the Behavior Therapist

special issue Diversity & Inclusion

Co-Editors: Kate Wolitzky-Taylor, Richard LeBeau, Angie Moreland, Monnica Williams

PRESIDENT'S MESSAGE

Gail S. Steketee, *Boston University*

IT IS AGAIN MY PLEASURE to write to you, this time to introduce our next *tBT* special issue on diversity. Editor Kate Wolitzky-Taylor has done a fine job of putting together this special issue, which covers the topic of diversity broadly, just as we hope many of you will do in your submissions for the 51st ABCT Annual Convention in San Diego. You can find the open portal at http://www.abct.org/Conventions/?m=mConvention&fa=dConvention (**note:** the deadline is March 15).

Accordingly, this March issue tackles:

- Increasing recruitment and retention of members of underrepresented minority groups in academia and science fields
- Culturally sensitive assessment and treatment
- Evidence-based treatment adaptations and models for underserved populations (for example, Spanish and other language speakers, refugees, LGBTQ populations, racial and ethnic groups, etc.)
- Clinical and ethical issues following the 2016 election.

This is a perfect fit for the upcoming conference, and I hope it will spark a myriad of ideas on these topics. Kate Wolitzky-Taylor has done an impressive job of introducing this special issue, so I will simply comment from my own perspective on these excellent topics.

In fact, the field has been working on recruiting and retaining underrepresented minority faculty and scientists for many a

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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.

decade now. Where are we in this effort? Making progress, I think, but with quite a ways to go. I watch my own Boston University "wake up" and begin to work much harder in the last few years to diversify our faculty and student bodies. I'm aware that some of the impetus for this work is an effort to meet standards set by organizations that rank institutions of higher education on these issues. This is a good thing—laws, regulations, and watchdog expectations have always moved us forward when we have difficulty motivating ourselves to do what we know deep down is right and just.

In this same vein, I watch myself be proud that this year our faculty and I, as their dean, were very fortunate to have successfully recruited two faculty members from underrepresented groups in academia, both African American, both terrific young scholars. We worked hard on this and have a right to be pleased, but even as I do this, I am trying to understand my own racism and find it hard work. I watch my behavior— What I am doing wrong or right? What's too much or not enough? When am I being just too sensitive? Even as I write this, I noticed myself deciding not to write "African American" as the primary modifier of "faculty," because in fact, these new faculty members whom I am just beginning to know are so much more than just "African American faculty members." They are very different from each other in the focus of their research, in personality and communication style, in family background, in geography, in gender, and on and on. I only hope I will come to know them much better over time, to appreciate their uniqueness and their commonalities with their many faculty colleagues. I'm sad that I will retire well before they are truly launched in their faculty roles. Ours is a lifelong journey to understand our relationship with race and ethnicity. I wish us all the best in navigating complicated territory—somehow we will make progress and I hope we have some good laughs and cries along the way.

On the topic of culturally sensitive assessment and treatment, as a researcher who has developed and tested both assessments and interventions for OC spectrum conditions, I'm keenly aware that one size does not fit all, even for White clients/patients who populate many of our studies. For our future, my hope is that our recruitment efforts become more skilled in order to yield a wider variety of participants whom we can better serve. We will need to attract large numbers of specific subgroups to identify best assessment and intervention strategies for them. I know we have more and more researchers and clinicians working on this challenge. Sometimes it seems overwhelming—there are just so many demographic variations and this will only become more complex in the future. But gradually we will get more skilled at finding the best way to alleviate mental health problems among those who most need our help. Again, I wish us all the best in navigating complicated territory.

As for the clinical and ethical issues mental health professionals face following the 2016 presidential election, no matter how we voted or what we believe, we must remain sensitive to the wide variations in our clients' reactions to this election. Many people reacted with anxiety, frustration, depression and other negative emotions, even as supporters responded with joy and anticipation. But this campaign was divisive on a level we have not seen before. As I write this 2 weeks after the inauguration, I am heartened by the impressive activation of citizens in the form of marches, legal challenges, and advocacy in favor of the values on which our country was founded and that are integral to our professional ethical standards. Among these for clinical psychology are beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. For social workers, the list is very similar: service, social justice, dignity and worth of people, importance of human relationships, integrity and competence. It is my great hope that as Americans and as mental health professionals, we will work harder than ever to combat racism, homophobia, misogyny, and the many forms of intolerance that cause so much mental and physical harm to so many vulnerable people. Now is the time for us all to stand up for what we hold dear and what we know to be true.

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Introduction to the Special Issue on

Diversity and Inclusion

Kate Wolitzky-Taylor, *UCLA*

Monnica Williams, *University of Connecticut*

Angie Moreland, *Medical University of South Carolina*

Richard LeBeau, *UCLA*

LIKE MANY FIELDS, clinical psychology and related mental health professions have historically received their fair share of criticism for the underrepresentation of women and minorities in academic positions and positions of leadership. In addition, the alarming mental health disparities that exist in our health care systems and lack of understanding about how to adapt, refine, and develop evidence-based assessment tools and interventions for underserved populations is a critical, ongoing problem. Over the past several years, researchers, academic leaders, clinicians, patients, and patient advocates have made great strides toward increasing awareness of and addressing these deficits. For example, more attention has been paid to gender equity and racial/ethnic diversity in academic and professional settings, cultural competency training in graduate schools is now a standard part of curricula (and required for APA-accredited clinical psychology Ph.D. programs and ACGME-accredited psychiatry residency programs), and some evidence-based interventions have been adapted and evaluated for some minority groups.

ABCT and its members have supported the value of inclusion in clinical research and training, and have taken strides to support and encourage inclusion throughout their mission. Notably, of the two short paragraphs in the ABCT mission statement, one of those paragraphs relates exclusively to its support of gender and minority equality. ABCT and its members have demonstrated growing interest in these topics, as evidenced by recent webinars about cultural competency, seven SIGs that focus on issues specific to an underserved group, publication of articles related to access and equity in *the Behavior Therapist* over the years, and several symposia and panels at the annual conference related to these themes. The chosen theme of the 2017 ABCT Annual Convention, "Applying CBT in Diverse Contexts," also sends a message that the ABCT community values the importance of understanding and optimizing the utility of cognitive and behavioral therapies in diverse contexts and with diverse populations. We applaud these efforts, which have enhanced the organization.

Issues of access and equity in the context of mental health professions, treatment, research, and policy deserve our attention. To continue to raise awareness of these topics, we present to you this special issue focused on these themes. During the 2016 presidential election season, many of us reflected on issues of racial equality, religious freedom, women's and LGBTQ rights, discrimination, privilege, and the rights and protections relating to mental health care more than usual, as these were at the forefront of the campaign. Thus, this issue is incredibly timely.

Here we present 11 excellent articles on a broad range of topics related to our overarching theme of diversity. This theme is divided into three sections: Diversity in Academic and Clinical Settings; Clinical Considerations When Working With Minorities; and Addressing Mental Health Disparities: Applications and Recommendations. We wish to point out that several of these articles are written by leaders in minority mental health research, whereas others are written by those with other primary areas of research interest. We mention this to highlight that, although the field needs researchers and clinicians specializing in minority mental health to serve as experts in this area, we can all commit to incorporating these topics in our research and clinical programs. In fact, we know there are many more ABCT members doing excellent work in these areas. We welcome you to submit manuscripts to *the Behavior Therapist* showcasing your work that addresses mental health disparities or academic and professional disparities.

We extend our sincere gratitude to all of the authors who contributed to this special issue. As you read this collection of reviews, opinion and recommendation pieces, and empirical articles, we hope you will find it to be informative, thought-provoking, and useful for your academic, research, and clinical endeavors.

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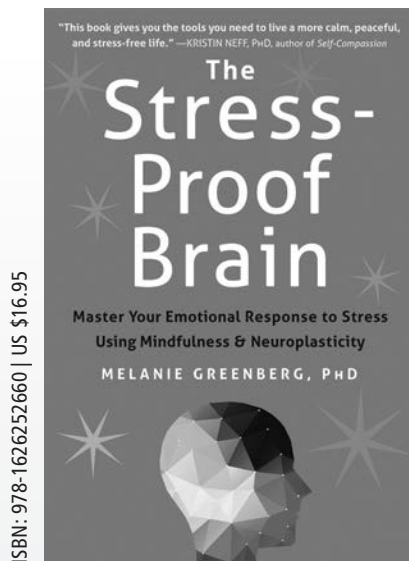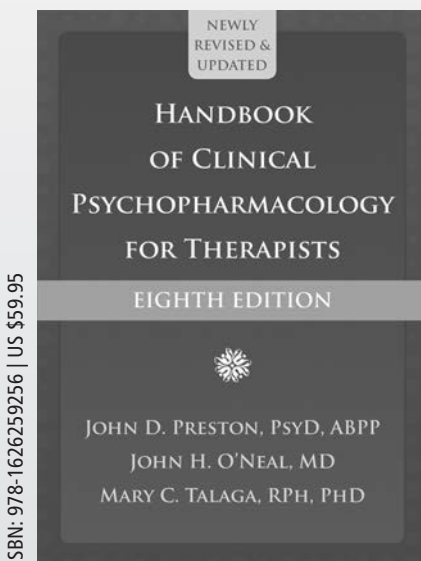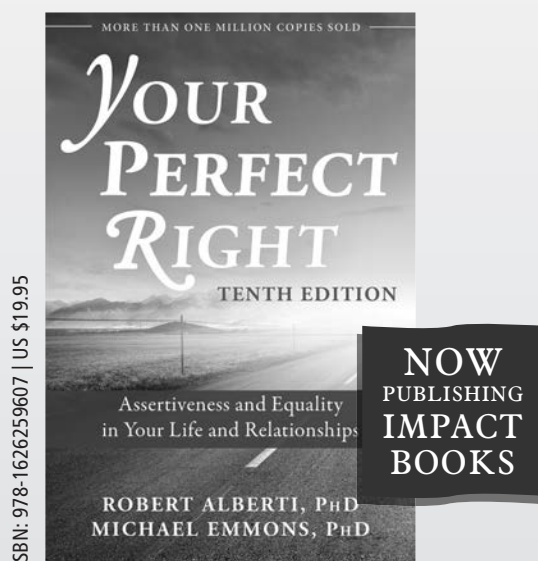
Diversify and Conquer: A Call to Promote Minority Representation in Clinical Psychology

Catherine E. Stewart, Sharon Y. Lee, Anders Hogstrom, and Monnica Williams, *University of Connecticut*

What Is the Problem? Why Should We Care?

The current racial makeup of the psychology workforce reflects systemic barriers to becoming a clinical psychologist. In 2013, the U.S. Census Bureau reported that 83.6% of active psychologists were White (U.S. Census Bureau, 2005–2013), which is consistent with the American Psychological Association's (APA) report that 81% of their Society of Clinical Psychology members in 2015 were White (APA, 2015). APA members identifying themselves as Asian, Hispanic, or Black each comprised between 2–3% of the membership. Multiracial and American Indians each represent less than 1% of members and the remaining member identities were not specified. According to the U.S. Department of Education's most recent statistics, 78% of full-time faculty at colleges and universities were White, and 84.1% of psychology faculty members were White (National Center for Education Statistics, 2008, 2016). In 2016, when ABCT members were asked to select a category describing their racial and ethnic background, 75.9% selected White (T. Schuler, personal communication, December 15, 2016). In 2013, approximately 37% of psychology bachelor's degrees were conferred to students of color and 28% of Ph.D. degrees in psychology were awarded to students of color (National Center for Education Statistics, 2014a, 2014b), indicating a notable disparity in the representation of individuals majoring in psychology versus pursuing a career in clinical psychology. The underrepresentation of racial/ethnic minorities in the field is maintained by multiple factors that influence individuals, institutions, and organizations.

Increasing diversity is critical from the perspective of mental health treatment. People of color in the United States experience increased rates of some mental health problems, such as PTSD, that are further exacerbated by race-based stress (Carter, 2007; Jackson et al., 2004). Among individuals with access to evidence-based mental health care, people of color face greater barriers and utilize fewer services than their White counterparts (Alegria et al., 2002; Gary, 2005; Kataoka, Zhang, & Wells, 2002). Treatment is less likely to be evidence-based and more likely to be delivered by a non-mental-health clinician for treatment-seeking individuals of color (Sue & Zane, 2006; Young, Klap, Sherbourne, & Wells, 2001). Furthermore, ignoring cultural differences in assessment and treatment may contribute to increases rather than decreases in symptoms. Evidence suggests that adopting a colorblind approach and ignoring issues related to race and ethnicity contribute to greater racial bias and negative affect in Whites, as well as higher rates of internalizing symptoms in people of color (Constantine, 2007; Holoien & Shelton, 2011; Richeson & Nussbaum, 2004).

Additionally, clients of color may prefer a clinician of the same race, based on their own stage of ethnic identity development and cultural needs (Flicker et al., 2008; Pole, Gone, & Kulkarni, 2008). Therefore, it is necessary to increase the number of therapists of color as well as to continue promoting cultural competence among all psychologists.

What Caused and Is Maintaining the Problem?

The field of psychology has been impeded in its effort to diversify both its leadership and its client base. One explanation for this lack of diversification points to automatic cognitive biases on individual and systemic levels. Due to the automaticity of these biases, they often go unexamined and affect the way psychologists grow the field and the profession. Research has shown that even when people of color overcome logistical barriers to mental health care, such as insurance coverage, therapists are unwittingly more likely to select White clients (Kugelmass, 2016; Shin, Smith, Welch, & Ezeofor, 2016). This bias further encumbers access to people of color in need of services.

Bias also greatly affects all levels of the education system. Because of the structure of locally funded public schools and racial/socioeconomic segregation, a White student receives on average $334 more per year in recourses than a student of color (Spatig-Amerikaner, 2012). This difference in funding translates into differential quality of education for Black and White students (Hanushek, 2001). A related hurdle is the inherent privilege required to enter a clinical psychology doctoral program. Access to such programs is contingent on access to prior educational institutions (e.g., attendance at competitive colleges), financial resources (e.g., fees for the Graduate Record Examinations and applications), and mentorship (e.g., sympathetic faculty who support students' professional development).

Ethnic/racial minorities tend to be at a disadvantage on all these dimensions. Pathological stereotypes, such as assuming that Black males on a college campus are criminals rather than students, hamper the efforts of minority students to access and feel belongingness in the ivory tower (Smith, Allen, & Danley, 2007). This may be one reason that minority students are less likely to attend a 4-year college and when they do, tend to drop out at disproportionate rates (Camera, 2015). With respect to financial means, minorities tend to have lower incomes compared to Whites and therefore are pressured to secure employment rather than sit out of the workforce for years while finishing a doctorate (with the exception of some Asian groups; Proctor, Semega, & Kollar, 2016). Concerns about employment are particularly salient for people of color, who experience higher rates of poverty; Whites have the lowest poverty rate (9.1%) compared to Blacks (24.1%), Hispanics (21.4%), and Asians (11.4%).

Finally, minorities may receive inadequate mentorship from members of the dominant society that reifies pathological stereotypes (e.g., encouraging a Hispanic student to seek blue-collar work rather than graduate education) or lacks necessary sociocultural support (e.g., failure to understand why a gay Black student has hesitations applying to programs in the rural South). Recent research by Milkman and colleagues (2014) illustrates that university faculty are more receptive to mentoring White male students compared to students from other groups, suggesting that entry into academia's informal pathway is made particularly challenging for students of color.

Essentially, these race-related cognitive biases are influencing psychologists' ability

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to provide mental health care as well as opportunities to diversify the field. By continuing to ignore or passively enable these biases, the individual and systemic decisions made by psychologists will continue to reflect these biases.

What Needs to Happen to Fix the Problem?

Academia

To address these systemic barriers, psychology programs and organizations should take meaningful steps to increase diversity at all levels. Hiring faculty from different cultural backgrounds and faculty who research diversity issues is imperative. The strong presence of diverse faculty implicitly communicates to potential graduate students of color that programs welcome them. As a consequence, more minority graduate students are likely to apply and be accepted into these programs. While having culturally similar mentors in psychology could benefit many undergraduate and graduate students of color, the paucity of minority psychologists makes this a chicken-or-egg problem. Therefore, White faculty will need to start mentoring more students of color if we expect to increase the diversity in our field.

With respect to academic training, faculty must discontinue teaching from a "colorblind" approach that ignores the intersection of race, ethnicity, gender, and culture in psychopathology (Terwilliger, Bach, Bryan, & Williams, 2013). By being champions of a more complex and integrated view of our clients and research participants, faculty can set an example for graduate and undergraduate students in terms of encouraging research from a multicultural perspective and fostering connections with different populations via psychotherapy (Miller et al., 2015).

Working With Diverse Groups

The study and application of clinical psychology requires recognizing the inherent diversity of the human experience. To adequately understand behavior and dysfunction, we must consider the individual's culture, which incorporates race, ethnicity, language, religion, gender, sexual orientation, and other aspects of identity (Kagawa-Singer, Dressler, George, & Ellwood, 2015). One important way to promote diversity within psychology and strengthen the quality of the mental health care is to increase the diversity of mental health providers, educators, and researchers.

One important step is removing barriers to accessing psychological services for minority individuals. Common psychological treatments are often constructed by and for White individuals (Hays, 2009). The development of culturally sensitive interventions has been a slow process, in part because White psychologists have tended to undervalue (or not study at all) how cultural differences impact treatment outcomes (Williams, Tellawi, Wetterneck, & Chapman, 2013). As a result, psychologists of color have often had to complete this research on their own. This phenomenon is sometimes dismissed as "me-search" by White psychologists, many of whom ironically fail to recognize that by focusing their own research on White samples, they too are engaging in "me-search" (Ray, 2016). The stakes are high: If an individual from a minority group encounters culturally insensitive therapies or hears about aversive experiences from peers of the same cultural background, they may believe that psychotherapy is an unwelcoming practice and may not pursue services. Therefore, it is important that all psychologists are trained in culturally sensitive intervention methods not only for therapeutic effectiveness (a worthwhile goal in and of itself), but also to demonstrate that psychology is an inclusive field.

Those with the highest unmet need for clinical psychologists' services are best addressed with culturally competent and diverse practitioners. In clinical work as in life, individuals draw from their own experiences to understand individuals who present to them, and this is especially true in clinical interviewing (Granger, 2002; McKinnon, 2016). When clinicians have similar racial/ethnic backgrounds or experiences, this limits the degree to which they are able to understand their clients. Psychology as a field has a history of predominantly White practitioners and clients. To credibly portray that psychological interventions have the potential to help a more diverse group, psychology needs to demonstrate this in the expert clinicians and academics the field graduates who are developing interventions (DeLapp & Williams, 2015).

Mentorship and Organizational Involvement

It is also critical for currently practicing clinical psychologists from minority backgrounds to serve as mentors for the current generation, to both demonstrate the possibility of this career path and to offer emotional and practical support for overcoming the myriad of obstacles that minority

individuals face in higher education. Within psychology there is a drop in the percentage of students of color between the undergraduate and graduate levels of study (National Center for Education Statistics, 2014a, 2014b). Psychology faculty can become more aware of their own racial biases when making decisions about undergraduate student mentees, research assistants, and graduate students.

Professional organizations, such as ABCT, have a unique responsibility to ensure representation of members from diverse groups, promote the training of culturally competent evidence-based clinicians and clinical supervisors, and encourage research that is relevant to clients of diverse backgrounds. To increase and diversify member involvement, organizations can provide resources that will benefit a broader array of trainees, clinicians, and client populations. Academic journals that are sponsored by an organization can make concerted efforts to report ethnoracial demographics in papers and publish research that features diverse samples or examines cultural issues, such as this issue and past issues of *the Behavior Therapist*, as well as those of *Behavior Therapy* and *Cognitive and Behavioral Practice*. Such research on diverse populations is necessary to develop therapies for all clients, yet in one mental health organization's flagship journal (*Depression and Anxiety*) over a 16-month period of 127 articles published, 53.5% did not report any demographic ethnoracial information at all (Smith, Davis, & Williams, 2013). These omissions limit our understanding of psychopathology in diverse groups. Additionally, featuring panels and presentations at scientific conferences about the diversity gap in our field will continue to promote greater awareness and brainstorming for solutions.

Making these types of changes is easier said than done. While the modern American social and political climate purports to value diversity and inclusion, individuals continue to hold implicit biases which are often difficult for them to identify but may have large social impacts (Greenwald, Banaji, & Nosek, 2015). Perhaps as a result of this cultural shift away from explicit racism, White individuals (who continue to be overrepresented in political office; Krogstad, 2015) are often uncomfortable discussing the ways in which they perpetuate systemic inequality. In fact, many White individuals are uncomfortable even acknowledging that systemic racial

inequality still exists at all (DiAngelo, 2011).

Until privileged individuals acknowledge inequality as a current important problem, change will continue to be slow. Based on the most recent presidential election, many Americans do not prioritize treatment of minorities as a key issue when considering a candidate (Pew Research Center, 2016). This suggests that Americans as a whole may not be receptive to making changes to benefit minority individuals; this election has demonstrated that many Americans are comfortable at least overlooking racially charged rhetoric (not to mention the potential appeal of this rhetoric to many).

Notable Progress So Far

Despite these barriers to progress towards cultural competence and a multicultural view, some notable progress has been made. The APA's continued emphasis on cultural diversity in training programs is a promising avenue for addressing these lapses in the field. Although not yet uniformly implemented, current APA accreditation requires cultural competence and diversity in all training areas for students and efforts to maintain a diverse faculty and student body (APA, 2016).

