the Behavior Therapist

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PRESIDENT'S MESSAGE

Why Is ABCT Organizing Think Tanks?

Sabine Wilhelm, *Harvard Medical School, Massachusetts General Hospital*

ABCT IS NOW MORE THAN 50 years old. Current and previous members of our Board of Directors have recently engaged in discussions during our strategic planning retreat and follow-up meetings on what ABCT can offer the field and where we are headed as an organization. We would like for ABCT to be viewed as a thought leader, bringing senior and mid-level members as well as advisors from other fields together to tackle big unanswered questions or stalled progress in important areas in the field. Our goal is to offer one to three think tanks per year to enhance the role of ABCT in moving specific areas forward. The topic for at least one of these think tanks per year will be determined by the ABCT immediate past president. Topics for any other think tanks held throughout the year will be determined by Board member vote.

ABCT think tanks can be conducted in both face-to-face meetings or via video conference. During the March 2017 strategic planning retreat, the Board charged Michelle Craske, immediate Past President, and Barbara Kamholz, Convention and Education Issues Coordinator, to organize the first face-to-face think tank. They invited the following people to participate: Kathleen Carroll, Denise Chavira, Kelly Koerner, Michael Kyrios, Joe Himle, Muniya Khanna, Ricardo Munoz, Jordana Muroff, Julia Reynolds, Raphael Rose, and Stephen Schueller. Bethany Teachman served

Annual Meeting *of* Members

ABCT in DC

52nd Annual Convention
November 15–18, 2018

www.abct.org/conv2018

NOTICE TO MEMBERS: This year the Annual Meeting of Members is scheduled for **Saturday, November 17 from 12:30 – 1:30 p.m**. in Hoover, Mezzanine Level of the Marriott Wardman Park Hotel.

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.

as facilitator and her graduate student, Nauder Namaky, served as the scribe. The think tank topic, "Digital Technologies to Provide Care to Difficult-to-Reach and Underserved Populations," was held on Thursday, November 16, 2017, during our Annual Convention in San Diego.

Many positive outcomes resulted from our 2017 think tank that will benefit our members, other professionals, and consumers. One of the think tank members, Stephen Schueller, is also the Executive Director of PsyberGuide, an organization that reviews apps for therapists and clients on their website. As a result of our think tank we are currently discussing a partnership between Psyberguide and ABCT. As you know, ABCT has a section in our journal *Cognitive and Behavioral Practice* that provides detailed reviews of apps as well. As the number of app-based interventions is ever increasing, we will all benefit from ABCT pooling resources with Psyberguide to determine which treatments are evidence-based, able to protect the privacy of their users, and which ones are the most engaging. Second, think tank members (Muñoz et al., 2018) recently published a groundbreaking article in *mHealth* proposing the development of "digital apothe-

caries," or online repositories of evidence-based digital interventions that could be accessed by patients, health care providers, and researchers. A third outcome of our think tank was an ABCT webinar. Julia Reynolds and Stephen Schueller worked with Kelly Koerner and the ABCT Continuing Education Committee and offered an outstanding webinar in August 2018 that provided helpful guidance on how to identify and evaluate technologies (e.g., websites, mobile apps) that can enhance cognitive and behavioral treatments.

In terms of future plans, *Cognitive and Behavioral Practice* Editor Brian Chu and Associate Editor Muniya Khanna are working with the 2017 technology think tank participants to organize a special issue. Plans are also under way for future think tanks (with helpful input from our previous facilitator Bethany Teachman). We are still working on the details, but possible topics might focus on how advances in neuroscience and technology might impact the future of cognitive behavioral treatments.

As your Board continues to develop the concept and topics for think tanks, the Development Committee and staff will work on funding options. We believe if we

can offer think tanks on a regular basis, they will fill a need for our senior members and create excitement within the membership that ABCT is a visible leader in the cognitive behavioral field. We envision that these think tanks could result in state-of-the-art manuscripts, generate research projects, and influence funding. We plan to invite international leaders from other disciplines (e.g., technology industry, health insurance companies) and to think broadly and big.

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SCIENCE

The Emerging Relationship Between Clinical Psychology and the Credibility Movement

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THERE HAS BEEN A GROWING conversation about how best to ensure the replicability and credibility of published research in psychology in recent years. However, clinical psychologists have only recently entered this discussion (Leichsenring et al., 2017; Tackett et al., 2017). The pace of reform in psychological science has been surprisingly rapid, and it can be challenging to keep abreast of the latest developments. However, it is critical that clinical psychologists continue to expand their involvement in this movement. To facilitate this involvement, we review the history of the Society for the Improvement of Psy-

chological Science (SIPS) and its intersection with clinical psychology, as well as some meta-science initiatives deserving of further time and attention. We hope that this article will be useful to clinical psychology researchers and practitioners as (a) an introduction to some of the meta-science projects already under way that may be of use to you in your current work, and (b) an invitation for your contributions to ensure that clinical psychology is as rigorous and trustworthy as we can make it.

The Society for the Improvement of Psychological Science (SIPS)

History of SIPS

SIPS began from a series of email exchanges in late 2015 between founders Professor Simine Vazire (University of California, Davis) and Brian Nosek (University of Virginia, also co-founder of the Center for Open Science, a nonprofit dedicated to improving transparency and openness in scientific research). Both had been actively involved in the science reform movement for several years, but given mounting evidence that reproducibility problems are pervasive (e.g., Bakker, van Dijk, & Wicherts, 2012; Ioannidis, 2005; Pashler & Harris, 2012), they wanted to shift the collective focus from discussions of whether there was a need to improve methods and practices in psychology to how to begin active work to improve (Srivastava, Tullett, & Vazire, 2017). They also sought to gather people interested in improving psychological research practices to allow professional connections and collaboration.

After the first SIPS meeting, which took place in June 2016 at the Center for Open Science (https://cos.io) in Charlottesville,

Virginia, the roughly 100 individuals in attendance voted to install an interim executive committee who began the process of formally launching SIPS as a scientific society. The interim executive committee drafted the society's mission statement (https://improvingpsych.org/mission), which emphasizes the five core values—(a) self-improvement, (b) transparency and openness, (c) critical evaluation, (d) civil dialogue, and (e) inclusivity—that SIPS uses to guide its work.

In the two years since that first meeting, SIPS has formally incorporated as a 501.3(c) non-profit, held elections for executive committee members, hosted two additional meetings, and more. It just became possible to formally join SIPS (https://improvingpsych.org/join) in November 2017, but already SIPS has over 400 members, many of whom are early in their careers. Because Vazire and Nosek primarily identify as social and personality psychologists, and perhaps because a lot of focus in the open science movement in psychology has been on social and personality findings, many early SIPS attendees were also from these subdisciplines. However, many projects conceptualized by SIPS members have been aimed at reaching psychology more broadly.

Past SIPS Initiatives

In its short tenure, the society has helped to spawn a number of influential initiatives to improve the field. PsyArXiv (psyarxiv.com), a preprint repository for psychology that allows researchers to post drafts of in-progress papers or their own manuscript copies of published papers, was born out of the 2016 meeting, as was StudySwap a virtual meeting space for researchers to form collaborations and share research resources (https://osf.io/view/StudySwap/). The 2017 meeting saw the launch of Psychological Science Accelerator (PSA; https://psysciacc.org/), "a globally distributed network of psychological science laboratories (currently over 300), representing over 45 countries on all six populated continents, that coordinates data collection for democratically selected studies." The first paper detailing the vision for this project has been accepted for publication and brings together more than 100 authors from around the world (Moshontz et al., 2018). Other accomplishments include a focal paper and a series of replies concerning the central role of replication for psychological science (Zwaan, Etz, Lucas, & Donnellan, 2017). Another team has published an initiative known as "Con-

straints on Generality," which implores researchers to clearly state the known or theorized boundary conditions for their published effects in their manuscripts (Simons, Shoda, & Lindsay, 2017).

Current SIPS Initiatives

Member-generated initiatives are beginning to emerge from the most recent (June 2018) SIPS meeting, which we expect will develop into more finished products and proposals in the coming months. SIPS members are continuing to develop teaching and training materials, as well as outreach plans to help spread open science practices even more broadly. As a society, SIPS has partnered with the open access journal *Collabra: Psychology*, which invites manuscripts describing rigorously conducted, high-quality research without regard for potential impact of the research. Clinical psychologists are welcomed and encouraged to submit papers and to volunteer as peer reviewers (https://www.collabra.org/author/register/reviewer/).

Another initiative to serve the field is "Statements From Candidates for Election." When contacted by a SIPS member who is also a member of another professional society, SIPS will reach out to candidates for election in that society and ask them to answer this question: "If elected to [OFFICE] of [ORGANIZATION], what (if any) policies would you promote to improve research in psychology, and how would you support open science practices and research transparency at [ORGANIZATION] and in the field of psychology more broadly?" Unedited responses are then posted to the SIPS website, giving voters in various society elections additional information about candidates' stances on open science and replicability on which to base their voting decisions.

Upcoming SIPS Meeting

The next annual SIPS meeting is already scheduled for July 7–9, 2019, and it will take place in Rotterdam, the Netherlands. Updates and a call for programming will be published to the SIPS mailing list (join here: https://improvingpsych.org/) and announced via Twitter (@improvingpsych). Importantly, new executive committee members will soon be elected, and volunteers for various committees are being sought. Readers are invited to subscribe to the list or follow SIPS on Twitter to stay abreast of the latest initiatives. In the spirit of our society mission, we invite your feedback on how SIPS itself can improve, as well as your ideas for how psychologists

can work together to improve methods and practices.

Clinical Psychology and Open Science

Clinical psychologists have been largely removed from ongoing efforts to reform methods and practices in psychological science, although this integration is slowly emerging. For those clinical psychologists new to these ongoing conversations, one useful resource might be a recent paper on how and why clinical psychology has been less involved in issues of replicability and open science (Tackett et al., 2017). It is not entirely clear why some subdisciplines in psychology have been more removed from these efforts than areas like social, cognitive, and personality psychology, which have been leading the way. Some subfield differences may shed some light on this discrepancy—for example, a reliance on difficult-to-collect data, an emphasis on descriptive and correlational analyses over dichotomous experimental hypothesis-testing, and a sense that proposed field-wide reforms may not be suitable for different types of psychological research (Tackett et al., 2017). Nonetheless, clinical psychologists have been stepping into these conversations in a number of ways, and much more engagement and discussion is needed in order to move toward reforms and revised practices that will improve the credibility of clinical psychological research.

The available resources on openness, transparency, replicability, and methodological reform are vast and rapidly growing, particularly with the accelerated pace of content accessible on social media, blog posts, and podcasts. The amount of information may serve as a deterrent to some, so we offer some initial resources here for (primarily clinical) psychologists who are looking for ways to begin getting involved—we would love to have you.

The Open Science Framework

In addition to some initial reading, there are many other resources and ways to get involved. We recently documented some of our early experiences using the Open Science Framework (OSF, https://osf.io; Tackett, Brandes, & Reardon, 2018), which is an extensive resource (maintained by the Center for Open Science) serving many different functions to facilitate openness, transparency, and reproducibility in our scientific research. In the paper, we document some of our early attempts at (and challenges with) engaging with pro-

posed reforms, including (pre-)registration of research (particularly research using archival data and preregistration of assessment and scale development studies) and ways to maximize OSF resources to increase research transparency. The paper is meant to serve as a combination of hands-on suggestions, documentation of struggles that clinical researchers may encounter when implementing proposed reforms, and current thinking on solutions and the path forward.
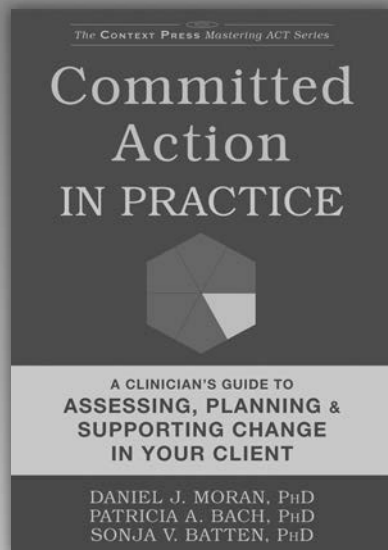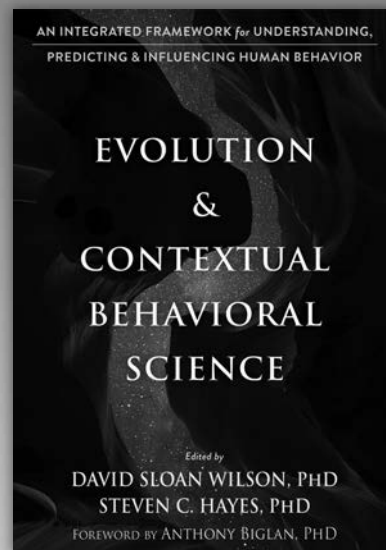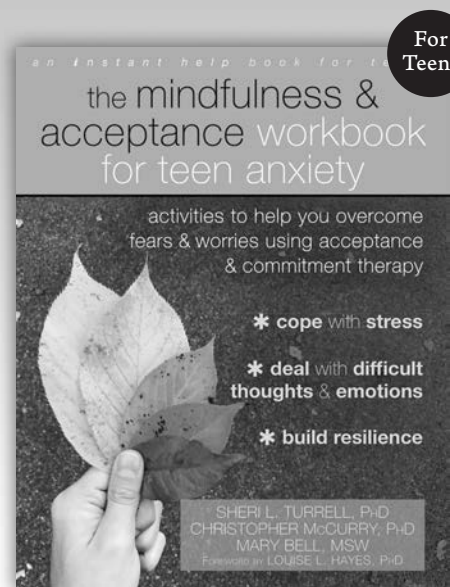
Probably unsurprisingly, our primary recommendation moving forward was for clinical psychologists to become more involved in considering these problems and generating solutions and reforms. We need more voices in the conversation bringing perspectives from diverse clinical research areas to more fully delineate the types and extent of problems in our research and develop appropriate reforms to address them.

