shown that comorbid emotional disorders, such as anxiety, depression, and PTSD, are critical factors in the initiation and maintenance of opioid use disorders (Goesling et al., 2015). Individuals seeking relief from emotional and physical pain may choose to self-medicate to relieve their symptoms; however, relief is temporary and as addiction to medications develop, pain symptoms are actually enhanced. Veterans have been particularly vulnerable to this pathway to addiction as many veterans with chronic, painful health conditions face challenges reintegrating back into society after serving in the military. One study found that veterans with PTSD and other mental health conditions were more than twice as likely to be prescribed an opioid for a pain diagnosis, to receive higher doses of opioids, and to have adverse outcomes when compared to veterans without mental health diagnoses (Seal et al., 2012). These data support the need to develop more effective and transportable nonpharmacological therapies for addressing the high rates of comorbidity between pain and emotional disorders.

Evidence-Based Treatment for Chronic Pain

Based on our understanding of the biopsychosocial model of chronic pain, cognitive-behavioral therapies have been developed with the goal of addressing negative and catastrophic thoughts and behaviors that can serve to maintain and exacerbate the experience of pain (Otis, 2007; Thorn, 2017; Turk & Fritz, 2005). CBT for pain involves teaching patients ways to challenge maladaptive thoughts and safely reintroduce enjoyable activities (Otis, Pincus, & Murawski, 2010). Key components of CBT for chronic pain include cognitive restructuring focused on negative thoughts related to pain (e.g., "This pain is going to kill me"), relaxation training (e.g., diaphragmatic breathing, progressive muscle relaxation, and meditation), time-based activity pacing (e.g., teaching patients how to safely increase activity level), and graded homework assignments designed to decrease patients' avoidance of activity and reintroduce a healthy, more active lifestyle. CBT also focuses on promoting patients' increased activity and

productive functioning using techniques such as exercise homework, activity scheduling, and graded task assignments. A substantial literature exists documenting the efficacy of CBT for a variety of chronic pain conditions including osteoarthritis, chronic back and neck pain (Linton & Ryberg, 2001), diabetic neuropathic pain (Otis et al., 2013), and tension headache (Holroyd et al., 2001). In a meta-analysis of 22 randomized controlled trials of psychological treatments for chronic low back pain, cognitive-behavioral and self-regulatory treatments specifically were found to be efficacious (Hoffman, Papas, Chatkoff, & Kerns, 2007).

Although there is considerable evidence that CBT is a very effective approach for many people with chronic pain, symptoms related to emotional disorders can complicate and interfere with many elements of treatment including goal setting, plans for exercise, cognitive restructuring, and motivation to participate (Kerns & Haythornthwaite, 1988). For example, it is not uncommon for patients with pain and anxiety to catastrophize and worry about the meaning of pain, to avoid activities for fear of movement, or to socially isolate themselves. Similarly, patients with pain and depression may report that they understand the benefits of setting therapy goals but also report that they lack the motivation to take the first step to achieve them. Despite the high comorbidity rates of chronic pain and emotional disorders, and the negative impact of emotional disorders on the experience of pain and its treatment, there is currently no established protocol for how to best address the needs of patients with chronic pain and comorbid emotional disorders. Patients with pain and emotional disorders would benefit greatly from learning more adaptive emotion regulation strategies that could be used across a variety of situations and contexts.

A Unified, Transdiagnostic Approach to Pain Management

One treatment approach that may have the potential to address shared mechanisms across chronic pain and comorbid emotional disorders is the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2018a, 2018b). The UP was developed based on evidence suggesting that the high rates of comorbidity among the various emotional disorders may be due to what has been called a "general neurotic syndrome" in which symptom-specific presentations are

seen as a manifestation of an underlying syndrome. Neuroticism is a personality trait that is commonly associated with anxiety, mood, and substance use disorders (Ormel et al., 2013). Research has shown that neuroticism, which is also referred to as negative affectivity, may represent a psychological vulnerability across disorders that is demonstrated by a tendency to respond with increased emotional reactivity, a heightened tendency to view experiences as aversive, and attempts to alter, avoid, or control emotional responding. People who show high rates of neuroticism are often self-critical, sensitive to the criticisms of others, and feel personally inadequate. Although a number of studies have linked neuroticism to emotional disorders, recent studies suggest that it may play an influential role in the development of chronic pain through its influence on pain-related catastrophic thinking and avoidance, both of which are considered key factors in the development of chronic pain as described in the cognitive-behavioral fear-avoidance model. For example, Goubert, Crombez, and Van Damme (2004) examined the interaction between pain severity, catastrophic thinking, pain-related fear, and personality characteristics. Of the five personality dimensions that were investigated, only neuroticism was found to be consistently related to pain catastrophizing and fear. Further, neuroticism was found to moderate the relationship between pain severity and pain catastrophizing. Wong et al. (2015) found that neuroticism was significantly associated with catastrophizing, pain-related fear, and pain anxiety. Wilner, Vranceanu, and Blashill, (2014) examined a sample of adolescents with pain and found that neuroticism predicted the odds of pain 1 year later. Taken together, these studies suggest that neuroticism may be an important construct in the development of chronic pain. When confronted with a stressful pain condition, neuroticism may lower the threshold at which pain is perceived as threatening, and at which pain elicits catastrophic thinking and pain-related fear. Thus, targeting the underlying characteristic of neuroticism, and reducing the threat value of pain, may be an effective way of addressing pain-related fears and anxiety that contribute to the development and maintenance of chronic pain.

The UP consists of 5 core modules that target characteristics underlying all anxiety, depressive, and related disorders: (1) mindful emotion awareness, (2) cognitive flexibility, (3) identifying and preventing patterns of emotion avoidance, (4) increas-

ing awareness and tolerance of emotion-related physical sensations, and (5) interoceptive and situational emotion-focused exposures. The main premise of the UP is that people with emotional disorders use maladaptive emotion regulation strategies, such as avoidance and catastrophizing, that are ultimately ineffective and counterproductive by preventing extinction of distress and anxiety to situational or interoceptive cues. The effectiveness of the UP was recently demonstrated in a randomized controlled trial comparing the efficacy of the UP to established single disorder protocols (SDPs) for patients with panic, generalized anxiety disorder, obsessive-compulsive disorder, and social anxiety disorder. The results of the study indicated that the UP produced equivalent symptom reduction when compared to the four different SDP psychological treatments at posttreatment and at 6-month follow-up, with less attrition (Barlow et al., 2017).

Preliminary support for the use of a unified approach to treating pain and emotional disorders was demonstrated by Allen, Tsao, Seidman, Ehrenreich-May, and Zeltzer (2012), who described the application of a modified version of the UP for two adolescents with pain and emotional disorders. The results indicated that both participants demonstrated improvements at posttreatment, some of which were more evident at the 3-month follow-up. A pilot study is currently under way at the Center for Anxiety and Related Disorders at Boston University to assess the feasibility, acceptability, and potential efficacy of the UP for patients who have chronic pain and comorbid emotional disorders. As part of this study, we are specifically examining the relationship between neuroticism and other mechanisms that may contribute to the development and maintenance of chronic pain, including catastrophizing and avoidance. In addition to the self-report of pain, important outcome measures include pain-related interference in activity level, types of coping strategies utilized, and productive functioning (i.e., goal achievement and return to work). This line of research will include the examination of physiological and biological markers associated with pain to assess potential changes associated with UP treatment outcome. We will also be examining whether integrating more traditional CBT pain management components to the UP, such as goal setting, time-based activity pacing, and increased physical activity, results in additional clinical benefit. In addition, we will be monitoring the extent to which the

skills acquired by the UP can assist patients in developing and employing additional adaptive health-related behaviors, including the management of other medical conditions that are often comorbid with chronic pain.

A unified approach that targets the underlying, shared mechanisms that are central to the development of both chronic pain and emotional disorders would have several advantages. First, using a unified, transdiagnostic treatment approach for patients with pain and emotional disorders may help patients improve more quickly and may produce more comprehensive improvement in symptoms across a range of emotional disorders. Second, using a transdiagnostic treatment approach that focuses on a single set of core therapeutic principles rather than several diverse protocols would simplify the training of therapists treating patients with those disorders. Additionally, this approach to the treatment of pain and emotional disorders

would potentially be much more cost-effective, would simplify the dissemination of evidence-based treatments, and broaden the reach of treatment to those who need it most. A unified approach to treating patients with comorbid pain and emotional disorders has the transformative potential to overcome these problems in care.

References

Allen, L. B., Tsao, J. C. I., Seidman, L. C., Ehrenreich-May, J., & Zeltzer, L. K. (2012). A unified, transdiagnostic treatment for adolescents with chronic pain and comorbid anxiety and depression. *Cognitive and Behavioral Practice, 19*(1), 56–67. doi.org/10.1016/j.cbpra.2011.04.007.

Bair, M. J., Robinson, R. L., Katon, W., & Kroenke, K. (2003). Depression and pain comorbidity: A literature review. *Archives of Internal Medicine, 163*, 2433–2445. doi: 10.1001/archinte.163.20.2433.

Bair, M. J., Wu, J., Damush, T. M., Sutherland, J. M., & Kroenke, K. (2008). Association of depression and anxiety alone and in combination with chronic musculoskeletal pain in primary care patients. *Psychosomatic Medicine, 70*, 890–897. doi: 10.1097/PSY.0b013e318185c510.

Bar, K. J., Wagner, G., Koschke, M., Boettger, S., Boettger, M. K., Schlosser, R., & Sauer, H. (2007). Increased prefrontal activation during pain perception in major depression. *Biological Psychiatry, 62*(11), 1281-1287. doi: 10.1016/j.biopsych.2007.02.011.

Barlow D. H., Farchione T. J., Bullis J. R., Gallagher, M. W., Murray-Latin, H., Sauer-Zavala, S., … Cassiello-Robbins, C. (2017). The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders Compared With Diagnosis-Specific Protocols for Anxiety Disorders: A randomized clinical trial. *JAMA Psychiatry, 74*(9), 875–884. doi:10.1001/jamapsychiatry.2017.2164.

Barlow, D. H., Farchione, T. J., Sauer-Zavala, S., Latin, H., Ellard, K. K., Bullis,

J. R., … Cassiello-Robbins, C. (2018a). *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide* (2nd ed.) New York: Oxford University Press.

Barlow, D. H., Sauer-Zavala, S., Farchione, T. J., Latin, H., Ellard, K. K., Bullis, J. R., … Cassiello-Robbins, C. (2018b). *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Patient Workbook* (2nd ed.) New York: Oxford University Press.

Berna, C., Leknes, S., Holmes, E. A., Edwards, R. R., Goodwin, G. M., & Tracy, I. (2010). Induction of depressed mood disrupts emotion regulation neurocircuitry and enhances pain unpleasantness. *Biological Psychiatry, 67*, 1083-1090.

Elliott, T. E., Renier, C. M., & Palcher, J. A. (2003). Chronic pain, depression, and quality of life: correlations and predictive value of the SF-36. *Pain Medicine, 4*(4), 331-339.

Flink, I. L., Boersma, K., & Linton, S. J. (2013). Pain catastrophizing as repetitive negative thinking: A development of the conceptualization. *Cognitive Behaviour Therapy, 42*(3), 215-223. doi: 10.1080/16506073.2013.769621.

Gaskin, D. J., & Richard, P. (2012). The economic costs of pain in the United States. *Journal of Pain, 13*(8), 715-724. doi: 10.1016/j.jpain.2012.03.009.

Goesling, J., Henry, M. J., Moser, S. E., Rastogi, M., Hassett, A. L., Clauw, D. J., & Brummett, C. M. (2015). Symptoms of depression are associated with opioid use regardless of pain severity and physical functioning among treatment-seeking patients with chronic pain. *Journal of Pain, 16*, 844-851. doi: 10.1016/j.jpain.2015.05.010.

Goubert, L., Crombez, G., & Van Damme S. (2004). The role of neuroticism, pain catastrophizing and pain related fear in vigilance to pain: A structural equations approach. *Pain, 107*(3), 234-241.

Hoffman, B. M., Papas, R. K., Chatkoff, D. K, & Kerns, R. D. (2007). Meta-analysis of psychological interventions for chronic low-back pain. *Health Psychology, 26*(1), 1-9. doi: 10.1037/0278-6133.26.1.1.

Holroyd, K. A., O'Donnell, F. J., Stensland, M., Lipchik, G. L., Cordingley, G. E., & Carlson, B. (2001). Management of chronic tension-type headache with tricyclic antidepressant medication, stress-management therapy, and their combination: A randomized controlled trial. *JAMA, 285*(17), 2208-2215.

Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. (2011). *Relieving pain in America: A blueprint for transforming prevention, care, education, and research*. Washington, DC: National Academies Press.

International Association for the Study of Pain (IASP) Taxonomy (2011). *Descriptions of chronic pain syndromes and definitions of pain terms* (2nd ed.). Seattle: IASP Press. Retrieved from https://www.iasp-pain.org/PublicationsNews/Content.aspx?ItemNumber=1673

Kerns, R. D., & Haythornthwaite, J. A. (1988). Depression among chronic pain patients: cognitive-behavioral analysis and effect on rehabilitation outcome. *Journal of Consulting and Clinical Psychology, 56*, 870- 876. doi.org/10.1037/0022-006X.56.6.870

Kerns, R. D., Otis, J. D., Rosenberg, R., & Reid C. (2003). Veterans' concerns about pain and their associations with ratings of health, health risk behaviors, affective distress, and use of the healthcare system. *Journal of Rehabilitation, Research and Development, 40*(5), 371-379.

Kroenke, K. (2003). Patients presenting with somatic complaints: Epidemiology, psychiatric comorbidity and management. *International Journal of Methods in Psychiatric Research, 12*(1), 34-43.