ABCT's 51st Annual Convention Theme is "Applying CBT in Diverse Contexts" and aims to highlight research, clinical work, and training (ABCT, 2016a). ABCT maintains active special interest groups specifically for racial and ethnic minority groups. This includes African Americans in Behavior Therapy, Asian American Issues in Behavior Therapy and Research, Hispanic Issues in Behavior Therapy, and Native American Issues in Behavior Therapy and Research (ABCT, 2016b). Ethnic/cultural diversity is one topic area that can be selected by all podium presenters. Presenters at the most recent Annual Convention selected a total of 1,897 topic areas, with ethnic/cultural diversity was selected as a topic area 37 times out of 1,897 by presenters (T. Schuler, personal communication, December 14, 2016). ABCT as an organization, as well as clinical psychology as an entire field, is taking steps to demonstrate that diversity is important as a topic for research and clinical practice, and representation of diversity among psychologists in our field is a worthy goal.

Conclusion

While notable progress has been made, there is a clear gap in ethnic and racial diversity within psychology. It is critical to continue to address the lack of diverse members within our field in order to accurately reflect the population of U.S. and improve treatments. It is vital that privileged individuals within the clinical psychology structure and the broader American culture recognize the influence of culture and commit to working to address systemic barriers to education, access, treatment, and professional opportunity.

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The Gap in Leadership Training for Scientists From Underrepresented Groups

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INCREASING DIVERSITY in Science, Technology, Engineering, and Mathematics (STEM) and biomedical fields is recognized as a critical national issue, yet African-Americans, Hispanic/Latinos, and Native Americans still remain chronically underrepresented (Ginther et al., 2011; National Institutes of Health, 2012; National Science Foundation, 2010). The obstacles that impact their advancement can likely be found at every stage of career development. Much attention has been placed on increasing interest in the sciences by underrepresented minorities (URM) prior to graduate training. Newly minted initiatives are also studying the factors that impede forward mobility in the sciences during graduate and postgraduate training. However, little to no emphasis is placed on the equally crucial latter stages of career development where budding scientists are poised to become academic, industry, and community leaders and mentors.

A range of efforts and funding have been committed to increasing the success of URM students and scientists (National Research Council Committee for the Assessment of NIH Minority Research Training Programs, 2005). In particular, specific emphasis has been placed on increasing the career development pathways of individuals from URM backgrounds pursuing STEM and biomedical degrees through outreach and support programs that are primarily institution-based and generally lack a national presence or coordinating body. Progress with such interventions has been slow. In response, significant funding has recently been committed by the National Institutes of Health to support programs such as Building Infrastructure Leading to Diversity (BUILD) and the National Research Mentoring Network (NRMN). The BUILD initiative is an experimental program aimed at understanding how to best prepare students for Ph.D. training in order to curb attrition. BUILD concurrently aims to positively impact faculty development and institutional development. NRMN aims to establish a single, nationwide consortium of scientific leaders across a range of bio-medical disciplines who will serve as external mentors for undergraduates, graduate students, postdoctoral scholars, and early career faculty from diverse backgrounds. A complementary component to these two initiatives is the Coordination and Evaluation Center (CEC), which conducts a longitudinal, consortium-wide evaluation of the efficacy of the training and mentoring approaches, developed by BUILD and NRMN awardees. Over time, the data will impact mentoring and training programs and methodologies across the country.

Although the BUILD and NRMN programs are addressing vital components of increasing URM STEM career initiation and early success, less emphasis has been placed on fostering leadership development of URM scientists, particularly those who are professionals already positioned in roles where they may have a compounded impact. To this point, significant investments have been made in the way federal and organizational funds to attract URMs into science career tracks. The Leadership Alliance, National Institutes of Health, Research Initiative for Scientific Enhancement, Federation of American Societies for Experimental Biology, Annual Biomedical Research Conference for Minority Students, Hispanic Association of Colleges and Universities and other entities have actively encouraged diversity within academic tracks. However, little emphasis is placed on supporting these individuals professionally after the undergraduate and graduate training period. Even less effort is made to track and analyze the impact of these interventions and professional development programs. Individuals from underrepresented backgrounds may have unique obstacles to overcome in pursuit of leadership positions, such as nontraditional educational histories, significant family and community obligations, and less developed professional networks (Kachchaf, Ko, Hodari, & Ong, 2015; Grossman & Porche, 2014; Ong, Wright, Espinosa, & Orfield, 2011). However, few programs have been carefully constructed to address these issues. We developed a qualitative survey to assess knowledge of leadership development programs among URM scientists. The purpose of the 6-question survey was stated at the onset: learning more about existing leadership programs for the career advancement of URMs in STEM fields. The questions then measured the participant's awareness of such programs. Out of approximately 50 responses from a broad group of URM scientists at varying career stages, the Society for the Advancement of Chicanos and Native Americans in Science Summer Leadership Institute (SLI) was the only national leadership development program specifically targeting URM scientists. SLI prepares participants to assume leadership roles in the global scientific community by offering advanced strategic trainings that develop critical leadership skills through didactic lectures, networking exercises, and formation of a leadership development plan. Although past SLI participants have obtained significant leadership positions, quantifiable metrics are necessary to ascertain the impact of the program as well as to determine the critical programmatic components leading to success that could be disseminated through other programs. As an example, in response to this notable training gap, an SLI alumnus who is the Director of the Science Alliance at the New York Academy of Sciences (NYAS) has developed the Science Alliance Leadership Training (SALT) program for graduate students. Launched in 2016, the program has the expressed goals of supplementing science acumen with interpersonal skills, conflict management, and assertive communications techniques. The 5-day program also connects participants with a network of established STEM leaders from an array of fields. The program will certainly have a measurable impact; however, when compared to national organizations/programs such as SACNAS, NRMN or BUILD, NYAS is not as well positioned to impact URMs in the sciences. Further, it should be noted that SLI is limited in reach, as only a small cohort (30 individuals) are accepted for participation each year.

Given the pressing need to diversify the American scientific workforce, it is not possible for one program to fill the leadership training void. Promising URMs in STEM fields must not only be increased in number, but also adequately trained as leaders of the enterprise. Otherwise, the fields risk attrition occurring at later stages. As such, partnerships must be cultivated with sustainability and broad reach in mind. An NIH- or NSF-led initiative, similar to BUILD and NRMN, targeting URM

leadership development, would be a logical starting point. Likewise, partnership and emulation to promote URM leadership in different industries (such as the pharmaceutical and technology industries) are also needed for measurable impact across disciplines and geography to occur in an expeditious manner.

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Recruitment, Promotion, and Retention of Underrepresented Minority Faculty in Academic Medical Settings: Challenges, Barriers, and Strategies for Change

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OVER THE PAST DECADE, attention has been devoted to the need for increasing the number of underrepresented minorities (URMs) in academic medicine (Bollinger, 2003; Cooper & Powe, 2004; Daley, Wingard, Reznik, 2006; Institute of Medicine, 2003; Powe & Cooper, 2004). Given that URM faculty in academic medicine serves as a key component for reducing health and health care disparities in underserved populations (Peek, Kim, Johnson & Vela, 2013), the low percentages of URM faculty both recruited and retained in academic medical centers warrants further attention. Specifically, according to the AAMC faculty roster, approximately 71.9% of faculty members in academic medical settings were White, 12.6% were Asian, and 7.2% were URM (Hispanic/Latinos, African Americans, American Indian/Alaska Natives, and Native Hawaiian/other Pacific Islanders; Castillo-Page et al., 2005). Importantly, 20% of all URM faculty are concentrated at historically Black or Puerto Rican medical schools (Association of Medical Colleges, 2012), thus the representation of URM faculty at the majority of medical institutions is even lower. While URM faculty constitute only 7% of all academic medical school faculty, 14.1% of medical students and 30.0% of the U.S. population are underrepresented minorities (Castillo-Page, 2008).

In addition to low overall percentages of URM in any faculty position, the advancement of URM faculty into higher positions in academic medical settings is skewed, with URM faculty primarily concentrated at the rank of Assistant Professor and non-Hispanic Whites concentrated at the rank of Full Professor (Castillo-Page et al., 2005; Fang, Moy, Colburn, & Hurley, 2000). Studies have found that URM faculty are less likely to be promoted than White faculty, even after controlling for cohort, sex, tenure status, degree, department, medical school type, and receipt of NIH awards (Castillo-Page, 2008; Fang et al., 2000). Studies have also found that URM faculty

report more discrimination (Castillo-Page, 2008) and significantly lower job satisfaction than nonminority counterparts, and that they are more likely to consider leaving the academic institution within 5 years (Palepu, Carr, Friedman, Ash, & Moskowitz, 2000).

Why Is Recruitment, Promotion, and Retention of URM in Academic Medicine Important?

Racial and ethnic population changes in the United States continue to reshape the need of diversity in the health-care workforce, as research repeatedly shows that diversity in health care improves healthcare quality and access to care for ethnic minorities (Cooper & Powe, 2004; Peek et al., 2013; Smedley, Butler, & Bristow, 2004). First, URM are more likely to work in underserved communities (Kingston, Tisnado, & Carlisle, 2001). As minority patients are more likely to have a minority physician than nonminority patients, more minority provider options can provide better access to care for minority patients, who prefer racially concordant providers (Davidson & Montoya, 1987; Moy, Bartman, & Weir, 1995). Similarly, minority patients report higher satisfaction and higher rates of patient-centered care from racially and ethnically concordant providers, which then links to improved health outcomes and chronic disease management (e.g., diabetes). Finally, URM health care providers can establish relationships with communities that are often not connected to universities, and thus, connect communities with a vast array of resources.

These factors are specifically pertinent to URM in academic medicine, as recruitment and retention of URM faculty in academic health centers has been identified as a key factor in increasing the pipeline of URM health care providers. Specifically, URM in academic medicine can promote more health disparities research, train stu-

dents and residents to provide culturally competent care, provide health policy leadership that can improve organizational processes that affect health care quality, and introduce new kinds of scholarship to the institution (Daley et al., 2006; Lypson, Gruppen, & Stern, 2002; Smedley et al., 2004; Steinbrook, 1996). Further, URM faculty serve as critical role models and mentors within academic medical settings, as inclusion of diverse backgrounds provides students and faculty colleagues with the opportunity to interact and learn from varied and diverse perspectives (Daley et al., 2006). Importantly, research has found that higher numbers of URM faculty contribute better educational experiences for all students, particularly URM students (Cohen, Gabriel, & Terrell, 2002; Sugrue, Foner, & Camarillo, 2012; Whitla et al., 2003).

What Are the Barriers That Contribute to the "Pipeline Leak"?

A number of barriers have been identified to contribute to the "pipeline leak," which describes the disparity between the number of URM faculty in academic settings despite the established importance of URM faculty recruitment and retention in increasing the pipeline of URM health-care providers. For this article, we focus on barriers beginning during the medical education stage of training, although we recognize that multiple barriers exist for URMs prior to entry into medical school, as highlighted by several studies that identify contributory factors, such as limited knowledge and exposure to career options, lack of resources to access this knowledge, discrimination and stereotyping from high school counselors and other mentors, and qualifications for training programs. Other studies have also highlighted how parental education and income often impact whether students are financially and academically able to pursue a college education and then a subsequent medical education, which may place URMs at a disadvantage due to disproportionately lower socioeconomic status (DeNavas-Walt, Proctor, & Mills, 2004). Accordingly, we focus on reasons for the pipeline leak beginning at medical school training and continuing through all stages of the academic medicine trajectory into the recruitment, promotion, and retention of URM faculty in academic medicine.

Discrimination and Harassment

Beginning early in medical school training and extending throughout the entire career path, URM students and faculty report high rates of discrimination and harassment (Mahoney, Wilson, Odom, Flowers, & Adler, 2008). This impacts professional satisfaction and motivation for pursuing advanced careers in academic medicine and for remaining in the academic medical setting. Research has noted that URM students and faculty report various coping skills and reactions to discrimination, which range from confrontation to avoidance (Mahoney et al., 2008).

Lack of Mentorship

Across multiple studies, lack of mentorship is highlighted as a significant barrier to success for URMs in academic medicine (Mahoney et al., 2008; Thomas, 2001; Wright & Carrese, 2003), as general mentorship can assist URM students and faculty in navigating the structure of the organization. Further, URM faculty often seek out minority mentors to provide necessary cultural and emotional support, as well as sense of belonging; and mentors are difficult to find due to the low prevalence of URM faculty members (Mahoney et al., 2008).

Specific to promotion, URM faculty are less likely to receive adequate mentoring as junior faculty, which is important for developing a competitive academic plan for promotion (Thomas, 2001; Wright & Carrese, 2003). This has been reported at the individual mentoring level, as well as report of junior faculty being burdened by a lack of institutional commitment or lack of resources for career development offered by institutions, particularly geared towards promotion and advancement of URM faculty. URM faculty often report difficulty navigating the promotion and tenure process, adding an additional challenge (Mahoney et al., 2008).

Burden of Committee Assignments and Institutional Pressure

URM faculty are often burdened by committee assignments and institutional pressure to participate in diversity efforts, which is often described as a "minority tax" or "racial fatigue" that does not count towards promotion, but takes time away from other scholarly activities that do count towards promotion (Mahoney et al., 2008). In addition, URM faculty often feel disproportionately obligated to participate in community service activities that are not typically integral to advancement in academic medical settings (Daley et al., 2006). Coupled with the lack of protected time to pursue scholarly endeavors, this can significantly impact opportunity and readiness for promotion and contributes to additional stress to maintain similar productivity as non-minority colleagues.

Social Isolation

URM faculty often report social isolation due to the limited percentage of other URM faculty to serve as colleagues and peer mentors (Price et al., 2005). In addition, perceived and/or experienced discrimination, ethnic harassment, and racial/ethnic bias are commonly described among URM faculty, which greatly affects morale, motivation, and job satisfaction (Corbie-Smith, Frank, Nickens, & Elon, 1999; Peterson, Friedman, Ash, Franco, & Carr, 2004). This social isolation and perceived discrimination can lead to unhappiness and dissatisfaction, which in turn may cause URM faculty to seek alternative positions outside of academic medicine. As a result, when URM faculty members leave academic medicine, it leaves less opportunity for future recruitment and retention of other URM students and faculty members, causing a vicious cycle of limited recruitment, promotion, and retention of URM faculty.

Lack of Commitment by Leadership and Institution

While URM faculty are often asked to participate in diversity initiatives and to make recommendations regarding ways to improve diversity, these recommendations are often not implemented. Faculty report that their efforts are often challenged by lack of resources, undercommitment, and competing priorities from leadership (Mahoney et al., 2008). This response often leaves URM faculty feeling discouraged, and highlights the lack of commitment from leadership and the organization as a whole.

Strategies for Improving Recruitment, Promotion, and Retention

Despite the many barriers, researchers have outlined several strategies that can be implemented to improve recruiting, promoting, and retaining URM faculty in academic medical settings. Due to the significant impact that limited recruitment, promotion, and retention of URM faculty has on the overall success of academic medical centers, several institutes and reports (i.e., Institute of Medicine, Sullivan

Commission) have called for action in increasing diversity in academic medicine (Betancourt, 2006; Missing Persons, 2004; Smedley, Butler, & Bristow, 2004). In addition, several academic medical centers have established initiatives and workgroups to examine these issues and establish strategies and initiatives moving forward. For example, the Department of Medicine at Johns Hopkins University School of Medicine established the Diversity Council to specifically address recruitment and retention of URM in medical training programs and faculty positions (Price et al., 2005). Similarly, the University of California, San Diego (UCSD), National Center for Leadership in Academic Medicine (NCLAM), in collaboration with the Hispanic Center for Excellence, chartered a faculty development program specifically focused on increasing the success of junior URM faculty (Daley et al., 2006).

Although many of the multilevel strategies are effective for recruiting, promoting, and retaining URM faculty, other strategies focus specifically on targeting one or two barriers. Researchers note the importance of not only recruiting URM faculty into academic medical centers, but the pertinence of also promoting and retaining URM faculty so that they will remain at the institution and continue to excel (Palermo et al., 2008).

Increase Awareness of Attitudes and Behaviors

As many faculty members are not aware of their own attitudes and behaviors regarding minority populations, it is very important to increase faculty members' and leadership awareness of attitudes and behaviors around diversity and inclusion (Price et al., 2005). In addition, it has been suggested that institutions encourage faculty to openly express opinions and insights regarding diversity and inclusion (Thomas & Ely, 1996). Research has established that all persons are subject to unconscious bias in hiring and promotion practices. Academic medical centers can mandate training and interventions to educate individuals involved in the hiring and promotion of faculty on how to avoid unintentional bias. Given that faculty members are an integral component to whether faculty members are hired and promoted, and thus retained, in academic medical settings, providing more opportunities for awareness and discussion of the effects of "unconscious bias" is critical for recruitment, promotion, and retention of URM faculty.

Increase Institutional Leadership Commitment to Improving the Diversity Climate

While attention has been given to reducing health disparities in academic medical settings over the past decade, leadership is not always supportive of the initiative, and even when supportive, do not make this issue a priority (Price et al., 2005). In order for the diversity climate to be improved, all levels of leadership must be committed and willing to institute changes for advancement of URMs to occur (Mahoney et al., 2008). In addition, institutions and leaders must be willing to implement and adapt policies to incorporate diversity initiatives and efforts. As described above, several institutions have implemented special task forces or initiatives with the aim of improving recruitment and retention of URM faculty, and research findings have demonstrated the success of these programs. Specifically, 4 years following implementation of the diversity initiative at UCSD, URM junior faculty had increased from 58% to 80% (Daley, Wingard, & Reznik, 2006). Relatedly, if leadership is committed to improving the diversity climate, then URMs should be present and active within the organization. Specifically, it is critical that diversity be increased within institutional leadership itself, as well as within the faculty and staff of academic medical centers (Price et al.). Finally, it is important that URM feel valued within academic medical settings and that faculty perspectives are incorporated into the mission and culture of the organization, which ties directly to leadership and the commitment to improving the diversity climate (Price et al.; Thomas & Ely, 1996).

Incorporate Diversity and Inclusion Initiatives Into Policy

Specifically, policies and procedures should be adapted and implemented to specifically address increasing URM faculty in academic medicine. For example, it is important that institutions incorporate diversity and inclusion initiatives in criteria for promotion and tenure, as well as disseminate their promotion procedures, which will help URM faculty to become aware of criteria and also increase likelihood for promotion to higher ranks and tenure (Levinson et al., 1991). Other institutions that have been successful in improving the diversity climate have implemented policies to buy out protected time for URM faculty to focus on career

development activities (Daley et al., 2008). Not only does this provide URM faculty with invaluable skills, but it also provides department chairs with an incentive for recruiting additional URM faculty.

Utilize Unique Recruitment Methods

Although a common method for recruiting URM faculty into academic positions involves noting in job postings that "URM candidates are encouraged to apply," this method is extremely ineffective (Peek et al., 2013). Rather, successful strategies include utilizing social networks (e.g., informal lists of potential candidates) and interpersonal connections with colleagues to identify potential candidates, networking at national conferences, and asking those in leadership positions (e.g., section chiefs, department chairs) to make interpersonal contact with candidates (Peek et al.). In addition, many institutions have successfully utilized the "grow your own" strategy, in which programs cultivate, mentor, and recruit their own URM medical students, residents, and fellows into subsequent faculty positions (Peek et al.). Finally, when recruiting URM faculty into academic positions, it is crucial that institutions formulate attractive recruitment packages that include competitive salaries and developmental funds, as well as create supportive environments that will foster growth and success through flexible work hours and diverse work experiences that are unique to the candidate's needs (Peek et al.).

Career Development and Ongoing Training

Assisting URM students and faculty with career development is vital to improving the diversity climate within academic medical centers. Specifically, career development can pertain to a range of services, including preparation of curriculum vitas, providing an introduction and ongoing education on institutional culture, examining promotion and tenure criteria, and balancing service work and committee involvement that "count" for promotion. At the institutional level, it is recommended that organizations offer formal career counseling and faculty development programs to encourage promotion and retention, to assist URM faculty to be promoted into higher ranks (Levinson et al., 1991). Additional suggestions include establishing internal faculty development programs, institutional URM faculty development awards, and salary support/pro-

tected time prior to receipt of independent funding (Peek et al., 2013).

To promote and retain URM faculty within academic medical centers, which are competitive environments for members of all backgrounds, it is crucial to provide ongoing trainings to advance skills relevant to career advancement and success (Palermo et al., 2008). Successful trainings often consist of workshops, guest speakers, or summer institutes that focus on unique needs of URM faculty. For example, workshops on pedagogy and grant writing can assist faculty with necessary skills, as well as provide opportunities for mentoring via collaboration and networking during and following workshop participation (Daley et al., 2006). These techniques will not only assist with retaining URM faculty, but may increase likelihood that URM faculty will be promoted into higher ranks.

In addition to providing training directed toward URM faculty, it is also important to train leadership on issues relevant to improving the diversity climate. For example, unconscious bias training for all members of leadership can assist with selecting promotion and leadership candidates based on objective criteria (e.g., developing a list of characteristics that are wanted for the position then examine curriculum vitas to ensure that those are met).