Ongoing Conversations

In addition to these readings, there are other examples of clinical psychology entering the conversation. The *Journal of Abnormal Psychology* has two special issues forthcoming: one on promoting openness, transparency, and replicability in clinical psychology (Tackett & Miller, 2018), and another on improving methods and practices in clinical research (Gruber & Joorman, 2018). The recent annual convention of the Association for Psychological Science (May, 2018) featured a discussion panel (Fried, 2018; Lucas et al., 2018) on the replication crisis from a clinical psychological perspective. We see an increase in empirical efforts to explicitly examine questions of replicability and open science practices from clinical psychological researchers (Forbes, Wright, Markon, & Krueger, 2017; Fried et al., 2018; Hengartner, 2018; Walsh, Xia, Denny, Harris, & Malin, 2018). Importantly, all NIH-funded clinical trials now have to register with clinicaltrials.gov, and many journals ask for the registration number when a manuscript is submitted, increasing the breadth of clinical researchers gaining familiarity with registration and submission of data. In addition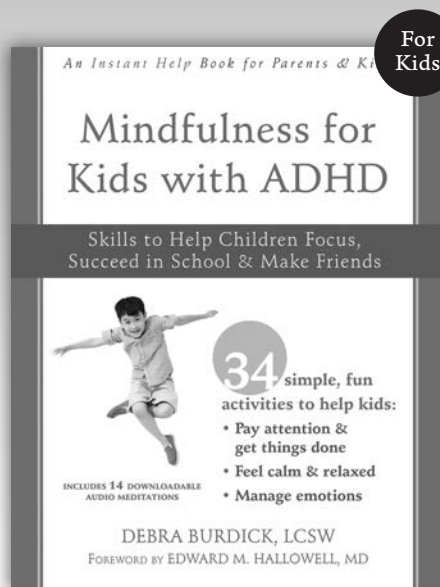, open science badges have been formally adopted in a clinical psychology journal for the first time (Lilienfeld, 2017). Indeed, there are an increasing number of such examples across the field.

Clinical Representation in SIPS

We have seen an increase in representation of clinical psychologists within SIPS, as well. Among current SIPS members (as of early July 2018), about 10% had indicated some expertise or research interest in clinical psychology, and we would like to continue to grow this number.

At the most recent SIPS meeting, those who identified as clinical psychologists joined with colleagues from developmental psychology, education, and some other areas to discuss challenges for our subdisciplines (https://osf.io/cgafy/; Kouros et al., 2018). Namely, we often work with data that is expensive and difficult to collect. Relatedly, it is often the case that researchers publish more than one empirical paper from a dataset, making issues of data sharing more complex. Large longitudinal datasets, which seem to be more common in clinical and developmental psychology than cognitive or social psychology, create challenges around measures that are added along the way and not available at each wave, and how to share data and resources for the greatest scientific benefit. The frequent use of proprietary materials (e.g., psychopathology ratings scales, cognitive testing materials, diagnostic assessments) and sensitive information (e.g., psychopathology diagnoses, trauma histories) means that completely open data and materials are not always possible. Determining what is permissible to share and in what form is a further challenge. Finally, open sharing of data and materials in research with vulnerable populations may meet with more resistance from regulatory stakeholders, such as human subjects review boards. Indeed, through discussion, challenges that at first seem to be unique to our subfield sometimes turn out, upon further examination, to be a version of a problem that has been tackled by another area. By acknowledging this, clinical psychologists have an opportunity to fine-tune solutions that meet our specific needs while maintaining rigorous and open scientific practices.

Clinical SIPS Initiatives

One major area of focus at the recent SIPS meeting was around outreach, and how to bring more clinical psychologists into the conversation about open science and reform practices. One concrete initiative with the goal of increasing outreach was to build a database of clinical psychologists interested in transparency, openness, and credibility to coordinate efforts across a broader swath of clinical psychology. Identifying clinical psychologists interested in these initiatives opens opportunities for creating a mailing list, social media out-

reach, a blog, or collaborating on more traditional scientific products such as papers, grants, or conference presentations. If you'd like to be involved, you can fill out an interest form here: https://tinyurl.com/y8kdvo38.

Another initiative is being developed in response to the specific challenges of complex longitudinal and multivariate datasets, considering the flexibility in reporting that they may allow. That is, many projects collect more than one measure of a construct, and authors may have the opportunity to make data-dependent decisions about which variable to use. Authors do not always report that other variables were collected. The creation of reporting guidelines aimed at multivariate and longitudinal studies such as those common in clinical and developmental research would increase transparency and allow researchers to be able to assess the evidentiary value of published results in the appropriate context. Relatedly, although strict preregistration is not always feasible for long-term longitudinal projects, another SIPS product is a registration template for secondary data analysis (https://osf.io/bpuw3/; Weston & Bakker, 2018), which helps to tackle the statistical and reporting challenges associated with publishing several papers from the same dataset.

One of the most pressing needs we identified during this first clinical and developmental SIPS workshop was a way to more effectively share and pool existing data (https://osf.io/qjnar/). Many clinical researchers have rich existing datasets that are potentially going to waste because they may not be powerful enough to answer research questions on their own. Creating a platform that matches researchers and their data to other potential collaborators would have several benefits for clinical psychological science. First, it would allow for greater power and more robust inferences by increasing the available sample size for certain variables of interest (McShane, Tackett, Bockenholt, & Gelman, in press), and it would eliminate wasted resources by making use of that data. Such a platform would create a more systematic way of knowing what data have been collected, and what types of constructs and measures are commonly used in the field. This process of collaboration often happens informally at conferences and other events, but making it publicly available would allow for an even greater level of cross-field integration. Sharing what data is available without making the data itself publicly
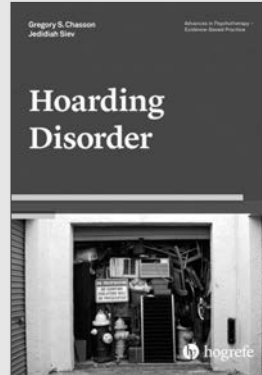
New Advances from Hogrefe!

available represents a beginning step to open data for those researchers who may be unable to make all data open access immediately. Finally, such a platform that indexes available datasets and measures would mean that those researchers undertaking meta-analytic projects could more easily and systematically identify unpublished data that may be relevant to their research question. Similar databases exist in other fields, such as epidemiology, and we think it could provide an essential next step forward in improving the robustness of clinical psychological science to introduce a valuable resource like this one to our field.

Conclusion

We hope that clinical psychologists will continue to be more involved in this conversation as we move forward. How? The resources offered here present a starting point. Set up an OSF account, if you don't have one already. Try registering a study, even if it's an ongoing study that is not a clinical trial or suitable for strict preregistration (see Tackett et al., 2018). Consider contributing to a special issue on open science, transparency, or replication. Consider guest editing a special issue on these topics, or urge an editor you know to consider one, particularly at clinically focused journals. Relatedly, you might approach an editor you know about adopting Registered Reports, a format of publication where peer review happens prior to data collection (for more information and frequently asked questions: https://cos.io/rr/). Post a dataset online. Post the full syntax and results from a recent paper online. Submit a symposium to a conference on the topics of open science and replication. Share a preprint or a postprint on PsyArXiv. Take a look at recent tools developed to advance the methods and practices in our field: examine what works for your type of research, what doesn't, and how we can make them more applicable to the work we do. Start a course or reading group in your area on openness and replication (e.g., https://osf.io/maqv7/; Brandes, Reardon, Hall, & Cowan, 2017), or invite a relevant speaker to give a brown bag talk on these topics. Conduct a replication study, either of one of your own findings or of another finding in your area. Likely one of the most valuable steps you can take: ask your graduate and undergraduate students what they think about all of this. In many respects, they are the ones leading the way. Ultimately, it is much better to get involved than not. Take one step forward. We could use the company.

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Racial Differences in the Appraisal of Microaggressions Through Cultural Consensus Modeling

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WHILE SOCIETY GENERALLY denounces overt acts of racism (Nadal, 2018), more subtle forms of discrimination regularly impact the daily lives of people of color. Chester Pierce (1970) referred to these seemingly innocuous but racially discriminatory acts as *microaggressions*. Directed towards people of color and those with lesser power (Nadal), microaggressions are exhibited through actions, verbal remarks, or nonverbal behaviors that are perpetrated consciously or unknowingly by both ill-intentioned and well-meaning people (Solorzano, Ceja, & Yosso, 2000). Examples could include locking the car door when a Black man walks by; asking a woman where she is from just because she is not White; refusing to learn how to pronounce a non-Anglo name; a White student giving a professor of color unsolicited advice on how to improve the class syllabus; or telling a Hispanic person born in Puerto Rico that they are not a real American. Microaggressions reinforce pathological stereotypes and communicate hostility that can have detrimental psychological effects (Chapman, DeLapp, & Williams, 2014; Kanter et al., 2017; Sue, Zane, Hall, & Berger, 2009; Torres, Driscoll, & Burrow, 2010; Williams, Kanter, & Ching, 2017), as the subtlety of microaggressions introduces uncertainty into the evaluation of a situation and may be internalized by the victim, resulting in psychological distress (Noh, Kaspar, & Wickrama, 2007).

Microaggressions and everyday racial discrimination are associated with increased stress (Torres et al., 2010), anxiety (Soto, Dawson-Andoh, & BeLue, 2011), depression (Huynh, 2012; Mouzon, Taylor, Keith, Nicklett, & Chatters, 2016; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), PTSD symptoms (Williams et al., 2017; Williams, Printz, & DeLapp, in press), low self-esteem (Nadal et al., 2014; Thai, Lyons, Lee, & Iwasaki, 2017), obsessive-compulsive disorder (Williams, Taylor, Mouzon, et al., 2017), substance use (Blume, Lovato, Thyken, & Denny, 2012; Clark, Salas-Wright, Vaughn, & Whitfield, 2015; Gerrard et al., 2012) and suicide (Hollingsworth et al., 2017; O'Keefe, Wingate, Cole, Hollingsworth, & Tucker, 2015). While some have argued that the association between microaggressions and negative health outcomes may be driven by trait-level differences in negative affectivity, the majority of studies conclude that negative affectivity does not sufficiently account for the relation of microaggression to poor health outcomes (Broudy et al., 2007; Wadsworth et al., 2007; Williams, Kanter, & Ching, 2017). Within the context of therapy, the commission of microaggressions by clinicians against clients of color may further exacerbate racial health disparities by contributing to lower engagement, reduced therapeutic alliance, and poor treatment adherence (Sue et al., 2007). Indeed, in one study, African American satisfaction with counseling was directly correlated to their experiences of being microaggressed against by their clinicians (Constantine, 2007). It is important that therapists understand how subtle, everyday forms of racism contribute to the etiology of psychological stress in clients of color and also receive training to prevent these acts from undermining the therapeutic process itself.

Current efforts to operationalize microaggressions have largely focused on stigmatized individuals' self-report of these negative experiences. This includes various groups that experience microaggressions, including people of color (Forrest-Bank, Jenson, & Trecartin, 2015; Gamst et al., 2002; Jones & Galliher, 2015; Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013), lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016), and women (Capodilupo et al., 2010). Although there are several well-validated self-report measures of racial microaggressions, these measures have generally been intended for victims of microaggressions, with little examination of those who may commit these acts.

The feasibility of operationalizing an interpersonal construct that can take so many forms has come under criticism. Some have argued that there is no clear agreement on what sorts of behaviors constitute microaggressions, even asserting that challenges in operationalizing this construct provide evidence against its validity (Haidt, 2017; Lilienfeld, 2017b). Yet in the psychological sciences, many lived experiences and internal appraisals have strong validity and consensus but can be challenging to operationalize through self-report. Indeed, many psychological constructs, ranging from state anxiety and quality-of-life to happiness and stigma, are well understood by evaluating the subjective state of involved actors (Elasy & Gaddy, 1998). By their very definition, microaggressions occur within inherently ambiguous circumstances that can therefore differ by context and be shaped by the racial and ethnic stereotypes of the interacting people. Accurately understanding the context-dependent experiences of microaggressions may improve our understanding of the extent to which microaggressions reflect verifiable acts of discrimination by both perpetrators and victims (Kanter et al., 2017).

To this end, the Cultural Cognitions and Action Survey (CCAS) was developed to investigate the ability of both perpetrators and victims to appraise the nature of various microaggressions delivered by White students and aimed toward Black students (Kanter et al., 2017). The present study addresses the issues of ambiguity in the experience of microaggressions by utilizing the analytical and methodological strengths of Cultural Consensus Modeling (CCM). CCM is a mathematical technique developed in a collaboration between anthropology and psychology experts, which measures the degree to which group

members share an underlying knowledge representation (Anders & Batchelder, 2012; Romney, Weller, & Batchelder, 1986). It is based on a concept of shared cultural knowledge, as opposed to universal ground truth. That is to say, it foregrounds what groups of participants agree to be true, rather than focusing on validation of self-report by other measures. This makes it especially apt for the study of microaggressions, which may be appraised differently by individuals and across groups (Kanter et al., 2017; Sue et al., 2007; Williams, Kanter, Collins, et al., 2017). The model takes as its foundation that participants use a shared cultural understanding of the true answers when responding to questions. The differentiation in participants' answers arises from four sources: random variation, between-participant differences in cultural expertise, question difficulty, and individual response biases. Using these foundations, along with signal

detection theory and item response theory, CCM estimates the underlying group knowledge on which participants draw. These analyses can reveal nuanced distinctions between group understandings of the same knowledge domain. The CCM method has been used to understand ecological cognition (Medin, Ross, Cox, & Atran, 2007; Ojalehto, Medin, & García, 2017), mental models of romantic affection (Heshmati et al., 2017), and organizational innovation (Jaskyte & Dressler, 2004). Using this technique in the study of microaggressions allows us to take advantage of the nuanced nature of the microaggressive phenomena.

This study examines the ability of Black and White students to accurately appraise whether subtle situational statements and actions (microaggressions) are undesirable. Specifically, it was predicted that White students' ratings of whether they would think about or commit a microag-

gressive behavior would be negatively correlated with Black student and diversity expert ratings of whether or not such behaviors were racist, determining if both student samples can accurately appraise microaggressions as universally undesirable across a variety of social situations. Specifically, we hypothesize that the more likely Black students and diversity experts would rate the behavior as racist, the more likely White students are to indicate that they would not think or say/do the microaggression. Furthermore, we conducted CCM to explore similarities and differences in the culturally shared knowledge among the groups of participants.

Methods

Data included in the present analysis were collected during the baseline testing phase of a larger study, the Racial Harmony Workshop (RHW), and pretesting

data from a validation study using the CCAS. The RHW was conducted at a predominately White university and was designed to evaluate the efficacy of a 6-hour campus-workshop intervention for undergraduate students aimed at addressing racism, decreasing microaggressions, and promoting cross-racial understanding. This study and its main outcomes are reported elsewhere (Kanter & Williams, 2018). The university's Institutional Review Board approved the study.