Kroenke, K., Outcalt S., Kerbs, E., Bair, M. J., Wu, J., Chumbler, N., & Yu, Z. (2013). Association between anxiety, health-related quality of life and functional impairment in primary care patients with chronic pain. *General Hospital Psychiatry, 35*(4), 359-365. doi: 10.1016/j.genhosppsych.2013.03.020.

Linton, S. J., & Ryberg, M. (2001). A cognitive-behavioral group intervention as prevention for persistent neck and back pain in a non-patient population: A randomized controlled trial. *Pain, 90*, 83-90.

Nahin, R. L. (2015). Estimates of pain prevalence and severity in adults: United States, 2012. *Journal of Pain, 16*(8), 769-780. doi:10.1016/j.jpain.2015.05.002.

Ormel, J., Jeronimus, B. F., Kotov, R., Riese, H., Bos, E. H., Hankin, B.,… Oldehinkel, A. J. (2013). Neuroticism and common mental disorders: Meaning and utility of a complex relationship. *Clinical Psychology Review, 33*(5), 686-697. doi: 10.1016/j.cpr.2013.04.003.

Otis, J. D. (2007). *Managing chronic pain: A cognitive-behavioral therapy approach, therapist guide*. New York: Oxford University Press.

Otis, J. D., & Pincus, D. B. & Murawski, M. (2010). Cognitive behavioral therapy for chronic pain management. In R.D. Kerns & M. E. Ebert (Eds.), *Behavioral and psychopharmacologic pain management* (pp. 184-200). New York: Cambridge University Press.

Otis, J. D., Sanderson, K., Hardway, C., Pincus, M., Tun, C., & Soumekh, S. (2013). A randomized controlled pilot study of a cognitive behavioral therapy approach for painful diabetic peripheral neuropathy. *Journal of Pain, 14*(5), 475-482. doi: 10.1016/j.jpain.2012.12.013.

QuickStats: Age-Adjusted Percentage of Adults Aged ≥18 Years Who Were Never in Pain, in Pain Some Days, or in Pain Most Days or Every Day in the Past 6 Months, by Employment Status — National Health Interview Survey, United States, 2016. *Morbidity Mortality Weekly Report 2017, 66,* 796. doi: http://dx.doi.org/10.15585/mmwr.mm6629a8.

Racine, M., Moulin, D. E., Nielson, W. R., Morley-Forster, P. K., Lynch, M., Clark, A., … Jensen, M. P. (2016). The reciprocal associations between catastrophizing and pain outcomes in patients being treated for neuropathic pain: A cross-lagged panel analysis study. *Pain, 157*(9), 1946-1953. doi: 10.1097/j.pain.0000000000000594.

Ramirez-Maestre, C., Esteve, R., Ruiz-Parraga, G., Gomez-Perez, L., & Lopez-Martinez, A. E. (2016). The key role of pain catastrophizing in the disability of patients with acute back pain. *International Journal of Behavioral Medicine, 24*(2), 239-248. doi: 10.1007/s12529-016-9600-9.

Rudd, R. A., Seth, P., David, F., & Scholl, L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *Morbidity and Mortality Weekly Report.* doi:10.15585/mmwr.mm655051e1.

Seal, K. H., Shi, Y., Cohen, G., Cohen, B. E., Maguen, S., Krebs, E. E., & Neylan, T. C. (2012). Association of mental health disorders with prescription opioids and high-risk opioid use in US veterans of Iraq and Afghanistan. *Journal of the American Medical Association, 307*(9), 940-947. doi: 10.1001/jama.2012.234.

Seminowicz, D. A., & Davis, K. D. (2006). Cortical responses to pain in healthy individuals depends on pain catastrophizing. *Pain, 120*, 297-306. doi:10.1016/j.pain.2005.11.008.

Staerkle, R., Mannion, A. F., Elfering, A., Junge, A., Semmer, N. K., Jacobshagen, N., … Boos, N. (2004). Longitudinal validation of the fear-avoidance beliefs questionnaire (FABQ) in a Swiss-German sample of low back pain patients. *European Spine Journal, 13*(4), 332-340. doi: 10.1007/s00586-003-0663-3.

Thorn, B. (2017). *Cognitive therapy for chronic pain. A step by step guide* (2nd ed.). New York: The Guilford Press.

Toblin, R. L., Quartana, P. J., Riviere, L. A., Walper, K. C., & Hoge, C. W. (2014). Chronic pain and opioid use in US soldiers after combat deployment. *JAMA*

Internal Medicine, 174(8), 1400–1401. doi: 10.1001/jamainternmed.2014.2726.

Turk, D. C., & Fritz, W. (2005). *The pain survival guide: How to reclaim your life.* Washington, DC: American Psychological Association.

Vlaeyen, J. W. S., & Linton, S. J. (2000). Fear-avoidance and its consequences in musculoskeletal pain: A state of the art. *Pain, 85*, 317-332. doi: 10.1007/s10865-006-9085-0.

Wiech, K., & Tracy, I. (2009). The influence of negative emotions on pain: Behavioral effects and neural mechanisms. *Neuroimage, 47*, 987-994. doi: 10.1016/j.neuroimage.2009.05.059.

Wong, W. S., Lam, H. M. J., Chen, P. P., Chow, Y. F., Wong, S., Lim, H. S.,… Fielding, R. (2015). The fear-avoidance model of chronic pain: Assessing the role of neuroticism and negative affect in pain catastrophizing using structural equation modeling. *International Journal of Behavioral Medicine, 22,* 118-131. doi: 10.1007/s12529-014-9413-7.

. . .

Considerations for Clinical Work and Research With Transgender and Gender Diverse Individuals

Jae A. Puckett, *University of South Dakota*

Sebastian M. Barr, *University of Louisville*

Lauren P. Wadsworth, *University of Massachusetts Boston*

Jayden Thai, *University of Louisville*

THE AIM OF THE PRESENT article is to provide psychologists, other mental health professionals, and individuals in training with a selection of clinical and research recommendations for working with people who are transgender (or trans) and gender diverse. In addition to recommending review of the APA *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (APA, 2015) and the more in-depth anthology *Affirmative Counseling and Psychological Practice With Transgender and Gender Nonconforming Clients* (Singh & dickey, 2017), we suggest a number of ways you can become a more inclusive and knowledgeable researcher and clinician. These ideas are based on our experiences, both personally and professionally, and we incorporate literature where available, although this is extremely limited at this time. This article is in no way exhaustive, but is intended to take our field's thinking a few steps forward and give practical suggestions for ways to improve our work with trans and gender diverse individuals and communities. In addition, these recommendations are specifically focused on work with adults, yet some of the recommendations may be applicable regardless of the age of the population you work with.

Before discussing suggestions, it is important to acknowledge the long and sordid history of gender diversity in the field of psychology (dickey, Hendricks, & Bockting, 2016). In both research and clinical realms of psychology, people who identified as trans, gender nonconforming, or who expressed their gender in a way that was not deemed "typical" in society have been historically treated as outsiders, abnormal, and needing treatment (Winters, 2008). Additionally, Western society has historically erased gender identities that have existed for centuries in many cultures among trans and gender diverse people of color, even within indigenous cultures, particularly by assimilating these identities into westernized conceptualizations of gender and gender identity. Only recently has the field of Western psychology begun to acknowledge gender as a spectrum (rather than binary), and movement along that spectrum as a normal part of the human experience.

Society at large continues to uphold and create anti-trans policies, which contribute to psychological health disparities in people who identify as trans and gender diverse (Reisner, White, Bradford, & Mimiaga, 2014). Research shows that the trans population is more likely to experience symptoms of depression and anxiety compared to cisgender people (Reisner, Katz-Wise, Gordon, Corliss, & Austin, 2016), and suicide rates remain extremely high (Perez-Brumer, Hatzenhuehler, Oldenburg, & Bockting, 2015), higher even among trans and gender diverse people of color (Lytle, Blosnich, & Kamen, 2016). Additionally, anti-trans policies may limit, or even exclude, trans and gender diverse individuals from receiving the health care and resources that are important to reducing mental health disparities (e.g., trans-exclusionary clauses in insurance policies). Thus, it is our duty as psychologists and mental health professionals to not only increase our awareness, but also work to increase the competency of our field as a whole. Increasing this awareness would be in line with our ethical principles, as we seek to improve the work done with marginalized communities and reduce the harm that they are exposed to (American Psychological Association, 2017), and

addresses calls for more training and research on best practices with trans and gender diverse clients (Hope, Mocarski, Bautista, & Holt, 2016).

First and foremost, we must come to understand our own identities, biases, and learning history (or, socialization) regarding gender. Regardless of our own backgrounds, it is necessary that we commit to engaging in a constant process of learning the many ways people identify and the varied personal experiences individuals may have across gender identities. In preparing this article, we (the authors) have been reflective about how our own identities may relate to our viewpoints. Our backgrounds cut across privileged and marginalized spaces in terms of gender, race, ethnicity, sexual orientation, social class, educational attainment, geographical locale, and regional background. We encourage readers to reflect on how their own backgrounds may influence their clinical work and research as well.

Further, it is important that we advocate for psychology training programs and training centers to take on the responsibility of increasing cultural competence in working with trans and gender diverse individuals. Currently, few psychologists and other mental health providers receive any training at all in working with trans and gender diverse clients, let alone how their gender identity intersects with other identities, yet trans and gender diverse people are relying on these very individuals for care. In one study, approximately half of participants reported that they had the opportunity to learn about issues faced by trans and gender diverse people in school yet only 27% of respondents said they felt competent in this area (APA, 2009). This data indicates that many individuals are not receiving training and even those that are still may not feel competent working with this population. Receiving education in working with trans and gender diverse clients is especially important as trans and gender diverse individuals are often forced to interact with mental health professionals in order to receive gender-affirming medical care (Puckett, Cleary, Rossman, Mustanski, & Newcomb, 2017). Our field must take on this issue and address it within our graduate programs, practicums, and internships. We hope that by doing so, we might create a more affirming field broadly, rather than isolated experts, or leaving the burden where it is now (on psychologists who identify as trans or gender diverse).

Quick Vocabulary Tutorial

Culture, and therefore language, is constantly changing and reshaping; however, we provide some definitions of terms that we think would be helpful in the reading of this article.

• *Cisgender*: A person is cisgender if their gender identity aligns with what is typically socially associated with the sex they were assigned at birth. Example: I (author Wadsworth) was assigned female at birth and I identify as a woman, so I am a cisgender woman.

• *Transgender/Trans*: A person whose gender identity does not align with what is typically socially associated with the sex they were assigned at birth. The term *trans* has been used as an umbrella term to capture many diverse experiences of gender, including trans men, trans women, and many other identities. Some trans individuals may not identify with any gender or feel that their gender exists between or outside binary notions of gender. These trans individuals may use terms like *agender*, *genderqueer*, and *nonbinary* to describe their identities. It also is important to note that individuals who align with these latter identities may or may not also identify with the term *trans* or *transgender*. Instead, terms like *gender diverse* or *gender nonconforming* may better describe these identities. Further, some individuals may not even identify with a Western conceptualization of gender or trans identity, but rather, identify with a gender identity associated with their ethnic culture of origin (e.g., Fa'afafine, Kathoey, Hijra, Two-Spirit, etc.). In this article, to recognize the range of experiences and labels used, we will use the term *trans* and *gender diverse*.

• *Special note about the prefix* trans: Not every transgender person perpetually identifies with the prefix trans. Many people who may have identified as trans women and trans men at some point in their life may drop the prefix trans and just identify as women and men instead. And, some transgender individuals may never identify with the prefix and instead just identify with the term that describes their affirmed gender (e.g., woman, man).

Considerations for Clinical Work With Trans and Gender Diverse Individuals

Within clinical work, there are many considerations for how to create an affirming atmosphere and engage in culturally competent care with trans and gender diverse clients. Although the following is not exhaustive, we have detailed a few major areas and suggestions for improving the care that trans and gender diverse clients receive. We refer readers to other sources for more specific discussions of cognitive behavioral therapy techniques that may be affirming for gender minorities (e.g., Austin & Craig, 2015; Craig & Austin, 2016; Perry, Chaplo, & Baucom, 2017; Puckett & Levitt, 2015), as here we focus more broadly about practice with trans and gender diverse clients.

Create an Affirming Intake Process

During intakes, there are many tasks to be accomplished and arguably one of the most important is to connect with the client and create a space for them to feel heard and understood. As we know, the therapeutic alliance and relationship are essential components of effective therapies more generally (Martin, Garske, & Davis, 2000; Wampold, 2015), and within cognitive behavioral therapies (Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012). When working with trans and gender diverse clients, it is imperative that therapists are reflective about how best to create an affirming intake process so that they do not rupture the alliance. Here we discuss some main issues that should be considered.

For starters, examine your clinic paperwork for how inclusive it is of the experiences of trans and gender diverse clients. For example, many trans and gender diverse people may not have changed their name legally, and instead go by a different name. There are many challenges to legally changing a person's name, including social and financial barriers. *Be clear that you are not only asking for a legal name in your paperwork. In addition, ask for pronouns.* Designating a space on your paperwork for this can be a signal to clients that your practice is a safe space and invested in affirming their gender. In addition, evaluate whether sex and gender are conflated on your forms and whether there is a need to have both. When given options or checkboxes of male and female only (designations of assigned sex), this may not reflect the identities of your clients. Instead, *provide a blank for clients to self-describe their gender.* If you are in a clinic that conducts research as well, consider a longer list of options, as well as a place for people to write in how they identify (see our recommendations in the research section that follows). Importantly, *use the requested pronouns, name,*

and the identified gender of your client when discussing their case, regardless of the setting. Often therapists who have put great effort into using affirming names and pronouns during session will revert to using legal name or nonaffirming pronouns and gender when writing notes or consulting with colleagues; this does not represent an affirming position and makes it more likely that you will err when in the client's presence. This also increases the likelihood that they will be misgendered by others who might interact with them in your setting. When documentation or consultation requires legal name, identify it as such and also include the name the client uses.