Increase Opportunities for Quality Mentorship

As described above, mentorship is a key component to successful promotion and retention of URM faculty in academic medicine (Jackson et al., 2003; Kosoko-Lasaki, Sonnino, & Voytko, 2006; Sambunjak, Straus, & Marusic, 2006). Researchers have identified several key functions of mentoring, which include socialization, or grooming, into academic medicine; development of communication, teaching, and networking; understanding research methods; identifying and addressing social isolation; and involving students from diverse academic and cultural backgrounds in collaborative networks. Increasing opportunities for quality mentorship, as well as clearly defining mentoring commitments, removes opportunities for "anti-mentoring" and ensures not only that mentoring takes place, but that it is effective and appropriate. This increased mentorship will assist in all levels of increasing URM faculty in academic medicine, from recruitment, to retention, and promotion into higher ranks.

It is important for mentoring programs to be unique and specifically developed to meet the needs of the setting and environment where URM students and faculty are embedded (Lewellen-Williams et al., 2006). Several mentoring programs have been established to facilitate mentorship across institutions, including the Peer-Onsite-Distance model (Lewellen-Williams et al.), given the difficulty in finding minority mentors within one's own institution. Finally, mentorship around institutional culture, as well as promotion and tenure guidelines, can assist faculty in making informed decisions regarding which activities to become involved in, and also how to describe their involvement in teaching, research, and community service activities (Daley et al., 2006).

Decrease Isolation

One strategy to address the social isolation barrier includes integrating URM junior faculty with other URM junior faculty and alumni via social networks (Daley et al., 2006). That being said, social networks are only successful when both senior mentors/faculty members and junior faculty are actively engaged in professional activities that increase regional and national visibility (Daley et al.). In addition, researchers note the importance of facilitating both formal and informal support structures for URM students and faculty (Palermo et al., 2008). Finally, a successful method for retaining faculty in academic positions includes building in regular "check-ins" to ensure satisfaction in responsibilities, work environment, and career trajectory (Peek et al., 2013).

Conclusions

Poor retention of URM faculty leads to less effective recruitment of URM students, resulting not only in fewer potential URM faculty, but also fewer URM health-care providers, which affects the engagement and adherence of many URM patients to health-care services as well as patient satisfaction. Given that low percentages of URM faculty achieving leadership and senior rank in academic medical centers results in a domino effect that contributes to perpetuating health-care disparities, various strategies (e.g., workshops, unconscious bias training, mentoring programs) have been developed to address several of the barriers that contribute to the lack of URM comprising faculty membership at academic medical health centers. Increased attention on institutional support of diversity and inclusion efforts can be seen in the vast creation of chief diversity officer positions during the past 18 months (e.g., the National Association of Chief Diversity Officers in Higher Education experienced 35 percent growth in one year; Malewski & Jaramillo, 2017). Despite recent efforts of institution-wide diversity and inclusion task forces and initiatives to support URM faculty, it is the responsibility of all faculty and leaders (both URM and non-URM) to know the factors that contribute to the URM pipeline leak, to promote and support effective implementation of strategies chosen by task forces that overcome these barriers, and to increase the understanding and awareness of colleagues through discussion of the relevance of URM faculty to health-care quality. We encourage researchers and institutions to evaluate different efforts and programs implemented at their local levels so that strategies can continue to improve and that more dissemination of these findings lead to more visibility and awareness of this critical issue.

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Diversity in Clinical Psychology: Reflections on Privilege

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AFTER RECENTLY COMPLETING a clinical graduate course in ethnic minority psychology, it has been profoundly eye-opening to reflect on my own privilege, and the many social forces that have affected and continue to affect me as an individual. It has also been valuable to consider the important ways in which psychology as a field has developed and continues to exist as a relatively narrow reflection of White upper-middle-class European American values and worldviews, and consider the ways in which we can move towards a more inclusive multicultural perspective. We as a society and a graduate program often learn about and discuss individual discrimination and systemic oppression, but rarely consider the flip side of oppression—privilege. For me, this one-sided approach to considering racism, oppression, and discrimination made it much easier to talk and think about aspects of my identity and cultural background that have been barriers to my pursuit of graduate studies, like my gender and the economic conditions in which I was raised. However, it was much harder to consider the ways in which I was also inherently privileged.

The dominant culture in American society values hard work, rugged individualism, and competition (Sue & Sue, 2012a), and perpetuates a "myth of meritocracy"—the idea that if you work hard you can succeed no matter what (Sue et al., 2007). The idea of privilege, with the direct implication that there are forces outside one's control that have contributed to one's success, is very uncomfortable in part because it flies in the face of these values. The admission that I, as an individual, benefit from oppression and injustice in our society is unpleasant to come to terms with. Nevertheless, it is a reality, and recognizing and coming to terms with that reality is a crucial step in working towards a new reality rooted in greater multiculturalism and social justice.

I am privileged in countless ways, ways which have helped to facilitate my pursuit of graduate studies, and which inevitably impact my day-to-day life. First, and certainly foremost in my mind when I consider privilege, I am White. While I recognize that Whiteness is not a "neutral" or "default" identity, the progress I have made in moving to somewhat more advanced stages in the development of my racial identity does not eliminate the privilege associated with my skin color and race. Being White is associated with a host of privileges, from seemingly small everyday interactions (e.g., I can easily buy books, posters, and children's toys featuring people of my race) to freedom from serious systematic discrimination and oppression (e.g., I can be sure that my race will not work against me if I need medical or legal help), which people of color cannot take for granted (McIntosh, 2003, p. 193). As a White person who grew up in the United States, I have lived my entire life in a social environment in which I am largely protected from race-based stress (DiAngelo, 2011). If I wanted to (which I don't), I could likely go through my life fairly easily without thinking of myself as a racialized individual, or without considering the role my race has played in my life. In reality, however, I cannot discount the role of race in my life. My skin color has protected me from ethnoracial microaggressions, including those based on pathological stereotypes about my intelligence, my role in institutions of higher learning, my academic performance, and my professional competency (DeLapp & Williams, 2015; Sue et al., 2007; Williams, Gooden, & Davis, 2012). It means that the fear of confirming negative racialized stereotypes has never impacted my academic performance or professional work (Steele, 1997). It means that I can, with reasonable assurance, interact with law enforcement officials or campus police without concern that my life, liberty, or reputation could be taken away without justification (Smith, Allen, & Danley, 2007). It means that I have no reason to fear that medical and mental health professionals will use their position of power to discriminate against me, experiment on me without my consent, or violate my rights (Suite, La Bril, Primm, & Harrison-Ross, 2007; Williams, Domanico, Marques, Leblanc, Turkheimer, 2012). It means that academic leaders, health care professionals, and policymakers will not argue that my enthoracial group is inherently inferior, or use my race to attempt to justify disparities in health, education, and achievement (Lynn, 2002; Thaler, Thames, Cagigas, & Norman, 2015; Williams et al., 2012). All of these privileges have made my life easier in crucial ways, and have facilitated my pursuit of graduate studies and a career in psychology.

I also believe it is possible that I might not have chosen a career in psychology were it not for my racial background. As a White person, I am privileged in that the history of my profession is innately tied to the history of my ethnoracial group (Pickren, 2009). When I learn about the history of my field, I learn about people of my own race. Even when I consider the field's deeply problematic engagement with issues of race, I learn about ideas that prioritized and idealized individuals of my skin color—erroneously, and to great scientific and social detriment, but idealized nonetheless. There is no denying that the foundational ideas that still underlie much of our field have their roots in my cultural traditions, and my ethnoracial group has long been treated as the psychological norm in both clinical practice and research (Sue & Sue, 2012b). While this is certainly a serious problem for our field, I cannot rule out the possibility that I might not have considered a career in psychology and worked hard to attain that goal if those social forces had not been in place. I can imagine that, were I a person of color, I might be justifiably mistrustful and skeptical of psychologists and psychology as a field (Suite et al., 2007). The privilege provided by my race has facilitated my studies and my interest in our field in critical ways.

While the experiences in my ethnic diversity coursework have focused my attention on the privilege that has shaped and continues to shape my life as a White person, I also experience unearned privilege related to other aspects of my identity. As a heterosexual and cisgendered individual, I do not experience personally directed homophobia or transphobia, and do not need to struggle against these forces to claim basic human rights or to achieve my broader goals. While I am certainly highly motivated to fight against these forces, I am also privileged in that I do not need to contend with such hurtful ideas if I choose not to. This privilege means that no one questions, vilifies, or mocks these very fundamental aspects of my identity. It means I am free to use the bathroom of the gender I identify with. It means I can show affection for my romantic partner in public without being concerned that others may ostracize us or discriminate against us. It means I do

not need to personally fear for my safety and well-being in the face of antigay and antitrans hate speech and hate crimes. These are additional areas of my life where I am privileged enough to be largely unconcerned that others might view me through the lens of a pathological stereotype, to not worry about or contend with microaggressions, and to go about my daily life largely unconcerned with these aspects of my identity because they are consistent with the dominant culture (McKinnon, in press).

Similar to my identity as a White person, I am not sure I would have pursued a career in psychology were I not heterosexual and cisgendered. The field of psychology does not have a good track record of supporting and celebrating sexual and gender minority individuals. Both these identities have been explicitly pathologized, and psychology has been historically used to justify harmful and ineffective "conversion therapies" that have done irreparable damage to the physical and mental health of gay, lesbian, queer, bisexual, and transgender people (American Psychological Association, 2009; Beer, 2015; Haldeman, 1991). If I identified with one of these groups, I can imagine that I might not necessarily be interested in being part of a such a discipline.

I also experience privilege as an individual who is physically and mentally healthy and able-bodied. I believe this is one of the aspects of my identity that I take the most for granted, yet I also feel like it is one of my biggest sources of unearned privilege. As an individual with no physical or mental disabilities, I benefit from a society that operates on the assumption that I am able to walk, see, hear, think, and learn in much the same way as the majority of other people of a similar cultural background. In this way, I am privileged not to face the same barriers to education, employment, and functional independence that many people with disabilities must contend with on a daily basis.

Last, in addition to the innate privileges I enjoy as a White, heterosexual, cisgendered, nondisabled individual in our society, my life has been marked by unearned privilege as a result of the environment in which I grew up. I was privileged to have two healthy, present, and deeply caring parents, who were and continue to be devoted to the ideals of education, gender equality, and multiculturalism. They created a home environment in which I felt loved and accepted, and was taught to love and accept other people. Although considerable financial stress was a constant feature in my childhood, I was also privileged to grow up in a small and close-knit community in which our friends and neighbors had the resources and generosity to support each other and each other's children, in order to ease economic burdens and keep children safe and engaged. Furthermore, my parents' hard work and privilege meant that we had relatively stable housing with access to safe and competent public schooling. Had any of these factors not been present, I believe that my pursuit of graduate studies, and my life more broadly, would have been much more difficult.

Reflecting on the unearned privileges of my childhood and upbringing also helps to highlight the intergenerational nature of privilege based on societal oppression. Both of my parents certainly worked hard and overcame substantial barriers to pursue their own educations and to provide for their children. Yet their privilege as White people within our society inevitably played a role in their achievements and the resources they were able to provide us. While I feel that some of the privileges of my childhood transcend ethnoracial divisions (e.g., having supportive friends and a close-knit community), many also reflect privileges enjoyed as the reverse of societal oppression and marginalization, at the expense of other groups of people who did not enjoy a same access. In a similar way, it is inevitable that my children will also benefit from the many sources of unearned privileges that have facilitated my studies and that will continue to benefit me over the course of my life.

While this pattern can make it seem impossible to break the cycle of privilege and oppression/marginalization, it is also abundantly clear that we can work to undermine our own privilege in ways that promote justice, equality, and multicultural perspectives throughout our society. Simply being aware of privilege through diversity education and self-reflection is a positive step forward, but it is not sufficient. Recognizing the privilege and limits of my own social lens has led me to a greater appreciation for the social lenses of others, and has emphasized that the inclusion of more and more diverse lenses is critical for our profession. When we consider that the history and current state of our field may actually deter large groups of people from pursuing careers in psychology, it becomes even more apparent that incorporating multicultural perspectives and diversity in our field will help us to break away from the limits of privileged perspectives and make psychology a more inclusive and broadly relevant discipline. It is one thing for individuals within psychology to espouse multiculturalism, but it is even more important for psychology to reflect multiculturalism through the active inclusion of people of all different identities, from all different backgrounds. By educating individuals at all levels of our field about sources of privilege, taking strong stances in favor of multicultural perspectives, clearly rejecting historical ideas that perpetuate injustice, and actively recruiting, supporting, hiring, and promoting students, clinicians and researchers who represent all aspects of diversity will help to make psychology a more relevant and welcoming field for individuals of diverse backgrounds.

Psychology as a field is uniquely positioned to inform and alter the social forces that perpetuate unjust systems of privilege and oppression. Moving forward, we must work consciously and deliberately to use our understanding of our own privilege to embrace diversity and multicultural perspectives, and change the way we do our work as clinicians, researchers, teachers, and advocates. Failure to address inequality, discrimination, and oppression when, through our research and clinical work, we become acutely aware of these issues, makes us part of the problem in allowing unjust systems to persist. We must strive to be aware of the ways our beliefs are shaped by our cultures, seek to better understand the different perspectives and experiences of our clients and research participants, carefully consider the implications of our conclusions about race and racial differences, and advocate within our communities and within our field for social justice and the promotion of human welfare for all people.

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When the Political Becomes Personal: Implications for Clinical Practice and Training

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THE NOTION THAT A PSYCHOTHERAPIST should be a "blank screen" is generally attributed to early psychoanalysis. The theory was that maintaining therapeutic neutrality would encourage the emergence of transference in which the patient would transfer experiences and perceptions of important individuals in their life onto the neutral therapist. As practiced, early psychoanalysis (and related therapeutic approaches) attributed relatively little importance to the social and political context in which patients lived their lives. Similarly, cognitive behavior therapy (CBT) does not explicitly address broader political and social context as part of therapy; rather, the therapist takes the role of a values-neutral teacher or coach whose primary role is to help patients adopt new patterns of thinking and behaving.

Early feminist psychologists, among others, identified the limitations to this approach, noting that dismissing or ignoring broader political context may result in overpathologizing individuals and constitute a form of "blaming the victim." Thus arose the maxim, "the personal is political," generally credited to Carol Hanisch (1969), who wrote an essay with this title as part of the second-wave feminist movement in the United States. This maxim became a rallying cry for feminist psychologists in their attempt to recognize the impact of political reality on the personal lives of female clients. The central concept was that small, intimate facets of a client's daily life both reverberate from and reflect the larger political context. For example, a woman's broad sense of dissatisfaction in her life may be inextricably linked to limited vocational opportunities, institutional or social policies that limit her self-efficacy, or financial dependence in an unhappy marriage rather than to inherent intrapersonal failings. In recent decades, multicultural psychologists have similarly recognized the personal impact of various forms of political and cultural marginalization on individuals.

Following the contentious 2016 U.S. presidential election and its outcome, graduate students and faculty in our program at the University of North Carolina at Chapel Hill (UNC) have considered revisiting and adjusting this feminist statement in order to recognize that "the political is personal"—a flipped statement we see as augmenting rather than competing with the original feminist conceptualization. Specifically, we acknowledge that public (e.g., television, media) and private (e.g., dinner table) debates and discourse surrounding a number of diversity and multicultural-related topics during the recent political election reverberate in the lives of our clients, trainees, and supervisors, as well as our own personal lives. In addition to the

2016 presidential election, in the past year we have seen an upsurge of discriminatory legislation targeting lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, especially concentrated in the southern U.S., such as North Carolina's House Bill 2 (HB2, known colloquially as a "bathroom bill") and Tennessee's Senate Bill 1556 (called a "religious freedom" bill). While this trend may represent a political backlash in response to the passage of the U.S. Supreme Court's 2015 federal marriage equality decision (i.e., *Obergefell vs. Hodges*), the impact might remain broadly harmful to clients and therapists.

Once we recognized that the political may become personal, we began to consider the current implications for CBT in our own academic training clinic. At UNC's clinical psychology Ph.D. program, we determined that the onus was on *therapists* to raise the issues with clients (and for *supervisors* to raise the issues with trainee therapists) in light of the fact that these discussions tend to be highly emotionally charged and generally avoided, yet may significantly impact client or therapist wellbeing. In either case, the individual with more perceived social power or influence will in most cases need to assume responsibility to raise this challenging topic.

Some researchers have specifically focused on the negative impact of discriminatory legislation on the health and well-being of sexual and gender minorities (e.g., Hatzenbuehler, Keyes, & Hasin, 2009; Russell & Richards, 2003). Moreover, the American Psychological Association's (APA) *Stress in America* surveys (APA, 2016) documented that discriminatory experiences are a significant source of stress for minority populations. Additionally, the Fenway Institute in Boston (Wang, Geffin, & Cahill, 2016) has written a legal brief in which they argue that conscience clause legislation and related religious freedom laws risk accelerating health disparities for already underserved groups. Although we recognize that the flipped maxim, "the political is personal," is relevant to multiple facets of multicultural identity (e.g., religion, physical ability, race, and ethnicity), we will limit the scope of the present article to the context of LGBTQ issues. This scope is driven in part by our local context of legislation specifically targeting LGBTQ individuals but will allow us to conduct a more in-depth examination of how the current sociopolitical context may affect clinical practice and training. Our hope is that this preliminary discussion may serve as a springboard for mental health professionals to continue considering the impact of discriminatory social and political context on clients, trainees, and clinicians with a wide range of diverse and intersecting identities.

Recognizing that traditional CBT does not provide a ready blueprint for systematically integrating political context into clinical practice or training, this article considers strategies and approaches for incorporating the notion that the political is personal into CBT. We do not seek to criticize or analyze specific politicians, policies, or political ideologies per se; rather, this article is intended to highlight what the U.S.'s emotion-laden discourse surrounding LGBTQ-related issues over the past 4 years, and our local context of state-level discriminatory legislation, means for (a) the therapeutic alliance, (b) case conceptualization, and (c) clinical training.

Implications for the Therapeutic Alliance

Substantial research and clinical evidence indicates that a strong therapeutic alliance (i.e., clinical rapport; the personal bond that contextualizes the working relationship between a client and therapist) is important for effective psychotherapy (Leach, 2005), perhaps because it creates a "safe space" for clients to discuss sensitive, distressing topics. Mainstream U.S. culture tends to avoid discussion of taboo topics such as sex, religion, and politics; if such topics of conversation are inappropriate in everyday settings, to what extent can (or should) a client or therapist broach these issues in the therapy room? Does bringing up the discriminatory context for LGBTQ individuals (e.g., hetero- or cisgender-normativity or superiority in society) contaminate the safe space of a therapist's office, or is therapy a safe space in which to start these conversations?

Given the dynamic demographic shift in the U.S. (e.g., increasing racial and ethnic diversity; Cohn & Caumont, 2016), as well as recent changes in LGBTQ-related law and policy (e.g., the 2010 repeal of "don't ask, don't tell" [DADT]; the Supreme Court's 2015 decision to legalize same-sex marriage nation-wide), avoiding traditionally taboo topics such as gender identity, sexual orientation and experiences of stigma or discrimination may not be best practice in that it may impede development of clinical rapport with some clients. In fact, the notion that avoiding LGBTQ-related aspects of identity may ironically hurt the therapeutic alliance is consistent with research showing that "colorblindness" contributes to racism more so than "race consciousness" (Bonilla-Silva, 2014). That is, ignoring facets of multicultural identity and related experiences may serve to maintain the very social injustices a therapist hoped to avoid.

In our own experiences as supervisees *and* supervisors, the majority of clients and therapists are hesitant to broach client experiences related to LGBTQ identity because they either wish to preserve the therapeutic alliance by remaining on "safe" topics or are afraid of using the "wrong words." Although being mindful not to offend clients and colleagues is admirable, it is also important to consider that therapists' avoidance of controversial issues might be partially influenced by personal discomfort or lack of familiarity with broaching culturally taboo topics. Although we sympathize with the uneasiness elicited by sensitive conversations, therapists should avoid burying their heads in the sand; the therapy room might be the only safe space a client has to work through diversity-related concerns. Anecdotally, many clients report that hearing a therapist proactively ask about relevant current events or sexual or gender identity feels like "opening a door," illustrating that the topic is safe to discuss in the therapy room.

If therapists might lean on the existing therapeutic alliance and "go there" during session, when should a therapist bring up diversity-related issues, and how? Does this vary as a function of a therapist's and client's constellation of identities (either separately or in combination)? Might the clinical setting (e.g., a university-based clinic, VA medical center, pastoral setting) inform how these conversations are initiated? Future research investigating clinical variables that present unique challenges to maintaining (or even building) therapeutic alliance when discussing clinically relevant LGBTQ topics would be helpful. Examination of how LGBTQ-related issues affect the therapeutic relationship might be especially important in states with discriminatory legislation or increased health or economic disparities (e.g., limited health-care coverage for same-sex partners). Similarly, there have been significant LGBTQ policy changes at the federal level (e.g., the Pentagon's end of the ban on transgender people serving openly in the U.S. military in 2016); however, the degree to which recent federal changes will influence VA- or community-based clinical settings is unknown.

It is important to acknowledge that not all clients will be ready or willing talk about

LGBTQ issues in the therapy room, nor will all clients (or therapists) identifying as LGBTQ find their gender identity or sexual orientation to be clinically relevant. However, it is highly possible that more LGBTQ clients *will* want to discuss their experiences than we expect. If this is the case, and the therapist is willing, how can they proceed while protecting the therapeutic alliance in the current sociopolitical climate? Following the multicultural counseling framework of building awareness, knowledge, and skills (e.g., Sue, Arredondo, & McDavis, 1992), we argue that an important first step is therapist self-examination in order to more deeply acknowledge one's own biases, values, and identities that may impact the lens through which one approaches clinical practice. As psychologists, we are aware that implicit bias influences overt behaviors, even if someone's implicit beliefs do not align with explicitly endorsed attitudes. Accordingly, we recommend that therapists take proactive steps to enhance the therapeutic alliance with diverse clients by first exploring their own personal multicultural identity and biases.