Participants

Participants were 20 Black and 44 non-Hispanic White undergraduate students between the ages of 18 and 40 attending a large university in the northeastern United States, who completed the measures on a computer in the lab and were provided with cash or course credits for their participation. Among Black students, 10 (50%) were female and the mean age was 19.95 (SD = 4.62). Among White students, 20 (45%) were female and the mean age was 20.49 (SD = 2.11). There was no significant different in gender, $\chi^2(3)$ = 6.60, p = 0.36, or age, $t(63)$ = -0.63, p = 0.53, between the two racial groups. An additional group of participants, consisting of 18 experts in the fields of multicultural psychology, diversity education research, social psychology, and sociology, were recruited by direct email invitation (herein referred to as the expert sample) and completed the survey online. Compared to the undergraduate sample, the experts were, on average, older (M = 34.17, SD = 9.12) and the majority female (83.33%). The expert sample reflected a broader range of racial backgrounds compared to the student samples with 44.4% Black/African American, 16.7% Non-Hispanic White and 16.7% Asian/Asian-American, 11.1% multiracial, and 5.6% Native American or other.

Measures

Cultural Cognitions and Attitudes Survey (CCAS). CCAS was developed for measuring a would-be perpetrator's self-reported likelihood of engaging in a microaggression. The wording and scaling of items was changed slightly to enable Black participants and the expert sample to rate how racist the behavior would be if they had observed it. An initial account of the scale's development has been described previously (Kanter et al., 2017). This expanded version of the scale consists of 112 items across eight scenarios involving potential Black-White individual or group

interactions. The scenarios presented were as follows:

1. Having a conversation with a Black law student at a social get-together
2. Meeting a young Black female with African-style dress and braided hair
3. A discussion about White privilege at a diversity training
4. A study session talking about various current events and political issues
5. A lost Black man asking for directions in your neighborhood
6. Doing karaoke with friends and a song with the "N-word" comes up
7. Watching the news about police brutality with mixed-race friends at a sports bar
8. Talking to a racially ambiguous lab mate about a science project

For each scenario, White students are presented with a series of behaviors that one might think, say, or do during the interaction, including those that are microaggressive (S2: "Are you from Africa?") and those that are not (S1: "What is law school like for you?"). Rating scales differed by participant groups; both Black raters and expert raters were asked to identify how racist or nonracist each item was on a Likert-type scale from 1 (*very racist*) to 5 (*very positive/nonracist*) while White participants were asked to separately rate whether they would (a) think or (b) say/do each item with anchors from 1 (*very unlikely*) to 5 (*very likely*). Although microaggressions are generally defined as consisting of behaviors, they are also socially unacceptable and therefore the White version of the CCAS asks about microaggressive thoughts in order to assess cognitive processes that may precede overt microaggressive behaviors, as well as whether some individuals may endorse having such thoughts but inhibit their behaviors, thereby potentially holding similar beliefs to perpetrators but differing in their actions. Previous studies have demonstrated that the prior shorter version of the CCAS had good concurrent validity and items correlated with other self-report measures of discrimination and racism (Kanter et al., 2017). In the present samples, the CCAS demonstrated strong reliability across the 88 microaggressive items, for Black participants (α = .97), White participants' thoughts (α = .95), White participant actions (α = .93), and the expert sample (α = .95). It had good reliability for the 18 supportive items among the expert sample (α = .84), the Black par-

ticipant (α = .80) and White participant actions (α = .81), with somewhat weaker reliability for White participant thoughts (α = .69).

Marlowe-Crown Social Desirability Scale (MCSDS). The MCSDS (Crowne & Marlow, 1960) is a 13-item scale measuring the extent to which responses are consistent with social desirability effects. It has been shown to improve predictive accuracy of measures on socially sensitive topics (Evans, 1982 ; Kanter et al., 2017).

Statistical Analysis

As the current report is a secondary analysis of a larger dataset, no a priori power calculations were conducted to determine sample size. Using G*Power (Erdfelder, Faul, Buchner, & Lang, 2009) post hoc obtained power for the correlational analysis was .80 for a medium-sized effect. All statistical analysis were conducted in either SPSS (IBM Corp., 2017) or R (R Core Team, 2013).

Given that White participants may consider microaggressions and racism to be socially sensitive topics, we tested whether social desirability effects drove race-based differences in CCAS responses. We conducted an independent samples t-test between the two groups on total scores of the 13-item MCSDS. Given that there was no significant difference in social desirability between Black and White students, $t(42)$ = 1.12, p = .27, total MCSDS scores were entered as a control variable in item-level correlational analyses between groups. Item-level Pearson correlations were conducted between groups by averaging the scores of items that were deemed microaggressive (at least slightly or very racist) by the CCM analysis (described below) of the expert dataset. For Black students, responses were reverse-scored to match the White participants' scale. These item-level correlations were conducted between each of the three groups (White students, Black students, and experts) and separately for the two responses from White participants (thinking and saying/doing the behavior).

The calculation of a cultural consensus model (CCM) focuses on the agreement between multiple group members on a set of questions (in this case, whether contextualized actions and statements are microaggressive). After identifying high-agreement questions, the model identifies relative expertise in a given culture's knowledge by seeing how much individual participants are in agreement with these

high-agreement questions. Using this information, it iteratively estimates the cultural representation underlying participant responses. Finally, the resulting model is used to generate simulated data, and model fit is assessed by comparing responses to the simulated datasets. Recent advances have expanded the technique, enabling the detection of multiple distinct subcultures within a data set (Anders & Batchelder, 2012). By comparing single-group and multigroup models within the same data, it is possible to evaluate the strength of the evidence for a single shared consensus in a group. Several measures of model fit are reported for the CCM analysis. The Deviance Information Criterion (DIC) is a Bayesian model fit statistic analogous to AIC (Akaike, 1973) and BIC (Schwarz, 1978), which trades off between overparameterization and reduced variance in repeated use of the model. Lower values indicate better model fit (Gelman et al., 2004; Spiegelhalter et al., 2002). There are two posterior predictive checks that assess how well the simulated data match the real data. The item difficulty check (which relies on the Variance Dispersion index, or VDI) reports how well the model estimates differences between questions based on item difficulty. The culture number check is a visual comparison of the screen plots of the simulated and true data to determine whether the appropriate number of cultures has been assigned (Anders & Batchelder, 2014).

We then use the results of the best-fitting model to describe the group consensus within the domain: in this case, how racist or supportive a behavior is (among the Black students and the expert sample), or how likely one is to think or do/say a particular behavior (among the White students). The model defines consensus values as continuous parameters. For considering the distribution of scores within a model (i.e., how many of the items a model classifies as "Very Racist"), we round the parameters to match the original response options of the participants. When considering the correlation between consensus values in different models, we use the continuous consensus value.

Using R (R Core Team, 2013) and CCT-Pack (Anders et al., 2014) we ran a latent truth rater model (LTRM) with the expert sample in order to establish which items were microaggressive, with all 112 statements rated from 1 to 5 by each expert participant.

Results

Expert Participant Latent Truth Rater Model

The best model fit among the experts was a single-group model, where difficulty varied by question and expertise and bias varied by person. This model demonstrated strong consensus among the expert sample and had good fit to the expert data (DIC = 3414.96, VDI = 25.2). The model-assigned evaluations of the stimuli were strongly bimodal: 16% (18 statements) of items were judged to be supportive (i.e., rated as "positive/non-racist" on the original scale), and 79% (88 statements) were judged to be microaggressive (i.e., rated as "racist" on the original scale), with only 5% (6 statements) falling into the intermediate "neutral" range. These classifications fall very close to the original design: 100% of investigator-designed supportive statements were model-assigned supportive (plus one extra), and 93% of investigator-designed microaggressive statements were model-assigned microaggressive. The results from this model were used to define subsets of questions—microaggressive behaviors and supportive behaviors—which were used in subsequent analyses of Black and White respondents. The 5% of intermediate items were omitted from further analysis.

Between-Group Correlations

In order to investigate the extent to which the items from the classification from the expert CCM were evaluated similarly across groups, item-level Pearson correlations were conducted between each of the three samples (with White responses being separated into thoughts and behaviors). There was a significant negative correlation between Black students' ratings of the statement being racist with White students' ratings of their likelihood of thinking the microaggression, $r(86) = -.64$, $p < .001$, and an even larger negative correlation with White students' ratings of saying or doing the microaggression, $r(86) = -.93$, $p < .001$. A similar pattern emerged when comparing White responses to expert responses; there was a larger negative correlation of White students' ratings of committing the microaggression, $r(86) = -.70$, $p < .001$, compared to the negative correlation of expert ratings with White students' ratings of thinking the microaggression, $r(86) = -.54$, $p < .001$. Consistent with our hypothesis, there was also a significant positive correlation between expert ratings and Black students' ratings of microaggressive

items, $r(86) = .69$, $p < .001$, indicating strong agreement. Within the expert group, average CCAS ratings of microaggressive items were fairly similar by racial group.

Cultural Consensus Modeling

Exploratory cultural consensus modeling (using the LTRM) was conducted separately on the supportive and microaggressive items on three distinct data sets: the Black students' ratings of racism, the White students' reported thoughts, and the White students' reported behaviors. For each of these, multiple models were run to assess the presence of up to three consensus subgroups. Fit was assessed by model convergence (i.e., > 1.10), DIC, per-culture item difficulty check, and a visual inspection of the similarity between the CCT scree plot and the scree plots of the simulated data. The results indicate that for each of the six models, the best-fitting solution was a one-consensus model, where difficulty varied by item, and competence and bias varied by participant (supportive: $DIC_{black} = 718.25$, $VDI_{black} = 51.2$; $DIC_{white-thoughts} = 2017.5$, $VDI_{white-thoughts} = 29.2$; $DIC_{white-actions} = 2038.1$, $VDI_{white-actions} = 27.6$; microaggressive: $DIC_{black} = 3570.256$, $VDI_{black} = 93.6$; $DIC_{white-thoughts} = 7440.2$, $VDI_{white-thoughts} = 63.2$; $DIC_{white-actions} = 4705.6$, $VDI_{white-actions} = 86.4$). In some cases, the higher-subgroup versions of the model failed to converge, an indication that the data does not support a multisubgroup model. In cases where the multisubgroup model did converge, the single-culture model had superior fit statistics (i.e., lower DIC, fewer > 1).

Microaggressive Models

The consensus model for microaggressive behaviors among Black students showed that the students generally agreed with the expert sample: 89.8% of the items (79 items) were classified as slightly or very racist. However, 4 of the 88 items (4.5%) were classified as slightly or very positive by Black students. These included three statements (S2: "Where did you grow up?", S8: "What is your nationality?", and S8: "What is your ethnicity?") that queried a Black person about their background. One item, where a White student says as little as possible because they are worried a Black student will become upset by something they say [S4], was rated very positively by Black students. These points of disagreement suggest some divergence between the understanding of microaggressions among

the experts and African American students. However, there was still a notable subset of Black students that deemed these items to be racist (28%, 33%, 13%, and 38%, respectively), and several similar items were deemed highly offensive by most (e.g., S8: "What are you?" and S2: "How long has your family been in the U.S.?", and S3: "We shouldn't talk about race. It makes people uncomfortable").

The consensus models about microaggressive thoughts and behavior among the White students were highly concentrated: the consensus was "Very Unlikely" for thinking 83.0% of the statements and doing 93.2% of them. Table 1 illustrates microaggressive items that White students were most likely to think or do—items that were rated as "Neutral" for either thought or behavior. This included two items involving denial of personal racism, and an item about minimizing interactions with a Black man who was lost. White ratings of these items suggest some ambiguity in their appraisal and perhaps uncertainty about how such items would be perceived. In terms of mean item scores, there were significant differences between White students' thoughts ($M = 1.85$, SD 0.54) and actions ($M = 1.41$, SD 0.38), $t(6.46)$, $p < .0001$.

Black students' consensus ratings of an item as racist were correlated with White students' consensus ratings of unlikelihood to think or do a behavior, $r(86) = 0.50$, $p < 0.01$; $r(86) = 0.36$, $p < 0.01$. This suggests that both groups are tapping into shared knowledge about the socially undesirable nature of these behaviors.

Supportive Models

The ratings for the African American consensus model were highly concentrated: 17 of the 18 statements were rated as "Very Positive" (the 18th was rated as "Slightly Positive"). This suggests that Black students have a strong basis of agreement about evaluating statements as nonracist, and that it matches closely with that of the experts.

The distribution of ratings in the consensus models (thought and behavior) of the White students were less concentrated, where 4 of the supportive statements were seen as "Very Unlikely" or "Unlikely" thoughts and behaviors of the White students. This includes one item asking about the differential experience of being Black and three involving direct actions to assist or show consideration for a Black person (Table 1). The consensus rating of the supportive items in the White-thought and

White-behavior models were highly correlated, $r(16) = 0.95$, $p < 0.01$, indicating that the cultural model for thinking and saying each of the supportive items was similar.

Black-rated positivity of the statement and the White-rated likelihood of thinking, $r(16) = 0.54$, $p = 0.02$, or doing, $r(16) = 0.60$, $p = 0.01$, the behavior were significantly correlated. This suggests that White students usually expressed interest in engaging with behaviors that the Black students perceived to be supportive, but that Black students perceiving an act as supportive was not enough to ensure that White students would express interest in that behavior.

Competence in Consensus Knowledge

One component of cultural consensus modeling is the assignment of competence scores to each individual. This continuous parameter indicates how closely each participant hews to the consensus model—how much of an expert they are at accessing and reporting the shared knowledge. Among the African American students, competence in reporting the two models (i.e., the microaggressive consensus model and the supportive consensus model) was not significantly correlated, $r(18) = 0.23$, $p = 0.32$, though a post-hoc analysis indicates our power to detect this correlation was limited (i.e., 70% power to detect a correlation of 0.53).