Beyond paperwork, your interactions with clients have the potential to either affirm their identity or to recapitulate the marginalization that trans and gender diverse people go through socially. *Have a discussion with your client about their pronouns and share yours as well* (Austin & Craig, 2015). Sharing your pronouns helps to disrupt the power dynamics that reinforce trans and gender diverse people being seen as "other." This can be smoothly incorporated into initial conversations of the name(s) clients use for you. During intakes, it is also typical to explore a person's past and how this relates to their presenting problem. When discussing a trans or gender diverse person's history, it can be difficult to know how to talk about childhood or earlier parts of their life in an affirming way. *Instead of using language such as "when you were a boy/girl growing up," consider something neutral, like "in your childhood" or "as a kid, what were your experiences like?" Also, ask your client how best to talk about their past in a way that is affirming to their current identity.* This level of transparency can be useful in ensuring that you do not make assumptions about what is best for the person sitting in the room with you. In addition, if you are conducting a structured intake, consider making time for additional questions related to a client's past exposure to minority stressors and social marginalization. You also might consider what types of assessments or self-report measures are utilized in your work with clients. In monitoring and evaluating change over the course of therapy, it may be worthwhile to include measures of specific minority stressors (Perry et al., 2017; see Shulman et al., 2017, for a review of measures for use with trans and gender diverse adults).

Another important point to note is that *just because a person is trans or gender diverse, this does not mean that what they* are coming to therapy for is related to their gender. Trans people come to therapy for all of the same reasons that cisgender people do. However, it is not uncommon for therapists and medical providers to assume that the reason for a trans or gender diverse client seeking services is related to their gender and transition. This may or may not be the case and you do not know unless you have this conversation with your client. It is important to explore openly how their presenting problem does or does not relate to being trans or gender diverse.

An additional common intake task with trans or gender diverse clients relates to discussing transition, or what is becoming more commonly called "gender affirmation." The process of affirming one's gender is unique to a given person—this may include social elements (such as going by a different name and pronoun, telling others that you are trans, changing your appearance, etc.), as well as medical steps to affirm your gender (such as taking hormones to masculinize or feminize your body or surgeries). As stated, though, the process of gender-affirmation varies from person to person and there is no one way to be trans/gender diverse or to affirm your gender. As such, some trans or gender diverse people may socially affirm their gender only, whereas others may be interested in medical processes of affirming their gender (Puckett et al., 2017), and these decisions may vary over time.

When discussing transition or gender-affirmation with clients, be open to them not aligning to any preconceived notions that you may have. If you impose a particular expectation, this may impact the degree to which a client is comfortable sharing their experiences with you and ultimately conveys to a client that you are not knowledgeable about their particular experience as a trans person, potentially rupturing the relationship. In addition, if you come across as having a particular expectation for your trans or gender diverse clients, they may feel pressured to conform to this instead of sharing their genuine experiences. And, if someone else has conducted the intake with your client, do not unquestioningly accept the information provided. You may be overlooking important information, or the other provider may not have asked important questions like those detailed above.

Along with this, we believe that it is important that you tell a client upfront what your policy is regarding providing letters of support for transition-related care.

Although not all medical providers require this, letters of support from therapists are still a regular part of obtaining hormone therapy and gender-affirming surgeries for many people whose providers adhere to the World Professional Association of Transgender Health's (WPATH) guidelines (Coleman et al., 2012). When therapists are unclear about how to provide a letter or what is typical in letters, they should be seeking supervision or consultation from someone with expertise in this area. Moreover, therapists should clarify with their clients if a letter is the only purpose of their seeking services, or if this is part of longer term therapy. If the sole purpose of therapy is to obtain a letter, then discuss with the client how much time you anticipate needing to see them in order to provide this. Although there are many barriers to pursuing gender-affirming care (Puckett et al., 2017), one barrier is the gatekeeping role therapists play. When therapists require an unknown/undiscussed number of therapy sessions in order to provide a letter, this does a disservice to their clients and impedes them from obtaining care that can be vital to improving their mental health and well-being (e.g., Keo-Meier et al., 2015; White & Reisner, 2016).

Therapists also should know that *WPATH's guidelines for gender-affirming care are meant to be flexible and medical providers have a choice in whether they adhere to these or not.* A growing number of providers utilize an informed consent model to providing hormone therapy. It may be that you can educate medical providers about this type of model if you encounter medical professionals adhering to outdated standards or who are denying trans and gender diverse individuals care.

Throughout all of the above points, *it is imperative that we also understand the ways that other aspects of identity influence barriers to mental health services for trans and gender diverse individuals—including areas of race and ethnicity, as well as social class and ability status.* For instance, trans and gender diverse people of color are not only facing working with mental health professionals who may not be well-versed in working with gender minorities, but who also may lack training and awareness about cultural competence with racial and ethnic minority clients. Furthermore, there may be cultural stigma related to health care (particularly mental health care; Clement et al., 2015) that may need to be addressed when reducing barriers to care, throughout the intake process, and beyond, over the course of therapy. And, groups

that are experiencing multiple forms of marginalization are likely navigating various forms of systemic, institutionalized oppression that impacts their socioeconomic status and ability to pay for services. Through the intake process, therapists can discuss these challenges with their clients. Further, we would encourage providers to think through ways to help their clients overcome these barriers, potentially by providing a reduced rate for their services or pro bono work with a portion of clients.

Consider what your online presence conveys to trans and gender diverse clients. For instance, consider whether your website has information about your approach to working with gender minorities and any training that you might have received in this area. Providing this information may help clients to make informed decisions about whether to see one therapist over another. As such, it is important to accurately describe your skill and expertise. Many people have not had experience or training in working with gender minorities but perceive themselves as affirming. Sometimes our desires to see ourselves as affirming may cast shadows on areas we can improve on. *Providing specifics of your training will help clients learn factual information that can help in their decision-making process in choosing a therapist whereas blanket statements about being affirming or checking off options on sites like* Psychology Today *to say that you work with transgender clients may not be especially useful.* In addition, *consider the physical space that you work within.* For instance, does your space have access to gender-inclusive restrooms, materials in the waiting room that are inclusive of trans identities and diverse intersecting identities, and is your space accessible for a trans person with a physical disability?

Case Conceptualization and Sociopolitical Climate

When gathering information about presenting concerns and making diagnostic and conceptualization decisions, clinicians must consider the degree to which experiences of bias, gender dysphoria, and other contextual factors are affecting clients' symptoms and functioning (Perry et al., 2017). If the broad goals of psychotherapy are to reduce psychological distress and improve psychological functioning, it follows that case conceptualizations should identify possible sources of distress and barriers to improvement. There are a number of important factors to consider when conceptualizing such sources of distress and barriers to

recovery within trans and gender diverse populations, many of which disproportionately affect more marginalized members of the community whose identities and experiences (e.g., people of color, immigrants, femmes, people with lower socioeconomic status, individuals engaged in sex work) place them at intersections of oppression.

First, *clinicians should incorporate clients' external and internalized experiences with bias into their understanding of clients' mental health and psychological functioning*, as is suggested by the American Psychological Association's (2015) *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. These experiences, often described as minority stressors (Hendricks & Testa, 2012; Meyer, 2003) or double/triple/multiple jeopardy (Bowleg et al., 2003; King, 1988), are associated with poor mental health (Testa, Habarth, Peta, Balsam, & Bockting, 2015). Discrimination and other experiences with prejudice also introduce practical difficulties (e.g., unemployment, homelessness) that increase stress and reduce access to resources, thus likely increasing experiences of clinically significant psychological distress. Exposure to anti-trans stigma is also related to harmful cognitive and emotional processes and experiences, including internalized transphobia (or shame around being trans) and expectation of rejection/prejudice (Bocking et al., 2013; Puckett & Levitt, 2015; Rood et al., 2017a; Rood et al., 2017b). Additionally, rejection from family or peers can lead to increased substance misuse and suicide attempts (Klein & Golub, 2016).

In formulating your case conceptualization, it may be beneficial to assess how these oppressive life experiences relate to the cognitive or behavioral patterns observed in clients (Austin & Craig, 2015; Craig & Austin, 2016; Perry et al., 2017). Further, sharing a case conceptualization that incorporates these social stressors with your client may help them to challenge or decenter from maladaptive cognitions of self-blame and to develop more compassionate understandings of their current mental health. This also allows for therapists to provide psychoeducation on the ways that exposure to adverse life experiences, such as stigma, may shape the client's current cognitive or behavioral patterns (Austin & Craig, 2015; Perry et al., 2017). Therapists also should consider how a case conceptualization that incorporates an understanding of stigma and experi-

ences related to a trans or gender diverse person's identity may shape individual interventions, such as cognitive restructuring, behavioral experiments, and exposure exercises.

It is important to remember that it is simply not possible in the current sociopolitical climate for a trans or gender diverse person to avoid exposure to anti-trans stigma and for trans people of color to avoid this in combination with exposure to racism, xenophobia, and White supremacy. The overwhelming majority of trans people have experienced direct discrimination and hostility, and a substantial portion have experienced gender-based violence (James et al., 2016). Those who have not directly experienced this will have no doubt heard anti-trans positions on the news, read hateful comments in online articles, read about a trans person's murder on social media, etc. *People with additional oppressed identities are more likely to encounter anti-trans bias, as well as bias due to their multiple and intersecting socially devalued identities.* This means such persons (e.g., trans people of color, trans immigrants, trans people with disabilities, etc.) face greater risk for minority stress-related psychological distress and are likely to experience some degree of multiple jeopardy, in which they are marginalized in cisgender communities for their gender identity/history and marginalized in trans communities for their intersecting identities (Bowleg et al., 2003, Grant et al., 2011; James et al., 2016; James, Brown, & Wilson, 2017). In working with trans and gender diverse clients, you are likely to see individuals whose cognitions or behavioral patterns are shaped by these very real threats that surround the lives of trans communities. Therefore, it is important to validate the origins of these patterns as rooted within a client's lived experiences while also helping to empower them to manage those stressors.

Many trans and gender diverse people, particularly those early in their transitions, experience gender dysphoria, which can significantly impact their mental health and psychological functioning (Kozee, Tylka, & Bauerband, 2012). This distress over the incongruence between a person's gender identity and the sex they were assigned at birth (as well as accompanying gendered physical traits and social gender roles) may present similarly to mood or anxiety disorders. It is important to understand this as a distinct contributor to psychological distress and impairment, because it is often effectively addressed with gender-affirm-

ing social transitions and/or medical interventions. For example, controlled longitudinal research has found significant reductions in MMPI-2 scales within 3 to 4 months of hormone therapy for transgender men (Keo-Meier et al., 2015) and sustained decreases in symptoms of depression and stress across the first year of hormone therapy (Barr et al., under review). Cross-sectional research also indicates that trans people who are able to transition exhibit better mental health than those who want to transition but have not (White Hughto & Reisner, 2016).

Meet the Client Where They Are

When gender identity and/or expression become topics of focus in therapy, it can be easy as clinicians to let our own anxieties and/or desire to be affirming prevent us from remaining in a therapeutic stance. *When clients present with uncertainty about their gender identity or their needs around that identity, it is our role to create space for exploration, validate the person's concerns and experiences, provide information and resources, and/or help the client learn ways to cope with associated distress. It is not our role to figure out the client's identity or the best next steps.* Meet your client where they are and be effortful to avoid making assumptions or pressuring your client to pursue certain paths, or to "make a decision." This stance may need to be communicated explicitly to your client.

For example, as an openly transgender man, I (Barr) told my trans and gender diverse clients that I understood our identities, needs, and paths may be different and that any differences would be welcomed and appreciated. I tell clients exploring their gender identities that our connections and therapeutic relationships will not be altered by changes in their relationships with the trans community. Similarly, particularly with trans and gender diverse people of color, it is important to avoid making assumptions of their relationship with and cultural meaning of their intersecting identities. When working with my clients of color as a transgender man of color (Thai), I share with them that I do not make assumptions of shared experiences or cultural meanings of our gender identities; rather, I want to ensure that I follow their lead in their own understandings of their cultures and the meanings they make for their intersecting identities. In a sociopolitical context in which trans and gender diverse people are often devalued by cisgender people, cisgender clinicians may need to explicitly state that they will not

care less or more for a client if that client ultimately identifies as trans or gender diverse. We must also be mindful of ways we may be perceived as communicating expectations or desires regarding clients' identities and transitions. For many clients, sessions with you will be the only space where they can be truly free to explore who they are and what they need. Additionally, while many people exploring their gender will ultimately find comfort identifying with a specific gender identity label (e.g., trans woman, genderqueer), gender is complex and some clients may instead find themselves tasked with accepting a lack of a label or a lack of certainty. As clinicians we must support them in this and cannot lean into any of our own discomfort with ambiguity.

In the same vein, identity is not static; this is true of gender identity and gender expression, as well. For example, the pronouns or names that clients want you to use for them may change throughout your work together. Be preemptively affirming about your intention to honor identity shifts and shifting needs; you can do this both by creating an environment that is receptive to and affirming of exploration, and by explicitly giving clients permission to share such shifts with you should they arise in the future.