Another way therapists may better foster therapeutic alliance with LGBTQ clients is by eliminating microaggressions (i.e., "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership"; Sue, 2010) from the clinical setting. In practice, this might manifest as examining and removing heterosexist bias and other assumptions from clinical assessments (e.g., assuming a male's partner is female). Additionally, therapists could ensure that psychoeducational handouts, intake forms, clinic brochures, or websites celebrate diverse constellations of client identities (e.g., including photos of racially and ethnically diverse same-sex couples or gender nonconforming presenting individuals, or using gender-neutral terms). Therapists and researchers may also consider the subtle ways in which cisgendered and heteronormative biases are implied in the clinical context. Asking about (and using) preferred gender pronouns, or posting a flyer in one's office listing more than two options for gender pronouns,[1] is an easy way to support and validate gender-nonconforming clients. Therapists may further

strengthen the clinical relationship by acknowledging or assessing LGBTQ minority stress factors at the intrapersonal (e.g., internalized homophobia), interpersonal (e.g., social support from family of origin or "chosen family," experiences of discrimination or hate crimes), and environmental (e.g., institutional or community-level stigma) levels. Proactive discussion of these issues in treatment sessions can communicate awareness and genuine interest in learning about broad LGBTQ issues as well as experiences unique to that individual.

In summary, we anticipate that recent political events such as the U.S. presidential election, demographic shifts in the U.S., and increased public discourse around multicultural identities and LGBTQ issues will contribute to a new norm where most clients and therapists will identify with some facet of diversity in a way that either challenges or strengthens the therapeutic relationship. As such, it is imperative that therapists—no matter their years of experience—gain comfort discussing diversity-related issues with clients, peers, and supervisors/supervisees in an open and humble manner. Although a comprehensive description of multicultural competency is beyond the scope of this article (interested readers are referred to APA, 2003; Sue et al., 1992), striving to provide multiculturally competent psychological services requires constantly challenging one's own assumptions and being open to learn. Therapists must continually and proactively work to reduce overt or subtle discrimination in the clinical context, and taking steps to do so may benefit the therapeutic alliance.

Implications for Case Conceptualization

As noted above, the therapeutic relationship may be optimized if the therapist can openly acknowledge the current political climate and create space for a client to discuss how they[2] are personally impacted. In addition, at a theoretical level, a therapist's case conceptualization of an LGBTQ individual's presenting problem and the factors maintaining their distress may be more nuanced and comprehensive if it considers the broader political and social

climate in which the client lives and how this environment may be validating or invalidating. Three important themes emerge when considering case conceptualization for individuals with a marginalized identity such as sexual and gender minorities, all of which are heightened in a heated political climate. Specifically, therapists must consider: (a) the salience and centrality of a client's LGBTQ identity, (b) the potential impact of minority stress on the presenting problem and client's well-being more holistically, and (c) the complexity brought on by intersecting identities and the power and privilege associated with each. These three factors are discussed in turn below, including considerations regarding how each may impact a therapist's understanding of the presenting problem.

The racial identity literature clarifies the difference between *salience* and *centrality* of one's identity (e.g., Sellers, Smith, Shelton, Rowley, & Chavous, 1998), and these concepts may be extended to understanding sexual or gender minority identities. Salience is the degree to which one's identity is relevant in a specific moment and this may change based on context (time, physical location, being around others versus alone). However, centrality is more stable and refers to the degree that someone typically defines themselves using that identity across a range of situations and contexts. Thus, any two LGBTQ individuals may differ in the *centrality* of their sexual or gender identity as part of their larger, more permanent sense of self and/or the *salience* of that identity in given moments across the day.

As suggested above, feminist and multicultural psychotherapy perspectives add a critical lens to cognitive-behavioral case conceptualizations by considering the impact of intersecting identities and the importance of appropriately attending to a client's identities (and how societal context may stigmatize or marginalize one or more of those identities) as part of their presenting problem. To illustrate, an individual who identifies as a lesbian, cisgender female may be at risk for heterosexism, sexism, and internalized homophobia, all of which may interact and compound the negative impact on her overall psychological distress (Szymanski, 2005). Transgender or gender-nonconforming individuals face additional stigma in light of not conforming to societal gender norms (for further reading see APA, 2015).

LGBTQ minority stress is broadly defined as discrimination, stigma, or preju-

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[1]A flyer we have printed and used at UNC may be found at: https://levanacentre.files.wordpress.com/2011/01/pronouns1.pdf

[2]The singular form of the word "their" is used as a gender-neutral pronoun, to be more inclusive than she/her or he/him pronouns (Bennett, 2016).

dice that LGBTQ individuals face across the lifetime as a result of their sexual or gender minority identity (DiPlacido, 1998; Meyer, 2003; Lombardi, Wilchins, Priesing, & Malouf, 2001). LGBTQ individuals have historically been compared to heterosexual or cisgender individuals who are typically considered "normal" or "desirable" (Martell, Safren, & Prince, 2004). Understanding the breadth and consequences of LGBTQ minority stress[3] can help therapists attend to these factors that may uniquely impact LGBTQ individuals' wellbeing. Moreover, such awareness can help inform a sensitive and affirming case conceptualization that "picks up on," rather than minimizes, these issues. As noted earlier, incidents of LGBTQ minority stress and stigma may occur at many levels, including intrapersonally, interpersonally, and institutionally. Increased experience of LGBTQ minority stress has documented negative effects (interested readers are referred to Hatzenbuehler et al., 2014); accordingly, it is not unreasonable that some of these issues may be relevant for LGBTQ clients in the current sociopolitical climate.

Although we argue that the above points should be considered when developing a sensitive case conceptualizations for an LGBTQ client, all case conceptualization must be iterative and responsive to the client's growth and development. For example, a client's LGBTQ identity may not be highly relevant to their overall distress levels prior to a major political or current event, but may increase in salience after a largely publicized anti-LGBTQ event or when discussing LGBTQ identity in detail with friends or loved ones. In addition, there is a documented negative impact of discriminatory public discourse (e.g., on the news or radio; APA, 2016) on LGBTQ individuals' mental health. Thus, therapists must titrate their consideration of political and minority stress-related factors in the case conceptualization based on ongoing assessment, current events, and clinical judgment.

Implications for Clinical Training

We argue that the onus is on therapists to critically think about and discuss the impact of the sociopolitical context on our diverse clients. However, this position raises a number of questions in terms of clinical training both for graduate-level trainees as well as for established psychologists. Notably, there is often a lack of training or integration of sexual or gender minority issues (or multiculturalism more generally) into graduate training programs. Historically, the mid 1990s was the first time that APA accreditation standards required any diversity training in graduate psychology programs; prior to that, no such training was required.

A few key questions often remain unanswered for trainees striving for multicultural humility. First, to what degree can a therapist share his or her personal viewpoint in the therapy room? For example, failing to communicate support for same-sex marriage may be a missed opportunity to validate clients. Importantly, it is impossible to do entirely values-free CBT while also being explicitly LGBTQ-affirming, recognizing intersecting identities and systems of oppression, or working within psychological ethical principles to affirm and treat diverse clients. Second, to what degree can therapists publicly engage in social justice advocacy work? These questions do not have definitive answers, but raise numerous ethical dilemmas that complicate the training of future psychologists.

For example, conflicts of values for religiously conservative therapists in training have resulted in ethical and legal dilemmas when these trainees refuse to treat or provide affirmative therapy to LGBTQ clients (Paprocki, 2014; Wise et. al., 2015). Within university-based clinical training programs, faculty members play an important role in fostering a safe space for LGBTQ trainees or for trainees working with LGBTQ clients. Institutional policies in many academic settings may limit whether faculty take a clear stance on political events or make public statements (especially if using a university email account for such statements). When individual faculty or programs as a whole fail to take a clear stance against various events, however, it may result in a sense of ambiguity or uncertainty among LGBTQ-identifying individuals or allies regarding whether the program explicitly affirms and supports clients or therapists holding marginalized identities. In fact, it has occurred to us that there may be a parallel between this potential negative message sent by clinical program faculty trying to remain apolitical in the wake of diversity-related political events and the counterproductive effects of therapists presenting as a "blank screen" or "colorblind" with diverse clients.

In addition to conscience clause–related dilemmas, psychologists—no matter their level of experience—must navigate their professional obligation to be multiculturally informed and appropriately tailor clinical interventions to diverse groups (APA, 2003). However, this professional aspiration to be multiculturally informed raises numerous questions. To what degree should psychologists remain informed about current events or political decisions that may impact their clients' lives? To what degree must population-specific skills or knowledge be developed as opposed to developing a broader framework of cultural humility and curiosity? In order to best tackle these questions, clinical training programs and supervisors must continue brainstorming how to simultaneously train therapists to understand broad systems of power and oppression but also appreciate within-group idiosyncrasies and consider clients who break stereotypes.

Conclusions

As discussed in the present article, the intersection of political events and individual client mental health points to immediate implications for clinical training and practice. That is, the sociopolitical climate that developed prior to and after the 2016 U.S. presidential election has highlighted a number of important clinical variables that will inevitably affect clients and therapists in the future. In this paper, we do not argue for a particular political party or set of policies; rather, we aimed to call attention to the need for us as researchers, trainers, and providers to recognize that for some, "the political is personal."

We discussed how recent political dialogue around diversity issues may affect the therapeutic alliance, case conceptualization, and clinical training. All of our arguments, however, point to a central theme: the need for multiculturally informed and affirming psychological practice across clinical settings. Much like the APA ethics code holds that there are aspirational standards (i.e., aspirational ideals of professional conduct) alongside enforceable standards, we recognize that multicultural competency is a direction, not a credential. Moreover, multicultural competence is an ongoing process throughout professional development which requires a humble and

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[3]In addition to sexual and gender minority stress, there is also a large body of research on LGBTQ individuals' strengths and resiliency.

open approach to learning about diverse groups and individuals.

There are many pathways toward multicultural competence, including formal trainings (either in graduate training programs [e.g., Bardone-Cone et al., 2016] or through continuing education [e.g., APA, 2017]), clinical supervision, and peer consultation. Indeed, we have witnessed full professors in our own clinical program approach graduate students in order to seek consultation regarding appropriate and sensitive language related to LGBTQ identities. Initial discomfort when broaching sensitive topics is understandable (who conducted their first suicide risk assessment without feeling anxious or unqualified?); discomfort, however, should not be an excuse for ignoring a client's multicultural identity altogether (Sue, 2010). As we learn to lean into these difficult discussions with each other and our clients, it is likely that we will establish more compassionate and affirming relationships in our training programs, in our supervision, and with our clients, especially when we live in a community affected by discriminatory discourse or legislation.

By pursuing multicultural competency throughout the professional trajectory—and continually seeking awareness, knowledge, and skills across clinical contexts—psychologists may help to shift the field's recognition and appreciation of multiculturalism altogether. That is, rather than being a module within clinical training, diversity should be the lens through which all clinical activities occur. By treating multiculturalism as a philosophy to be infused into the field of psychology more generally, psychological professionals might be better equipped to improve the health and well-being of all clients in the current and future sociopolitical context.

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Culturally Responsive Assessment and Diagnosis in the Mental Health Intake

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THE QUESTION OF HOW one's identity is constructed and communicated to others has occupied scientists, philosophers, and writers alike. In the *Odyssey*, Homer suggests that our identities consist not merely of the stories we tell ourselves, but rather of the tales we tell each other. The answer to the question "Who are you?" is never a short one in the *Odyssey*. It is an invitation for a story. "Who are you? Where do you come from? Where's your home and family? What kind of ship is yours and what course brought you here? Who are your sailors?" An individual's identity is manifold, consisting of, among other things, their geography, family, friends, and route. To know them is to know their tales, the sum of their contexts. But a tale is never a complete account. When Telemachus asks Nestor, "Recall those things to me as they were," he is making an impossible request. The telling of stories entails picking and choosing between facts, deciding what to "say first" and what to "keep until the end." Nestor's reply to this demand is therefore perfectly appropriate: "Could any mortal man tell the whole story?" Telling the story of one's life is a challenging endeavor. Being able to listen to the life story of another is no less of a challenge. An interpretation of an interpretation—piecing together the details of another's story requires as much art as science. It seems that there are few better places to examine these complexities than during clinical assessment.

Health Disparities as Failure of Mental Health Service Delivery

Clinical assessment most often occurs during the mental health intake, the first contact between clients seeking mental health services and their clinicians. During intake, clients are expected to present themselves and communicate the problems that brought them to care. The clinician, on the other hand, is expected to understand the person asking them for help and what brought them to seek care, including attention to the psychological, biological, social, and cultural factors that converge to explain the client's behavior. This task has revealed many challenges, including differential quality of care between racial and ethnic communities.

Documented health disparities in the mental health system have revealed a crisis in service delivery, including disparities in access to care, quality of care, and treatment outcomes (Rosen, Nakash, & Alegria, 2014). Relative to White clients, Latino and Black clients in the United States tend to terminate their treatment prematurely, and to underutilize mental health services (Alegria, Canino, et al., 2008; Cook, McGuire, & Miranda, 2007; Jimenez, Cook, Bartels, & Alegría, 2013). Clients of color often delay seeking treatment, resulting in utilization of psychiatric emergency services (Snowden, Masland, Libby, Wallace, & Fawley, 2008). Such delay is typically ascribed to mistrust, shown to be based on the expectation of being stereotyped and receiving lower quality care (Burgess, Fu, & Van Ryn, 2004). These and other challenges persist for clients of color who engage in care. The intake assessment process is an early point in treatment, and therefore critical to addressing such disparities.

A socio-cultural framework (Alegría, Canino, & Pescodolido, 2009) is required to both understand the etiology of this crisis as well as provide guidance to address root causes. And while it is essential to address structural issues (e.g., health policy, economic forces) and client factors (e.g., health literacy, readiness for change), clinicians also need to be held accountable for providing treatment that meets the needs of all communities. Culturally responsive care is now ethically mandated for psychologists (American Psychological Association, 2003, 2010), and cultural formulation has been defined as essential for compre-hensive diagnosis within the DSM-5 (American Psychiatric Association, 2013). For clients of color entering treatment, an accurate assessment and diagnosis provides a foundation for effective care. In an effort to support clinicians in this critical task, this article will address the context that has resulted in problematic clinical behaviors and provide clinical recommendations that support culturally responsive care.

The Context of (Mis)Assessment and (Mis)Diagnosis

The intake poses great challenges to mental health clinicians who are faced with accomplishing multiple goals, including and not limited to, creating a therapeutic alliance, establishing diagnosis, generating an initial treatment plan, and providing psychoeducational tools (Nakash, Rosen, & Alegría, 2009; Turner, Hersen, & Heiser, 2003). To achieve these goals, providers must make rapid decisions on how to use the limited time allocated for assessment and diagnosis, which are more difficult when working across cultural differences (Nakash, Rosen, et al., 2009). Despite a growing awareness of significant racial disparities throughout the mental health delivery system, providers rarely receive specific training in effectively adapting services for clients of color.

Factors contributing to mental health disparities rooted in the clinical encounter (Alegria, Sribney, Perez, Laderman, & Keefe, 2009; Dovidio, Gaertner, Kawakami, & Hodson, 2002; Penner, Albrecht, Coleman, & Norton, 2007; Van Ryn, Burgess, Malat, & Griffin, 2006) center on processes in the client-therapist interaction. The role of these processes was highlighted by the Institute of Medicine's report (2002), which posited that prejudice and stereotyping are important variables in accounting for health service disparities. Support for this proposition comes primarily from research in the general medical field. Physicians were shown to be less client-centered (Cooper et al., 2003; Johnson, Roter, Powe, & Cooper, 2004), to engage in less joint decision-making (Gordon, Street, Sharf, Kelly, & Souchek, 2006), and to have shorter medical encounters (Siminoff, Graham, & Gordon, 2006) when interacting with patients of color. Furthermore, primary care doctors rated African American patients as less intelligent, less educated, more likely to abuse drugs and to avoid medical advice, than non-Latino

White patients (Van Ryn et al., 2006; Van Ryn & Burke, 2000).

Within a mental health context, a recent study of providers' diagnostic decisions documented that socially advantaged therapists were twice as likely to misdiagnose mental health disorders (either overdiagnose or underdiagnose) when assessing a socially disadvantaged client compared to an advantaged client during the mental health intake. Although clients' accounts of the working alliance did not differ by ethnicity, socially advantaged therapists reported worse working alliance with clients of disadvantaged groups and rated disadvantaged clients as less warm (Nakash & Saguy, 2015).

Correct diagnosis is foundational for effective treatment of mental health disorders. An initial interview with a client entails inquiring into the diagnostic criteria necessary for each disorder. Therapists are often trained in diagnostic skills and to make clinical decisions within a universalistic framework, giving little attention to cultural and socio-contextual factors that may influence disclosure of psychiatric symptoms and the diagnosis of disorder. Moreover, existing practice frameworks and guidelines are most often based on Western European White cultural norms, failing to recognize common manifestations of symptoms among clients of color.

Multiple lines of research suggest that the collection of diagnostic information might differ as a function of the client's ethnicity. For example, the Surgeon General's Report on Culture, Race and Ethnicity (Department of Health and Human Services [DHHS], 2001) found that a person's socio/cultural background may impact what an individual reports, what the therapist prompts the client to report, and how the therapist interprets the information provided. For instance, findings have indicated that Latino clients tend to be less inclined to bring up information voluntarily during the mental health intake compared to White clients, regardless of their clinical presentation (Nakash, Dargouth, Oddo, Gao, & Alegría, 2009). Regarding therapist behavior, providers have tended to elicit different clinical information depending on the client's ethnicity and race, increasing the likelihood of diagnostic bias (Alegria et al., 2008). Of equal importance, therapists tend to underuse the DSM, failing to collect sufficient information to establish a correct diagnosis for most conditions (Nakash, Nagar, & Kanat-Maymon, 2015a, 2015b). The problem of "missing information" is particularly harm-

ful with working with people of color as it exacerbates the likelihood of misdiagnosis (Alegria et al.).

In summary, these findings suggest that therapists' assessment of clients of color is prone to significant error and that behavioral recommendations are needed to obtain the clinically relevant information needed for diagnostic accuracy, a foundation for effective treatment.

Clinical Recommendations

Given the significant challenges of assessment and diagnosis within the intake, therapists must focus on both intrapersonal and interpersonal behaviors to best serve their clients. Implicit bias has been revealed as a significant concern for many of the provider-related disparities previously documented, and especially relevant for White therapists (Dovidio et al., 2002). While a discussion of understanding and countering these intrapersonal processes is beyond the scope of this article, the central work of increasing one's cultural awareness, including recognition and reduction of personal biases and prejudices that impact one's behavior, is critical. This is especially true in a diagnostic context, as the clinician's implicit bias may be activated by external stimuli (e.g., client's visible social identities), leading the clinician to fill in missing information with stereotypes rather than data (Greenwald et al., 2002).

Regarding the interview itself, therapists may engage in culturally responsive care by attending to each client's cultural context in establishing an accurate conceptualization of the presenting problem. Kleinman and Benson (2006) have emphasized the necessity of a curious and inquisitive stance that balances an anthropological (emphasizing the uniqueness of each client) and epidemiological (emphasizing generalizability) approach to care. Effective assessment also relies on a transparent process of informed consent that encourages client questions and participation in the process of establishing care (Nakash, Rosen, et al., 2009).

The outline for cultural formulation was updated in the DSM-5 (American Psychiatric Association, 2013), and now includes a Cultural Formulation Interview (CFI), supporting systematic assessment of the: (a) cultural identity of the individual; (b) cultural conceptualization of distress; (c) psychosocial stressors and cultural features of vulnerability and resilience; (d) cultural features of the relationship

between the individual and clinician; and (e) an overall cultural assessment. Supplementary modules of the CFI are also useful for exploring specific areas in greater depth, and include interview questions for both specific content areas (e.g., level of functioning, social network) and populations (e.g., immigrants and refugees, caregivers).

Beyond the DSM, there are a number of excellent cultural assessment protocols that have been developed over the past two decades by researchers seeking to conduct culturally sensitive and inclusive intake assessments across diverse groups of clients (Berg-Cross & Chinen, 1995; Grieger, 2008; Ridley, Li, & Hill, 1998; Yamada & Brekke, 2008). After reviewing these existing protocols, we have combined similar content areas and expanded on some as appropriate, resulting in the 10 content areas outlined below. Within each category, we present key assessment exemplars (Table 1), but encourage the clinician to contextualize the interview to the unique needs and concerns of their client and recognize the many additional questions that could be included within these broad areas. Where applicable, we present different assessment tools (e.g., scales, measures, interviews) developed to assess an aspect of a client's cultural background or racial experience. Though many of the scales presented were developed for research purposes, they contain questions that may be instructive to assess specific content areas.

1. Conceptualization of the Problem, Attitudes Towards Help-Seeking, and Ways of Coping

Examples of questions in this category include: How does the client explain his/her current concerns? How does the client feel about seeking professional mental health support? How does the client's family feel about client seeking professional mental health support?