Among White students, competence in the two microaggressive models (i.e., thoughts and behaviors) were highly correlated, $r(42) = 0.61$, $p < 0.01$, as well as in the supportive models, $r(42) = 0.68$, $p < 0.01$. This suggests that participants successfully drawing on consensus knowledge about microaggressions had similar access to that knowledge about both thoughts and behaviors and therefore these were combined for comparing across models. Comparing microaggressive and supportive competence scores in the White sample (collapsing competence across thoughts and behaviors), there was a significant positive correlation, $r(42) = 0.38$, $p = 0.01$. This suggests that White participants who were close to their consensus on microaggressive statements—i.e., did not endorse thinking or doing any of the microaggressive behaviors—were also close to their consensus on supportive statements—i.e., endorsed doing some but not all of the supportive behaviors. This correlation indicates that the distribution of knowledge within this population is similar for the two models: White students who apply group knowl-

edge do so about both microaggressive and supportive situations.

Discussion

This study utilized a CCM approach to characterize the complex appraisal of microaggressions by potential perpetrators, victims, and experts. While a few researchers have claimed that the construct of microaggressions defies operationalization (Lilienfeld, 2017a), these data support that both minority and majority individuals demonstrate a shared understanding of the construct. Both Black and White students are tuning into similar signals, even if they may approach these interactions differently. When comparing item-level correlations of White student ratings to Black student or expert ratings, there was a stronger negative correlation with actions compared to thoughts. These findings suggest the possibility that White students are suppressing or otherwise not acting on these thoughts in racially sensitive settings and are more likely to think microaggressive statements but less likely to act on these thoughts.

Analysis of points of disagreement indicates that Black students rated several microaggressive statements as slightly positive. Most of these items concerned questions about the Black individual's ethnicity, nationality, or place of birth. It may be that Black students interpreted this question as genuine interest in learning more about them as individuals (rather than as members of a racialized group), although the rating of only slightly positive suggests that there was some uncertainty around intention. It is possible that people in other ethnoracial groups would rate these items as more racist, given that similar statements have been used as exemplars of microaggressions as they presume one is foreign born (Ong et al., 2013), which is a type of microaggression that may be more salient to Asian and Hispanic Americans. While one microaggressive item (S2: "The White student says as little as possible because they are worried [the Black student] will get upset at something they say") was rated very positively by Black students, it should be noted that this statement does not reflect active avoidance of racial topics but rather White students censoring their verbal content. It may be that people of color prefer that White students censor or limit their actions when uncertain about whether such behavior would be considered microaggressive in nature. Importantly, in this scenario, doing so does not result in the

avoidance of discussing racial topics, an action that is viewed as a microaggression itself (Constantine et al., 2008).

Points of disagreement were especially illustrative for understanding microaggressive statements that White respondents were more likely to endorse. These items centered around minimizing interactions and denial of being or acting racist. This suggests that White individuals may frequently interact with minorities superficially and in a manner consistent with racial color-blindness, an approach that is linked to racism and bias despite White individuals' claims that it is not (Apfelbaum, Norton & Sommers, 2012; Neville et al., 2013). White students were less likely to endorse several supportive items, notably those that centered on direct engagement with Black students and objecting to potentially racist actions. These suggest that White individuals' interracial anxieties and avoidance may result in hesitation to ask people of color about their experiences, failure to directly interact with people of color, or failure to intervene when observing microaggressions (Britt et al., 1996; Trawalter, Adam, Chase-Lansdale, & Richeson, 2012). Such actions would be considered helpful and should not be avoided.

Collectively, these statements provide more specific examples of concepts that would be of particular importance to address during therapy. When working with clients of color, therapists should be aware of color-blind attitudes and interracial anxieties that may result in minimizing the importance of the client's culture or their experiences with racism. Our results support the recommendation that clinicians should seek to understand clients' experiences of racism, discrimination, and microaggressions, acknowledge ways in which they may have benefited from privilege, and understand how such experiences have shaped their own learning experience (Miller, Williams, Wetterneck, Kanter, & Tsai, 2015). Clients of color may perceive the avoidance or inability to discuss racism as a microaggression itself.

The following study has several limitations. Although the sample size was adequate for CCM analysis, it was underpowered to detect the possibility of racial differences between expert responses, a group that was more racially diverse than the student samples. Yet within the expert group, average CCAS ratings of microaggressive statements were fairly similar across race, suggesting that consensus on items was more likely to be due to expertise in the area of multicultural psychology rather than racial differences in the experience of microaggressions. Another limitation of the sample is its focus on college-aged students within one region of the United States, a demographic that is increasingly exposed to diversity training and therefore whose response may not generalize to older, community or clinical samples. Despite good consensus for characterizing microaggressions through the use of CCM, validation of the CCAS is ongoing and the final scale will be a subset of those included here.

Despite speculation that microaggressions are a vague concept that cannot be reliably measured (Lilienfeld, 2017a), the results of this study indicate that both potential perpetrators and targets can accurately appraise the construct, and that despite endorsing microaggressive thoughts, would-be perpetrators often know better than to act on these thoughts. These findings may be especially helpful for recognizing microaggressive comments and increasing the use of supportive statements in therapeutic context with clients of color, thereby increasing rapport, therapeutic alliance, and engagement. Future work is needed to investigate whether these appraisals can characterize increased ability to recognize microaggressions following diversity trainings aimed at reducing racism. Another possible extension of this work may be improving the ability of targets to more quickly recognize and respond to microaggressions, as there is some evidence that doing so may therapeutically protect against internalizing the discriminatory actions of others (Noh et al., 2007). Given the significant mental health impact of these subtle forms of racism (Nadal et al., 2014; O'Keefe et al., 2015), it is imperative that research initiatives aimed at improved operationalization of the microaggression construct translate to improvements in clinical practice such that therapists can better understand the experiences of their clients and avoid replicating previous negative experiences of racism.

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Table 1. Discrepant Microaggressive Items in White Student Models

Item (Scenario)	Behavior Rating	Thought Rating
Microaggressive Items Most Likely to Be Endorsed		
■ The White student gives him directions as quickly as possible to minimize interacting (S5)	Neutral	Somewhat Unlikely
■ "I would never treat a Black person differently than anyone else. I'm not like that." (S3)	Somewhat Unlikely	Neutral
■ "I am not a racist." (S3)	Somewhat Unlikely	Neutral
Supportive Items Least Likely to Be Endorsed		
■ "What's it like for Black students in the law school?" (S1)	Very Unlikely	Very Unlikely
■ The White student stops singing song that includes the n-word and beat boxes instead. (S6)	Very Unlikely	Very Unlikely
■ The White student walks with the lost Black man to the store since they are going that way anyway. (S5)	Unlikely	Unlikely
■ The White student says s/he objects to the song with the n-word because it bothers their friend. (S6)	Unlikely	Unlikely

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Reports on the 2018 NIMH Professional Coalition for Research Progress and the Open Session of the National Advisory Mental Health Council

Nathaniel R. Herr, *Chair, ABCT Research Facilitation Committee, American University*

ON MARCH 20, 2017, the National Institute of Mental Health (NIMH) hosted the 9th Professional Coalition for Research Progress (PCRP) meeting at the Neuroscience Center in Rockville, MD. This conference is a chance for Dr. Joshua A. Gordon, the Director of NIMH, to meet with representatives from various organizations across a range of mental health professions, including the American Psychological Association, the American Psychiatric Association, the Association for Psychological Science, and the National Association of Social Workers. I attended as the representative for ABCT. Two months later, on May 17, 2018, NIMH hosted an Open Session of the National Advisory Mental Health Council (NAMHC), a group of researchers and clinicians who advise the Director of NIMH on policies and activities relating to the conduct and support of mental health research and training. Members of this council include Dr. Ian H. Gotlib from Stanford University, Dr. Gregory A. Miller from UCLA, Dr. Lisa H. Jaycox from the RAND Corporation, and David C. Henderson from Boston University School of Medicine. I attended this meeting as well and in this article I will describe what was discussed in these meetings that is relevant to the members of ABCT.

Unlike last year's PCRP conference, which featured presentations by several NIMH administrators that were designed to disseminate the then-incoming director's vision for NIMH (see my report in the December 2017 issue of *the Behavior Therapist*; Herr, 2017), this year's conference consisted primarily of research talks by NIMH-funded principal investigators intended to highlight some of NIMH's topical priorities. These talks covered research on the use of Ketamine in the acute treatment of depression, improvements in suicide screening in emergency care settings, and programs that are striving to reduce mental health disparities.

Dr. Gordon was the only NIMH representative to speak, and his talk focused on the issues that are currently of greatest interest to Congress and the Department of Health and Human Services (HHS). In January 2018, Alex Azar replaced Tom Price as the Secretary of HHS. Secretary Azar previously worked as the Deputy Secretary of HHS under President George W. Bush, and as a senior vice president for Eli Lilly. Dr. Gordon described Azar as someone who is "known as a friend to NIH." The topics that are receiving increased congressional attention, and therefore increased prioritization at NIMH, are (a) coordinated specialty care for first episode psychosis; (b) suicide prevention; (c) comorbidities, in particular conditions comorbid with opioid abuse; (d) serious mental illness; and (e) experimental therapeutics. Furthermore, NIMH is particularly interested in projects that demonstrate promise for reducing the societal burden of disease and that incorporate cost-benefit analyses, with an eye toward a shift in the health care system to value-based care.

Dr. Gordon also provided updates on NIMH funding. In 2017, 21% of applications were funded, down from 23% in 2016, due in part to an increase in the number of applications received. Grants scoring in the 18th percentile and above were the most likely to be funded; however, those as low as the 37th percentile were selected for funding. At the NAMHC meeting, Dr. Gordon elaborated on the prospects for future funding, reporting that an unexpectedly large increase in the NIMH budget this year has brought the total up to $1.7 billion, a level last seen in 2006, which will allow NIMH to fund virtually all low-priority grants that have a successful review in the upcoming fiscal year. In terms of types of projects that are receiving NIMH funding, before 2013, the largest percentage (generally around 50%) of funded grants were designated as Therapeutics Development and Services. In 2013, however, there was a decline in these types of awards (down to about 40% in 2017), and an increase in grants designated as Disease-Related Basic (now up to 45%). The remaining 15% of grants are designated as Fundamental Basic. Dr. Gordon asserted to the organization representatives at PCRP that, despite the fact that he hears researchers saying NIMH is intentionally trying to limit support for treatment development grants, "we have no preconceived notion or goal … we should be spending money on excellent science," regardless of the type of application. He therefore attributed this shift in the types of funded projects to a reduction in submissions for treatment development grants due to researchers' belief that these types of grants are less likely to be funded.

An additional topic of interest discussed at the PCRP conference was that NIMH has created a very comprehensive and user-friendly page of mental health statistics—including many visualizations of data—that should be helpful for educators, clinicians, and researchers. This page can be found at: https://www.nimh.nih.gov/health/statistics/index.shtml. Just be sure to ignore the irony that it is conceptually set up to be consistent with the DSM-5, rather than RDoC.

Regarding RDoC, Dr. Bruce Cuthbert, the chief of the Research Domain Criteria Unit at NIMH, spoke at the NAMHC meeting about proposed changes to RDoC. Both he and Dr. Gordon emphasized the fact that RDoC should be seen as a "rapidly evolving framework" built from the bottom up by researchers rather than as a top-down, rigid structure imposed by NIMH. In this spirit, recent meetings of the Changes to the RDoC Matrix (CMAT) workgroup have focused on revising the Positive Valence constructs. The revision now specifies three primary domains (Reward Responsiveness, Reward Learning, and Reward Valuation), each containing several subconstructs. The next areas slated for revision are the Motor and Negative Valence domains. Dr. Cuthbert also acknowledged the growing need for refinements to the criteria for making changes to RDoC that take into account advances in computational processes.

This focus on computational methodologies was an additional theme throughout both conferences. One talk at NAMHC centered on the need to develop mathematical equations that quantify human

behavior. As the presenter revealed a complex mathematical notation that parameterized a wide range of behavioral constructs in an effort to demonstrate a computational approach to having a social interaction, several council members expressed frustration and skepticism. Nonetheless, it seems clear that NIMH is prioritizing research that integrates behavioral parameters into experimentally grounded mathematical formulations. In particular, these methods will be needed for the analysis of data in NIH's All of Us Research Program (https://allofus.nih.gov/), an initiative that seeks to gather extensive behavioral, biological, and environmental data relevant to health, including mental health, on over 1 million Americans. With beta testing completed last year, All of Us formally launched in May 2018 and is now one of the top research priorities of NIMH.

For more information on NIMH priorities and other support for developing successful grants, be sure to attend the "Q & A With NIMH Program Staff: Current Priorities and Funding Opportunities for Clinical Research and Research Training" (Friday, November 16, 1:45 P.M. in Maryland Suite) and "Getting the Grant" (Saturday, November 17, 10:15 A.M., in Roosevelt 5) sessions organized by the Research Facilitation Committee at this year's ABCT Convention in Washington, DC.

Reference

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Integrating Neuroscience Into Research on Cognitive Behavioral Therapy on a Continuum of Involvement

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IN RECENT YEARS, the field of clinical science has increasingly emphasized better understanding of who benefits from cognitive behavioral therapy (CBT) and the mechanisms that lead to improvement. As clinical scientists of ABCT, we are united by our common goal to advance knowledge about the core patterns of psychopathology underlying psychological disorders as a way to inform treatment development and refine treatment targets. We have many tools at our disposal: well-validated experimental paradigms and challenge tasks, advanced statistical methods, electronic data capture platforms, app-based forms of passive and active data collection, proven recruitment practices, and randomized controlled trial protocols. To move our field forward and keep up with the latest advancements in related disciplines, in this article, I discuss how neuroscience offers another tool in our toolbox to serve our common goal. First, I will provide a general introduction to the tools that are available to the neuroscientist, and how they may be relevant for clinical scientists. Second, I discuss some of the advantages of integrating neuroscience into research on CBT. Finally, I examine some of the challenges in this integration, and provide suggestions for becoming more involved in neuroscience along a continuum of involvement.

Neuroscience Tools and Relevance to Clinical Science

Neuroscience is growing at a rapid pace, with new subdivisions emerging each decade. The field is committed to examining the nervous system, which is the biological system at the seat of human cognition and behavior. Neuroscientists may employ a variety of tools, including imaging-based methods (e.g., magnetic resonance imaging [MRI], functional MRI [fMRI], magnetoencephalography [MEG], positron emission tomography [PET], diffusion tensor imaging [DTI]), and neurostimulation approaches (e.g., transcra-

nial magnetic stimulation, transcranial direct current stimulation). Electroencephalography (EEG) is another tool in which electrical activity is recorded from the scalp, and can be used to examine the precise temporal dynamics associated with a cognitive or motor process. This can be done even at the single cell level in both animals and humans. With the advent of intracranial electrode recordings, neuroscientists can even record electrical activity from both local field potentials and single cells directly on the human cortical surface. These methods may not appear immediately useful to the clinical psychologist; however, when combined with the tools we already use, we have the power to answer some key questions about treatment process and change.