Critically, it is our position that you must trust your clients' understandings of their gender and their gender-related needs. Far too often, we have heard clinicians discuss trans clients' identities with disbelief, dismissiveness, or in the context of psychopathology (e.g., identity instability). There is no empirical evidence base for such behavior, and in fact it runs counter to best practice guidelines (APA, 2015), as it contributes to gender diverse individuals' minority stressors and often damages the therapeutic relationship. Thus, taking the role of assessing the validity or "accuracy" of a client's gender identity is contraindicated for desired mental health outcomes. Still, clinicians are often put in a gate-keeping role, in which medical providers ask or require us to determine whether our clients are appropriate for medical gender affirmation steps. In such cases, as is recommended by WPATH's Standards of Care (SOC, Version 7), *clinicians should be mindful that they are not tasked with evaluating a person's identity, but rather their capacity to make informed decisions about their own care.*

Research and Maintain a List of Vetted Local Health Care Providers and Therapists

Navigating the health care system can be extremely stressful and difficult for trans and gender diverse clients. Many healthcare providers are not trained in how to serve the trans population (Jaffee, Shires, & Stroumsa, 2016; Obedin-Maliver et al., 2011; Unger, 2015), and further, might hold anti-trans beliefs or opinions (Poteat, German, & Kerrigan, 2013; Puckett et al., 2017). Thus, *it is our professional responsibility to both become informed of the unique risks our trans clients face across health care services, and further, to keep a live list of vetted health care providers that have worked with and are affirming and supportive of people who are trans and gender diverse.* To start such a list, we recommend reaching out to other therapists who have worked with gender diverse clientele, as well as local LGBTQ organizations for recommendations. In forming such a list, providers should take into consideration the accessibility of the individuals they are recommending—for instance, collect/provide information about whether the provider has a sliding scale for people who may be experiencing socioeconomic hardships, or whether the setting is accessible to individuals with physical disabilities. Here are some websites that may help you find information on providers to look into more:

- http://www.trans-health.com/clinics/
- RAD Remedy: https://radremedy.org

Considerations for Research on the Experiences of Trans and Gender Diverse Individuals

Below we detail recommendations for ways to improve research with trans and gender diverse individuals. Some of these suggestions are particularly important if your study population is trans or gender diverse, but some are applicable regardless of your target sample.

Whose Perspective Is Being Attended to?

Currently, the research literature on the experiences of trans and gender diverse individuals is growing. However, much of what is known is from the standpoint of white trans and gender diverse communities. It is important that you consider the representation of people of color across the various suggestions that are made here. There is a lack of representation of trans and gender diverse people of color in the

literature and this needs to change—more representative sampling or even the centralization of people of color in trans-focused research is sorely needed (dickey et al., 2016). Historically, and currently, the literature has largely been from a white trans community's point of reference. Subsequently, the literature, policy changes, development of training programs, and overall understanding of the trans community continues to be from the perspective of the white trans community.

As such, we urge you to consider the following questions: Who has access to your study? How can you improve the outreach to communities of color? Are people of color involved and integrated in your research team? Are you tokenizing people of color on your team? How do the questions in your study attend to the experiences of people of color? Do you adequately address the limitations of your study if you do not have representation of people of color? Simply saying that you have limited racial and ethnic diversity in your sample is not enough—say more about why that is important.

Incorporating Community Members Into the Research Process

When conducting research on the experiences of trans and gender diverse communities, it is important to recognize the biases that we all hold. We need to each be responsible for this process and recognize the areas that we have more or less knowledge about, as well as the ways that our research is shaped by our individual backgrounds. As such, we may be researching areas that we deem personally interesting or important, but that do not feel substantively important to the lives of the trans and gender diverse people in our studies. Likewise, we may be missing important areas that we might otherwise have included had trans and gender diverse individuals been involved in the research process.

One way to increase diverse perspectives in your research is to incorporate trans community members into the research process by constructing a community advisory board (CAB). Generally speaking, a CAB in this type of research would include a small group of trans and gender diverse individuals who provide feedback on one's research. However, CABs can take different forms and vary in the way they are implemented. For instance, a CAB may simply meet with the researcher and give them feedback on a specific study idea and the measures being used. Or, a CAB can be involved throughout the entire research

process of a study, from the conceptualization, to the design, implementation, and interpretation of findings. And, other times, a CAB may be involved more generally in a researcher's work and not just a specific project. These forms of CABs are structured in ways that will help benefit the researcher and the work being conducted and help in bridging the academic and community/lived experience divide.

Other CABs may function from more of an empowerment, participatory model wherein the CAB is a separate entity that does provide feedback to the researcher, yet also identifies areas that they would like to work on to better the lives of their communities. Researchers can then give back to these communities by using their skill sets to help implement these ideas (e.g., assisting community organizations with grant writing or producing summaries of research findings that can be used in advocacy and community education projects). For a more extensive review of how to incorporate feminist participatory action methods into your work with trans and gender diverse communities, including incorporating community members into the research process, we recommend reading Singh, Richmond, and Burnes (2013).

When constructing a CAB, it is important to try to include diverse perspectives. This means ensuring that you have as diverse a group as possible (within the limitation of the size of the CAB) in terms of race, ethnicity, gender identity, age, social class, ability status, etc. Constructing and maintaining a CAB is no simple task. If you are in an area with fewer trans or gender diverse individuals, consider having some members of the CAB be local and others video conference in for meetings. Also, pay the members of your CAB for their time. CAB members need to be compensated for the work that they are doing, as you will be benefiting from their involvement.

Finding ways to involve community members in the research process can be important, regardless of the researcher's gender identity. For instance, I (Puckett) identify as trans, specifically genderqueer, but recruited a CAB of other trans and gender diverse individuals for my work. Although I personally am part of the trans community, I find it important to include other trans and gender diverse people in the process. I wanted to ensure that my research felt relevant to the lives of many trans and gender diverse people and not just those with similar experiences as me. Further, being part of the trans and gender diverse community does not exclude

researchers from many of the issues presented in this article. We all are susceptible to actions that may not be affirming of participants in our research.

Taking Research Outside of the Ivory Tower

Unless you make explicit efforts to overcome this, the ivory tower of the academe is disconnected from many of the communities researchers focus on in their studies. Researchers need to connect their work more to the very communities that are impacted by the areas they research as opposed to solely publishing their findings in academic journals that then own the copyright to their work or presenting the findings only at academic conferences that cost hundreds of dollars for registration alone. These formats are inaccessible for many trans and gender diverse people outside of the privileged circle of academia. There are a number of ways that researchers can work to overcome this disconnect, albeit they require time and relationship building with trans and gender diverse communities. Arguably, though, if researchers expect trans and gender diverse people to share their lives with them in ways that benefit researchers' careers, we think it is understandable to ask researchers to give back to the community in some fashion beyond contributing to the scientific literature.

For starters, *researchers can ask the participants in their studies if they are interested in being updated on the findings of the work*. Many participants never hear the outcome of what they have helped contribute to, although researchers go on to benefit by accruing publications, getting tenure, securing grants, and getting promotions for their work. Researchers can keep a list of individuals interested in being notified of the results of their studies and send them information as it becomes available (see dickey et al., 2016, for a discussion of this, including ethical issues that may arise). Researchers should also consider the format they use to share information about their research findings. As mentioned above, there can be copyright issues once a manuscript is published. Researchers can create summaries of their work that do not interfere with these copyrights or may go a step further and create infographics that detail the findings. These creative ways of sharing your work will engage the community and can easily be shared over email or social media.

Researchers should also consider non-academic outlets to present their findings

(dickey et al., 2016). For instance, I (Puckett) have presented my work to a Parents of Trans Individuals Group. In these meetings, I shared findings about the importance of family social support to coping with minority stressors for trans and gender diverse people. This particular presentation also included specific suggestions for how to best support trans and gender diverse youth (based on the findings from the study) and a brainstorming session with the parents about some of the challenges they faced and how these can be overcome. Academic conferences can be very expensive and likely include added costs of travel and taking time off from work. Instead, these types of community presentations offer a way for community members to connect to our work in ways that can be informative and empowering.

For researchers who do present their findings at academic conferences, some considerations may be: (a) invite members of your CAB (if you have one) to attend and/or present with you, (b) share your slides or a PDF of your poster online on a website or social media, or (c) stream your presentation on social media so that others have access to it. Ultimately, we need to better value the willingness of our participants to share their lived experiences with us and not take participants for granted. Taking the time to share the products of their contribution is one way of giving back to these communities.

Research also can contribute to creating more affirming social settings for trans and gender diverse individuals. Think through if your findings can be useful in social justice initiatives and how to connect with community groups doing this type of work. For instance, in one of my studies (Puckett), I examined the associations between having trouble accessing a restroom and various negative correlates, such as depression, anxiety, internalized stigma, and less acceptance of participants' gender identities. I also happened to be involved with a group of local parents and concerned community members who were encouraging our local school board to create gender-inclusive policies regarding restrooms in the public schools. As such, I went to a school board meeting and presented what we know in the literature currently about this issue, including my own research findings. *Research can be used for social change, but if we wait for someone else to find our article published in an academic journal and use it in advocacy efforts, it might be years before this happens, if it even happens at all.* As researchers, we can be part of this

process and use our skill sets to benefit trans and gender diverse communities in meaningful ways.

The Power of Words

Many times, when researchers write papers they may overlook the implications of their wording. However, there are many consequences that can come from our writing. Below, find a few major considerations for language choice/use.

• *Consider your audience.* We encourage you to imagine a trans or gender diverse audience and an audience that has a bias against trans or gender diverse people reading your paper. *First, if a trans or gender diverse person was to read it, would they feel affirmed in the way that you discuss the experiences of their community?* This is one of many reasons why it can be important to have trans and gender diverse individuals on your research team or a CAB involved in your work. Many researchers may not realize the impact of their wording or times when something is said in a problematic way. Nonetheless, we need to do better by the communities we research and taking the extra step of having trans and gender diverse people involved in the research process can help ensure this. When you do have trans or gender diverse individuals involved in this process, it also is important that their contribution be recognized, whether that be in an acknowledgment or as a co-author, depending on the extent of their work. And, second, if a person with bias against trans and gender diverse people were to read your paper, would they find something to use as ammunition in their fight to marginalize trans and gender diverse people? Be mindful of avoiding language that would be used against the populations that have provided the time and effort to participate in your research. When your research is misused against these communities, make efforts to refute the misuse.

• *(Unintentionally) Blaming transgender people for their own social oppression.* Frequently, we come across publications or review manuscripts where authors (more than likely unintentionally) write in a way that blames trans and gender diverse people for the social stressors that they endure. The following statement is characteristic of many of these examples: "As a result of being transgender, this community experiences disproportionate rates of depression and suicidality." This sounds as if mental health issues come from a person being transgender. This simply is not the

case. *There is not something harmful or inherently pathological about being transgender or gender diverse. Instead, these mental health issues are experienced because of the stressors that disproportionately impact this community.* Furthermore, these stressors are based on structures, biases, and beliefs that marginalize trans and gender diverse people and these should be acknowledged. Another similar statement is "Because of being transgender, this group encounters high rates of victimization." Victimization is due to the bias and prejudice of other people towards trans and gender diverse people—not because people are trans and gender diverse. Although this may seem simplistic or picky to some, what is being communicated is substantially different when this wording is changed.

• *Definitions and terminology.* Sometimes authors describe transgender people as "non-cisgender" and/or describe cisgender people as "non-transgender." Instead, provide definitions of "transgender" and "cisgender" that do not center on the contrast between them. Additionally, using the term "cisgender" labels the dominant group instead of simply treating this experience as the norm and only labeling individuals outside of this. Also, some researchers still use language like "biological sex"; it is more affirming to use terms like "sex assigned at birth." In addition, occasionally, we see authors using terms like "transgendered" or "transgenders"—both of which are problematic. Instead, use terms like "transgender people" or "trans and gender diverse communities."

Mislabeling Participants' Identities— "The 500 Characters Are Worth It"

Historically, psychological research demographic questionnaires and clinic intake forms have offered limited gender, sex assigned at birth, and sexual orientation options (many times not including some of these important categories). When we offer people limited options that do not include the way they identify, they have the choices of checking a box that does not fit or leaving the item blank. This is often one of our first points of contact with participants/clients and can be hurtful, send a message of what our values are (and are not), can contribute to erasure/invisibility of non-dominant identities, and does not collect accurate data. Collecting more inclusive, affirming, and accurate data serves not only the client/participant, but also the sci-

entist/researcher, clinician, and field at large.

We suggest collecting both information on participants' sex assigned at birth and their current gender identity, in line with the suggestions of others (dickey et al., 2016). More specifically, we suggest the following:

1. What was your sex assigned at birth? (Response options: Female assigned at birth; Male assigned at birth)

2. Do you identify as intersex or as having a difference of sex development? (Response options: Yes, No, Unsure)

3. Which of the following best describes your gender identity? (Response options: Man, Woman, Trans Man, Trans Woman, Genderqueer, Nonbinary, Agender, Androgyne, Bigender, Not listed, please specify: (with a write in option)

This allows for participants to endorse a variety of gender identities without having to choose an option that may not align well with them. Further, given that not all trans or gender diverse people continue to identify with the prefix of "trans," this provides options for individuals to choose gender identity labels without this language. Researchers are, however, still able to determine which participants are transgender by examining gender identity endorsements relative to participants' sex assigned at birth.

It is worth noting that I (Puckett) have modified or added notes to questions about gender in my surveys in response to feedback I have received from participants. For instance, in one study I conducted that was only meant for trans and gender diverse people, some participants thought that the survey was open to people who are cisgender because of the various gender identity options (e.g., woman and trans woman; man and trans man). In this type of situation, I have included a note saying "This survey is only for people who have identified that they are trans or gender diverse, but we recognize that not everyone prefers to identify themselves using the terms trans men and trans women and so the terms man and woman are included above. We left out options for cisgender people because the survey is only intended for people who identified as trans or gender diverse (this also is why there are no prefixes before the options of man and woman above)." Depending on the population you

are working with, you may find that a note like this is helpful in explaining your decisions to your participants so that they can see their identities represented and feel validated by the questions that you provide.

More recently, some studies and clinics have started offering more inclusive questionnaires, but when reporting data, streamline the demographics section, presenting statistics/frequencies for only the most prominent identities in the sample (e.g., men/women, heterosexual/gay, male/female), or collapsing groups together (e.g., heterosexual/sexual minorities). Worse even, reports sometimes misgender participants—for example, referring to trans women as MSM (men who have sex with men) or regrouping nonbinary participants into binary categories, and often do not include sexual orientations that are more commonly endorsed by the trans and gender diverse community (e.g., queer or pansexual). Asking about these areas in an inclusive way takes little time, creates a more inviting experience for participants, and it allows us to collect more accurate data. Reporting demographics fully in publications and presentations educates the field about the diversity of identities within each of these groups. Identifying more subgroups also allows us to perform subgroup analyses on groups that have hardly been researched, and understand more about important next steps for our field.