It is also important to assess the client's ways of coping as research has found that an individual's cultural orientation (collectivistic versus individualistic) can influence and shape how one copes with struggles (Kuo, 2013; Yeh et al., 2006). Some cultural coping scales include the Africultural Coping Systems Inventory (Utsey, Adams & Bolden, 2000), the Collectivistic Coping Styles Inventory (Heppner et al., 2006), and the Collectivistic Coping Scale (Yeh et al., 2006). The subscales to these measures provide the clinician an idea of the ways that clients from more collectivistic cultures may cope (e.g., family support, reli-

gion/spirituality, reframing, forbearance, fatalism).

2. Cultural Identity/Reference Groups of the Client/Collective Network

It is important to assess how clients identify themselves culturally. Examples of questions in this category include: How does the client identify culturally in terms of ethnic racial background but also other cultural reference groups (e.g., gender, socioeconomic status, sexual orientation, religion)? What are the most salient or important cultural identities for the client?

The Multigroup Ethnic Identity Measure was developed by Phinney (1992) to measure ethnic identity amongst adolescents and young adults. It was later revised and shortened into a 12-item self-report measure and it has been used across diverse ethnic groups and ages (Roberts et al, 1999). Other relevant measures include the Collective Self-Esteem Scale–Race (CSE-R; Luhtanen & Crocker, 1992) and the Multidimensional Inventory of Black Identity

(MIBI; Sellers et al., 1997; Sellers et al., 1998).

3. Level of Acculturation, Experience With Bicultural Stress

How comfortable and connected a client is to their culture of origin as well as mainstream American culture could provide the clinician insights into the client's sense of belonging to either or both cultures, which has implications for health and wellbeing (Berry, 2006). Examples of questions from this category include: How comfortable is the client with different aspects of mainstream American culture? Does the client experience any cultural conflict with family or other close loved ones? Are there areas in which the client might feel alienated from, distant from, or not fitting into mainstream American culture? Does the client experience being pulled towards or alienated by their culture of origin and/or mainstream American culture?

The Stephenson Multigroup Acculturation Scale is a 32-item self-report scale that

measures an individuals' degree of acculturation and can be used with individuals across different ethnic groups (Stephenson, 2000).

4. Literacy, Language, and Communication (Yamada & Brekke, 2008)

Questions in this category include ones about the client's English ability and whether it interferes with different areas of functioning and the client's (and family's) preferred language.

5. Racial/Cultural Identity Development

The questions in this category assess the client's feelings about and sense of connection to their race and/or culture, the salience of the client's race and/or culture to them, the racial and/or cultural background of the client's community, and level of cultural engagement (e.g., food, music, attire, affiliations, holidays). Note that a client's racial and cultural identities can often be ascertained by the manner in which they respond to other questions and often do not have to be assessed separately. That said, multiple measures exist that have investigated racial identity development, and include both general measures for clients of color, such as the People of Color Racial Identity Scale (PCRIS; Helms, 1995) as well as race-specific measures including the Cross Racial Identity Scale (CRIS; Cross & Vandiver, 2001, Vandiver et al., 2002), Black Racial Identity Attitudes Scale (RIAS-B; Helms, 1990), and White Racial Identity Attitude Scale (WRIAS; Helms & Carter, 1990).

6. Family Structure, Expectations, and Values

Examples of questions in this category include: What is the client's definition of family? What is client's role in the family? What are the family's views and role in relation to the current situation? What are some significant family values? How does the client feel about these values and do they or to what extent do they integrate these values into their life today? Some clients may not understand what a clinician is referring to when they say "values," so being prepared to give some examples would be important.

In the 24-item, open-ended Person-In-Culture Interview (Berg-Cross & Chinen, 1995), the authors suggest two questions to help an individual share more about their family. The first is to ask clients to draw a "psychological map" of the people in their lives from closest to furthest and to then

Table 1. Cultural Assessment Content Areas with Sample Questions

Content Area	Sample Questions
1. Conceptualization of the problem, attitudes towards help-seeking, and ways of coping	1. What is your hypothesis about why you are struggling with (*insert presenting issue here*)? 2. How do you tend to cope with (*insert presenting issue here*) and in general?
2. Cultural identity/reference groups of the client / Collective network	1. How do you define yourself ethnically? Racially? (and other reference groups) 2. Which of your cultural identities (for example, race, gender, socioeconomic status, etc.) are most important to you?
3. Level of acculturation, experience with Bicultural Stress	1. Do you experience any cultural conflicts with your family? 2. Are there areas in which you feel distant from, alienated from, or not fitting into American culture / your culture of origin?
4. Literacy, language, and communication	1. Do you have any trouble talking to others in English? 2. Has your English ability impacted different areas of your life such as your ability to make friends or get a job?
5. Racial/cultural identity development	1. Tell me a little bit about how you feel about being (*insert client-identified racial background here*). 2. Are there aspects of your racial background you feel proud of? That you distance yourself from?
6. Family structure, expectations, and values	1. Who would you consider to be in your family? 2. What are some significant family values that impact who you are today?
7. Experiences with racism, oppression, discrimination, microaggressions	1. What have been your experiences with discrimination/oppression/microaggressions? 2. Have you ever had the experience of feeling invalidated or made invisible because of your race?
8. Immigration history for client and/or family	1. What is your family's country of origin? 2. What was it like for you and your family when coming to the U.S.? What have been some of the losses/gains?
9. Spiritual and/or existential issues	1. How does spirituality or religion play a role in your life? In your family's life? 2. How does your spirituality/religion play a role in how you see your mental health (*insert specific struggle here*)?
10. Impact of culture on the relationship between client and clinician	1. Are there any of my cultural identities that are particularly important to you? 2. What is like for you to be working with a (*insert visible identity*) clinician? *(Use only if this question is grounded in or connected to the client's comments or narrative)*

draw different kinds of lines to denote conflict, distance, closeness, and so forth. The second question asks clients to draw a totem pole of important people in the client's life with the weakest person on the bottom and the most powerful person on top.

7. Experiences With Racism, Oppression, Discrimination, Microaggressions

Examples of questions in this category include: What are the client's experiences with oppression and discrimination and what has the impact been for the client and their family? Has the client felt invalidated due to their ethnicity and/or race? Here, if the client indicates they have not experienced any oppression or discrimination, it could be helpful to ask these questions less directly. For example, if applicable, what is it like for the client to be living in a predominantly White city? Or for the client to be working in a predominantly male-dominated field? This is an area in which clinicians may want to be prepared to provide some examples as clients may want clarification of what the clinician means by "oppression," "discrimination," or "microaggression."

There are a number of scales that have been developed to measure experiences and impact of racial discrimination. The Race-Based Traumatic Stress Symptom Scale (RBTSSS; Carter et al., 2013) is a 52-item self-report measure that assesses the psychological and emotional stress reactions one has to racism and racial discrimination. Landrine and Klonoff (1996) developed an 18-item self-report inventory, Schedule of Racist Events (SRE), that assesses the frequency of racist discrimination for African-Americans in an individual's past year and across their lifetime as well as the extent to which the discrimination was perceived as stressful. The General Ethnic Discrimination Scale (GEDS; Landrine et al., 2006) is an 18-item measure that assesses perceived ethnic discrimination among different ethnic groups and was developed to be used in health research. The Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011) measures the frequency with which individuals experience different types of microaggressions. Similarly, the Racial Microaggressions Scale (RMAS; Torres-Harding, Andrade, & Romero Diaz, 2012) is a 32-item scale that measures the occurrence and distress elicited by incidents of racial microaggressions. Williams and her colleagues (in press) also designed a survey (UConn Racial/Ethnic Stress and Trauma Survey; UnRESTS) to assess for racial stress and trauma to help clinicians ask clients difficult questions about their experiences with race-based trauma that also includes multiple questions for assessing racial and ethnic identity.

8. Immigration History for Client and/or Family

Examples in this category include: What is the client's family's country of origin and what are the circumstances or experiences surrounding the client's family leaving their country of origin? What has the impact been on the family due to this change? What was lost and what was gained? What was the transition to the United States like for the family? For the client (if applicable)? What brought them to the specific city or region that the family chose to settle in? Lee (1989) developed a more extensive immigration interview for use with Chinese-Americans that could be adapted by the clinician for broader use.

9. Spiritual and/or Existential Issues

These questions assess the salience and importance of religion or spirituality to the client and their family. Questions here can also assess whether and how spirituality plays a role in client's conceptualization of their presenting concern or in their healing. Existential issues may inquire into issues such as the client's feelings about death or into what gives the client's life meaning.

The Duke University Religion Index (DUREL; Koenig & Bussing, 2010) is a 5-item measure of religious involvement developed for use in large cross-sectional and longitudinal studies. The Brief Religious Coping scale (Brief RCOPE; Pargament, Feuille, & Burdzy, 2011) is a 14-item self-report scale that measures religious coping during major life stressors.

10. How Culture Impacts the Relationship Between the Client and the Clinician

Examples in this category include: Are there important aspects of the therapist's cultural identities which may be important to the client? How do the clinician's perceived cultural identities affect the client and his/her ability to relate to and connect with the clinician? If the client mentions choosing you intentionally, inquire about what characteristics the client may have been looking for, as many of these characteristics are often related to the visible cultural identities of the clinician. Readers may be interested in understanding the Functional Analytic Psychotherapy approach to conceptualizing how client and therapist identities intersect during the clinical encounter (Miller, Williams, Wetterneck, Kanter, & Tsai, 2015). This may include obtaining feedback from the client as to the cultural fit with the therapist, using weekly session-bridging forms (e.g., Tsai et al., 2009, Appendix IV).

It is important to keep in mind the art and science of providing any kind of intake assessment, and this is particularly true when conducting a culturally responsive assessment. To enhance trust and rapport, the clinician would be wise to start the intake by being transparent with the client and clarifying the purpose of the assessment with the client (Nakash, Rosen, et al., 2009). Here, the clinician could explain why they might be asking questions beyond the presenting concern, and about issues related to culture and race. While the aforementioned content areas provide a guideline for the clinician, it is critical that the clinician allow the process to be more organic and fluid, allowing the responses from one question guide and inform how much or even whether one might ask questions from another category. For example, if a client of color responds to early questions about cultural identities and racial identity in ways that downplay or omit race, it would be important to ease off on asking more questions directly related to race as the client could feel missed and, at worst, as though the clinician is unable to see beyond the client's race.

Conclusion

Culturally responsive assessment and diagnosis is an integral part of establishing effective care. Balancing the formation of a new clinical relationship with the task of assessment and diagnosis is complex, and requires the therapist to attend to both personal biases and best practices in cultural assessment. Attention to each client's cultural context and the cultural factors that facilitate an effective alliance have the potential to support treatment with each and every client, address existing racial disparities in mental health care, and support the ethical and effective practice of psychology.

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Family and Friendship Networks and Obsessive-Compulsive Disorder Among African Americans and Black Caribbeans

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OCD INVOLVES OBSESSIONS and/or compulsions. Obsessions involve repetitive thoughts, ideas, or impulses that are excessive and experienced as outside of the individual's voluntary control (American Psychiatric Association, 2013). Compulsions are defined as repetitive behaviors or mental acts that are performed according to specific rules or standards and are designed to relieve distress and/or reduce the frequency or intensity of obsessional thoughts. Obsessions and compulsions center on a range of issues including but not limited to concerns related to dirt or contamination, symmetry or order, making catastrophic mistakes, harm coming to or harming others, and religious blasphemy (American Psychiatric Association).

OCD typically first occurs in childhood or early adulthood (Kessler, Chiu, Demler, Merikangas, & Walters, 2005) and approximately 2% of the general population in the U.S. meets structured interview-based diagnostic criteria for the disorder in their lifetime (Kessler et al., 2005). International studies indicate that OCD is present at similar rates across culture and that symptom profiles are remarkably similar from country to country (Weissman et al., 1994). Within the U.S., there is some variation in the prevalence rates of OCD across race/ethnic groups. Our previous research indicates that approximately 1.6% of African Americans and Blacks of Caribbean descent meet criteria for OCD at some point in their lives (Himle et al., 2008). This prevalence rate is somewhat less than rates typically found among Whites in the U.S. However, when OCD is present in African American and Caribbean Blacks, it is typically more severe compared to Whites (Himle et al.). Contamination compulsions are particularly common among African Americans (Williams, Abramowitz, & Olatuni, 2012) whereas symptoms related doubt and uncertainty may be more prevalent among Whites (Nota et al., 2014).

OCD is associated with detriments in several important areas of functioning, including family relationships (Murphy & Flessner, 2015). Two dimensions of family functioning, family accommodation and high levels of expressed emotion within the family, have received substantial attention in the OCD literature. Family accommodation refers to OCD-related behaviors/avoidance performed by family members (e.g., participating in compulsions, providing repetitive reassurance) in order to relieve distress among sufferers (Braga et al., 2014). These behaviors, although they can reduce anxiety in the short run, have been found to be associated with a worsening of symptoms over time and a recent meta-analysis indicates that high levels of family accommodation have a substantial negative impact on treatment outcome (Bloch, Lebowitz, Panza, & Su, 2012). Expressed emotion refers to a range of interpersonal behaviors involving loud talking, belittling, criticism, arguments, and overinvolvement in another person's affairs (Vaughn & Leff, 1976). Prior research indicates that high levels of expressed emotion in the family are associated with more severe OCD symptoms (De Berardis et al., 2008) and poorer response to treatment (Peris, Yadegar, Asarnow, & Piacentini, 2012). The temporal relationships between OCD severity, treatment outcomes, and expressed emotion in the family are largely unknown given the paucity of longitudinal studies related to this issue, but it is likely that high symptom levels and poor treatment response both contribute to and result from increased expressed emotion among OCD families.

The relationship between OCD and family functioning beyond issues of accommodation and expressed emotion is not well known, particularly among adults with OCD. The pediatric OCD literature indicates that parents of children with OCD are less likely to encourage independence (Barrett, Shortt, & Healy, 2002), are overprotective (Wilcox et al., 2008), expect their children to be highly responsible (Farrell, Hourigan, & Waters, 2013), and are less positive and warm (Barrett et al., 2002) in their interactions compared to parents of children without OCD. Literature related to the impact of adult OCD on family interactions beyond the influence of high expressed emotion and family accommodation is also limited. It is clear that having an adult family member with OCD is often distressing for their relatives (Amir, Freshman, & Foa, 2000). Family members often report feelings of anxiety and depression (Amir et al., 2000; Cooper, 1996) and feel burdened by their relatives with OCD (Cooper, 1996). These burdens include disruption in relatives' social life and financial well-being as a result of living with a family member who has OCD (Cooper, 1996). Only one study has looked at the connection between family communication and OCD in African Americans. Using a retrospective self-report questionnaire, no connection was found between OCD severity and problematic family functioning in the areas of "communication and emotionality" (Sawyer, Williams, Chasson, Davis, & Chapman, 2015).

Beyond the association between OCD and family functioning, very little is known about the impact of OCD on other relationships. Much of the research that has been done related to friendships and OCD is limited to pediatric OCD. Kim and colleagues found that children with OCD had reduced social competence, fewer friend-

ships, and had greater difficulty making friends compared to matched controls without psychiatric problems (Kim, Reynolds, & Alfano, 2012). A second recent study confirmed increased difficulties with peer relations among youth with OCD compared to nonpsychiatric controls. Borda and colleagues (Borda, Feinstein, Neziroglu, Veccia, & Perez-Rivera, 2013) found that youth with OCD report having fewer friends, more trouble making friends, experience increased levels of peer victimization, and report greater fears of negative evaluation from peers compared to youth without OCD. In terms of ethnic minority youth, a large study in London found that minorities receiving treatment for OCD had more peer relationship difficulties as reported by parents compared to their White British counterparts with OCD (Fernández de la Cruz et al., 2015). If this pattern of difficult interpersonal functioning also occurs in Black American youth with OCD, it could result in greater alienation when compounded with marginalization due to minority status (Williams & Jahn, in press). As for adults with OCD, information regarding the impact of OCD on relationships outside of the immediate family is limited to studies that report high levels of overall social impairment without reference to impairment in friendships specifically (Piacentini, Bergman, Keller, & McCracken, 2003). Thus, there is a clear paucity of information about the relationship between OCD and friendships.

The limited knowledge base related to the impact of OCD on relationships with family and friends notwithstanding, essentially nothing is known about family functioning and friendships among African American and Caribbean Blacks with OCD. Gathering information about family and other interpersonal relationships among African Americans and Blacks of Caribbean descent with OCD in the U.S. is critical in order to understand the treatment needs of these groups.

The purpose of the present investigation is to gain further understanding on the impact of OCD on family relations and friendships. This is the first investigation on the impact of OCD on the family and social network of African American and Caribbean Blacks with OCD. This study utilizes data from the National Survey of American Life, the largest representative study of the mental health and well-being of African Americans and Caribbean Blacks available in the U.S. to date.

Methods

Participants

The National Survey of American Life: Coping with Stress in the 21st Century (NSAL) was collected by the Program for Research on Black Americans at the University of Michigan's Institute for Social Research. The NSAL includes the first major probability sample of Black Caribbeans. For the purposes of this study, Black Caribbeans are defined as persons who trace their ethnic heritage to a Caribbean country, but who now reside in the U.S., are racially classified as Black, and who are English-speaking (but may also speak another language).

Procedure

The data collection was conducted from February 2001 to June 2003. A total of 6,082 face-to-face interviews were conducted with persons aged 18 or older, including 3,570 African Americans, 891 non-Hispanic Whites, and 1,621 Blacks of Caribbean descent. Due to time and cost restraints, OCD was assessed in the African American and Black Caribbean subsamples but not among non-Hispanic White participants. Consequently, this analysis is only among African Americans and Black Caribbeans.

The overall response rate was 72.3%. Response rates for individual subgroups for African Americans and Black Caribbeans were 70.7%, and 77.7% respectively. Final response rates for the NSAL two-phase sample designs were computed using the American Association of Public Opinion Research (AAPOR) guidelines (for Response Rate 3 samples; see Jackson, Neighbors, Nesse, Trierweiler, & Torres, 2004, for a more detailed discussion of the NSAL sample). The NSAL data collection was approved by the University of Michigan Institutional Review Board.

Measures

DEPENDENT VARIABLE

Diagnostic assessment of OCD. Diagnostic assessment was conducted using the *Diagnostic and Statistical Manual* (DSM-IV) *World Mental Health Composite International Diagnostic Interview* [WMH-CIDI] (Kessler & Ustan, 2004). The WMH-CIDI is a structured, lay interviewer-administered diagnostic interview. The CIDI short-form version (CIDI-SF) Obsessive-Compulsive Disorder diagnostic module (Kessler, Andrews, Mroczek, Ustun, & Witchen, 1989) was administered rather than the full WMH-CIDI OCD

module. A CIDI-SF OCD diagnosis should be considered a probable DSM-IV OCD diagnosis, since the section does not fully assess DSM-IV criteria. Specifically, persons with a positive CIDI-SF OCD are estimated to have an 84.21% chance of also meeting full CIDI criteria for OCD according to the CIDI-SF OCD scoring guidelines. The CIDI-SF OCD questions assess the presence of obsessions and compulsions, the inability to put such thoughts "out of your mind," a sense that these obsessions/compulsions were unreasonable and/or unnecessary, and levels of distress and impairment.

INDEPENDENT VARIABLES

Family and friendship variables. There are five independent variables representing selected measures of involvement in extended family and friendship informal social support networks. Three measures assess involvement in family support networks and two measures assess involvement in friendship support networks. Degree of subjective family closeness is measured by the question: "How close do you feel towards your family members? Would you say very close, fairly close, not too close or not close at all?" This item was also asked of friends (i.e., Subjective Friendship Closeness). Frequency of contact with family members is measured by the question: "How often do you see, write or talk on the telephone with family or relatives who do not live with you? Would you say nearly every day, at least once a week, a few times a month, at least once a month, a few times a year, hardly ever or never?" This question was also asked of friends (i.e., Friend Contact). Lastly, negative interaction with family members is measured by an index of three items. Respondents were asked, "Other than your (spouse/partner) how often do your family members: (1) make too many demands on you? (2) criticize you and the things you do? and (3) try to take advantage of you?" The response categories for these questions were "very often," "fairly often," "not too often" and "never." Higher values on this index indicate higher levels of negative interaction with family members ($M = 1.85$, $SD = 0.59$) (Cronbach's alpha = 0.74).

Control variables. Demographic variables used in this analysis included age, gender, marital status (married, unmarried), education, family income, and ethnicity (African American, Black Caribbean). Missing data for family income and education were imputed using an iterative

regression-based multiple imputation approach incorporating information about age, gender, region, race, employment status, marital status, home ownership, and nativity of household residents. The distribution of the study variables is presented in Table 1.

Data Analytic Strategy

The distribution of basic demographic characteristics, Cronbach's alpha and weighted logistic regression analyses were conducted using SAS (Version 9.1.3). Odds ratio estimates and 95% confidence intervals are presented. Standard error estimates are corrected for unequal probabilities of selection, nonresponse, poststratification, and the sample's complex design (i.e., clustering and stratification), and results from these analyses are generalizable to the African American adult and Black Caribbean adult populations.

Results

Multivariate Analysis

Table 2 presents the logistic regression of the family and friendship social support variables and lifetime obsessive-compulsive disorder among African Americans and Black Caribbeans. The frequency of negative interaction with family members was the only family or friendship variable that was significantly associated with OCD. Respondents with OCD had more frequent negative interactions with their family members than respondents without OCD. Based upon the findings of previous research (Taylor et al., 2015), we tested whether there were significant interactions between the family and friendships social support variables and lifetime OCD. In particular, we tested interactions between negative interaction and family contact, negative interaction and family closeness, negative interaction and friendship contact, negative interaction and friendship closeness, family contact and family closeness, friendship contact and friendship closeness, as well as family contact and friendship contact. None of these interactions was significant.