Many neuroscience discoveries impact our daily work as clinicians delivering empirically based interventions. There is a long history in the animal literature examining the brain mechanisms underlying fear learning and fear extinction, much of which has been translated by leading clinical scientists to develop a concept known as "inhibitory learning" (Craske et al., 2008, 2014). This body of work has challenged our thinking about the mechanisms underlying CBT for fear-based disorders, and the ways in which we deliver CBT. I am a member of the ABCT Neurocognitive Therapies and Translational Research (NTTR) Special Interest Group (SIG), whose mission is to bridge the gap between basic and applied science in understanding the nature and treatment of psychiatric disorders. Many of our SIG leaders and members are conducting research on CBT from a neurocognitive perspective. For example, Drs. Greg Siegle and Rudi de Raedt have been developing and testing neurocognitive trainings that reliably increase prefrontal activity (specifically in the dorsolateral prefrontal cortex or DLPFC) in patients with depression, as decreased control in this region has been linked to rumination. Their work is a wonderful example of the potential of combining neuroscience

with research on CBT by translating findings from neuroscience (decreased DLPFC activation in depression) into behavior-based interventions (cognitive training paradigms) that directly target a core psychopathological process (rumination).

Advantages to Integrating Neuroscience

There are numerous advantages to integrating neuroscience into our study of CBT. Perhaps the most compelling is that it offers another level of objective analysis to examine predictors of treatment response and mechanisms of successful and unsuccessful treatment. There is a growing literature showing that brain markers may be more sensitive to predicting outcomes in CBT, compared to clinical or demographic variables based largely on self-report or clinician ratings (Doehrmann et al., 2013). Moreover, a recent study demonstrated that these brain markers can show specificity in the modality of treatment that an individual patient is likely to respond to—whether CBT or medication (McGrath et al., 2013). Second, it may be possible to identify self-report or behavioral measures that reliably map onto dissociable neural circuits. For example, I am currently investigating the extent to which commonly used measures of maladaptive self-focus and related constructs, such as rumination, specifically map onto dysfunction in the default mode network, a functional network of neural regions that are associated with internally focused mentation and that are functional dissociated from regulatory regions of the executive control network. In this way, certain self-report measures or behavioral measures that we commonly use in clinical practice may serve as robust proxies for neural dysfunction without the use of an fMRI scan. Third, it behooves us as a field to capitalize on interdisciplinary approaches in order to advance the science of clinical psychology. The Director of the National Institute of Mental Health, Dr. Joshua Gordon, has made it clear in his Director's Messages (Gordon, 2017) that he remains interested in funding proposals on psychosocial interventions, but only if they target the mechanism they presume to target (i.e., experimental therapeutics). Whether or not we choose to include brain measures to achieve this, the onus is on us to validate the mechanisms through which we believe CBT works before we can test whether an intervention modulates that mechanism. Neuroscience can be a strong tool to help

with this validation, by offering an objective measure through which to clarify processes captured by our rich armament of subjective self-report and behavior-based measures. Additionally, assessment across multiple modalities (self-report, behavior, and brain-based measures) offers more opportunities for examining convergent and discriminant validity than single modality assessment. Even if through the integration of neuroscience and CBT we develop a neuroscience-informed intervention that helps only a subset of patients (how wonderful if we could understand patterns of neural dysfunction in therapy resistant patients), having these treatment options at our fingertips is critical for successful clinical practice.

Challenges to Integrating Neuroscience

Logistical and Financial Barriers

What are some of the challenges to integrating neuroscience into research on CBT? A myriad of logistical and financial barriers exist. First, clinical psychology doctoral training programs historically have been isolated from departments of neuroscience, and do not include neuroscience-based courses as part of the required curricula. However, this trend is beginning to change. More departments are converting their department names from "Department of Psychology" to "Department of Psychological and Brain Sciences" or "Department of Psychology and Neuroscience" to reflect our overlapping disciplines. Educators are revising their curricula at the undergraduate and graduate level, phasing out courses on physiological psychology and folding them into courses on cognitive and behavioral neuroscience. Second, a perceived barrier to integrating neuroscience into CBT research is lack of available time to take additional courses or learn new analysis techniques and programs in the midst of an already busy schedule. As I will describe below, there are ways to learn about neuroscience methods without taking formal coursework. Learning a new method or software conducive to neuroimaging data does take time, but may not be any more time-consuming than learning how to conduct and test a novel advanced statistical model on your particular dataset in an unfamiliar statistical program. Third, the perceived difficulties associated with identifying good collaborators who are sympathetic to CBT research may be another bar-

rier. The truth is, the important work our field has been doing over the last 40 years has left a strong impression on the neighboring disciplines of neuroscience, psychiatry, and neurology, which now largely view CBT as the gold standard of psychological intervention and are eager to engage in collaborative research. I will describe some additional solutions to this barrier below, but the NTTR SIG is a great place to network and identify potential collaborators and mentors at ABCT and beyond. Fourth, it may be difficult to obtain initial funding for doing this type of work. Collaboration is extremely helpful to resolve this problem, as collaborators may assist in applying for institutional postdoctoral fellowships (T32s) that provide training in cognitive neuroscience, or work with you to write a review article that addresses an important neuroscientific gap or debate. These types of publications, although not empirical, provide documentation of your enthusiasm for translational clinical neuroscience, which are helpful during grant reviews.

Emotional Barriers

There are also some emotional factors that may be challenging to overcome. Among trainees and senior scientists alike, a common belief is that we have to either fully commit to neuroscience training or opt out. Contributing to the opting out side may be some feelings of intimidation associated with the esoteric terminology and jargon involved in neuroimaging papers and talks, especially in terms of acquisition parameters and neuroanatomy. Combined with the logistical factors of not having time to delve into the nuts and bolts of conducting neuroimaging analyses, one is likely to feel that it is not possible to engage in this type of translational work. However, there is actually a continuum of involvement with neuroscience in which clinical scientists can choose to participate, described in Table 1.

Political Barriers

Political factors may also pose barriers to integrating neuroscience with research on CBT. It has been unpopular in some clinical circles to incorporate biological measures with research on CBT, as it is viewed as reductionistic and potentially threatening to our guild. Others believe that we should not just turn to wherever the sun shines in terms of the NIMH funding priorities, which appear more brain-focused in recent years. However, the tools and methodologies you employ in your

work should be motivated by your research questions, rather than vice versa, and the use of tools from one discipline are not mutually exclusive or theoretically incompatible with those from another. It may be helpful to find allies in your department and professional organizations who support your interests. As described below, NTTR SIG members are passionate about this kind of translational work and have organized many ways of getting more involved, such as SIG poster competitions, mentorship programs, and preconference events.

Ways to Integrate Neuroscience on a Continuum

Table 1 provides suggestions for integrating neuroscience into your research along a continuum of involvement. These suggestions can be applicable to clinical scientists at various levels of training, although dedicated training opportunities for neuroscience, such as institutional T32s, K and F awards, are geared toward early-career investigators and trainees at the graduate or postdoctoral level.

Minimal Involvement

At the minimal involvement level, you may be able to commit some time to develop a new collaboration with a neuroscientist who is interested in examining the clinical populations you study. If you are a graduate student, you could suggest strategies for recruiting the patients of interest for the collaborator and even offer to serve in some formal role on the study, in the form of a protocol therapist, independent evaluator, or even graduate research assistant. Rather than taking formal coursework and reading neuroscience journal articles, you may be willing to invest some time in following prominent neuroscientists on social media, who often disseminate their research findings in 280 characters or less on platforms like Twitter. Or perhaps you may be willing to submit and present

Table 1. **Integrating Neuroscience With CBT Research on a Continuum of Involvement**

Minimal Involvement	Moderate Involvement	Heavy Involvement
Find a collaborator who will run the studies in his/her lab and you provide the clinical patients	Find a collaborator who will run the studies in his/her lab and you can assist in data collection (scans)	Find a collaborator who has collected data on clinical populations of interest and assist a postdoc in conducting data analyses; generate a secondary hypothesis to test
	Complete safety training and obtain a yellow badge to assist in fMRI data collection	Complete safety training and obtain a green badge to assist in fMRI data collection
Follow neuroscientists on social media (Twitter) and informally read about neuroimaging studies	Read neuroimaging papers and keep track of the neural circuits and brain regions associated with your area of study	Read neuroimaging papers and keep track of multiple circuits and networks involved in your area of study
	Complete informal courses on neuroanatomy or basic imaging methods through free online venues, such as Coursera or Khan Academy	Apply for formal coursework in computational methods and neuroimaging methods or audit a course led by your local institution through the Department of Neuroscience or any neuroscience institute; Apply for training fellowships such as an institutional T32 fellowship to train in neuroscience, K award, NRSA fellowship, Kavli Summer Institute in Cognitive Neuroscience, or UC Davis/SDSU ERP Boot Camp
Attend networking opportunities at your home organization: the Neuroscience and Translational Therapies and Research (NTTR) Special Interest Group (SIG) at ABCT	Obtain a mentor through the new Mentor Program in the NTTR SIG	Offer to mentor someone through the new Mentor Program in the NTTR SIG
Submit a poster to organizations whose membership include researchers who employ imaging methods and are interested in clinical translational research, such as ADAA, SOBP, SPR, ACNP, and SFN	Submit abstracts to organizations interested in clinical neuroscience, and consider joining their membership to have access to their journals	Join communities of researchers at organizations interested in clinical neuroscience, such as ADAA, SOBP, SPR, ACNP, and SFN, and participate in leadership roles in the organization

abstracts at organizational meetings dedicated to clinical neuroscience, such as the Society of Biological Psychiatry, Anxiety and Depression Association of America, American College of Neuropsychopharmacology, or the Society for Psychophysiological Research. These meetings offer networking opportunities that allow you to become familiar with specific researchers who may be interested in collaboration and sympathetic to your area of study.

Moderate Involvement

If you are interested in investing more time to integrating neuroscience into your research, there is a way to be moderately involved. For example, taking a free online course on neuroanatomy or basic imaging methods can significantly enhance your understanding of the brain regions and procedures reported in neuroscience journal articles. Coursera is a popular online resource for video-based lectures and there is a course offering on neuroanatomy that has received good reviews. Khan Academy is another great resource for free, online, and focused learning. Although it does not currently offer a neuroanatomy course, there is a section for Advanced Nervous System Physiology in the Health and Medicine category that touches on structural and functional organization of the brain. If you are a graduate student or postdoc, you may be willing to obtain safety training to assist other labs in obtaining scans for their studies. This will help you gain a sense of the diversity of scan protocols, as well as common scanning parameters between labs, and familiarize you with potential future collaborators. Be prepared to volunteer some unpredictable times and to be punctual if you assist with scans, as scan slots are often assigned based on a center's policies and are fairly rigidly structured in a back-to-back manner due to multiple labs accessing the same scanner. Another way to experiment with integrating interdisciplinary tools and methods is to consider adding another level of analysis in your research, such as blood, urine, or saliva, as this may be equally if not more interesting than brain measures, depending on your research area. It will also teach you to write to a broader audience by publishing your work in nontraditional clinical psychology journals, and there may be technical issues and methodological confounds that may be generalizable if you decide to integrate brain measures down the road. The NTTR SIG also recently initiated a Mentor Program, an excellent way to receive more tailored guidance for your research trajectory.

Additionally, the NTTR and Technology SIGs are jointly sponsoring the ABCT mHealth Preconference as part of this year's Annual Convention in Washington, DC, which will include talks on the integration of neuroscience and CBT research, as well as hands-on demonstrations of neuroscience-based tools for use in both research and clinical practice.

Heavy Involvement

To be more fully engaged in neuroscience-informed CBT research, this may take more formal training on the details and nuances of neuroimaging methods and neuroanatomy. One strategy for initially cultivating this interest is to identify a dataset in which brain measures were collected and generate a secondary hypothesis or exploratory analysis you would be interested in examining. The key is to pair up with a postdoc in a neuroscience lab who would be willing to guide you through the details and pipeline of the data analysis and interpretation. Depending on your level of experience and their involvement, you may offer co-authorship for their contribution. The best way to learn new software, neuroanatomy, and computing challenges is when they are applied to real data for an existing project. Some ways to obtain formal training in neuroscience include the following opportunities: institutional T32 fellowships for postdocs for training in neuroscience (may be offered through a local neuroscience institute or medical school affiliation); NIH Career Development K Award; NIH National Research Service Award (NRSA) F Award for predoctoral students; Kavli Summer Institute in Cognitive Neuroscience program (http://sicn.cmb.ucdavis.edu); University of California Davis/ San Diego State University Event Related Potential Boot Camp (https://erpinfo.org); submitting a diversity supplement with a neuroscience-focused research question for an existing R01 project (applicable only to NIH-defined individuals from disadvantaged backgrounds). There may also be discounts for trainees or free opportunities to audit courses on neuroanatomy or neuroimaging methods at your local institution.

Regardless of your level of participation, a key principle when integrating neuroscience into CBT research is to stay true to your interests and research questions. Learning to incorporate statistical maps of brain images in your publications is not a fool-proof way to convince readers and reviewers of your work that you have identified mechanisms underlying CBT. Neu-

roscience is fallible and susceptible to the same methodological challenges we face in our field, such as reliability and reproducibility issues, issues of interpretation, and balancing a priori, adequately powered, hypothesis-driven tests with exploratory hypothesis-generating studies. It is important to remember that as clinical scientists, we have extremely valuable expertise to a neuroscientist, as we understand the heterogeneity and individual differences that form the nuanced presentations of psychopathology we see in the clinic, as well as the unique case formulations and mechanisms by which an individual improves in treatment. Through thoughtful collaborations between clinical scientists and neuroscientists, we can more easily achieve the promise of greater precision in psychotherapy.

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Additional Suggested Readings and Events

2018 ABCT mHealth Pre-Conference—A Joint Preconference Sponsored by the Technology and Neurocognitive Therapies/Translational Research SIGs: http://www.abct.org/conv2018/?mn=15&fn=ss_mHealth

Mohlman, J., Deckersbach, T., & Weissman, A. (Eds.) (2015). *From symptom to synapse: A neurocognitive perspective on clinical psychology.* New York, NY: Routledge.