Letter to All the Editors

Trans and gender diverse research needs to be read by the audiences of general journals, not just by other individuals conducting research in the same area reading trans specific journals. However, it seems common that researchers conducting trans and gender diverse research have the experience of desk rejections from journal editors stating that their work is better suited in a niche journal. This practice of rejecting and pushing trans and gender diverse research into specialty journals also has implications for the researchers conducting this work. Many of the specialty journals do not have impact factors and, depending on the author's position and institution, this may influence the researcher's tenure and promotion process negatively. And, although we are focusing on trans-specific research, this type of issue exists for work with other marginalized communities, such as racial minorities. In summary, manuscripts should not be rejected simply because of the focus on trans and gender diverse communities. Instead, the quality of the work should be

the basis of whether a manuscript is reviewed or not. In many instances, when this work is published in specialty journals, it is viewed by those who are already relatively well-informed on these topics. Creating greater accessibility in journals with a broader audience will ensure that others who may know less about trans and gender diverse people get more exposure to these topics.

Establishing Connections With Researchers Who Are Experts

Many research labs, institutions, and clinics are starting to understand the importance of researching and publishing on treatment response, psychopathology, and other factors in underrepresented groups. This is without doubt an excellent shift in our field, and it is important for those starting to embark on such endeavors to acknowledge that there are already experts in the field who have been working long and hard (often with little to no grant funding) to research these topics. That being said: Collaborate! Look up and reach out to the experts who have likely been underappreciated, and ask them to co-author your paper with your team, or compensate them to consult with your team on how you might become more competent working with gender minorities.

Compensating Participants and Avoiding Harm

We believe it is exploitative to use a vulnerable population for research without effort to compensate them. Due to continued high levels of discrimination and prejudice, trans and gender diverse people are underemployed, with high rates of unemployment and poverty (James et al., 2016). The reality of psychological research is that despite being a critical piece of progress, it is slow to effect change. Thus, for most studies, research participants' participation alone will not result in direct benefits. Additionally, much of the important trans and gender diverse focused research being done asks participants to do hard work that is emotionally difficult, even distressing. *Rather than asking high-need participants to engage in this labor without benefit, seek funding that will allow you to compensate participants.* We propose that it is ethical best practice to seek to obtain such moneys before initiating recruitment. Even so, we understand the challenges in acquiring funding and we must note the relative lack of funding for trans-specific health research (particularly trans research in psychology) and join those calling for

increased funding opportunities (Coulter, Kenst, Bowen, & Scout, 2014; Hammond & Wertz, 2015; Owen-Smith et al., 2016).

In addition to offering compensation, we encourage you to think beyond Institutional Review Board requirements and truly consider the harm your study may cause participants, how you might minimize it, and the clarity with which such risk is discussed in your informed consent and recruitment processes. Be intentional in selecting the resources and information you provide when people complete or prematurely exit your study/survey (e.g., suicide hotlines), ensuring they are appropriate for diverse trans people. Finally, consider how you can debrief with participants and communicate with them about the study purpose, design, conclusions, etc. as your work progresses. I (Barr) want to acknowledge that many of the suggestions regarding compensation and risk of harm were developed following feedback from trans and gender diverse participants who were disappointed or frustrated with how I was conducting research. This point provides further evidence of the benefit of CABs. Also, consider providing room at the end of questionnaires for participants to provide general feedback about the study. This strategy is very easy to implement and will likely improve your understanding of your findings and your future research studies.

Conclusions

We hope that this article opens up conversations about how to engage in affirming clinical work and research with trans and gender diverse communities and that it encourages you to think critically about practices in your organization, graduate program, or research lab. As mentioned at the outset of this article, this is not an exhaustive list of considerations, but rather some of the more common and salient issues that we have come across. There are likely others that we have not been able to acknowledge here and we would encourage others to write similar pieces to bring to light areas that we have not included. For instance, we have focused more broadly about the practice of therapy in our clinical recommendations, but more work is needed about specific, best practices for adapting cognitive behavioral interventions to be affirming with trans and gender diverse clients. Also, although many of our points may apply across various points in a person's identity development, we provided suggestions that were primarily focused on working with adults in research and clinical work. We hope that others who work primarily with children, youth, and families may write similar pieces to improve work with these populations.

If you are feeling motivated, there are a number of actions you can take right now. For one, add your pronouns to your email signature line (e.g., pronouns: she/her/hers) to normalize discussions of pronouns in social situations. You could also forward this article to your research team, clinical team, colleagues, or other psychologists and mental health professionals you think might benefit from reading it. If you teach in a graduate program, ask the Director of Clinical Training in your program if you can work together to create educational seminars on working with trans and gender diverse clients. Bring in an expert to discuss this area of clinical work. If you are a researcher, create a summary of your latest findings and share it with others. Find a community group to connect to where you can share your work and engage in meaningful discussions about the implications for trans and gender diverse communities. Last, find ways to get involved in professional organizations that work with trans and gender diverse individuals. For instance, you could become involved in the Association for Behavioral and Cognitive Therapies Sexual and Gender Minority Special Interest Group. We also suggest the American Psychological Association Division 44's (Society for the Psychological of Sexual Orientation and Gender Diversity) webpage for more resources that might be helpful to you: http://www.apadivisions.org/division-44

References

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *The American Psychologist, 70*(9), 832.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct.* Washington, DC: Author.

Austin, A., & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. *Professional Psychology: Research and Practice, 46*, 21-29.

Barr, S., Thai, J., Rey, E., Adelson, J., Sharp, C., & Keo-Meier, C. (in review). *The effects of testosterone on the mental health of transgender men: A controlled prospective study of the first year of treatment.*

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*(5), 943-951.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies, 7*(4), 87-108.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11-27.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165-232.

Coulter, R. W. S., Kenst, K. S., Bowen, D. J., & Scout. (2014). Research funded by the National Institutes of Health on the Health of Lesbian, Gay, Bisexual, and Transgender Populations. *American Journal of Public Health, 104*, e105-e112. doi: 10.2105/AJPH.2013.301501

Craig, S. L., & Austin, A. (2016). The AFFIRM open pilot feasibility study: A brief affirmative cognitive behavioral coping skills group intervention for sexual and gender minority youth. *Children and Youth Services Review, 64*, 136-144.

dickey, l. m., Hendricks, M. L., & Bockting, W. O. (2016). Innovations in research with transgender and gender nonconforming people and their communities. *Psychology of Sexual Orientation and Gender Diversity, 3*, 187-194.

Fluckiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 59*, 10-17.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. Professional Psy-

chology: Research and Practice, 43, 460-466.

Hope, D. A., Mocarski, R., Bautista, C. L., & Holt, N. R. (2016). Culturally competent evidence-based behavioral health services for the transgender community: Progress and challenges. *American Journal of Orthopsychiatry, 86*, 361-365.

Jaffee, K. D., Shires, D. A., & Stroumsa, D. (2016). Discrimination and delayed health care among transgender women and men: Implications for improving medical education and health care delivery. *Medical Care, 54*, 1010-1016.

James, S. E., Brown, C., & Wilson, I. (2017). *2015 U.S. Transgender Survey: Report on the Experiences of Black Respondents*. Washington, DC and Dallas, TX: National Center for Transgender Equality, Black Trans Advocacy, & National Black Justice Coalition.

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

Keo-Meier, C. L., Herman, L. I., Reisner, S. L., Pardo, S. T., Sharp, C., & Babcock, J. C. (2015). Testosterone treatment and MMPI-s improvement in transgender men: A prospective controlled study. *Journal of Consulting and Clinical Psychology, 83*, 143-156.

King, D. K. (1988). Multiple jeopardy, multiple consciousness: The context of a Black feminist ideology. *Signs: Journal of Women in Culture and Society, 14*(1), 42-72.

Klein, A., & Golub, S. A. (2016). Family rejection as a predictor of suicide attempts and substance misuse among transgender and gender nonconforming adults. *LGBT Health, 3*(3), 193-199.

Kozee, H, B, Tylka, T. L., & Bauerband, L. A. (2012). Measuring transgender individuals' comfort with gender identity and appearance: Development and validation of the Transgender Congruence Scale. *Psychology of Women Quarterly, 36*, 179-196.

Lytle, M. C., Blosnich, J. R., & Kamen, C. (2016). The association of multiple identities with self-directed violence and depression among transgender individuals. *Suicide and Life-Threatening Behavior, 46*, 535-544.

Martin, D. J., Garske, J. P., Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual

issues and research evidence. *Psychological Bulletin, 129*, 674-697.

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., . . . Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender related content in undergraduate medical education. *Journal of the American Medical Association, 306*, 971-977.

Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual-and structural-level risk factors for suicide attempts among transgender adults. *Behavioral Medicine, 41*, 164-171.

Perry, N. S., Chaplo, S. D., & Baucom, K. J. W. (2017). The impact of cumulative minority stress on cognitive behavioral treatment with gender minority individuals: Case study and clinical recommendations. *Cognitive and Behavioral Practice, 24*, 472-483.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine, 84*, 22-29.

Puckett, J. A., Cleary, P., Rossman, K., Mustanski, B. M., Newcomb, M. E. (2017). Barriers to gender-affirming care for transgender and gender nonconforming individuals. *Sexuality Research and Social Policy*. Advance online publication. https://doi.org/10.1007/s13178-017-0295-8

Puckett, J. A., & Levitt, H. L. (2015). Internalized stigma within sexual and gender minorities: Change strategies and clinical implications. *Journal of LGBT Issues in Counseling, 9*, 329-349.

Reisner, S. L., Katz-Wise, S. L., Gordon, A. R., Corliss, H. L., & Austin, S. B. (2016). Social epidemiology of depression and anxiety by gender identity. *Journal of Adolescent Health, 59*, 203-208.

Reisner, S. L., White, J. M., Bradford, J. B., & Mimiaga, M. J. (2014). Transgender health disparities: comparing full cohort and nested matched-pair study designs in a community health center. *LGBT Health, 1*(3), 177-184.

Rood, B. A., Maroney, M. R., Puckett, J. A., Berman, A. K., Reisner, S. L., & Pantalone, D. W. (2017a). Identity concealment in transgender adults: A qualitative assessment of minority stress and gender affirmation. *American Journal of Orthopsychiatry, 87*, 704-713.

Rood, B. A., Reisner, S. L., Puckett, J. A., Surace, F. I., Berman, A. K., & Pantalone, D. W. (2017b). Internalized transphobia: Exploring perceptions of social messages in transgender and gender-nonconforming adults. *International Journal of Transgenderism, 18*, 411-426.

Shulman, G. P., Holt, N. R., Hope, D. A., Mocarski, R., Eyer, J., & Woodruff, N. (2017). A review of contemporary assessment tools for use with transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity, 4*, 304-313.

Singh, A. A., & dickey, l. m. (Eds.). (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients*. Washington, DC: American Psychological Association.

Singh, A. A., Richmond, K., & Burnes, T. R. (2013). Feminist participatory action research with transgender communities: Fostering the practice of ethical and empowering research designs. *International Journal of Transgenderism, 14*, 93-104.

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity, 2*, 65-77.

Unger, C. A. (2015). Care of the transgender patient: A survey of gynecologists' current knowledge and practice. *Journal of Women's Health, 24*, 114-118.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*, 270-277.

White Hughto, J. M., & Reisner, S. L. (2016). A systematic review of the effect of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgender Health, 1*, 21-31.

Winters, J. (2008). *Gender madness in American psychiatry: Essays from the struggle for dignity*. Dillon, CO: GID Reform Advocates.

. . .

Correspondence to Jae A. Puckett, Ph.D., Department of Psychology, University of South Dakota, 414 E. Clark, Vermillion, SD 57069; Jae.Puckett@usd.edu

Raja, S., & Ashrafi, J. (2018)

The PTSD Survival Guide for Teens

Oakland, CA: New Harbinger Publications

Reviewed by Amy R. Murrell, *University of North Texas*

The PTSD Survival Guide for Teens, written by Sheela Raja, Ph.D., along with her teenage daughter, Jaya Ashrafi, is the newest installment in New Harbinger's Instant Help Solution Series for Teenagers. The series is made up of evidence-based self-help books meant for youth who are experiencing symptoms of trauma, anxiety, depression, or related issues. Prior to the publication of this text, there were two others focused on PTSD or traumatic events, one written by Dr. Raja. There is a good deal of overlapping content with the two previous books, but this content is novel in a couple of ways. This book addresses specific traumatic events (i.e., bullying, physical and sexual assault, natural disasters, witnessing violence, and experiencing illness) and it includes a teen perspective.

The book begins with a distinction between normative stress and stress related to having experienced a trauma. It then outlines common ways that people respond to trauma. This is the first time that it is clear, to a well-informed reader, that empirical literature is being accurately used to back up the points being made. The use of citations is a bit inconsistent; in self-help books it is sometimes deemed unnecessary to use many references, but some things are frequently cited, and other literature is not cited at all, or nonstandard references are used. As examples, Janoff-Bulman is not cited when the shattered world assumptions are discussed, and the ACT *Practical Guide*, rather than articles, is cited for statements related to experiential avoidance. This occurs as odd to a professional but would likely not be an issue of concern to the book's intended reader, a teenager with PTSD. There is a list of resources, along with the references, at the end of the book that will likely be very helpful to teens and their parents. The DSM-5 criteria for PTSD are presented and cited early in the text. The introduction ends with a "how to use this book" section—guiding readers to focus on certain chapters, depending on the difficulties that they are experiencing. For example, the last bullet point in this section says, "Do you feel out of touch with yourself and your environment? Please read chapters 4 and 9."