Discussion

Negative Interaction

The present paper adds to a growing literature confirming the relationship between negative family interactions and OCD. Similar to previous research (Chambless, Floyd, Rodenbaugh, & Steketee, 2007), the present study found that persons with OCD reported significantly more negative family interactions compared to persons who did not have OCD. This is the first paper to report this relationship among a nationally representative sample of African Americans and Blacks of Caribbean descent living in the U.S. This finding is concordant with prior research; studies on risk factors for psychiatric problems among African Americans have documented a positive relationship between negative interactions and a range of psychiatric problems. Individuals who report more negative interactions with family members are more likely to meet criteria for mood and anxiety disorders as well as a greater number of these disorders (Lincoln et al., 2010). For instance, several national studies of depression in African Americans found that respondents who reported more negative interactions with family members were one and a half times more likely to meet criteria for major depression (Taylor, Chae, Lincoln, & Chatters, 2015) and experienced more depressive symptoms (Chatters, Taylor, Woodward, & Nicklett, 2015). Negative interactions are also predictive of suicide ideation and attempts (Lincoln, Taylor, Chatters, & Joe, 2012; Nguyen, Taylor, et al., 2016), PTSD (Nguyen, Chatters, Taylor, Levine, & Himle, 2016), and social anxiety disorder (Levine, Taylor, Nguyen, Chatters, & Himle, 2015) among African Americans.

Elevated levels of negative family interaction among African American and Caribbean Blacks with OCD is likely a bidirectional phenomenon. It is likely that African Americans and Caribbean Blacks with OCD exhibit behaviors that are frustrating and worrisome to their family members. It is not difficult to imagine that family members express these concerns with a range of interpersonal behaviors ranging from words of sympathy and support to excessive criticism and angry outbursts (Alonso et al., 2015). This broad range of responses is understandable given that clinical impression suggest that many individuals without OCD view OCD symptoms as senseless, excessive, and at times manipulative. Conversely, it is also

Table 1. Demographic Characteristics of the Sample and Distribution of Study Variables

	% (SE)	Mean (*SD*)	*N*
Lifetime OCD		0.02 (0.10)	4995
Negative Interaction		1.85 (0.59)	5145
Family Closeness		3.64 (0.49)	5145
Family Contact		6.06 (1.00)	5147
Friend Closeness		3.29 (0.59)	5070
Friend Contact		6.60 (1.00)	5175
Age		42.18 (12.45)	5191
Gender			
Male	44.50 (0.81)		1914
Female	55.50 (0.81)		3277
Education		12.46 (1.94)	5191
Income		$37,545 (28,775)	5191
Marital Status			
Unmarried	57.75 (1.00)		3268
Married	42.25 (1.00)		1915
Ethnicity			
African American	93.02 (0.52)		3570
Black Caribbean	6.98 (0.52)		1621

Note. Frequencies are unweighted; Percents and means are weighted to be nationally representative of the given population and subpopulations in the U.S.

likely that increased stress associated with negative family interactions can increase risk for the development of OCD. The onset of OCD is often associated with stressful life events among individuals at risk for OCD (Albert, Asinari, Bogetto, Maina, & Rosso, 2011). It is possible that persons with subclinical OCD experience increased vulnerability to development of clinical OCD when family interactions are overly negative. Overall, the increased rate of OCD among respondents reporting higher-than-average negative family interactions is consistent with the literature documenting the relationship between high EE and OCD (Chambless et al., 2007).

In terms of clinical implications, when working with African Americans with OCD, it would be important for clinicians to ascertain the nature of the family communication styles to determine if high EE is present. If so, clinicians should consider including these family members in the certain aspects of the treatment process to provide education as to how they can best support their loved one while in treatment, for example, by emphasizing the importance of reducing conflict and increasing compassionate communications surrounding mental illness. Family members who have been involved in the client's rituals may be suffering and stressed as a result; therefore, therapists should provide coping resources for these individuals and also work with the client to underscore the importance of not involving family members in OCD rituals.

Family and Friendships Social Support and OCD

Somewhat surprisingly, no other relationship variables were predictive of OCD risk. This finding stands in contrast to other research documenting the protective qualities of family support against meeting criteria for a range of disorders among Black Americans, including posttraumatic stress disorder (Nguyen et al., 2016), social anxiety disorder (Levine et al., 2015), and major depression (Lincoln & Chae, 2012; Taylor et al., 2015). However, our finding that neither positive family relations nor supportive friendships reduced the likelihood of developing OCD is consistent with research indicating that biological factors such as genetic abnormalities (Taylor, 2015) and altered functional activation in brain regions involving affective and cognitive cortico-striatal-thalamic circuits (Brem et al., 2012) are central to the etiology of OCD. Perhaps family support and close friendships are not powerful enough to protect vulnerable individuals from developing OCD whereas negative family interactions may be toxic enough to increase the risk of OCD among those with a predisposition to OCD. In fact, research on negative interactions has indicated that the harmful effects of negative interactions can offset the protective effects of social support (Gray & Keith, 2003; Lincoln, Chatters, & Taylor, 2003, 2005). Negative interactions are particularly pernicious to mental health because they can erode one's positive self-appraisals and perceptions of competence and efficacy (Lincoln, 2000, 2007) and interfere with effective coping (Glanz & Schwartz, 2008). The use of adaptive stress coping strategies is often dependent on perceptions of self-efficacy and competence (Glanz & Schwartz). Thus, along with a decreased sense of self-efficacy and competence, negative interactions can also lead to compromised stress coping responses. The results of this study may be particularly relevant here given that the particularly close kinship ties in Black communities were still not associated with reduced risk of OCD. The relationship between high levels of expressed emotion within the family and increased risk for the development for a range of psychiatric disorders (Barrowclough & Hooley, 2003) clearly suggests that negative interactions are either a marker of elevated psychiatric symptomatology, a particularly strong contributor to psychiatric distress or a combination of both. These results suggest that assessing and remediating negative family interactions could be of substantial benefit to both identifying and reducing OCD risk in the African American and Caribbean Black population in the U.S.

A second, somewhat surprising finding in this study was that OCD did not significantly impact friendships in a negative way. Clinical experience indicates that persons with OCD can display observable symptoms (e.g., washing hands, repeating) in the presence of friends, arrive late or not at all to scheduled activities because of time-consuming rituals, and appear distracted or distressed because of obsessional thoughts and accompanying anxiety. The maintenance of friendships despite these behaviors likely relates to how much these behaviors interfere with interactions and activities and degree to which these behaviors are seen by the nonaffected friend as disruptive or disturbing.

It is important to remember that unlike family members, friendships are relationships of choice. Whereas family ties are permanent, friendship ties are voluntary, based on a history of reciprocity and trust. Thus, individuals with OCD are more likely to lose friends who have difficulty with their symptoms and are able to maintain friendships with people who are more accepting of the disorder. In this analysis we found that the degree of subjective closeness to friends and the frequency of

Table 2. Multivariable Weighted Logistic Regressions of Family and Friendship Social Support Network Variables and Lifetime OCD Among African American and Caribbean Respondents in the National Survey of American Life (NSAL, 2001–2003; *n* = 4,857)

	Odds Ratio (95% CI)
Negative Interaction with Family	2.12 (1.56, 2.88) ***
Family Closeness	1.01 (0.66, 1.54)
Family Contact	1.04 (0.86, 1.26)
Friend Closeness	0.84 (0.56, 1.24)
Friend Contact	0.89 (0.73, 1.07)
Age	0.99 (0.97, 1.01)
Gender: Women vs. Men	0.80 (0.44, 1.47)
Marital Status: Unmarried vs. Married	1.28 (0.63, 2.59)
Education in Years	0.84 (0.76, 0.92)***
Income	0.99 (0.93, 1.06)
Ethnicity: African American vs. Black Caribbean	0.71 (0.30, 1.68)

Note. $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$; CI = Confidence Interval

contact with friends was not associated with OCD. However, those with OCD may have a smaller network of friends. Some of these individuals may also be socially isolated from friends as research has found that adults with depression and anxiety are more likely be socially isolated from their friends (Taylor, Taylor, Nguyen, & Chatters, in press).

The lack of an association between friendship quality and OCD diagnosis relates to the fact that many OCD symptoms are private (e.g., intrusive thoughts, mental rituals). Further research is needed to determine the impact of OCD on adult friendships across cultures to determine if our findings are specific to African Americans and Caribbean Blacks or whether the limited impact of OCD on friendships is found among most samples of adults with OCD.

Summary and Limitations

The findings from the current investigation are consistent with previous findings related to negative family interaction and OCD risk. It is clear, like with other psychiatric disorders, that negative interaction is more prevalent among respondents with OCD compared to those without OCD. The nonsignificant relationship between friendship quality and the diagnosis of OCD is interesting in that individuals appear to neither be protected by their friendships from developing OCD nor does the presence of OCD substantially impact their friendships in a negative direction. Overall, the findings are consistent with previous work which finds that social support is an inconsistent protective factor of psychiatric disorders, but negative interactions with support network members is more consistently associated with mental health problems (Lincoln et al., 2010).

This study has limitations. First, although the NSAL is the largest study of psychiatric disorders among Caribbean Blacks and African Americans conducted to date, the relatively small number of African Americans and Caribbean Blacks with OCD limits statistical power when examining the relationship between family relationships, friendships, and OCD. Thus, we caution against overinterpretation of the null findings (e.g., no association between friendships and OCD), which could have been due to insufficient power to detect a small effect, and suggest that future replication efforts are needed. Second, the cross-sectional nature of this study does not allow for assessment of temporal relationships between OCD and interpersonal relationship impacts. Third, the NSAL did not assess OCD among Whites, which obviously does not allow for comparison of the association between OCD and interpersonal relationships among Whites and Blacks in the U.S. Finally, the CIDI-SF may not yield identical rates of OCD compared to rates obtained using the full CIDI OCD diagnostic criteria.

In conclusion, this study is particularly notable given that it is among the first to investigate the relationship between friendship quality and adult OCD. This study is unique in its examination of family relationships and friendships and OCD risk among African Americans and Caribbean Blacks. Also, unlike the vast majority of research on relationship factors and OCD, which is derived from clinical samples of OCD patients, the present study involves a representative, national sample. Finally, further cross-cultural research is needed to expand our knowledge of the bidirectional nature of the relationship between OCD risk and notable interpersonal relationships to better inform research and clinical practice.

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the next ABCT **Webinar** | **March 31, 2017**

Context, Considerations, and Curriculum: Training Psychiatry Residents in CBTs

Barbara Kamholz, *Ph.D.,* VA Boston Healthcare System

- 11:00 A.M.–12:30 P.M. Eastern | 10:00 A.M.–11:00 A.M. Central | 9:00 a.m.–10:30 A.M. Mountain 8:00 A.M. – 9:30 A.M. Pacific
- $30 for members | $45 for nonmembers

CBT Training for Psychiatry residents is mandated by ACGME and further outlined by the Psychiatry Milestone Project. Key competencies for CBT education and practice have also been widely discussed and are at the heart of ABCT's Academic Training and Education Standards Subcommittee on Doctoral Training Competencies in CBTs. However, implementation of these ideals remains challenging. Despite increases in the quantity and quality of CBT education for psychiatry residents in recent years, CBT education in psychiatry residencies remains limited. This webinar will address goals and possible structures for residency training in CBTs, key factors for consideration in residency training (e.g., educational context, conceptual and practical challenges, mutual benefits, and career trajectories), and assessment of training outcomes.

Rejection Sensitivity in Members of Marginalized Groups: Implications for Understanding Mental Health Disparities

Richard T. LeBeau, Anni M. Hasratian, Y. Vivian Byeon, *UCLA*

THE EXISTENCE OF DISPROPORTIONATELY high rates of mental health concerns among members of marginalized groups has gained increasing attention in recent years. A great deal of research has been conducted exploring the psychological and sociopolitical correlates of the development and maintenance of these disparities, as well as intervention and prevention efforts designed to reduce (and eventually eliminate) these disparities. As a result of this research, several theoretical frameworks have emerged for understanding this phenomenon. Paramount among the theoretical frameworks is minority stress theory (Meyer, 2003). The theory, which was originally conceptualized with regard to lesbian, gay, and bisexual (LGB) individuals but has since been extended to other marginalized populations, posits that marginalized individuals experience unique stressors associated with their minority identities (referred to as minority stress) and that such stress accounts for their increased risk for psychological disorders.

Although there is a great deal of evidence in support of the relationship between minority stress and elevated rates of mental health problems, much remains unknown about the mechanisms through which minority stress exerts its deleterious impact on mental health. To address this gap in the research, Hatzenbuehler (2009) proposed the psychological mediation framework, which extended minority stress theory and (like the theory from which it emerged) focused on LGBs. The theory suggests that a combination of general psychological processes (e.g., emotional regulation deficits) and group-specific processes (e.g., internalized homonegativity) mediate the relationship between minority stress and psychopathology.

Despite this being a relatively new line of research, studies have already identified several potential mediators that hold promise for explaining the relationship between minority stress and elevated mental health concerns. One such process is Rejection Sensitivity (RS), a cognitive-affective process that reflects an individual's tendency to anxiously expect, readily perceive, and intensely react to social rejection experiences (Downey & Feldman, 1996). Significant research has been conducted on RS over the last two decades, mostly focused on two areas. The first explores the relationship between RS and mental health problems, particularly borderline personality disorder and depression. The second involves the interplay between minority stress and RS. In the present article, we aim to provide a brief overview of the extant research on (a) the relationship between RS and psychopathology, (b) RS in members of marginalized groups, and (c) using empirically supported psychological interventions to target elevated RS. Finally, we provide detailed recommendations for future research in this area.

The Relationship Between Rejection Sensitivity and Psychopathology

Extensive research has established a relationship between RS and various mental health problems, irrespective of identification with a marginalized group. The majority of this work has been conducted in individuals with borderline personality disorder (BPD; Bungert et al., 2015; De Panfilis, Meehan, Cain, & Clarkin, 2016; Staebler, Helbing, Rosenbach, & Renneberg, 2011) and unipolar depression (Flett, Besser, & Hewitt, 2014; Fountoulakis, Iacovides, Kaprinis, & Kaprinis, 2006; Kudo et al., 2016; Norona, Roberson, & Welsh, 2016; Zimmer-Gembeck, Nesdale, Webb, Khatibi, & Downey, 2016). Research has shown that high rates of RS are found in individuals with BDP compared to clinical (Chesin, Fertuck,

Goodman, Lichenstein, & Stanley, 2015; Staebler et al., 2011) and nonclinical (Berenson et al., 2009) samples. Findings indicate that high RS is strongly related to BPD (Bungert et al., 2015; Downey, Khouri, & Feldman, 1997) with heightened RS being highly correlated with symptoms of BPD (Bungert et al., 2015; Staebler et al, 2011) and that individuals with BPD have higher rejection expectancy and increased rejection anxiety (Bungert et al.). Similarly, much research has been done with RS and its relationship with depression. Studies have found RS to be a risk factor for depression (Ayduk, Downey, & Kim, 2001; Chango, McElhaney, Allen, Schad, & Marston, 2012; Downey & Feldman, 1996; Downey, Freitas, Michaelis, & Khouri, 1998; Pearson, Watkins, Mullan, & Moberly, 2010), with some suggesting that RS moderates the relationship between interpersonal stress and symptoms of depression (Ayduk et al., 2001; Chango et al., 2012). Research has also shown that heightened RS correlates with high levels of depression (Kudo et al., 2016; Liu, Kraines, Massing-Schaffer, & Alloy, 2014; Mellin, 2008).

Less research has been done with how RS relates to other mental health problems such as anxiety disorders, eating disorders, and substance use disorders. RS looks to be theoretically strongly related to social anxiety disorder (SAD), considering the emphasis on anxious arousal in RS and the research supporting the link between social pain experiences and social anxiety disorder onset (Fung & Alden, 2016; Schwartz, Snidman, & Kagan, 1999). The few studies that exist on RS and SAD found that RS is a key shared feature of SAD and body dysmorphic disorder (Fang et al., 2011; Lavell, Zimmer-Gembeck, Farrell, & Webb, 2014) and that social support moderates the relationship between angry RS and SAD (McDonald, Bowker, Rubin, Laursen, & Duchene, 2010). There is also some evidence linking RS to eating disorders, such that individuals with eating disorders demonstrate elevated attentional bias to rejection compared to healthy controls (Cardi, Di Matteo, Corfield, & Treasure, 2013), and individuals with anorexia who endorsed more negative interpretations of socially ambiguous scenarios also reported higher RS (Cardi et al., 2017). A handful of studies have also investigated the role of RS in individuals with substance use disorder. For example, RS has been found to mediate the relationship between substance abuse and risky sexual behaviors during a social rewards task in individuals with substance use disorder (Woerner, Kopetz, Lechner, Lejuez, 2016).

Status-Based Rejection Sensitivity and Its Correlates

A great deal of research has been conducted on the relationship between RS, minority stress, and psychopathology within specific marginalized groups. In such research, RS is usually conceptualized as status- or stigma-based rejection sensitivity, with studies examining group-specific constructs such as gay-related rejection sensitivity and gender-related rejection sensitivity (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002). The most comprehensive work in this area has been conducted in LGBs. Consistent with other studies on RS, sexual orientation–based RS has been found to be associated with the development of maladaptive behavior. In a study seeking to establish a valid measure of gay-related RS, higher RS contributed to unassertive interpersonal behavior (e.g., self-silencing, unlikely to approach others or respond to rudeness) in gay men in the context of internalized homophobia and parental rejection (Pachankis, Goldfried, & Ramrattan, 2008). RS also has been found to predict substance use among young sexual minority men when interacting with structural stigma (Pachankis, Hatzenbuehler, & Starks, 2014). Such research has also developed a great deal of support for RS as a risk factor to developing psychopathology (Cohen, Feinstein, Rodriguez-Seijas, Taylor, & Newman, 2016; Feinstein, Wadsworth, Davila, & Goldfried, 2014). For instance, RS was positively associated with depressive and social anxiety symptoms (Feinstein, Goldfried & Davila, 2012) in a large sample of gay men and lesbians. Findings such as these emphasize the importance of targeting RS in treatment with LGB individuals who have experienced discrimination based on their sexual orientation (Pachankis et al., 2008).

Although work has been done on race-based rejection sensitivity across a number of racial/ethnic groups, the majority of the work focuses on African and Asian Americans. The literature on African Americans have found that individuals with heightened race-based RS are more likely to experience difficult college transitions, decreased support seeking, decline in grades, higher negative affect, and lower forgiveness to perpetrators (Downey, Lebolt, Rincón, & Freitas, 1998; Henson, Derlega, Pearson, Ferrer, & Holmes, 2013;

Mendoza-Denton et al., 2002). A study on urban, primarily Hispanic and African American early adolescents showed that higher RS predicted interpersonal difficulties and, over time, these children demonstrated disruptive, oppositional behavior and decline in academic performance (Downey et al., 1998). However, one study found that affiliation with one's ethnic identity may be a protective factor against the effects of high RS by determining that ethnic identity predicted increased academic performance in students with low RS and did not affect performance in those with high RS (Mendoza-Denton, Pietrzak, & Downey, 2008).

Literature on Asian Americans has shown varying results. There are several studies that highlight the correlation between past experiences of discrimination among Asian Americans and internalizing (Greene, Way, & Pahl, 2006) and depressive symptoms (Liang, Li, & Kim, 2004). One study focusing on race-based RS regardless of actual discrimination experiences found that, while uniquely moderated by the maladaptive coping strategy of shame, high RS predicted more internalizing symptomatology, specifically low self-esteem (Chan & Mendoza-Denton, 2008). However, another study that specifically measured the frequency of discrimination among Hispanic and Asian American adolescents did not find that RS moderated the associations between discrimination and well-being (Huynh & Fuligni, 2010). Very little research has been conducted on other minority racial/ethnic groups, including Hispanics and Latinos, Native Americans, and biracial and multiracial individuals.

Compared to sexual orientation- and race/ethnicity-based RS, little research has been conducted on gender-based RS. London et al. (2012) highlighted this issue and noted a great need for future research to continue examining women who face gender-based discrimination in male-dominated institutions after associating high RS with self-silencing, avoidance of opportunities, and low academic self-confidence in women. To the authors' knowledge, no studies have specifically examined RS among transgender and nonbinary individuals.

Although heightened levels of RS seem to be impairing irrespective of group membership, the stigmatized status of these groups may make them prone to have higher RS. However, this hypothesis has rarely been explicitly tested. One notable exception is a study conducted by Feinstein et al. (2012). In this study, RS (along with

internalized homonegativity) mediated the relationship between discrimination experiences and symptoms of depression and social anxiety in a sample of 218 lesbians and 249 gay men. This study also revealed a significant relationship between gender nonconformity and RS, which appeared driven by the experience of elevated rejection experiences early in life among high gender nonconforming individuals. Although the extensive heterogeneity among (and within) marginalized groups prevents us from generalizing these findings between groups, they provide a useful framework that can be adapted and utilized in other groups.