Neurocognitive Therapies/Translational Research SIG website: https://www.neurocognitive-therapies.com/

Siegle, G. J., Thompson, W. K., Collier, A., Berman, S., Feldmiller, J., Thase, M. E., & Friedman, E. S. (2012). Toward clinically useful neuroimaging in depression treatment: Prognostic utility of subgenual cingulate activity for determining depression outcome in cognitive therapy across studies, scanners, and patient characteristics. *Archives of General Psychiatry, 69*, 913-924.

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CLINICAL PRACTICE

Development and Implementation of a Single-Session Diversity and Multicultural Psychology Group Intervention Within an Academic Psychiatric Hospital

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DECADES OF RESEARCH documents the significant influence social and cultural identities (including but not limited to ethnicity, race, sexual orientation, gender expression, health status and disability, socioeconomic status, indigenous heritage, and national original) have on psychological functioning and well-being (e.g., Haslam, Jetten, Postmes, & Haslam, 2009; Nadal, 2017). Numerous well-conducted meta-analyses have documented the sustained benefit of culturally responsive psychological treatments compared to treatment as usual or no treatment (see Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Hall, Ibaraki, Huang, Marti, & Stice, 2016) for historically marginalized patient populations (e.g., sexual and gender minorities, people of color, individuals with disabilities). This research informs a foundational dialectic inherent in biopsychosocial theories of mental wellness—that our psychology is influenced by both the neuron and the neighborhood (Shonkoff, 2003).

In the present article, we describe a recent initiative at McLean Hospital to provide patients and staff members with information about the important role of social and cultural identities in treatment and mental health more broadly. This article outlines the authors' attempts to integrate culturally responsive group treatments within a large mental health treatment and training setting. Our efforts can be broadly conceptualized as Stage 1 treatment development outlined by the National Institutes of Health (NIH), in so far as we have focused on the development and refining of an intervention and conducted very preliminary assessments to determine initial acceptability and feasibility with the aim of running a more formal Stage 2 efficacy trial in the near future (see Onken et al., 2014). We hope that sharing our experiences developing and piloting such interventions will provide other clinicians, researchers, and educators with an example of how to further infuse social and cultural identity factors into treatment settings that could benefit from becoming more culturally responsive and engaged.

Context and Identified Problem

The initiative we discuss in this article started at McLean's Behavioral Health Partial Hospital (BHP) Program, the primary clinical training site of the McLean Hospital/Harvard Medical School doctoral internship in clinical psychology. In addition to providing intensive evidence-based treatment for acute psychopathology and training to emerging psychologists, the BHP conducts integrated treatment outcome research (as described by Forgeard, Beard, Kirakosian, & Björgvinsson, 2018; Beard & Björgvinsson, 2013; Björgvinsson et al., 2014). The BHP treats individuals 18 years of age and older experiencing severe and acute symptoms of psychological disorders (e.g., mood disorders, thought disorders, personality disorders, anxiety disorders, OC-spectrum disorders, and severe stress-related disorders) requiring an intensive level of care. Approximately half of patients are referred directly from inpatient hospitalization for further stabilization, and the other half are referred from outpatient treatment to prevent further symptom exacerbation and possible inpatient hospitalization. Patients typically attend the BHP for 1 to 2 weeks (mean = 8 days) from 9 A.M. – 3 P.M. on weekdays (and return home or other residential context at night and on weekends).

Information about the demographic characteristics of the BHP patient population can help understand the context in which our initiative takes place.[1] The BHP serves approximately 850 patients each year. Patients are 35 years old on average

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[1] The descriptive information provided here was obtained for patients attending the BHP from November 2016 to August 2017 (from the date the group described in this article started, to the last date at which data were available for analysis).

(SD = 14.6). Approximately half (50.5%) report identifying as female, 45.5% as male, and 1.8% as nonbinary. Regarding sexual orientation, approximately 20% of patients identify as a sexual minority (9% as bisexual, 7% as gay or lesbian, 2% as queer, and 3% identify as a sexual orientation not listed). Over half have obtained a 4-year college degree (53.8%). When asked to report their ethnicity/race, approximately 20% identified as individuals of color (10.3% as multiracial, 5.5% as Asian, 1.7% as Black, 0.3% as Latino, 0.2% as Native American or Alaskan Native, 1% endorsed another ethnicity or race).[2] A majority (61.3%) have never been married, 22.3% are married, 9.3% are separated/divorced, 3.7% are living with a partner, and 1% are widowed. Approximately a third of patients (30.5%) report being students. Approximately half (50.3%) of patients are not employed, 15% are employed part-time, 32.2% are employed full-time. Among patients who report being unemployed, 25.3% report that this is due to a disability. Half of patients (50%) have been hospitalized for psychiatric reasons in the past 6 months prior to admission to the BHP. The mean number of prior hospitalizations is 1.5 (SD = 2.17).

The BHP offers nearly 100 protocol-driven 50-minute group therapy sessions each week. Group content is adapted from evidence-based treatments well-suited to a short-term treatment program focused on equipping patients with a wide array of concrete skills to manage acute symptoms. This includes content and skills from cognitive-behavioral therapy (CBT; Beck, Rush, Shaw, Emery, 1979), dialectical behavior therapy (DBT; Linehan, 2015), and acceptance and commitment therapy (ACT; Hayes, Strosahl & Wilson, 2012). In addition to group therapy, patients engage in regular individual therapy, case management, vocational support, and psychiatric/medical consultation. Yet across this vast array of services offered weekly, none of the BHP interventions explicitly focused on broaching issues of social and cultural identity as they relate to psychological suffering and well-being (though, as explained below, more indirect opportunities to discuss and examine these topics did exist).

Although many systems of care have historically ignored identity-related factors in health, research supports that addressing social and cultural identities in treatment improves the quality of care (e.g., Chowdhary et al., 2014; Hall et al., 2016). This is particularly important because significant scholarship documents the enormous impact of identity-related stress on mental health for social and cultural minority groups, including experiences of stigma, bias, and discrimination across many different forms of identity. Examples of identity marginalization and related psychological suffering include those based on race and ethnicity (e.g., Williams, 2012), religion and spirituality (e.g., Cheng, Pagano, & Shariff, 2017), sexual orientation (e.g., Pachankis & Bränström, 2018), gender expression and gender identity (e.g., Resiner et al., 2016), mental health status and disability (e.g., Pearl et al., 2016), physical health status and disability, (e.g., Stone & Wright, 2013), national origin and immigration status (e.g., Tran, Lee, & Burgess, 2010). Whereas being the survivor of overt acts of identity-based discrimination and oppression may engender traumatic stress and/or other downstream psychological suffering, everyday experiences of stigma, bias, and discrimination based on one's identity may also strongly influence mental health via implicit bias (e.g., Greenwald & Banaji, 2013), stereotype threat (e.g., Steele, 2010), and microaggressions (e.g., Sue et al., 2007) among other processes. Without assessing and addressing these common factors that drive suffering in historically marginalized patient populations, we perpetuate an enormous disservice. With the goal of interrupting some of these oppressive processes and to create sustainable and enduring system changes, we engaged in a process of community-based participatory research (Hacker, 2013). We spoke with key stakeholders (staff members and patients) in our program to identify strengths, barriers, and areas for growth in order to provide more culturally responsive and social and cultural identity affirming treatment within the BHP.

First, conversations with staff members clarified that several treatment groups at the BHP already indirectly discussed how social and cultural identities relate to mental health. For example, a subset of psychoeducational groups provided patients with information about specific diagnoses and asked them to reflect on how receiving a diagnosis relates to one's identity and mental health. Another subset of groups allows patients to process with others their experiences of living with mental health difficulties. In these groups discussions of social/family roles, changes in identity, stigma, and their effects on well-being often take place. Importantly, during our preliminary conversations, whereas some staff members expressed a desire to further expand and address social and cultural identities more intentionally in treatment at the BHP, other staff did not perceive a problem, either because they were unaware of the significant effects of social and cultural identities on mental health, or because they felt that the short duration of the partial hospital program made it an inappropriate venue for discussing social and cultural identities. A majority of patients at the BHP rate their experiences as very positive in the program; on a scale ranging from 1 (worst possible care) to 10 (best possible care), patients rate treatment at the BHP as 8.7 (SD = 1.32). However, at times some patients (especially patients identifying with historically marginalized groups) voiced concerns regarding the lack of attention paid to issues of social and cultural identity in their treatment either in person, or during discharge questionnaires that specifically ask for feedback.

Moreover, treatment outcome data from our program underscored a need to further understand and address the role of social and cultural identities in treatment. For example, in a study examining treatment response at the BHP, individuals identifying as bisexual reported worse perceptions of the quality of their care and more suicidal and self-injurious cognitions at discharge compared to other sexual minorities and heterosexual-identified patients attending the program (Beard et al., 2017). Other manuscripts focused on treatment outcomes across other social and cultural identity groups are currently under way. Thus, gathering data-driven information about the mental health treatment we provide and the experiences of both clinicians and patients in our program, we identified the need to more intentionally integrate culturally responsive and social and cultural identity affirming care into our treatment services. Our aim was to establish a tangible way to begin to integrate aspects of identity as they influence psychological health directly into treatment and to further demonstrate the pro-

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[2] According to the most recently available town census data, the demographics in our program (including racial and ethnic makeup as well as education level) are very similar to those within the town of Belmont, MA, where McLean Hospital is located.

gram's evolving critical consciousness (e.g., examining and taking action on complex systems of power and oppression) of such processes (e.g., Freire, 1993).

Identified Solution Based on Need and Program Pragmatics

Given both the strengths and limitations of our partial hospital program (average stay of 8 days, 50-minute group therapy format, a constantly changing milieu of patients due to rolling admission and discharge dates), we developed a 50-minute protocol that integrated several key principles from culturally responsive psychological treatments for mental health problems (e.g., Smith, Rodríguez, & Bernal, 2011). While a multisession group may be more ideal for enhanced learning, in the structure of our current program, and that of many short-term treatment programs, this is logistically not possible, so we opted for this structurally feasible, but potentially imperfect, single-session option. The broad programmatic goals of developing this group were multifold: (a) to demonstrate to patients the program's desire and value to be more culturally responsive and inclusive; (b) to provide an opportunity for psychoeducation and self-reflection among patients and staff about the impact of identity-related oppression, stigma, bias, and marginalization on mental health; (c) to increase patients' sense of belongingness and alliance with providers, fellow patients, and the broader program, especially for patients who might often feel marginalized or "othered" in traditional mental health treatment settings; and (d) to provide evidence-informed strategies about how to cope with systems of oppression that may negatively influence psychological health (e.g., structural barriers to treatment, minority stress theory, microaggressions) and that could be folded into CBT treatment with other providers.

Staff Training and Education on Diversity, Inclusion, and Culturally Responsive Care

Throughout the development of this project we continually discussed the importance of continued staff training in multicultural psychology and culture-adapted psychological treatments to move in parallel with the new group. We felt that if we introduced new language and concepts into standard treatment and asserted that we (as a program) aim to be an affirming and safe environment, we as an entire

staff needed to continually push and reflect on our own thinking and behaviors.

Ongoing staff training and continued conversations to provide a deep level of understanding of the concepts discussed in the group appeared indispensable to ensure that this initiative might benefit patients. For example, imagine a patient is introduced to a personally relevant identity-related concept during a group session (e.g., potential effects of explicit/implicit bias and identity marginalization on mental health); the patient then brings this topic to their well-intentioned but naïve individual therapist in the program and has an encounter that reinforces that treatment is not culturally responsive (e.g., the clinician does not effectively address the topic or is unintentionally invalidating). As a result, not only is this patient harmed by the clinician's behavior, but the patient may be less likely to bring up these issues to a provider in the future, perpetuating the culture of silence that surrounds conversations about identity in health care. To aspire to wrap-around culturally responsive care (e.g., clinicians and services functioning as an integrated team across admission, treatment, and discharge) is no small task and requires consistent dialogue across all program staff at all levels. As the group was integrated into the program we emphasized to all staff that moving forward with this group required acknowledging that we are all fallible, will certainly make mistakes (and strive to learn from them), and will work as a community to continue to provide the best possible care to a diverse population of patients.

Treatment groups were facilitated by a pair of clinicians (as is common in our program) and dyadic co-leadership is often ideal in psychological intervention groups focused on social and cultural identity factors in treatment because leaders can model effective cross-identity dialogue (e.g., Ellis et al., 2013). Three of this manuscript's authors (JPW, LPW, MF) and another psychology intern ran all groups. Three clinicians were current McLean psychology interns (in their final year of their clinical psychology Ph.D.), and MF was a postdoctoral fellow and former McLean intern. The four clinicians all occupied a range of both historically dominant and historically marginalized identities as defined within the ADDRESSING framework and modeling and disclosure of various aspects of identity is an important part of group facilitation (see below for description of the ADDRESSING Framework; Hays, 2016). All clinicians had significant

training in multicultural psychology prior to coming to McLean and all received extensive peer and faculty supervision related to culturally responsive interventions and the role their own identities play in treatment. Furthermore, all participated in a formal biweekly culturally responsive group supervision (see below for a description of the Multicultural Psychology Consultation Team).

With regards to other program staff not directly running groups but involved in the care of patients who received groups, all staff attended a community meeting and orientation at the introduction of the group to the treatment schedule (run by JPW and CB). In this orientation, the rationale for the group was presented as well as the specific content that would be discussed. Initial group leaders (JPW and MF) also met individually and in small group meetings with multiple BHP clinical teams to discuss the group and administrative procedures (e.g., clarifying that the group is open to all patients, not only patients with observable historically marginalized identities). Additionally, all staff within the BHP are regularly encouraged to attend department and hospital-wide trainings focused on social and cultural diversity which occur multiple times per month and many staff are members of specific identity affinity groups on campus.

Goals of the Single-Session ADDRESSING Identities Group Treatment

We anchored our single-session group, entitled "ADDRESSING Identities," around Dr. Pamela Hays' ADDRESSING framework (2016). The ADDRESSING framework is a tool for engaging individuals in self-examination related to their multifaceted and intersecting social and cultural identities. Simply, ADDRESSING is a pedagogical acronym encapsulating multiple social and cultural identities that may influence psychological functioning and well-being. In our current use, the acronym stands for **A**ge and generational influences, **D**isability status (e.g., physical, cognitive, sensory, intellectual, etc.), **D**iagnosis status (e.g., mental health), **R**eligion & spirituality, **E**thnicity & race, **S**exual orientation and expression, **S**ocioeconomic status, **I**ndigenous heritage, **N**ational origin and current national status, and **G**ender identity and expression. Of note, we made a minor adaptation to the second and third letters of the original ADDRESSING acronym in consultation with Dr. Hays. We changed "Developmental or other Dis-

ability" to "Disability status" and "Diagnosis status." Although physical and mental health are inherently intertwined, we made these changes with the specific goal of clarifying and deepening conversations related to mental health stigma. Based on our previous conversations with key stakeholders (see above), we expected that experiences of mental health stigma would represent one of the most common shared experiences of identity marginalization among patients in our program.