The chapters map on to common PTSD symptoms and characteristics; there are chapters that focus on avoidance, intrusion, anger, depression, fear, and anxiety. There is also a chapter on resilience and posttraumatic growth. Every chapter has "Try This" exercises in several places throughout. These exercises are linked to the written content that precedes them and include varied activities, such as prompts to monitor and record thoughts and feelings, breathing exercises, behavioral activation strategies, defusion work, and more. Many of these exercises have significant empirical support and, because these are principle-based, they can be used for several different presenting issues. The only downside of this is that some of the same exercises, or very closely related ones, are presented in more than one place in the text. This may make it more likely that teens find it repetitive and boring. To reduce this possibility, many chapters give multiple choices for how activities can be conducted. For example, in Chapter 8, the book says to examine your thoughts like a reporter to determine if they are true, or to look at them like a friend would—to see if they are kind. Another example is in Chapter 10 in the discussion of physical exercise. The book mentions to do yoga, or dancing. Each chapter also includes a section labeled "Putting It All Together," which is a review of all the key points, and "Our Final Thoughts," which gives the professional and teen perspective on everything in the chapter.

Having Jaya's thoughts throughout each chapter, in boxes labeled "Jaya Says," in addition to the conclusion of each, may make it more likely that teenagers read this book on their own. This will be an interesting empirical question to watch over time. Although this book, like all the books in the series, is targeted to teens, it is fairly unlikely that youth would actually pick up a book like this on their own and read it and do the activities in it without prompting from a parent or, even more likely, from a mental health professional. This book is written at a level that most teenagers will understand. Further, once introduced, most teens who have experienced a trauma that is addressed in this book will likely be engaged. However, the book is not a gripping young adult sci-fi or rom-com novel. It is evidence-based treatment in book form. This book will be very useful to cognitive-behavioral clinicians who work with youth. It is well written, packed with useful therapy tools, and certainly covers an important topic.

· · ·

Mentoring in Clinical Psychology

Anna M. Bardone-Cone, *University of North Carolina at Chapel Hill*

ASKED TO CONTRIBUTE a perspective piece on the topic of mentorship in clinical psychology, I was prompted to think about how I have been mentored and how I try to mentor students. I also realized that I knew very little about the research on mentoring. Below I will highlight some of the more recent mentorship research, share some personal reflections, and finish with recommendations for mentors and mentees. Of note, because my lens is that of a research mentor (and most of the mentoring literature in psychology focuses on research), this article will primarily have a research mentoring focus.

Defining Mentoring

There is no universally accepted operationalization of mentoring in academic and clinical training settings, but substantial overlap exists between proposed definitions. Johnson (2014) proposes mentoring as "a dynamic, reciprocal, personal relationship in which a more experienced trainer (mentor) acts as a guide, role model, teacher, and sponsor of a less experienced trainee (protégé)." Jacobi's (1991) review of the mentoring literature across disciplines, including psychology, highlights the following in defining mentoring: intentional assistance of mentees toward long-term goals; provision of both career/professional and psychosocial/emotional support; greater professional experience, achievement, and influence of the mentor; mentorship as mutually beneficial; and mentorship as personal. In their conceptualization, Chan, Yeh, and Krumboltz (2015) described mentoring as promoting "professional and personal growth of the protégé through coaching, support, and guidance." Last, Forehand's (2008) review of successful mentorship in psychology doctoral programs emphasized both instrumental behaviors of the mentor (e.g., helping mentees reach their training goals) and more relational characteristics of the mentor (e.g., open to student ideas, engaged in the relationship).

Consistently, both professional and psychosocial support are mentioned in defining mentorship. Professional support encompasses an array of actions such as inclusion in research, facilitation of connections with others, assistance with navigating academia, and guidance in charting a roadmap for graduate school and beyond. The psychosocial aspect of mentoring emphasizes connection, emotion, communication, and openness, thus situating mentoring firmly as a relational competency (Mangione, Borden, Nadkarni, Evarts, & Hyde, 2018). Indeed, in their examination of mentor-protégé dyads where mentors were established, high-quality mentors to ethnic minority students, Chan et al. (2015) found that relationship building was key to successful dyads. Another explicit part of psychosocial support refers to being able to communicate support and validate the stressful experiences of being a graduate student (Cobb et al., 2018)—and not waiting for the student to express distress, but being proactive in checking in on the student's well-being. Of note, while the instrumental part has long been part of the conceptualization of mentoring, the focus on psychosocial aspects and relational competency is relatively newer.

Impact of Mentoring

Clinical psychology doctoral students overwhelmingly report that having a mentor enhanced their experience in graduate school and/or training (Mangione et al., 2018), with mentoring associated with greater benefits and a more satisfying graduate school experience (Clark, Harden, & Johnson, 2000), greater research self-efficacy (Hollingsworth & Fassinger, 2002), and decisions to pursue a career in academia (Dohm & Cummings, 2002). When female graduate students are the focus, research shows that mentoring tends to be associated with greater involvement in professional activities (Benishek, Bieschke, Park, & Slattery, 2004). In a study of ethnic minority clinical and counseling psychology graduate students, "comprehensive professional support" provided by mentors was central to students' satisfaction, productivity, and perseverance in both research and clinical work (Chan et al., 2015). More broadly, mentoring has been proposed as the most critical factor in relation to graduate students' academic and career development (Hollingsworth & Fassinger, 2002), with both instrumental and psychosocial mentoring differentially predicting outcomes 5 years postgraduate school from science and engineering disciplines (Paglis, Green, & Bauer, 2006).

Multiple Mentors: "No Single Guru"

There is support for the value of having multiple mentors. This may be particularly true for clinical psychology programs that involve a wide range of trainings and experiences (academic coursework, research, clinical practice, and teaching) and perhaps particularly true for women and racial/ethnic minorities who often are not mentored by people of their same gender or race/ethnicity. Importantly, Lundgren and Orsillo (2012) noted that often mentors cannot serve all the needs of a trainee and that some of the needs may be in opposition, making it further challenging for one person to address all of them. In their qualitative analysis of mentoring among clinical and translational researchers, Robinson, Schwartz, DiMeglio, Ahluwalia, and Gabrilove (2016) found that the idea of a "single guru" to serve as mentor was rejected and replaced by a proposal of five types of mentors needed: (a) scientific mentor for discipline-specific training and guidance; (b) career mentor for guidance on career strategy and choices; (c) confidante who provides a confidential emotional outlet; (d) impartial senior mentor, ideally from a different department; and (e) peer mentor role model to whom the mentee aspires. Certainly, one person could serve several of the roles listed above, but the point is that one person cannot be all people to a mentee. From another perspective, participants noted that seeking advice on the same topic from more than one mentor could provide differing views whose assimilation and reflection on could optimize solutions (Robinson et al., 2016).

Despite the value of having multiple mentors, assembling a mentorship network is not usually done in a systematic way. One exception is the adoption of a "multilevel mentoring matrix" involving self, senior, scientific, peer, and staff mentorship, creating a holistic and synergistic mentoring effort that has been associated with greater inclusion of women and underrepresented minorities in clinical and translational research (Byington et al., 2016). Even without institutional support, however, mentors can facilitate a mentee's connections with

other mentors, resulting in a "constellation" of mentors.

Mentoring Through a Multicultural Lens

Valuing multiple mentors aligns with mentor multicultural competence, where recognizing the limits of one's knowledge and the importance of expanding relevant knowledge and referring mentees to others for additional mentor support is critical (Chan et al., 2015). In their multicultural, ecological, and relational model of mentorship, Chan and colleagues explicitly emphasize multicultural competencies and cultural humility. The competencies component refers to awareness of one's biases and assumptions, knowledge of others' worldviews, and efforts to develop skills that would promote successful mentoring of those from varied cultural backgrounds (Chan et al.; Sue & Sue, 2016). Cultural humility refers to an attitudinal stance conveying limited knowledge and understanding of the mentee's cultural perspective along with a curiosity and willingness to increase understanding (Sue & Sue).

Based on their "deep dive" into successful mentoring dyads involving ethnic minority clinical and counseling psychology students, Chan and colleagues (2015) highlighted the need for career support and guidance tailored for ethnic minorities; the focus on the relationship (including trust-building via being open to talk about race/ethnicity, validating the protégé's experiences, and being "real" and showing vulnerabilities); and an attention to context, noting that the mentoring relationship does not exist in a vacuum but rather amid sociocultural forces that may affect the mentor, the mentee, and the relationship. Translating this multicultural approach from a focus to race/ethnicity to a focus on gender seems relevant (e.g., considering career support tailored to women, noting that the mentoring dyad exists in the context of androcentric institutions).

Benishek and colleagues (2004) proposed a multicultural feminist model of mentoring, arguing that most conceptualizations of mentoring do not consider how different life histories and contexts of the members in the mentoring dyad may impact the mentoring experience. Thus, their model is presented as an interactive process where differences between the mentor and mentee are clearly identified and discussed as needed in order to determine their relevance to the mentee's professional development and the mentoring relationship. Benishek and colleagues' model of mentoring emphasizes relational elements and demands greater authenticity in the discussion of, for example, varying career paths, challenges related to sexism, discussion of power and empowerment, and vulnerabilities. By being "real" and modeling and sharing struggles, mentors convey a professional process of ongoing development and the reality of professional imperfection.

Situating mentoring of women in a multicultural feminist framework is important given that, although women outnumber men as clinical psychology doctoral students, there are still more men than women in faculty mentor roles (Dohm & Cummings, 2002). The good news is that there is evidence that among female students in clinical psychology doctoral programs, women report similar rates of mentoring and similar satisfaction with mentoring relationships compared to their male peers (Clark et al., 2000). Interestingly, there is some evidence that female doctoral students (including those in psychology) are more likely than males to want a mentor who recognizes their potential, serves as a role model, believes in them, and sees them as a junior colleague (Bell-Ellison & Dedrick, 2008).

Lundgren and Orsillo (2012) note that there is little rigorous research on evidence-based mentoring in clinical psychology programs. They draw parallels with treatment outcome research in terms of key questions such as: What is the role of nonspecific, common factors on the outcomes of mentoring? What is the effect of mentor/mentee match on key characteristics, including gender and race/ethnicity? Although these questions are worth researching, given that white mentors outnumber mentors from underrepresented minorities and male mentors outnumber female mentors, it is important to conceptualize how any mentor can be a positive mentor to any mentee.

What is likely most important in successfully mentoring women and underrepresented racial/ethnic minorities is a mentor's multicultural competencies and cultural humility. In mentoring women, multicultural competencies may include a willingness to examine preconceived assumptions related to gender as well as knowledge of issues particularly relevant to women such as sexism, underrepresentation in academic leadership, lack of role models, potential isolation, sexual harassment, decisions about starting a family, and the imposter phenomenon. Cultural humility may include being willing to facilitate connections with other mentors who may be more adept at providing guidance on gender-specific challenges; this may be most relevant for male mentors. Indeed, with multicultural competencies and cultural humility in action, both similarities and differences between mentors/mentees have benefits. Similarities between mentor/mentee can help foster a good relationship if there is familiarity of potentially common struggles (e.g., the experience of sexism for female mentor/female mentee dyads). Differences may foster different perspectives which can help stretch the mentee in a new direction of learning.

My Experience as a Mentee

When I reflected on what was valuable mentoring to me as I started out in clinical psychology, three things stood out.

Providing Good—and Realistic—Advice

It was my senior year of college and I was in a bit of a panic. The professional trajectory I had anticipated was not going to happen (I was not going to be a math professor), and now in my second-to-last semester I discovered something called "clinical psychology"—how could I go there and be that? I met with one of my introductory psychology professors to share my situation and ask for guidance, and I will be forever grateful for the time she took to educate me about the process of pursuing a career in clinical psychology. First, she stressed the importance of showing prospective graduate mentors that I had done my due diligence and settled on clinical psychology. Specifically, this translated to finishing out my senior year with an array of different psychology classes so that I could confirm that clinical was the way I wanted to go—thus, I took classes and/or did research related to neuroscience, cognitive psychology, and developmental psychology. Second, she emphasized the importance of having research experience to give me a sense of what research involves and so that a research advisor could get to know me and write on my behalf. Thus, I spent the rest of my senior year volunteering in a cognitive psychology lab. Finally, I received guidance on options to consider as I approached graduation. My mentor told me frankly: You are not going to be competitive for doctoral programs given your current résumé and experiences. But she encouraged me to consider some well-respected master's programs. I ended up applying to a master's program, and even

though I pursued a different path to prepare myself for eventually applying to a clinical psychology doctoral program, receiving an acceptance to the program right out of college was a boost. Thoughtful advice, tailored to my situation, that balanced realism with genuine encouragement made all the difference in moving me onto a pathway toward clinical psychology.

Fostering Connections

My mentors in graduate school took opportunities to connect me with other researchers in the field. In one case, I was part of a research group preparing for the next wave of data collection for a longitudinal study and I found myself with Big Name Scholars and, of course, completely nervous and intimidated. Even though this connection did not develop into anything, it gave me confidence that I could hold my own in conversations with preeminent researchers. This is huge for someone starting out and doubting their place at the table. Later, my graduate mentor facilitated a connection with another highly respected researcher, which ultimately led to brainstorming together and publishing. And, as important, another mentor I could turn to.

Respecting Ideas

My most striking example of this was when I changed mentors due to my initial mentors moving out of the country, which coincided with my moving into a research direction that was not represented in my clinical program. Another faculty mentor graciously agreed to mentor me, despite her acknowledgment of not knowing much about my proposed research program. This meant we were in the position of me educating her about what the field was grappling with, what was known and what were gaps of knowledge in this area, and what impassioned me about the topic. I remember intense meetings replete with her questions of genuine interest and attempts at learning from me. Her mentoring me by playing the role of the student was empowering.

Now that I am more senior in the field, I still look toward mentors and the categories above still apply, although perhaps to different degrees. Most important to me these days is the good, realistic advice piece—including having many people to go to for different domains: grant-writing, responding to journal reviewers, mentoring graduate students, teaching strategies, balancing work and family.