Targeting Rejection Sensitivity Through Psychological Intervention

Although the evidence reviewed above suggests that RS may be an important factor in understanding the relationship between minority stress and psychopathology, the question of whether RS can be significantly reduced as a result of psychosocial intervention remains. Insofar that RS is demonstrated to be a malleable process, it may be beneficial not only as an explanatory construct for mental health disparities, but also a useful treatment target. Theoretically, cognitive behavioral therapy (CBT) is well-suited to target RS, particularly as delivered in the treatment of SAD (Heimberg, 2002). For example, anxious expectation of rejection can be targeted through cognitive techniques, such as estimating the odds and decatastrophizing; exaggerated perceptions of rejection can be addressed through cognitive restructuring; and intense reactions can be targeted through repeated in vivo and interoceptive exposure, as well as stress management and mindfulness techniques.

Unfortunately, the majority of studies utilizing CBT primarily report changes in symptomatology and functioning as a result of treatment but not cognitive and affective process variables, such as rejection sensitivity. One notable exception is the randomized control trial comparing an LGB-affirmative CBT protocol (Effective Skills to Empower Effective Men; ESTEEM) to a waitlist control (Pachankis et al., 2014). ESTEEM is composed of 10 individual therapy sessions corresponding to the Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2010), but adapted to include a focus on gay and bisexual men's experience of minority stress and maladaptive attempts to cope with it. In the study (n = 63 young gay and bisexual men), traditional outcome measures (e.g., depression and risky sexual behavior) were measured alongside minority stress process variables (including RS). Results suggested that individuals receiving ESTEEM experienced significant reductions across most traditional outcome measures compared to waitlist control, but that the results for RS and other minority stress process variables had only small effects and did not differ between the two groups. The authors did note, however, that results were in the hypothesized direction and that future studies with larger sample sizes may be better suited to detect a statistically significant effect. Although these results were far from conclusive, the study provides an example of how processes such as RS can be easily assessed in treatment research.

Recommendations for Future Research

Over the last 2 years, the National Institute of Mental Health has made significant progress in its support of research on minority health and mental health disparities, through the inclusion of these topics as a major cross-cutting research theme in its 2015 Strategic Plan for Research (NIMH, 2015) and expanding the category of health disparity populations to include sexual and gender minorities in 2016 (Perez-Stable, 2016). Systemic support of this nature is essential to the advancement of research in this area, but it is not sufficient. Below we provide some specific recommendations for future research in this area.

First and foremost, we encourage researchers investigating mental health disparities across all marginalized groups to consider the minority stress and psychological mediation approaches described above as guiding frameworks. Despite the fact that the experiences of sexual minorities cannot be assumed to generalize to members of other marginalized groups, the approaches developed in these populations provide an empirically supported theoretical framework for studying the relationship between minority stress and psychopathology in other marginalized groups. Second, special attention should be paid to RS in marginalized populations for whom little relevant data exists, such as Hispanics and Latinos, transgender and nonbinary individuals, individuals with disabilities, and members of certain religious groups. Additionally, intersectionality should be carefully considered as an individual's identity is made up of numerous group memberships. Third, future research should aim to better understand the relationship between RS and mental health problems outside of depression and BPD. For example, despite the fact that RS is highly theoretically related to SAD and eating disorders, little research has been conducted in these areas. Fourth, well-controlled and well-powered intervention research is essential to determining whether RS is a viable treatment target.

Finally, future research should focus on the development of more nuanced and accurate conceptualizations and measurement tools for RS. One framework that is likely to be of great utility in this endeavor is the National Institute of Health's Research Domain Criteria (RDoC; Morris & Cuthbert, 2012). Individuals high in RS are likely experiencing disruptions across a number of domains highlighted by the RDoC. Specifically, individuals with high RS likely experience disruption across all five elements of the Negative Valence domain, with rejection being the potential threat being anticipated, actual or perceived rejection being as the acute threat being experienced, and sustained threat resulting from expecting and perceiving rejection repeatedly over a long period of time. Furthermore, feelings of loss are likely sequelae from the perception that significant others have been rejecting and frustrative nonreward may occur depending on the degree to which the individual feels they have put effort into the rejecting relationship. In terms of the Social Processes domain, it is plausible that some individuals who have an exaggerated tendency to perceive rejection may experience disruptions in reception of facial and nonfacial communication. To the degree that the rejection is misperceived, deficits in perception and understanding of others may be present. Individuals with high RS may have disruptions in the Cognitive Processes domain as well, including attention (e.g., attentional bias to threat) and declarative memory (e.g., exaggerated mental representations of past rejection experiences). Clearly RS is a complex process with multiple components and understanding of the process would undoubtedly benefit from deconstructing its various components and investigating them in detail.

With regard to measurement, it remains a limitation of the existing body of research on RS that the vast majority of studies have solely utilized self-report scales to measure RS. Although there are valid and reliable scales for the measurement of RS (most notably the Rejection

Sensitivity Questionnaire; Downey & Feldman, 1996), the limitations of relying on self-report alone in research is well-documented (for a thorough review of these issues, see Stone et al., 1999). Here, the RDoC framework may be useful as well, as it is likely that RS can be assessed across all of the units of analysis included in RDoC beyond self-report—genes, molecules, cells, circuits, physiology, behavior, and paradigms. For example, research could utilize experimental paradigms assessing behavioral responses to rejection experiences in which changes in physiology and circuit activation are measured. In fact, research of this nature is emerging in adjacent fields such as social cognitive neuroscience, which has developed innovative paradigms for the assessment of responses to social rejection that go beyond self-report (e.g., cyberball; Eisenberger, Lieberman, & Williams, 2003). Increased collaboration with social and cognitive psychologists would likely be of great benefit to enhancing the quality of research being conducted in this area.

Conclusion

A large body of research suggests that RS is linked to psychopathology, with the majority of research being conducted with regard to depression and BPD. Additionally, the relationship between RS and minority stress has been well established, with most research focusing on LGBs and African Americans. Recent research on LGBs has advanced our understanding of how RS may impact the well-documented mental health disparities experienced by marginalized groups by providing empirical evidence that RS may in fact be a mediator of the minority stress–psychopathology relationship. Despite this emerging research on RS as a useful construct for understanding mental health disparities, little research exists regarding whether RS is a viable treatment target. We recommend that research in this area should utilize the minority stress and psychological mediation frameworks, extend previous findings to additional outcome variables and other stigmatized groups, and utilize the RDoC framework to improve the conceptualization and assessment of RS.

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Addressing Refugee Mental Health Needs: From Concept to Implementation

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THE CURRENT REFUGEE CRISIS continues with outward signs indicating that political, social, and economic causes are ongoing and in some cases worsening. The most recent statistics from the United Nations High Commissioner on Refugees reveal that in 2015 alone, more than 60 million individuals were forced to flee their home countries in search of a safer place to live (Edwards, 2016). This flight often requires that individuals leave behind families, possessions, and ways of life in search of freedom in a new location where they can build a new life. All too frequently, these individuals have witnessed or experienced torture themselves or family and friends have been tortured. It has been estimated that more than half a million survivors of torture live in the U.S. through refugee resettlement initiatives (Aniyizhai, 2014). This, combined with the stressors of complete loss of stability, safety, and familiarity, may exacerbate underlying health issues, including mental health. Furthermore, once refugees arrive in the U.S., the adjustment process may be difficult. They may face xenophobia, racism, and discrimination, which also are linked to mental health sequelae (Berger & Sarnyai, 2015; Helms, Nicholas, & Green, 2012).

Assessments of health conditions of refugees consistently have recognized multiple mental health problems among newly arriving refugees. According to information provided by the Refugee Health Technical Assistance Center (Mental Health, 2011), posttraumatic stress disorder (PTSD), depression, generalized anxiety, panic disorder, adjustment disorder, and somatization are the most common mental health diagnoses associated with refugee populations, with rates of PTSD ranging between 10% to 40% in resettling refugee populations. In response to this, provision of comprehensive mental health services to these newest U.S. citizens is vital.

In 2012, the University of Louisville Global Health Center (UL-GHC) partnered with the Kentucky Office for Refugees and in 2014 began providing initial refugee health assessments to the more than 2,500 refugees resettling in Louisville each year. These health assessments include the Refugee Health Screener 15 (RHS-15), a well-used, culturally appropriate and valid mental health screening tool for refugees over the age of 14 (Hollifield et al., 2013). The tool screens for anxiety, depression, and PTSD. We found that more than 20% of the refugees scored positively on the RHS-15 and showed distress on a distress thermometer included in that tool, indicating increased risk for mental health problems. We also found that a significant proportion of those refugees expressed reluctance to follow-up on outside referrals but openness to mental health services if provided at the UL-GHC site. We noted that there was limited expertise in culturally appropriate, trauma-informed care available in the Louisville area, outside of the UL-GHC. In response to these findings, the UL-GHC concluded that mental health services represented a critical and immediate need of the refugee population. As the UL-GHC care model is based upon a patient-centered medical home approach, it was determined that mental health services could be provided on site and integrated into the total care of the refugee via a holistic, refugee-centered medical home (RCMH).

The objective of this report is to describe the concept, implementation, and initial impact of these mental health services on trainees at the UL-GHC.

Methods

Concept

The framework of the mental health service component of the RCMH approach included four interrelated elements: (a) full integration of evidence-based trauma-informed mental health care into primary care, beginning at the time of first contact with the refugee, (b) provision of individual and family counseling, (c) facilitation of support groups and referral linkages to help refugees build a sustainable social support network, and (d) coordination of a holistic care delivery process using an interprofessional approach that engages medicine, including psychiatry, psychology, nursing, law, and social work.

Implementation

First contact with the refugees was for their initial health assessment at UL-GHC, and the RHS-15 was performed there by psychologists with expertise in trauma-informed care. Using professionals with this level of expertise for their first mental health assessment enabled rapid identification of refugees demonstrating mental health issues, resulting in immediate integration into mental health services.

An additional pathway for recognition of mental health service needs involved assessments during primary care visits. This enabled identification of at-risk and in-need refugees who may have initially screened negatively on the RHS-15, refugees who were seen at another health assessment site and did not have RHS-15 results, or refugees who had migrated from another resettlement state. Referrals were also received from the resettlement agency case workers as well as other mental health providers in the Louisville community.

Building upon the holistic RCMH approach to care, clinical psychologists and psychiatrists provided individual mental health care and counseling that often

necessitated inclusion of families and counseling expanded into home visits when culturally appropriate. Successful paths toward healing were conceptualized to include not only services provided within the RCMH but also within the individual communities where the refugees lived and socialized. Support groups were facilitated and community-based trainings were provided and supported.

Considerations of sustainability required recognition of existing limitations in capacities for mental health services and the need to increase capacity through development of sustainable training programs. We therefore formed a training program that could immediately increase the capacity for mental health service provision and also could function as a culturally focused and trauma-informed training site for students. We assembled a novel team including the primary care physician, nurse practitioner, clinical psychologist, and social worker collaborating to address the body, mind, spiritual, and sociocultural needs of the refugee. Clinical psychology graduate students were included to assess and treat refugees as an external practicum placement with culturally informed supervision from knowledgeable clinical faculty.

Six clinical psychology students participated, as well as one visiting MSW therapist completing her clinical hours. The therapist trainees were a diverse group, consisting of three African Americans, two Hispanic Americans, one Syrian American, and one non-Hispanic White student. Two students were sexual minorities. Three students were fluent in Spanish and one was fluent in Arabic. The curricula for student therapists included training in CBT interventions, including behavioral activation for Hispanics (Kanter et al., 2015), functional analytic psychotherapy to improve the therapeutic alliance when working cross-culturally (Miller, Williams, Wetterneck, Kanter, & Tsai, 2015), and prolonged exposure for PTSD (Foa, Rothbaum, & Hembree, 2007; Williams et al., 2014). Supervision often included guidance on how to tailor empirically supported treatments developed for Americans to meet the needs culturally diverse patients (Hays, 2009). Students also received training in issues impacting the mental health of marginalized groups and working with interpreters (Farooq & Fear, 2003; Laban, 2015). In addition to the RHS-15, students administered clinical interviews, which included the DSM-5 Cultural Formulation Interview (CFI; American Psychiatric Association, 2013), Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5; Brown & Barlow, 2014), and Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013). Bilingual students translated and back translated measures that were not available in Spanish, such as the ADIS-5 and many self-report measures. Several psychologists in the community with expertise in trauma were willing to serve as individual supervisors for the students, donating their time to further the mission of the clinic.

Results

From November 2015 through June 2016, 540 refugees aged 14 and older were seen for their initial refugee health assessment at the UL-GHC. Of those, 525 completed the RHS-15. From those that completed the RHS-15, 65 (12.4%) screened positively, prompting an initial triage for mental health service needs. Of those 65, 40 were entered into a formal and comprehensive mental health service process. Among these 40 refugee patients, the most common mental health diagnoses were depressive disorders (40%), trauma and stressor-related disorders (35%), and anxiety disorders (11%). Schizophrenia and other psychotic disorders were also seen (5%). These refugees were resettled from Syria, Sudan, Iraq, Cuban, Bhutan, Afghanistan, and Democratic Republic of Congo. The care provided was individualized for the refugee and included a variety of family and social/community contacts.

It quickly became apparent that ideal outreach care needed to include an individual who could relate directly to the refugee in terms of cultural knowledge, understanding of resettlement issues, and the potential trauma involved. To that end, to promote and support care linkages and provide a solid foundation for interprofessional practice and education, a new group of health care workers, termed the *global health navigator*, were hired. Position requirements included experience as a refugee, fluency in native languages and English, and experience in health care and community outreach. These navigators assisted with multiple aspects of care, including interpreting, advocacy, teaching, and connecting with local groups and agencies as key elements in the mental health service process.

As the mental health program is in its early stages, it continues to be refined and outcome data are still being collected. However, nine medical and clinical psychology student trainees involved in the project were asked to describe their experiences and provide feedback on this new service. Their comments were overwhelmingly positive and included statements such as, "It has been an overall positive and great training experience," "A strength was the cooperation and collaboration between all involved," "I was able to see firsthand how consistent interpreting services enhanced the client-doctor relationships," and "It became a well-oiled machine." Suggestions for improvement included: "Have bilingual clinical psychologists in addition to the navigators," "Improve abilities in how to better work with interpreters," and "Address how to deal with cancelled appointments and when refugees do not show up for appointments."

Conclusions

Our experience is that employing a RCMH, interprofessional approach to embed mental health services into primary care for refugees at the UL-GHC has been a tremendous success. We were able to identify the mental health needs of our refugee patients, including the severity of need and the urgency of intervention, and provide culturally informed interventions. Although we have not yet analyzed outcomes, the program appears vital for the provision of safe and quality care for a vulnerable population and is well received by refugees and staff. Sustainability was considered foundational in our conceptual model, including financial and service resources. Financial metrics were developed that included expenses for staff and the related payments from health insurers. As most refugees are covered by Medicaid during their initial resettlement period, the financial evaluation focused on Medicaid reimbursement. This was the most critical hurdle in sustainability as reimbursement rates simply do not cover costs of care. Additional difficult coverage issues included delayed benefits, interruption in coverage, and lack of understanding of the health care system by the refugees themselves.

In terms of sustainability of service resources, the program must include training, recruitment, and retention of the full scope of experts in mental health and health care providers. Continuous opportunities for learning must be available with oversight for students provided by professionals with relevant expertise. Providing holistic care requires a full spectrum of participants. These participants include a team of trauma-informed and culturally aware

health care providers (e.g., primary care physicians, nurse practitioners, psychiatrists, and clinical psychologists), members of related disciplines (e.g., social services, health navigators, and case managers), and individuals who can facilitate effective communication with the patient in the context of their own communities and environments.

The mental health needs are not going away, and the difficulties facing refugees in this country may be expected to worsen in the current political climate. In this difficult context, our efforts are guided by an ethical responsibility to care for new and vulnerable members of our communities and an awareness that failing to provide needed care harms not only the individual but the community as well. Although much more work is needed, our experience is that an approach that uses existing strengths, identifies new partnerships, and provides care as good stewards of available resources can become the basis of a sustainable program that addresses a significant public health need in our communities.

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Addressing Barriers to Care Among Hispanic Youth: Telehealth Delivery of Trauma-Focused Cognitive Behavioral Therapy

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Prevalence and Impact of Traumatic Exposure Among Hispanic Youth

Exposure to potentially traumatic events (e.g., physical abuse, sexual abuse, witnessing domestic or community violence, violent or unexpected death of a loved one) is a significant public health concern with approximately half of all youth reporting experiencing at least one type of potentially traumatic event before the age of 18 (Finkelhor, Turner, Shattuck, & Hamby, 2013; Kilpatrick et al., 2003). Nationally representative surveys indicate that racial and ethnic minority youth, in particular Hispanics and African Americans, endorse higher rates of trauma exposure and greater rates of revictimization compared to Caucasian youth (Andrews et al., 2015; Crouch et al., 2000; Roberts et al., 2011). Hispanic female youth are a particularly vulnerable group, with approximately one in three endorsing some form of childhood maltreatment, with sexual assault, physical assault, and witnessing violence among the most commonly reported types of victimization (Warner, Alegría, & Canino, 2012).

Youth exposed to potentially traumatic events are at an increased risk of developing mental health disorders (e.g., posttraumatic stress disorder, depression, anxiety) and of engaging in risky behaviors (e.g., problematic substance use, self-injury,

unprotected sex; Danielson et al., 2010; Hanson, Moreland, & Orengo-Aguayo, in press). Similar to findings regarding trauma prevalence, there is evidence to suggest that Hispanics, compared to non-Hispanic Caucasians, may be particularly vulnerable to developing psychopathology secondary to experiencing trauma (Alcántara, Casement, & Lewis-Fernández, 2013; Pole, Best, Metzler, & Marmar, 2005).

Barriers in Accessing Mental Health Services

Evidence-based, trauma-focused treatments that have preliminary evidence to be effective for diverse populations (Huey & Polo, 2008) and can be tailored for specific cultural groups, such as Hispanics (de Arellano, Danielson, & Felton, 2012), are available for children and adolescents (e.g., Trauma-Focused Cognitive Behavioral Therapy [TF-CBT]; Cohen, Mannarino, & Deblinger, 2006; de Arellano et al., 2012). However, Hispanic youths are less likely to have access to these mental health services, and more likely to prematurely terminate services when they do engage in treatment (Alegría, Vallas, & Pumariega, 2010; Roberts et al., 2011; Smith, Domenech-Rodriguez, & Bernal, 2011). Common barriers to accessing mental health care

include: (a) limited availability of linguistically appropriate services for Spanish-speaking children and families; (b) limited services available in rural areas; (c) lack of transportation to mental health facilities; (d) being under- or uninsured; and (e) caregiver employment barriers (e.g., scheduled work hours, leave restrictions; National Research Council and Institute of Medicine, 2009).

Telehealth as an Alternative

Telehealth (i.e., the use of interactive technologies such as videoconferencing via computer and/or tablet to deliver mental health services to patients) has been proposed as an alternative to office-based delivery of treatment in order to address disparities in access to care (e.g., Kazdin, 2008; Myers & Comer, 2016). Such technology can allow for providers trained in evidence-based trauma treatments, and who are culturally and linguistically competent (i.e., are fluent in Spanish and familiar with Hispanic culture), to reach youth who might otherwise remain untreated (Yellowlees, Marks, Hilty, & Shore, 2008; Yellowlees et al., 2013). For instance, Spanish-speaking providers can offer services to monolingual, Spanish-speaking families who might not have linguistically appro-

priate clinicians in their communities. Logistical barriers such as lack of transportation, costs of parking and travel, as well as extended travel times can also be addressed via the use of this technology. Furthermore, services can be offered in more naturalistic settings such as schools, daycares, and homes (Gloff, LeNoue, Novins, & Myers, 2015), which may in turn provide a more nuanced understanding of the youth's presenting problems, strengths, and social supports (Comer et al., 2014).

The available evidence to date suggests that mental health services delivered via telehealth are as effective as office-based treatment in addressing a number of disorders in youth (see Gloff et al., 2015, for a review). Additionally, preliminary evidence indicates that such treatment delivery modality is feasible to implement and acceptable among youth and their parents (Goldstein & Glueck, 2016). Telehealth might also be more cost-effective as compared with traditional office-based delivery. For example, telehealth can be utilized as a way to circumvent the associated costs with travel and loss of work to attend weekly appointments (Spaulding, Belz, DeLurgio, & Williams, 2010).

Telemental Health Outreach Program in Schools

The Telemental Health Outreach Program in Schools (TOPS; Stewart, de Arellano, & Wallace, 2016) program provides school-based telemental health treatment for children and adolescents. The goal of the TOPS program is to reach populations that have traditionally been underserved by office-based mental health care programs, especially racial/ethnic minorities and rural populations. The program provides evidence-based trauma-focused therapy for trauma-exposed children and families. Referrals come from a range of agencies and individuals, including child advocacy centers, child protective service agencies, law enforcement agencies, schools, and individual caregivers. Services are provided via telehealth (e.g., HIPAA-compliant videoconferencing software) in schools in the southeastern United States.