Building upon cognitive, affective, and behavioral models of psychological suffering and change within stigmatized groups (see Pachankis, 2007), we theorized that positive treatment changes from receiving the group may be linked to reductions in internalized identity-based stigma, increases in alliance with treatment providers and fellow patients, increases in perceptions of social belongingness with the broader program, and increases in effective use of evidence-informed psychological skills during experiences of marginalization (which is introduced in the group and ideally built upon during individual psychotherapy sessions with the patient's program therapist and outside providers). These hypothesized mechanisms of change are all empirical questions that we seek to examine in future research.

The ADDRESSING framework has been widely used in clinical psychology, counseling psychology, and social work training programs. As of 2018 there have been multiple published books, chapters, and articles written about the potential utility of this framework. A PsycINFO search for "Addressing Framework" demonstrates at least 10 unique published manuscripts. This noted, and to our and Dr. Hays' knowledge, no empirical study testing the efficacy of patient-facing ADDRESSING intervention (e.g., teaching patients in group therapy the ADDRESSING framework for use in their own mental health treatment) has been conducted. This gap in the literature identified, a key aim of our project was to develop a single-session patient facing group based on the ADDRESSING framework and to obtain initial feasibility and acceptability data prior to conducting a more rigorous test of efficacy.

The specific psychoeducational treatment goals of the single-session group "ADDRESSING Identities" were as follows: (a) introduce patients to the ADDRESSING framework to help them define and examine their own multiple social and cultural identities; (b) help patients enhance their thinking about how their intersecting identities (i.e., intersectionality) may inform how they think, feel, and behave, how others may think, feel, and behave towards them, and how salient certain aspects of their identity are to them; and (c) examine the interaction between identities and mental health by exploring how social and cultural identities influence the development and treatment of mental health problems. Worksheets discussed in this article are available for download at www.multiculturalpsychology.com. In addition to working collaboratively as a team in the development of this group, as noted above, we consulted with the developer of the ADDRESSING framework, Dr. Pamela Hays, who provided invaluable perspective.

Single-Session ADDRESSING Identities Group Content

The first portion of the group introduces ecological systems theory (Bronfenbrenner, 1979) and explores how our complex social and cultural identities may be influenced by many ecologies or environments we live in (e.g., work, school, community, neighborhood, political climate). We discuss these systems through the CBT framework—on which patients of the program are thoroughly educated throughout their treatment at the BHP—specifically how social and cultural identities explicitly and implicitly influence how we experience the world (i.e., how we think, feel, and behave) and how others experience us. Using the ADDRESSING acronym, we then formally define each category (with a supporting handout of definitions) and provide examples of historically powerful identity groups as well as historically marginalized identity groups within the U.S. We also acknowledge that individuals may experience aspects of their identities in ways that are or are not consistent with these examples. We emphasize the importance of clearly defining language, while also stating that definitions provided for terms consist of working and flexible definitions based on current research and best-practices. Additionally, we acknowledge we will not be able to discuss every social and cultural identity that may influence mental health during the 50-minute group. We validate any potential frustration that may result from engaging in a very brief exploration of a vast, complex, and inherently emotional topic, and state that the group aims to help broach these big topics and help participants think of ways to continue to examine these issues after the group ends (e.g., bringing content into their individual therapy).

Following this framing, we discuss how individuals are typically asked to provide information about their identity. We state that in academic, medical, and/or evidence-based clinic environments (including the BHP environment that uses daily quantitative assessment), treatment providers often utilize questionnaires and ask patients to put complex phenomena about their life and experiences "into boxes." As a group, we engage with this dialectic by recognizing (a) the important role of quantitative assessment in mental health treatment and (b) the understandable feelings of invalidation that may stem from being told you must exist "in a box" (male or female; depressed or not depressed; Black or White; see Wadsworth, Morgan, Hayes-Skelton, Roemer, & Suyemoto, 2016). We state that in the group discussion of our own identities, participants can use whatever language they prefer to define themselves (and this can be informed by, or in disagreement with, terms and definitions presented earlier) and that in the upcoming self-assessment there are options for both "checking a box" (or no box, or multiple boxes) as well as open narrative responses.

We then transition into a self-assessment exercise using a form based on the ADDRESSING framework in which individuals spend time (approximately 10 minutes) reflecting on how they identify within a range of social and cultural identities (Hays, 2016). Given the time constraints of this group, we provide participants with the option of focusing their reflection on two or three identities (although some patients are able to complete the entire acronym). For each identity category, group members are prompted to reflect on how this identity influences how they think, feel, and behave, how they believe this identity influences how others think, feel, and behave towards them, and how often they think about this particular identity (i.e., identity salience; our worksheet was adapted from an initial ADDRESSING framework worksheet developed by Ng & Rollins, 2016).

Finally, the last portion of the group focuses on reactions (thoughts, feelings, and behaviors) to completing this self-assessment exercise, and any ways that this information could inform treatment and CBT and DBT skill use specifically (e.g., cognitive restructuring, distress tolerance, interpersonal effectiveness, managing

avoidance). In this discussion we guide participants to consider if they experience certain identities as a source of stress, strength, neither or both; and whether they noticed any intersections between multiple identities (e.g., processes of intersectionality) that seem to "fit seamlessly" together and/or seem to cause tension, and how this could inform their experiences moving forward.

To end the group, we encourage participants to bring the ADDRESSING self-assessment to their individual BHP therapist and outpatient therapist to further facilitate broaching discussions of identity and to ideally inform relevant psychological skill practice. Although this next step is crucial to maximizing the benefits of the group, we have found that 50 minutes is often not enough time to fully introduce and discuss the integration of psychoeducation, self-assessment, and psychological skills—often the skills discussion is brief given the time constraint. Nonetheless, we provide preliminary guidance throughout the group regarding topics and/or treatment tools and strategies an individual may want to discuss with their other treatment providers related to identity-based stress and coping. Among many possible examples, a person may want to use distress tolerance and/or interpersonal effectiveness skills to manage an interaction with a coworker, family member, or treatment provider who unintentionally directed microaggression at them. Additionally, we focus on strategies to manage painful thoughts around experiences of discrimination where traditional cognitive restructuring could be invalidating and iatrogenic (e.g., Graham, Sorensen, & Hayes-Skelton, 2013).

For example, if a patient in group described an experience in which they felt marginalized because of an aspect of their identity, a culturally responsive strategy could be to explicitly validate the painful emotions associated with this real experience, acknowledge and further validate that we live in a world that can be oppressive, where these types of events occur, and focus any cognitive restructuring strategies not on the "truth" of the event but on any underlying thoughts the patient has about what the event means to him or her — e.g., "I don't deserve the same service in stores because I am [a member of X marginalized group(s)]." Finally, group members are asked to complete an anonymous feedback survey about the group.

Patient Feedback

Since the inception of this group at the BHP in November 2016 we have received positive, negative, and constructive feedback from patients directly, via their treatment providers, and through anonymous program development surveys. Approximately 20 patients attend the group every month with weekly group sizes ranging from 2 to 12 patients. Of these participants, 56 patients provided anonymous feedback via a quality-improvement measure. Approximately 67% of patients reported finding the group "helpful" or "very helpful." In addition, patients provided ratings of adherence to main group treatment objectives on a 5-point scale (e.g., introduce the ADDRESSING framework, apply these ideas to mental health treatment); these indicated that objectives were discussed "well" or "very well" (means ranged from 3.9 to 4.8 out of 5).

Examples of patient reflections during the group have been powerful and diverse. Examples include struggles with disclosing mental health diagnoses (especially bipolar spectrum disorders, thought disorders, and personality disorders) to family and friends due to stigma and the cultural beliefs their family and friends hold about people with mental health problems. Patients who identify as gender and/or sexual minorities have discussed struggles with the coming-out process, and how and when discussions of their gender or sexual identity should be integrated into mental health treatment. Participants also regularly bring up the intersection of gender and sexual identities with religious, spiritual, and ethno-cultural identities they grew up with (e.g., experiencing increased stress due to their community's specific beliefs about gender and sexuality). Patients of racial and ethnicity minority backgrounds have commonly discussed experiences of being in a predominantly White treatment environment (e.g., McLean Hospital). Some patients of racial and ethnic minority backgrounds have reported the group was affirming and helpful in broaching this observable truth, others have reported lower levels of comfort discussing issues of race and ethnicity with White clinicians and patients (including during the group itself).

Importantly, individuals with primarily historically privileged identities have also reported the group was helpful. For example, male patients have discussed feeling emasculated in receiving intensive mental health services, especially when it requires a leave from work and an inability to provide financially for their family. Additionally, although not the primary intention of the intervention, patients with multiple historically dominant identities (e.g., White, higher SES, able bodied) often reported experiencing feelings of guilt linked to awareness of the privileges they hold and often expressed a greater desire to advocate and support other patients who have had more experiences of identity-marginalization.

Although we did not conduct a formal qualitative study of patient experiences with the group, we did record patient feedback received directly or obtained through optional and anonymous exit surveys. We reviewed the comments, which appeared to reveal four general types of experiences with the group: (a) This was powerful, and I appreciated the opportunity to examine and integrate this aspect of my life into treatment; (b) I appreciated the opportunity to connect and learn more about the diverse experiences of fellow patients in the program; (c) This was interesting but I'm not sure how it is related to my treatment—I wish I had learned more specific skills to use moving forward; and (d) Identity is too complex to discuss in a single-session, I found this group frustrating.

Implementation and Sustainability: Successes and Lessons Learned

We have continuously adapted and shaped the group in response to patient feedback, which we continue to collect. In response to patient feedback item c above, we continue to aim to improve the clarity of the connection between the ADDRESSING framework and the patient's treatment at the BHP. Some adjustments we have made include adding a prompt early in the group asking patients why they think aspects of identity are relevant to their mental health, and what they are "working on" in the BHP. Second, we created another version of our handout to include more of the group content to further enhance patients' ability to continue this work on their own or with a therapist. Third, within the updated handout we added additional reflection questions, including "Does this identity impact your mood/mental health?" and "Considering this aspect of your identity, what is one action you could take going forward to positively impact your treatment/functioning/mood?" Fourth, we developed a skills flow chart aimed at guiding patients through how they might respond to stigma, implicit bias, and explicit bias, which can

be used in individual therapy, and may be integrated directly into the group in the future. These worksheets are available for free download at www.multiculturalpsychology.com.

Encouraged by the success of our group at the BHP, we met with additional hospital stakeholders about the possibility of expanding this group (or groups like it) outside of a single program. As of this writing, the group has been embedded within an adolescent DBT partial hospital program with expanded worksheets and exercises to accommodate a program with a longer average length of stage (i.e., 20 days). Expanded content includes a new pedagogical acronym developed by the first author (JPW) to build off of initial identity assessment and examine the psychological processes (i.e., "threats in the air"; see Steele, 1997; 2010) that may influence common processes of marginalization and oppression (MIST; microaggressions, implicit bias, stereotype threat, targeted identities). Additionally, "ADDRESSING Identities" groups have been launched or are in development in several other inpatient, residential, and outpatient programs. We have facilitated several staff trainings using a similar structure of the group by applying it specifically to how social and cultural identities influence individuals' roles at work. Furthermore, the McLean Hospital Dimensions of Diversity Committee has incorporated the ADDRESSING framework into events open to all hospital staff (e.g., panel speakers with facilitated small group discussions focused on particular aspects of identity) and the ADDRESSING framework was integrated into a Grand Rounds series dedicated to compassionate patient- and self-care. Efforts to further enhance the social and cultural identity makeup of staff in our program, at McLean in general, and within academic mental health more broadly, is, of course, a fundamental issue in providing cultural-responsive care and one that is both a current limitation and continued area for improvement and enhancement at our institution.

Although we have been fortunate that, in general, program staff have been very supportive of this new group and related initiatives, engaging in conversations about social and cultural identities with both patients and coworkers is always complex, often physiologically activating and anxiety-provoking, and not without its stumbles. We have continued to learn that increased comfort and confidence in delivering interventions that broach issues of

social and cultural identity move in parallel with clinicians' own ability to understand and interrogate their own intersectional identities, including experiences of both privilege and marginalization. Clinicians in earlier stages of various forms of identity development may likely be more resistant to—and experience more anxiety, frustration, and confusion over—delivering (or even seeing the value) interventions focused on such identities. Clinicians occupying historically privileged identities may commonly experience increases in guilt and shame as the depth of their own privileges become more salient and phenomena that they were "blindfolded" to become more apparent (for examples and further reading regarding White Racial Identity Development see Helms, 1992, 1999, 2014, 2017). Continued self-reflection, an open and humble willingness to learn, a desire to take strong emotional reactions and channel them towards anti-oppressive work, and thoughtful supervision is paramount to successful personal development and effective treatment delivery of culture-focused interventions. Furthermore, it is ironic that clinical psychology as a field has collectively developed some of the best exposure treatments to reduce maladaptive avoidance behavior, yet when we (the authors of this article included) broach issues of privilege, sexism, racism, and oppression implicit within out work, some of our own avoidance behaviors emerge. As with the patients we serve, we must work to understand the function of this avoidance and work to do better.

In line with this phenomenon of avoiding identity-based discussions in treatment, one challenge of integrating culturally responsive groups into treatment programs is that clinicians and administrative leaders sometimes fear this type of work will "open up" complex conversations that we cannot "solve" or will even "make things worse." It is true that our emotional distress may increase when we are pushed to expand our critical consciousness with regards to social and cultural identities. Important and fruitful discussions are sometimes uncomfortable: attending or facilitating a treatment group where members disagree about the definition of privilege; attending a staff training during which provocative questions are asked; receiving feedback that we used insensitive language; discussing a concept with a patient that the patient understands better than you do; talking about issues of power and marginalization with coworkers or your boss, etc. We believe, and the

research literature supports, that it is through continued empathic conversations about the most complex topics that our systems can become more culturally responsive, multiculturally affirming, and inclusive (see Sue, 2015). Remaining silent is a choice—one that reinforces how things are, not how they could be.