My Experience as Mentor

What do I aim to do as a mentor? Although I do not always accomplish these aims, I would highlight the following as important parts of mentoring in addition to the concepts described above.

Playing to Your Strengths

It is always useful to know your areas of strength. With mentoring in mind, these are the areas where I especially give my time and energy to my students because I feel it is where I can most contribute to their growth. I am a stickler about precision in study design and analyses and committed to telling a clear and compelling story—these are areas of strength for me, so this is where I think I help the most as a mentor to my students: asking them pointed questions to ensure they have thought through details of a study in development; early on, spot checking analyses as another check on accuracy; copious feedback on drafts of manuscripts. Regarding the latter, my approach is to add in notes about the edits I recommend and to meet with the student to walk through the feedback together. I find that this makes the feedback experience more collaborative and helps them understand why I am making the particular recommendations. A corollary to this aim is knowing when to refer students to others for assistance and to not feel like you have to know it all.

Being Available, But . . .

A mentor's advice only has the potential to be helpful if there is time set aside for the mentor to listen to their students and reflect on crafting tailored advice. Thus, being easily available to students is something I aim to do—via email, in-person meetings, and phone/Skype meetings. However, I also think it is important to show that you have a life outside of work (for example, a spouse, children, a commitment to exercise or an avocation), that it is okay to reschedule because something personal comes up or because you are swamped, and that it is okay for them to do similarly: reciprocal flexibility. Related to this point, and perhaps more challenging, is balancing wanting to say "yes" to avenues that they want to stretch into that will involve one's time commitment, while also communicating the message that there are times when it will be sanity-preserving to say "no" more.

Creating a Culture of Inclusivity and Community

I think about inclusivity in two ways. One is inclusivity in all professional aspects of training, meaning including students as co-authors on manuscripts, as contributors to grant writing, as collaborators in study design and execution, and as mentors to other students. But by inclusivity I also refer to a sense of community so that all feel welcome regardless of their backgrounds and demographics. One way I try to foster this is through genuineness of caring and commitment and by active listening: what does this person in front of me need at this moment—or if they are not sure, how can I help them identify what they need? In my experience, starting off strong in this area of caring and commitment sends a clear message that I am on the student's team, will do all I can to understand where they are coming from, and will go to bat for them to help them grow as a professional and person. For example, when I was the faculty member on our clinical diversity committee, I took this stance as I learned about the students' desire for more thoughtful diversity training beyond what at that time was our program's "bookends" of a multicultural workshop at orientation and a multiculturalism course as a more advanced student. In the role of an informal mentor to the students on this committee, I listened and asked questions so that I could best understand their needs and desired areas of growth. Firmly "on the same team," we were able to collaboratively craft the elements of what would become our program's diversity training sequence. Creating a sense of genuine caring, commitment, and community was key to this outcome.

Summary and Recommendations

From the mentoring literature reviewed, I suggest three take-away messages. First, mentorship is valuable both for the psychosocial support and the instrumental support provided. Second, a constellation of mentors is beneficial to mentees for the breadth of professional and personal guidance it provides. Moreover, it may be especially important for students whose identities are not commonly represented among faculty mentors (e.g., women, racial/ethnic minorities). Conceiving of multiple mentors is also beneficial to the mentoring relationship in communicating that there is no "single guru"—and that is okay. Third, developing one's multicultural competencies and enacting cultural humility are both necessary in working with mentees, especially in considering unique experiences and challenges of female mentees and underrepresented minority mentees.

Lundgren and Orsillo (2012) propose recommendations to mentors in the absence of clear evidence-based mentoring data: familiarize yourself with the mentorship literature; apply an idiographic, single-case approach to mentoring, with frequent assessments of students' professional outcomes (and, I would argue, well-being) in order to determine mentoring adjustments; and provide ongoing validation and support, psychosocial aspects of mentoring that are buoying in the stressful context of graduate studies and can help boost confidence, which may be in short supply. Additionally, taking a stance of cultural humility is strongly recommended as a way to actively seek to understand a mentee's experiences and needs and to assess what you personally can help with and what constellation of mentors you can assist them to develop.

What recommendations can be proposed for mentees? Just as mentors should be aware of their strengths and weaknesses, playing to their strengths and connecting mentees to other mentors to shore up their weaknesses, mentees should also develop a keen self-awareness. Doing a self-inventory of areas of strength and areas of needed growth can be helpful in guiding a mentee in determining what areas they would most benefit from guidance, which they can then communicate to their mentors. Mentees may feel apprehensive of such disclosures if they feel the need to present as perfect, accomplished students, but in an authentic mentoring relationship where the mentor also discloses past and current challenges, authenticity from both members of the dyad will be the most fruitful. Zerzan et al. (2009) reflected on aspects of these recommendations, encouraging mentees to take "ownership" by letting the mentor know their needs (or requesting their assistance in clarifying areas of growth). In particular, the authors recommended that mentees identify and communicate their values, work style, and needs (e.g., knowledge and skill gaps) as an important starting point of any mentoring relationship. Another recommendation for mentees is that they be proactive in seeking out different mentors for different issues. For example, a female student with a good mentoring relationship with a male mentor may want to consider expanding her mentor network to include female mentors who may be better positioned to provide guidance on challenges more specific to women (e.g., sexism, decisions regarding starting a family and maternity leave).

Mentoring is one of the richest dyadic relationships around. Although the benefit to mentees is usually the focus, mentors gain as well via extrinsic benefits (greater scholarly activity, future colleagues, and professional recognition) and intrinsic benefits (career satisfaction, a sense of contributing to the future of research with well-trained new scholars, and validation as an influential role model; Johnson, 2002, 2014). It is well worth the time of both the mentor and mentee to put in the energy to develop a mutually respectful, beneficial, and collaborative relationship. And, frankly, it can be a joy.

References

Bell-Ellison, B. A., & Dedrick, R. F. (2008).What do doctoral students value in their ideal mentor? *Research in Higher Education, 49*, 555–567.

Benishek, L. A., Bieschke, K. J., Park, J., & Slattery, S. M. (2004). A multicultural feminist model of mentoring. *Journal of Multicultural Counseling and Development, 32*, 428-442.

Byington, C. L., Keenan, H., Phillips, J. D., Childs, R., Wachs, E., Berzins, M. A.,…Clark, E. B. (2016). A matrix mentoring model that effectively supports clinical and translational scientists and increases inclusion in biomedical research: Lessons from the University of Utah. *Academic Medicine, 91*, 497-502.

Chan, A. W., Yeh, C. J., & Krumboltz, J. D. (2015). Mentoring ethnic minority counseling and clinical psychology students: A multicultural, ecological, and relational model. *Journal of Counseling Psychology, 62*, 592-607.

Clark, R. A., Harden, S. L., & Johnson, W. B. (2000). Mentor relationships in clinical psychology doctoral training: Results of a national survey. *Teaching of Psychology, 27*, 262-268.

Cobb, C. L., Zamboanga, B. L., Xie, D., Schwartz, S. J., Meca, A., & Sanders, G. L. (2018). From advising to mentoring: Toward proactive mentoring in health service psychology doctoral training programs. *Training and Education in Professional Psychology, 12*, 38-45.

Dohm, F-A., & Cummings, W. (2002). Research mentoring and women in clinical psychology. *Psychology of Women Quarterly, 26*, 163-167.

Forehand, R. L. (2008). The art and science of mentoring in psychology: A necessary practice to ensure our future. *The American Psychologist, 63*, 744–755.

Hollingsworth, M. A., & Fassinger, R. E. (2002). The role of faculty mentors in the research training of counseling psychology doctoral students. *Journal of Counseling Psychology, 49*, 324–330.

Jacobi, M. (1991). Mentoring and undergraduate academic success: A literature review. *Review of Educational Research, 61*, 505–532.

Johnson, W. B. (2002). The intentional mentor: Strategies and guidelines for the practice of mentoring. *Professional Psychology: Research and Practice, 33*, 88–96.

Johnson, W. B. (2014). Mentoring in psychology education and training: A mentoring relationship continuum model. In W. B. Johnson & N. J. Kaslow (Eds.), *The Oxford handbook of education and training in clinical psychology* (pp. 272–290). New York, NY: Oxford University Press.

King, C. A., & Cubic, B. (2005). Women psychologists within academic health systems: Mentorship and career advancement. *Journal of Clinical Psychology in Medical Settings, 12*, 271-280.

Lundgren, J. D., & Orsillo, S. M. (2012). The science and practice of mentoring in psychology doctoral training. *Journal of Cognitive Psychotherapy, 26*, 196-209.

Mangione, L., Borden, K. A., Nadkarni, L., Evarts, K., & Hyde, K. (2018). Mentoring in clinical psychology programs: Broadening and deepening. *Training and Education in Professional Psychology, 12*, 4-13.

Paglis, L. L., Green, S. G., & Bauer, T. N. (2006). Does adviser mentoring add value? A longitudinal study of mentoring in doctoral student outcomes. *Research in Higher Education, 47*, 451–476.

Robinson, G. F. W. B., Schwartz, S. S., DiMeglio, L. A., Ahluwalia, J. S., & Gabrilove, J. L. (2016). Understanding career success and its contributing factors for clinical and translational investigators. *Academic Medicine, 91*, 570-582.

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th Edition). Hoboken, NJ: Wiley & Sons.

Zerzan, J. T., Hess, R., Schur, E., Phillips, R. S., & Rigotti, N. (2009). Making the most of mentors: A guide for mentees. *Academic Medicine, 84*, 140-144.

· · ·

Correspondence to Anna M. Bardone-Cone, Ph.D., Department of Psychology and Neuroscience (CB# 3270), University of North Carolina at Chapel Hill, Chapel Hill, NC 27599; bardonecone@unc.edu

The Sirens of Vienna[1]

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

CBT was a victim of a series of hypothetical constructs, as are we all.[2]

WHY I AM WRITING from the waiting room of Berggasse 19, 1090[3] is not important. What matters is that the harmful, unconscious influence that Vienna has had upon Cognitive Behavioral Therapy (CBT) since its inception be brought to light and stopped, once and for all. The hidden truth that I have long struggled with must be disseminated posthaste to my colleagues via CBT's most unimpeachable forum—obviously, the Lighter Side column in *the Behavior Therapist*.[4]

Granted, there has already been considerable lag time in communicating what I have uncovered to the CBT community-at-large, but such is the power of Vienna over even seasoned practitioner-scientists such as I. Allow me to explain. While still in training, I began to suspect that Vienna had its tentacles into CBT. (After all, what else could account for the mixed messages doctoral students in my program were subjected to by learning CBT in a curriculum that also included courses in the psychoanalytic approach?) But it was not until my hypothesis was corroborated by one of my own dreams that I learned the true meaning of repression. . . . It's still hard to deal with the anxiety-triggers that I must endure to describe it to you, but CBT is worth fighting for! Suffice to say that the insight I had gained through objectively interpreting the dream I will now painfully describe was almost immediately submerged from my conscious awareness. I am not seeking your compassion, but only note for the record that it has taken me 10 years of thrice-weekly analysis to retrieve my memory and develop the Willensstärke[5] to tell my story.

In my dream, I was back in training, and my supervisor's appearance kept morphing; at one moment looking like Beck,[6] another like Freud, then like Skinner, followed by Horney, then all-too-predictably my mother. My dream ended with Freud and I, along with a fellow who called himself Kilgore Trout,[7] partaking in some delicious schnitzel. Beck declined to join us since he had rejected the idea of ordering deep-fried veal cutlets in favor of a heathier, vegan entree. The schnitzel had seemed so real that I could taste each morsel in my mouth. I was just about to take another bite when I suddenly awoke in a cold sweat, feeling guilty about siding with Freud over Beck. Strangely, Trout's veal was raw rather than deep fried, and he ate it while saying nothing, blood dripping down his chin.

Further analyzing my dream while commuting to the evidence-supported CBT clinic in a small town called Ilium in idyllic upstate NY[8] where I then practiced, the parallel process became clear. My unconscious had been clueing me in on a greater truth—my dream wasn't about me, it was about CBT. And, it wasn't me, but CBT that was suffering from a guilt complex. But why? It was only when I was perusing some new research a few months later, "Mechanisms of Action in Dysfunctional Schemas," that I had had another revelation. In this article, schemas were dissected and talked about as if they were actual entities, as opposed to hypothetical constructs (HCs). More concerning was the fact that this "reification fallacy"[9] had apparently not triggered any problems in the peer review process of the journal in which it had been published.[10] What gave, I wondered?

Before answering this question, however, I must implore you not to get it twisted. HCs per se are not problematic in CBT. When used as intended, such abstractions have utility for understanding and communicating about psychological experiences that cannot be directly observed or measured—like "motivation." It's only when HCs are presented as if they were real, which then "authorizes" them being further studied as such, that their threat for CBT is revealed. Let's take "self-esteem," for example. Why has CBT stood by idly while this popular HC has been alchemized into an attribute that is presented as if it's as measurable and ratable as a skin lesion? I hate to be the bearer of bad news, but "self-esteem" is just as fictional as ego, id, and superego. Actually, it's not like CBT hasn't heard concerns about allowing reification to run rampant before (e.g., Hyman, 2010). But to no avail, which is what happens when you're in denial.

Returning to the subject: By deconstructing my dream into its latent elements retrospectively, I had discovered that CBT was destined to have a major guilt complex from the get-go. The visual fantasy of Freud morphing into Beck lined up perfectly with the origin of CBT in the repudiation of Vienna. When the founders of CBT rejected psychoanalysis, the discipline in which they were first trained, it must have felt liberating, but also like a betrayal.[11] Sure, psychoanalysis had prof-

---

[1]Apologies to Kurt Vonnegut, author of the 1959 Hugo-award nominated novel *The Sirens of Titan*, in which all of human history had unknowingly been influenced by extraterrestrials to form patterns that would broadcast the need for a replacement part for their spaceship.

[2]A modification of Sirens' famous "I was a victim of a series of accidents, as are we all," tailored for the CBT crowd.

[3]Where Freud lived in Vienna.

[4]What better proof of integrity could there be than having published so many pieces from yours truly?

[5]Strength of will.

[6]Point of clarification: The possibility that I was actually dreaming about Beck, the famous musician, has been ruled out.

[7]A fictional character in many of Vonnegut's books. Notably, he does not appear in *The Sirens of Titan*.

[8]Destination of the narrator in *Cat's Cradle*, also by Vonnegut.

[9]The reification fallacy means treating something that is not real as if it were.

[10]To our incredible shock, there is no actual published article with this title. We checked, more than once. Look for a submission soon with that title coming from your contributors, it's just too good not to use.

[11]Beck was initially schooled in the psychoanalytic model, as was Ellis and other CBT pioneers.

fered an unverifiable theoretical canon and arcane methodologies which needed to be usurped, but still . . . Vienna also had feelings about this rebuke from some of their most estimable acolytes, it would be sheer hubris to imagine they would not! CBT's big mistake was in underestimating the insidious vindictiveness of a Vienna scorned, even across generations of clinicians and scholars! My dream revealed other hidden truths about the guilt CBT suffered. The image of Skinner, who vigorously rejected mentalistic explanations, suggested that CBT had developed strong ego-defenses against the perfidy of embracing unobservable HCs. The struggle is real, my friends. Horney and my mother were just cruel jokes my ego was playing on me, and in my most astute analyst's interpretation, had nothing to do whatsoever with CBT's guilt, but instead were placed there to "throw me off the scent."

It's all so clear to me now! Vienna had unresolved anger at being rejected, and "acted out" through reification of HCs to get back at CBT. CBT, in turn, felt guilty about breaking up with Vienna and unconsciously tried to assuage its culpability by turning a blind eye to this glaring fault line in its research base, despite the sold behavioral foundations laid by Skinner, Mowrer, and others in the classical and operant conditioning traditions. It's an archetypal neurotic solution! Oh, if you're wondering about the meaning of the schnitzel in my dream; what could it represent if not a reified HC in all its seductive glory, transformed by my unconscious into a delectable but unhealthy entrée from Freud? And Trout eating raw veal? C'mon people! Surely you can see that only by embracing behaviorism, pure and unexpurgated, will CBT be assuaged of its massive guilt!

Yes, utilizing psychoanalytic theory and methodology to understand why reified HCs in CBT are accepted so uncritically is ironic. And so it goes.[12]

Bear with me, as I find myself trying to inhibit a doozy of a repetition compulsion to reiterate the same point over and over again. Easier said than done! CBT's Vienna-related guilt is expressed symptomatically in its "la belle indifference" about the way HCs are used in research and in clinical practice. This fixates CBT at an immature developmental stage as a science. It also makes CBT less competitive in terms of qualifying for research grants, which now require more connection to reality. It also explains CBT's head scratching alliance with various iterations of the *Diagnostic and Statistical Manual*—guilt-based symbolic parent pleasing, if there ever was (would the US Food and Drug Administration [FDA] tolerate researchers chanting Merlin's charm of making[13] to develop new psychiatric medications, even if the American Psychiatric Association [APA] voiced no objection? Hmm, on second thought, that would explain a lot).

No amount of rationalization or intellectualization can justify CBT's continued acceptance of HCs being presented in any way other than as abstract explanatory devices. "A house of CBT divided by hypothetical constructs cannot stand!"[14]

Now is the time for CBT to overcome its resistance to dealing with its guilty conscience and do the right thing; and for Vienna to accept the break-up with CBT and move on. Hasn't CBT suffered enough, Vienna? CBT, are you ready to come to terms with your past and get on with your life too, reification-free?

If so, then no longer shall CBT suffer clouds, which is what HCs are, being referred to as if they were clocks, which they most assuredly are not; nor go on pretending that clouds can have clock-like mechanisms.[15] Mental activities are emergent from the brain, which unlike psychological experiences, does exist in a tangible and observable form, but are like music from an instrument. You can experience music, but you cannot put it in a petri dish. That doesn't make music less important or relevant, or, analogously, CBT. I could go on and on, and unpack another dream I had that pertains to CBT's inferiority complex, but I just got called in for my session, and don't want to appear resistant. Weird, just noticed a sign in the waiting room, "Welcome to the CBT Monkey House."[16]

To our revered CBT founders, it's not your fault. After all, I felt guilty when opposing my parents to become a psychologist, and as a young adult experienced a nasty relapse of my Oedipal Conflict. Sorry CBT, Freudian slip.

See you on the couch!

Reference

Hyman, S. (2010). The diagnosis of mental disorders: The problem of reification. *Annual Review of Clinical Psychology, 6,* 155-179.

. . .

Correspondence to Jonathan Hoffman, Ph.D., Neurobehavioral Institute, 2233 North Commerce Parkway #3, Weston, FL 33326; drhoffman@nbiweston.com

---

[12]A Vonnegut-ism from 1969's *Slaughterhouse-Five.*

[13]It's "Anál nathrach, orth' bháis's bethad, do chél dénmha," in case you want to research if King Arthur's wizard's spell might qualify as an Empirically Supported Treatment (EST), like for OCD.

[14]Thanks, Abe! By the way, Lincoln conjured hypothetical constructs such as "angels of our better nature" for rhetoric, not science—historical records, however, do show a grant application from a Civil War–era alienist who had trained under Charcot proposing a nosology of angels to rank army medic candidates.

[15] See Popper, K.R.'s 1965 lecture at Washington University in St. Louis, "Of Clouds and Clocks."

[16]*Welcome to the Monkey House* is Vonnegut's 1968 collection of short stories, each one exemplifying biting, ironic social satire.

Eimer and Schuler Visit the Hill

Mary Jane Eimer, CAE, Executive Director, and Tammy A. Schuler, Ph.D., Director of Outreach and Partnerships, participated in the Consortium of Social Science Association's (COSSA) Advocacy Day on May 1, 2018. They went to Capitol Hill and met with staff members from the offices of Senators Tom Carper (Delaware), Charles Schumer (New York), Kirsten Gillibrand (New York), and Chris Coons (Delaware), as well as from the offices of House Representative Lisa Blunt Rochester (Delaware) and Carolyn Maloney (New York). In a group with other social scientists (representing membership organizations, universities, and government agencies), they seek increases to funding for social sciences research, in particular NIH and NSF. Mary Jane and Tammy will continue to foster relationships with these offices.

ABCT in **DC**

52nd Annual Convention
November 15–18, 2018

www.abct.org/conv2018

ABCT 52nd Annual Convention
November 15–18, 2018 | Washington, DC

Plan to attend Thursday events!

INSTITUTE OFFERINGS*:*

- **Colleen Carney, Ph.D.** Technology & Insomnia: Friend or Foe
- **Thomas R. Lynch, Ph.D.** Radically Open-Dialectical Behavior Therapy for Disorders of Overcontrol
- **Anne Marie Albano, Ph.D., ABPP, Shannon Bennett, Ph.D., Lauren Hoffman, Psy.D., & Schuyler Fox**
  Anxiety and Emerging Adults: Integrating Virtual Reality and Wearable Technology into the Launching Emerging Adults Program
- **Jonathan S. Abramowitz, Ph.D., Ryan J. Jacoby, Ph.D., & Shannon M. Blakey**
  Desirable Difficulties: Optimizing Exposure Therapy for Anxiety Through Inhibitory Learning
- **Mary A. Fristad, ABPP, & Eric A. Youngstrom, Ph.D.** Evidence-Based Assessment and Treatment of Bipolar Disorder and Mood Dysregulation in Youth and Early Adulthood
- **Trevor A. Hart, Ph.D., & Daniel McNeil, Ph.D.** Integrating Motivational Interviewing into CBT
- **Elizabeth McCauley, ABPP, Ph.D., Sona Dimidjian, Ph.D., Kelly Schloredt, Ph.D., Christopher Martell, Ph.D., Gretchen Gudmundsen, Ph.D.** Behavioral Activation Treatment for Adolescents
- **Tatiana D. Gray, Ph.D., & James Cordova, Ph.D.** The Relationship Checkup: Using Technology to Broaden the Reach of Relationship Health Care

CLINICAL INTERVENTION TRAININGS (1 DAY):

- **Stefan G. Hofmann, Ph.D., & Steven C. Hayes, Ph.D.** Process-Based CBT
- **Patricia A. Resick, Ph.D., ABPP, & Kathleen M. Chard, Ph.D.** Cognitive Processing Therapy for PTSD: Difficult Cases and Disruptions in Therapy
- *Final CIT pending. Stay tuned!*

AMASS OFFERINGS*:*

- **Karin Coifman, Ph.D.** Affective Science for Clinical Scientists: Theory, Design, and Methodological Tools for Investigating Emotion Processing and Emotion Dysregulation
- **Eric Youngstrom, Ph.D.** Decision-Making Statistics for Researchers and Clinicians: We Are Ready to ROC!

NEW *for* 2018:
- **mHealth & Technology**
- **Full day of sessions featuring 6 talks and 2 mini-keynotes**

ABCT Champions of Evidence-Based Interventions

ABCT is proud to announce a new initiative, the ABCT 2018 Champions of Evidence-Based Interventions Awards. These individuals have actively demonstrated exceptional dedication to the promotion of evidence-based research and interventions. This program is being coordinated by the Awards and Recognition Committee under the direction of Cassidy Gutner, Chair. The Board has approved the following Champions to date. These individuals will be listed on our website.

Champions Supporting CBT Research

- *David Chambers*, Deputy Director for Implementation Science, National Cancer Institute
- *Mark Chavez,* Associate Director for Research Training & Career Development, NIMH

- *Arthur Evans*, Chief Executive Officer and Executive Vice President, American Psychological Association
- *Joshua Gordon*, Director, NIMH
- *Rep. Joe Kennedy, III* (D, MA)
- *Sarah Hollingsworth Linsanby*, Director, Division of Translational Research NIMH
- *Beverly Pringle*, Program Chief, Global Mental Health Research Program
- *Denise (Denny) Pintello*, Chief, Child and Adolescent Research Program, NIMH
- *Jonathan Purtle*, Assistant Professor, Dornsife School of Public Health, Drexel University
- *Joel Sherrill*, Child and Adolescent Psychosocial Intervention Research Program at NIMH

Champions Supporting Clinicians

- *Pia Escudero, LCSW*, Director, School Mental Health, Los Angeles Unified School District
- *Kim Griffin-Esperon, LCSW*, Field Coordinator, Clinic Services, School Mental Health, Los Angeles Unified School District

How to Nominate

If you would like to nominate a champion, please visit the ABCT awards page (www.abct.org/Awards/) and download a nomination form. Please send your nomination to the following email address:

2018ABCTAwards@abct.org

Be sure to put "*Champion Nomination*" in the subject line of your email.

Featured Award Recipient: Carmen McLean

Katherine J.W. Baucom, *NYU*, and *2017 Chair, Awards & Recognition*

THIS MONTH we're happy to feature Dr. Carmen McLean, recipient of the 2017 Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice. The purpose of this award, which was made possible by a generous donation to ABCT, is to recognize early-career professionals (within 10 years of doctoral degree) who share Dr. Albano's core commitments.

Dr. McLean is a Clinical Psychologist at the National Center for PTSD Dissemination and Training Division at the VA Palo Alto Health Care System and a Clinical Associate Professor (Affiliated) at Stanford University. She received her Ph.D. in 2008 from the University of Nebraska-Lincoln under the mentorship of Dr. Debra Hope, completed a postdoctoral fellowship at the National Center for PTSD at the Boston VA under Dr. Brett Litz, and was an Assis-

tant Professor at the Center for the Treatment and Study of Anxiety in the Department of Psychiatry University of Pennsylvania with Dr. Edna Foa.

Dr. McLean's research focuses on increasing the reach of evidence-based treatments for PTSD and improving the efficiency and efficacy of PTSD treatments. She is currently the PI of a DoD-funded randomized controlled trial to test the efficacy of a web-version of prolonged exposure therapy in active-duty military personnel with PTSD and Co-PI of a DoD-funded study to increase the implementation of evidence-based psychotherapy for PTSD in the military health system. Dr. McLean has over 75 publications and has presented on clinical and research topics related to PTSD nationally and internationally.

Like Dr. Albano, Dr. McLean is an active ABCT member: she served a 3-year term as the ABCT Web Editor, is on the

Cognitive and Behavioral Practice Editorial Board, and serves on several ABCT committees. Her name is likely familiar to you from her research as well as her promotion of ABCT webinars on behalf of the CE Committee. The Awards Committee agreed wholeheartedly with her nominators that her "early career accomplishments … clearly indicate that she will have a successful and long career as a clinical researcher."

. . .

The author has no conflicts of interest or funding to disclose pertaining to this article.

Correspondence to Katherine J.W. Baucom, Ph.D., New York University, 137 East 25th Street, 6th Floor, New York, NY 10010; kb147@nyu.edu

Register now for upcoming live

Webinars

www.abct.org/Conventions/?m=mConvention&fa=Webinars

$30 for ABCT members
$45 for nonmembers

CE Credit: 1.5

ABCT is recognized as a California Association of Marriage and Family Therapists (CAMFT)-approved CE provider (provider number: 133136). Receive CAMFT-approved CE from ABCT's Annual Convention and from many of ABCT's live and recorded webinars. Please contact dmcpherson@abct.org with questions about which webinars are eligible.

AUGUST 23   **Practical Guidance for Using Technology to Enhance Behavioral and Cognitive Treatments: Advice for Practitioners**

— Dr. Julia Reynolds and Dr. Stephen Schueller

• 1:00 p.m.–2:30 P.M. Pacific | 4:00 P.M. – 5:30 P.M. Eastern
 Sponsored by ABCT Think Tank on Technology

SEPTEMBER   **Implementing EBPs in Community Mental Health: Challenges and Opportunities**

— Dr. Lynn McFarr

• exact date and time to be announced!