Continued Supervision, Consultation, and Training

In developing and implementing this group across sites at McLean Hospital, we learned that having thoughtful supervision specifically focused on social and cultural issues and culturally responsive treatment is essential for supporting clinicians who directly engage with these complex, and often activating, topics. As of December 2017, we started a Multicultural Psychology Consultation Team (MPCT; pronounced "m-pact") for clinicians leading these groups at McLean or aspiring to provide evidence-informed, culturally responsive treatment within the McLean system. Modeled after the DBT consultation team (see Linehan, 2015), the explicit goals of MPCT are to (a) support clinicians conducting culturally responsive mental health treatment, (b) foster a local network of clinicians and clinical leaders interested in multicultural processes in treatment, and (c) encourage innovation and dissemination of culturally responsive treatments at and beyond McLean Hospital. Similar to the DBT consultation team model, as a group we established guiding agreements (samples available at www.multiculturalpsychology.com) that inform our work and supervision. In addition to MPCT, one of us (TB), co-director of the McLean psychology internship program, supported the revamping and expansion of the psychology internship's multicultural psychology, diversity, and inclusion seminar series. Built into the 10-session seminar series (which JPW co-directed in 2017–2018 and JPW and LPW will be codirecting 2018–2019) is information about the ADDRESSING framework and didactic seminars discussing many of the identities within the acronym. The internship program also now includes more formal opportunities to observe, facilitate, and develop social and cultural identity-focused treatment group(s) at the hospital.

Conclusion

In summary, we sought to increase the cultural responsiveness of treatment at

McLean Hospital by (a) creating a single-session group intervention grounded in Hays' (2016) ADDRESSING framework to explicitly broach identity-related stress with patients and to determine initial accessibility and feasibility of such an intervention; (b) expanding this group into other treatment programs and adapting for use in staff trainings; and (c) creating further training, supervision, and consultation opportunities, including MPCT, for clinicians and researchers engaged in culturally responsive clinical work, research, and efforts to make and sustain social change at McLean Hospital. Future studies are now needed to evaluate the effects of this intervention and to identify potential mechanisms of action underlying any clinical improvements. Although we still have a long way to go, we are incredibly thankful for the patients and staff who have helped us to continue to improve the care that we provide and are hopeful that our experiences may provide some guidance for other clinicians, researchers, educators, administrators looking to enhance or improve the cultural responsiveness of their programs and systems.

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ABCT's Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.

2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.

3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Shona Vas at svas@uchicago.edu and include "Medical Educator Directory" in the subject line.

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this listing serve strictly in a volunteer capacity.

Access the directory:

abct.org > Resources for Professionals and Students > Teaching Resources

Nominations for ABCT Officers:
If Not You, Who? Run for ABCT Office!

David Pantalone, *Chair, Leadership and Elections Committee*

FOR ME, LIKE SO MANY OF YOU, ABCT is one of my most treasured professional homes. Indeed, I think of the Annual Convention as my "CBT family reunion" and spend months looking forward to connecting with new colleagues, and seeing old friends, every year. For many years, I thought of the elected leaders of the organization as "others," some rarefied CBT deities with magical leadership powers. However, over time—as I have interacted with them more, and as friends and colleagues ascended into those roles—I realized that those individuals are not some qualitatively different type of human but, indeed, are just "us"—but the "us" from among the membership who have chosen to step forward and make a public commitment to give their time, energy, and effort to this organization that we value so dearly (OK, arguably, some may actually have magical leadership powers, but that is definitely not a prerequisite).

This column signals the time of year when our committee, the Leadership and Elections Committee, begins its task of recruiting members to fill the slate of nominees for elected offices. I have met so many smart, dedicated, and committed members of ABCT, and many of them already serve in leadership roles in their practices, their academic departments, or in other professional organizations (which shall not be named). I encourage you to think about whether you might be in a position to run for one of these elected offices or, if not this year, whether you can think of any of the "us" among the membership who might be well-suited for that task.

There are many reasons why extremely qualified members might count themselves out from pursuing elected office at ABCT. Some members might be concerned about the time commitment being too great, or they might be concerned that they know too little about the governance structure of the organization. Others may worry, as I once did, that leaders require some greater skill and knowledge than we possess. To that end, I would encourage anyone in that position to engage heartily in some reality testing, or to be in touch with any of the Leadership and Elections Committee members, any of the current or former elected leaders, or the organization's Executive Director, Mary Jane Eimer. I am certain that any of us would be happy to talk through any member's potential candidacy with them (and the chances are that you are ready before you think you're ready).

For the 2019 election, we are recruiting for the President-Elect (2019–20; President, 2020–21; Immediate Past President, 2021–22) and for a Representative-at-Large (2019–22). Each of the Representatives-at-Large serves as a liaison to one of the branches of the association. The representative position up for 2019 election will serve as the liaison to the Academic & Professional Issues Coordinator and Committees.

All full members in good standing are eligible to be nominated, and there is no limit to the number of members you can nominate for any of the positions. According to ABCT's bylaws, we require two candidates for President-Elect and three candidates for Representative-at-Large to successfully run the election. Electioneering starts at the Annual Convention. So, if you have a candidate in mind, or wish to nominate yourself, start the campaign now with the nominations and go to the Annual Convention and start making your case to the electorate. Remember, the candidates with the most nominations will ultimately be the only official names on the ballot: two for President-Elect and three for Representative-at-Large.

The Board of Directors–approved Leadership and Elections Committee includes a chair and two members, each serving concurrent 3-year terms (2016–19). The Chair is David Pantalone (david.pantalone@umb.edu), from the University of Massachusetts Boston. The members are Patricia DiBartolo (pdibarto@smith.edu), of Smith College, and Kristen Lindgren (kpl9716@u.washington.edu), of the University of Washington School of Medicine.

One of the goals of the committee is to increase participation in the election process and, to that end, we are considering ways to further streamline the nomination and election process. Please know that such efforts are under way and, if you have any feedback or ideas, please don't hesitate to share them with me.

I nominate the following individuals:

▶ **PRESIDENT-ELECT (2019–2020)**

_____

_____

▶ **REPRESENTATIVE-AT-LARGE (2019–2022)**

_____

_____

_____

▶ **NAME (printed)**   **SIGNATURE**

_____

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2019, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years.Only full and new member professionals can nominate candidates. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Complete, sign, and send form to: David Pantalone, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 *or* FAX to 212-647-1865 *or* scan form as PDF and email to membership@abct.org

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Megan Cowie

Full
Diana Agudelo
Kevin Ashworth
Jacob Austin
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Melanie Biggs
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Christy Call
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Janet Campbell
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Richard Daigneault
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Elizabeth Eber
William Ellison
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Alexander Daros
Laura Frame
Maria Kambouras
Shraddha Kashyap
Stephanie Mager
Adam Mandel
Evgenia Milman
Emily Neger
Marc Puccinelli
Robin Sax
Christina Stiff
Courtney Walker
Emily Wolodiger

New Professional 2
Malak Abu Shakra
Nicole Hollingshead
Jeremy Jinkerson
Adam McGuire
Iona Naismith
Alyssa Norris
Meredith Ronan
Hannah Tyler
Shawna Ueyama
Brittany Williams

New Professional 3
Yulisha Byrow
Ateka Contractor
Deborah Ohm
Kelsey Sewell

Postbaccalaureate
Bridget Beggs
Allyson Blackburn
Grace Carter
Shreya Chadda

Simone Chad-Friedman
Madeline DeShazer
Katrina Farris
Christina Felonis
Olivia Fitzpatrick
Martina Fruhbauerova
Jordan Harris
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Rashed AlRasheed
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Arianna Delgadillo
Ecem Demirli
Mary Elsharouny
Sarah Ely
Aubrey Faber
Larissa Farah
Ryan Ferguson
Amanda Ferriola
Georgette Fleming
Samantha Fradkin
Sara Franklin-Gillette
Laura Frazee
Kyle Frost
Carly Geller
Cara Genbauffe
Holly Gerber
Isabel Ghisolfi
Samantha Glickman
Neha Goel
Annika Goldman
Leo Gonzalez
Morgan Hagner
Alaina Hanke
Madeleine Hardt
Sarah Hartmann
Cara Herbitter
Alexandra Hernandez-
  Vallant
Andrea Hill
Joel Hoffman
Claire Hsieh
Anna Hukill
Teresa Hulsey
Ciara James
Ashley Jennings
Lily Jiang
Hallie Johnson
Amanda Johnson

Lauren Johnson
Prasad Joshi
Nechama Kaiser
Ashley Kaufman
Hae-Joon Kim
Emily Kline
Evdokiya
  Knyazhanskaya
Jennifer Kramer
Lynette Krick
Megan Lanier
Jennifer Lent
Astrid Leth-Nissen
Erin Libsack
Vanessa Litoff
Raelyn Loiselle
Daisy Lopez
Kayla Lord
Naoise Mac Giollabhui
Maggie Manning
Emily Mariotti
Ana Martinez
Emma McBride
Chandler McDaniel
Merranda McLaughlin
Erin McLean
Daniel McNeil
Maha Mian
Melanie Midkiff
Izabela Milaniak
Cassidy Miles
Anna Milgramm
Rebecca Miller
Christopher Miller
Kaho Mitsuishi
Robert Montgomery
Da Yeoun Moon
Danielle Morabito
Nora Mueller
Alexa Myers
Michael Namekata
Cecelia Nelson
Kiturah Neppl
Jingwen Ni
Hannah Nordberg
Derek Novacek
Melise Ouellette
Mikayla Pachkowski
Sarah Palasick
Alyssa Pallo
Lauren Pascarella
Zabin Patel
Ainsley Patrick
Alisa Payne
Cameron Perrine
Lauren Peterson
Angela Pisoni

call

53rd Annual Convention
November 21–24, 2019 | Atlanta, GA

for **ticketed sessions**

Submissions will be accepted through the online submission portal, which will open after January 1, 2019. Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on "Convention and Continuing Education."

Please submit through the Cadmium portal.

Workshops & Mini Workshops

Workshops cover concerns of the practitioner/ educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than 4 presenters. Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than 4 presenters. When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

For more information or to answer any questions before you submit your abstract, contact **Lauren Weinstock, Workshop Committee Chair, workshops@abct.org**

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than 4 presenters.

For more information or to answer any questions before you submit your abstract, contact **Christina Boisseau, Institute Committee Chair, institutes@abct.org**

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday. Please limit to no more than 2 presenters.

For more information or to answer any questions before you submit your abstract, contact **Courtney Benjamin Wolk, Master Clinician Seminar Committee Chair, masterclinicianseminars@abct.org**

Research and Professional Development

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

For more information or to answer any questions before you submit your abstract, contact **Cole Hooley, Research and Professional Development Chair, researchanddevelopmentseminars@abct.org**

Submission deadline: *February 1, 2019*

Call *for* Award Nominations

to be presented at the 53rd Annual Convention in Atlanta, GA

The ABCT Awards and Recognition Committee, chaired by Cassidy Gutner, Ph.D., of Boston University School of Medicine, is pleased to announce the 2019 awards program. Nominations are requested in all categories listed below. Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, Marsha Linehan, Dianne L. Chambless, Linda Carter Sobell, and Mark B. Sobell. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2019ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line.
Nomination deadline: March 1, 2019

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, the Charleston Consortium Psychology Internship Training Program, and the Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University. Please complete the on-line nomination form at www.abct.org/awards. Then e-mail the completed form and associated materials as one pdf document to 2019ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. **Nomination deadline:** March 1, 2019

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent recipients of this award include Mark S. Bauer, Vikram Patel, Benedict Carey, Patrick J. Kennedy, and Joel Sherrill. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2019ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line.
Nomination deadline: March 1, 2019

Outstanding Clinician

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, Jacqueline Persons, Judith Beck, and Anne Marie Albano. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to 2019ABCTAwards@abct.org. Include "Outstanding Clinician" in the subject line.
Nomination deadline: March 1, 2019

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize of $1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Applicants should submit: nominating cover letter, CV, personal statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to 2019ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line.
Nomination deadline: March 1, 2019

Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2018. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the nomination materials (including letter of recommendation) as one pdf document to 2019ABCTAwards@abct.org. Include candidate's last name and "Student Dissertation Award" in the subject line. **Nomination deadline:** March 1, 2019

President's New Researcher Award

ABCT's 2018-19 President, Bruce Chorpita Ph.D., invites submissions for the 41st Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field.
Requirements: must have had terminal degree (Ph.D., M.D., etc) for at least 1 year but no longer than 6 years; must submit an article for which they are the first author; 3 letters of recommendation must be included; self-nominations are accepted; the author's CV, letters of support, and paper must be submitted in electronic form. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org. Include candidate's last name and "President's New Researcher" in the subject line. **Nomination deadline:** August 1, 2019

Nominations for the following award are solicited from members of the ABCT governance:

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to 2019ABCTAwards@abct.org. Include "Outstanding Service" in the subject line.
Nomination deadline: March 1, 2019

Friday, 5:30–6:30 p.m., Delaware A & B *Congratulations to ABCT's 2018 Award Winners*

AWARDS & RECOGNITION

Lifetime Achievement
Linda Sobell, Ph.D., ABPP, & Mark Sobell, Ph.D., ABPP

Outstanding Mentor
Ricardo Muñoz, Ph.D.

Midcareer Innovator
Shannon Wiltsey Stirman, Ph.D.

Outstanding Service to ABCT
Former *Behavior Therapy* Editors
Richard G. Heimberg, Ph.D., Thomas H. Ollendick, Ph.D.,
and Michelle G. Newman, Ph.D.

Distinguished Friend to Behavior Therapy
Joel Sherrill, Ph.D., Division of Services and Intervention
Research, NIMH

Anne Marie Albano Early Career Award
Joseph McGuire, Ph.D.

Virginia Roswell Student Dissertation Award
Gabriela Khazanov, Ph.D.

Leonard Krasner Student Dissertation Award
Eric Lee, M.A.

John R. Z. Abela Student Dissertation Award
Joanna Kim, M.A.

President's New Researcher
Ryan Shorey, Ph.D.

Student Research Grant
Laurel D. Sarfan, M.A.
HONORABLE MENTION: Daniel P. Moriarty

ADAA Travel Awards
Shannon Blakey, M.S.
Martha Falkenstein, Ph.D.