The present study illustrates the feasibility of delivering TF-CBT via telehealth using a multiple-case study design aimed at answering the following exploratory questions: (1) What barriers did these youth initially have in accessing mental health services? (2) How did telehealth help address these barriers? (3) Did patients complete telehealth treatment? (4) What adaptations had to be made for a telehealth delivery

Table 1. Participants

Participants	Gender	Age	Index Trauma Type(s)
Participant 1	Female	11	Sexual Abuse
Participant 2	Female	16	Sexual Abuse
Participant 3	Female	15	Sexual Abuse, Physical Abuse, Witnessing Domestic Violence
Participant 4	Female	10	Violent death of family member

Table 2. Pre-, Mid-, and Posttreatment Scores for All Participants

	UCLA PTSD-RI			CDI		SCARED	
Participant	Pre	Mid	Post	Pre	Post	Pre	Post
1	33	15	5	7	2	21	15
2	53	39	6	18	2	64	12
3	29	33	10	16	11	21	35
4	44	27	12	19	12	46	19

format? and (5) Did we see clinically significant change in symptoms pre- to posttreatment with this mode of delivery?

Method

Participants

Participants were four consecutively referred female Hispanic children and adolescents ages 10 to 16 who were referred for treatment at a trauma treatment center in the southeastern United States. Three out of four Hispanic youth had an index trauma (i.e., an individual's self-defined "worst" traumatic event) of sexual assault, one had an index trauma of traumatic death of a loved one, and one had multiple index traumas including sexual abuse, physical abuse, and witnessing domestic violence (see Table 1). All youth met criteria for PTSD according to the *Diagnostic and Statistical Manual* (4th ed., text revision; DSM-IV-TR; American Psychiatric Association, 2000), at the time of treatment initiation.

Measures

UCLA PTSD Reaction Index for DSM-IV (UCLA PTSD RI; Steinberg, Brymer, Decker, & Pynoos, 2004). The UCLA PTSD RI assesses trauma exposure and posttraumatic stress symptoms among children and adolescents, ages 7 to 18 years. Parent-, child-, and adolescent-report versions of the instrument are available. Part one consists of a lifetime trauma exposure screen. Part two evaluates A1 and A2 DSM-IV PTSD criteria of traumatic exposure and reaction to the exposure. Part three evaluates the frequency of occurrence of PTSD symptoms. Frequency of occurrence of PTSD symptoms during the past month is rated on a 5-point scale from 0 (*none of the time*) to 4 (*most of the time*). The UCLA PTSD RI yields a total scale score, as well as three subscale scores: reexperiencing, avoidance, and hyperarousal. To score the UCLA PTSD RI, the numerical ratings from items that comprise each subscale are summed. These scores range from 0–68, with higher scores representing higher distress. A score of 38 or higher is indicative of likely PTSD (Steinberg, Brymer, Decker, & Pynoos, 2004). The UCLA PTSD-RI can be used as either a self-report or clinician-administered instrument. In the present study the instrument was used as a clinician-administered instrument. The instrument has demonstrated good internal reliability in multiple studies, with Cronbach's α of 0.90–0.92. (Roussos et al., 2005; Steinberg et al., 2013).

Children's Depression Inventory (CDI; Kovacs, 1985). The CDI is a well-established self-report instrument for depressive symptoms in children. The CDI is comprised of 27 items assessing children's cognitive, affective, and behavioral depressive symptoms. The instrument has exhibited high internal consistency (α = .94). A score of 12 or lower on the CDI is considered to be normal.

Screen for Children's Anxiety Related Emotional Disorders, Child Version (SCARED; Birmaher et al., 1997). The SCARED is a 41-item self-report measure for children's anxiety symptoms. Internal consistency α values have ranged from .74 to .93. The clinical cutoff score for the SCARED is 25.

Intake Procedures

Participants completed a clinical evaluation consisting of semistructured clinical interviews completed separately with the child and a caregiver and completion of self-report questionnaires by the child and caregiver. The clinical interview elicited information related to trauma history, medical and psychiatric history, and current mental health. Self-report measures included measures of trauma, depressive symptoms, and anxiety symptoms. Initial assessments were conducted in person. After it was determined that the youth was appropriate for TF-CBT, school-based telehealth services were arranged and all subsequent psychotherapy sessions were provided via telehealth (i.e., HIPAA-compliant videoconferencing software). Assessment and treatment were provided in either English or Spanish, depending on the language preference of the child and caregiver. Services were provided in Spanish for two youths and in English for two youths. All caregivers preferred to receive services in Spanish and thus all parent sessions and conjoint child-parent sessions were conducted in Spanish. Assessment measures were used to track changes in PTSD severity, anxiety, and depression. Measures were administered at pretreatment and at the final session. PTSD measures were also administered at midtreatment (before beginning work on the trauma narrative). Table 2 presents individual participant scores at all assessment points.

Treatment

TF-CBT. TF-CBT (Cohen, Mannarino, & Deblinger, 2006) is an empirically validated, manualized treatment protocol utilized to treat posttraumatic stress symptoms in children and adolescents. TF-CBT is usually delivered in 12 to 16 weekly sessions and includes the following major components: (a) psychoeducation; (b) coping strategies, such as relaxation, identification of feelings, and cognitive coping; (c) gradual exposure (also referred to as creating the child's trauma narrative); (d) and processing or discussion of the abuse experience(s); (e) in vivo exposure to safe situations avoided due to distress caused by trauma memories; and (f) conjoint child-parent sessions. Efficacy for TF-CBT has been established through numerous randomized controlled trials in a range of populations (de Arellano et al., 2014).

Treatment was provided by a bilingual (English and Spanish) postdoctoral fellow with a Ph.D. in Clinical Psychology. The therapist received initial TF-CBT training and weekly clinical supervision from a licensed Clinical Psychologist who is a national trainer in TF-CBT.

Telehealth procedure. Telehealth patients presented at their local school for weekly TF-CBT sessions conducted in a private location within their school. Students connected to their telehealth sessions using a laptop computer and Vidyo (Vidyo Inc., 2010) videoconferencing software provided by our team. The therapist was located at an academic medical center located approximately 30 to 45 minutes away from the school locations. The therapist utilized a desktop computer and Vidyo videoconferencing software. Vidyo is a web-based videoconferencing tool that was chosen as the treatment delivery platform given its compliance with HIPAA confidentiality regulations and interactive capabilities. Vidyo allowed for the successful delivery of the individual treatment components, as the therapist was able to share treatment materials on the screen (e.g., psychoeducational fact sheets and TF-CBT workbook pages). In several cases, although the caregiver was unable to attend sessions at the school due to work- and transportation-related issues, the therapist was able to perform parallel caregiver sessions via telehealth in the caregiver's home or work location through the use of cellular data-enabled iPads and Vidyo videoconferencing software. Cellular data-enabled iPads were used by the parents because the majority of caregivers did not have Internet access available in their home. iPads were loaned to the caregiver for the duration of treatment and returned to the therapist at the time of treatment termination. The treatment regimen followed the TF-CBT

protocol described above. Treatment fidelity was maintained while providing services through the telehealth modality; however, the intervention required tailoring to address logistics associated with the telehealth service delivery model. One logistical variation in delivering TF-CBT via telehealth was that worksheets and informational sheets were presented digitally (via the clinician "sharing" her screen with the client). Physical copies of worksheets and informational sheets were sent to patients via traditional mail as needed. Another pragmatic variation was having children hold up drawings in front of the web cam in order to show clinicians what had been drawn. Further examples and details regarding telehealth adaptations for each participant are described below.

Results

Participant 1. Participant 1 was an 11-year-old Hispanic female with an index trauma of sexual abuse. Participant 1 presented with multiple symptoms of PTSD, including intrusive memories, nightmares, psychological reactivity to trauma cues, avoidance of trauma memories and trauma cues, difficulty experiencing positive emotions, sleep disturbance, hypervigilance, and exaggerated startle response. Telehealth was selected as the treatment modality for Participant 1 due to a lack of transportation and language preference of the caregiver (Spanish). The patient's family lived within close physical proximity of the patient's school. Thus, the patient's mother was able to walk to the school to attend school-based telehealth appointments. A number of adaptations specific to the telehealth delivery format were included in treatment. For example, as a part of psychoeducation, the clinician read a trauma-specific children's book with the patient. The clinician uploaded a digital copy of the book via scanner onto the clinician's computer, with each page of the book displayed as a separate page of a PDF document. The clinician "shared" the clinician's screen with the child, scrolling down the document page by page as the clinician read the book to the patient. Other adaptions were incorporated while completing the trauma narrative. The child dictated the narrative while the clinician typed what the child said into a Microsoft Word document. The clinician was able to "share" the clinician's screen with the child so that she could see the words that the clinician was typing in real time. Additionally, the child colored pictures with crayons and paper to illustrate specific elements of her traumatic

event. When the patient completed each picture, she held it up in front of the camera. The clinician took a screen shot of the picture and then digitally added it to the child's trauma narrative. In order to enhance engagement and positively reinforce the child's appropriate behaviors during therapy, the clinician mailed several small stickers and a hand-written note to the child weekly following each session. The child's mother reported to the clinician that the child enjoyed receiving mail each week and proudly displayed her stickers.

Participant 1 attended 18 sessions and successfully completed treatment. Her total UCLA-PTSD-RI score at baseline was 33. She met diagnostic criteria for PTSD according to DSM-IV symptom criteria at baseline. Participant 1's posttreatment total UCLA-PTSD-RI score of 5 represents an 85% decrease compared with baseline. Participant 1 no longer met diagnostic criteria for PTSD at posttreatment. Baseline total CDI score was 7 and posttreatment CDI score was 2. Baseline total SCARED score was 21 and posttreatment SCARED score was 15. The reduction in UCLA, CDI, and SCARED scores suggests a significant reduction in PTSD, depression, and anxiety symptoms, which is consistent with the patient's self-report of overall improvement in mood and PTSD symptoms. The patient and caregiver indicated that treatment was helpful and that they were happy with the telehealth format. The caregiver remarked that the telehealth delivery format allowed her child to reduce the amount of class time that she missed for therapy appointments, which helped her child to maintain her grades. The caregiver also remarked that she was thankful to receive treatment from a Spanish-speaking clinician.

Participant 2. Participant 2 was a 16-year-old Hispanic female with an index trauma of sexual abuse. Participant 2 presented with multiple symptoms of PTSD, including intrusive memories, nightmares, psychological and physiological reactivity to trauma cues, flashbacks, avoidance of trauma memories and trauma cues, difficulty experiencing positive emotions, feelings of detachment from others, inability to remember important aspects of the trauma, concentration difficulty, sleep disturbance, hypervigilance, and exaggerated startle response. Telehealth was selected as the treatment modality for Participant 2 due to multiple barriers to treatment engagement, including lack of transportation, language preference of the patient and

caregiver (Spanish), and the caregiver's chronic illness that prevented the caregiver from attending clinic-based appointments. Although other programs were able to provide therapy services for Spanish-speaking patients with the use of an interpreter, a Spanish-speaking clinician was not available through other programs at the time of treatment initiation.

A number of telehealth adaptations were utilized. For example, any printed materials needed during sessions, such as worksheets and psychoeducational materials, were presented electronically by the clinician through "sharing" the clinician's screen with the patient. Printed materials that were needed for homework assignments were mailed to the patient's home. Materials were mailed several days before the scheduled session so that they would arrive on the day of the appointment or soon after the appointment. Review of written homework was also tailored for telehealth. For example, the patient was assigned homework to rate her distress level each day using a calendar. In order to review this homework, the patient held the paper calendar that she had completed up to the web camera. The clinician took a screen shot of the calendar and then shared it on the screen with the patient. In this way, the clinician was able to review the calendar with the patient while both viewed it on the screen. During the writing of the trauma narrative, the patient exhibited significant resistance to talking about certain details of her trauma. The clinician was able to overcome this resistance by allowing the patient to first write about her trauma without verbally discussing it. In order to accomplish this via telehealth, the clinician utilized the text chat feature of the Vidyo software. Through the text chat, the patient typed portions of her trauma narrative and the clinician then transferred that text into the Microsoft Word document containing the entire trauma narrative.

Participant 2 attended 14 sessions and successfully completed treatment. Her total UCLA-PTSD-RI score at baseline was 53. Participant 2 met diagnostic criteria for PTSD according to DSM-IV symptom criteria at baseline. Her posttreatment total UCLA-PTSD-RI score of 6 represents an 89% decrease compared with baseline. She no longer met diagnostic criteria for PTSD at posttreatment. Baseline total CDI score was 18 and posttreatment CDI score was 2. Baseline total SCARED score was 64 and posttreatment SCARED score was 12. These scores reflect clinically significant reductions in the patient's presenting

PTSD, depression, and anxiety symptoms. The patient and caregiver reported that treatment was helpful. The patient also stated that she looked forward to appointments each week and liked talking with the clinician. The patient's caregiver remarked that she was grateful for the ability to attend sessions via iPad from her home, particularly due to her ongoing illness.

Participant 3. Participant 3 was a 15-year-old Hispanic female with multiple index traumas, including sexual abuse, physical abuse, and witnessing domestic violence. She presented with multiple symptoms of PTSD, including intrusive memories, nightmares, psychological and physiological reactivity to trauma cues, avoidance of trauma memories and trauma cues, difficulty experiencing positive emotions, feelings of detachment from others, inability to remember important aspects of the trauma, concentration difficulty, sleep disturbance, irritability, hypervigilance, and exaggerated startle response. Telehealth was selected as the treatment modality for Participant 3 due to multiple barriers to treatment engagement, including lack of transportation, language preference of the patient and caregiver (Spanish), and caregiver's work schedule. The patient's caregiver worked full-time and was unable to secure the extended amount of time off necessary to attend clinic-based sessions. The family lived approximately 45 minutes from clinic-based services. The time needed to pick the child up from school, drive to and from the clinic, park, and attend the session would have required several hours weekly. Through telehealth, the caregiver was able to attend sessions during her lunch break utilizing an iPad to connect with the clinician. Other telehealth adaptations included the use of Power-Point presentations, digital worksheets, and digital games. For example, when teaching about varying intensity levels of emotions, the clinician utilized an animated PowerPoint presentation to show a thermometer with the temperature rising as emotions intensified. When reviewing physiological responses to emotions, the clinician utilized a worksheet that asked the patient to indicate where in her body she felt specific emotions. The clinician utilized a PDF version of the document and enabled the "edit text and images" option in order to add text and images to the document. The patient indicated where in her body she felt a particular emotion and the clinician then colored the corresponding area of the body on the worksheet. The

patient was able to see the clinician change the worksheet in real time through the use of screen sharing via the Vidyo software. Another adaptation was the use of a Jeopardy-style game presented via PowerPoint, which was used to review psychoeducation regarding sexual abuse, physical abuse, and witnessing domestic violence. Additionally, the game Connect 4 was utilized briefly at the end of several sessions to reinforce appropriate participation during sessions. The clinician utilized Microsoft Excel to create an electronic Connect 4 board. The patient told the clinician where she wanted her marker to be placed on the board and the clinician then added a colored dot to that space.

Participant 3 attended 19 sessions and successfully completed treatment. Her total UCLA-PTSD-RI score at baseline was 29. Participant 3 met diagnostic criteria for PTSD according to DSM-IV symptom criteria at baseline. Her posttreatment total UCLA-PTSD-RI score of 10 represents a 66% decrease compared with baseline. Participant 3 no longer met diagnostic criteria for PTSD at posttreatment. Baseline total CDI score was 16 and posttreatment CDI score was 11. Baseline total SCARED score was 21 and posttreatment SCARED score was 15. The significant reduction in symptoms was reflected not only via these scores, but also via the patient's self-report of overall improvement in mood and PTSD symptoms. The patient and caregiver indicated that treatment was helpful and that they were appreciative of the telehealth format. The patient reported that she liked talking with a therapist in Spanish, which she had never been able to do previously. The caregiver stated that she greatly appreciated being able to meet with the clinician via telehealth during her lunch break. She said that as a single mother, she would not have been able to afford to take time off work in order to take her daughter to clinic-based appointments.

Participant 4. Participant 4 was a 10-year-old Hispanic female with an index trauma of the violent death of a family member. She presented with multiple symptoms of PTSD, including intrusive memories, nightmares, psychological and physiological reactivity to trauma cues, avoidance of trauma memories and trauma cues, difficulty experiencing positive emotions, concentration difficulty, sleep disturbance, hypervigilance, and exaggerated startle response. Telehealth was selected as the treatment modality for Participant 4 due to lack of transportation, lack of child-

care, and language preference of the patient and caregiver (Spanish). The patient's caregiver was unable to attend telehealth sessions at the patient's school and did not have Internet access at home. Thus, the caregiver attended telehealth appointments utilizing an iPad, which was provided by the clinician. Multiple telehealth adaptations were utilized during treatment. For example, when practicing diaphragmatic breathing and progressive muscle relaxation, the patient indicated that she would prefer to listen to music while completing these tasks. The patient selected particular songs that she would like to hear and the clinician located YouTube videos of the songs that the clinician played as the patient practiced the relaxation techniques. Further, while practicing diaphragmatic breathing and progressive muscle relaxation, the clinician had the patient move her chair farther away from the computer so that the majority of the patient's body could be seen, rather than just the patient's upper body. In this way the clinician could see if the patient was correctly engaging in diaphragmatic breathings and progressive muscle relaxation.

Participant 4 attended 12 sessions and successfully completed treatment. Her total UCLA-PTSD-RI score at baseline was 44. She met diagnostic criteria for PTSD according to DSM-IV symptom criteria at baseline. Participant 4's posttreatment total UCLA-PTSD-RI score of 12 represents a 73% decrease compared with baseline. She no longer met diagnostic criteria for PTSD at posttreatment. Baseline total CDI score was 19 and posttreatment CDI score was 12. Baseline total SCARED score was 46 and posttreatment SCARED score was 19. The reduction in UCLA, CDI, and SCARED scores suggests a significant reduction in PTSD, depression, and anxiety symptoms, which is consistent with the patient's self-report of overall improvement in mood and PTSD symptoms. The patient remarked that treatment was very helpful, which came as a surprise given that she did not feel like she would ever get better prior to beginning treatment. The caregiver reported that treatment was beneficial and that she appreciated the option to use telehealth as it facilitated her being able to attend appointments consistently.

Summary of Outcome Results

Participants' main barriers to treatment engagement included distance to clinic, lack of transportation, language preference of the patient and caregiver (Spanish), lack of childcare, caregivers' work schedules,

and caregiver chronic illness. Barriers were effectively addressed and all participants successfully completed treatment. The clinician was able to adhere to the TF-CBT model and treatment components while providing services through the telehealth modality; however, the intervention required tailoring to better meet needs associated with the delivery model. Tailoring such as digitally presenting written materials, utilizing the web camera to view patient's drawings, and screen "sharing" to edit documents in real time enhanced patient engagement in therapy sessions.

The average number of treatment sessions attended across participants was 16 sessions (range = 12–19). As a whole, the overall reported percent reduction in trauma-related symptoms for participants, as measured by total UCLA-PTSD-RI score, was 74%. Additionally, at posttreatment, all participants no longer met diagnostic criteria for PTSD. The overall reported percent reduction in depressive symptoms, as measured by the CDI, was 57%. The overall reported percent reduction in anxiety symptoms, as measured by the SCARED, was 44%. The reduction in UCLA, CDI, and SCARED scores suggests a significant reduction in PTSD, depression, and anxiety symptoms among all participants.

Discussion

Despite the high rates of PTSD among female Hispanic youth and the availability of efficacious clinic-based treatments for PTSD, significant and unique barriers to accessing and completing treatment remains (National Research Council and Institute of Medicine, 2009). The purpose of this multiple-case study was to determine the feasibility of the telehealth delivery of TF-CBT among female Hispanic youth to address their unique barriers to access and completion of mental health treatment. The cases presented in this paper reflect these unique barriers that female Hispanic youth and their families face. Specifically, lack of transportation (all patients), distance to clinic (Patient 3), Spanish-language preference (all patients), lack of childcare (Patient 4), and caregiver illness (Patient 2) were listed as barriers to receiving traditional clinic-based TF-CBT for the cases described in the current study. Results from this multiple-case study reveal that telehealth can be a feasible mode to deliver TF-CBT among Hispanic youth and may adequately address some of the unique barriers that this population faces

when in need of treatment. Further, the treatment resulted in clinically meaningful change for all patients.

The current study reveals preliminary findings that TF-CBT can be delivered via telehealth for female Hispanic youth to address barriers to receiving treatment for PTSD. Hispanic youth are not only less likely to access PTSD treatment, but they are also more likely to drop out of treatment prematurely (Alegría, Vallas, & Pumariega, 2010; Roberts et al., 2011; Smith, Domenech-Rodriguez, & Bernal, 2011), suggesting that there is a need to address barriers to this population. By using telehealth as a delivery modality, patients were able to access and complete treatment, perhaps for several reasons. First of all, the barriers of lack of transportation and distance from the clinic were overcome by not requiring patients and their parents to attend clinic-based sessions. Second, the Spanish language preference of both the patients and their parents was able to be addressed using telehealth because a Spanish-proficient therapist can be made available over telehealth more easily than through home-based treatments by reducing travel time to deliver treatment. Third, caregivers' work schedules were able to be accommodated by scheduling therapy sessions during the caregivers' lunch break. Finally, lack of childcare and caregiver illness were addressed by completing home-based telehealth sessions with caregivers via data-enabled iPads loaned out by the clinicians, thus eliminating the need for caregivers to leave their homes or incur in additional costs.

Treatment fidelity was maintained while providing services through the telehealth modality. Nonetheless, a number of adaptations specific to the telehealth delivery format were included in treatment to better meet needs associated with this delivery model. These included digitally presenting written materials using the screen "sharing" function, utilizing the web camera to view patient's drawings, using the "text chat" feature to allow a patient to write part of her trauma narrative, and using the screen "sharing" function to edit documents in real time, play interactive games with the patients, and illustrate skills (e.g., identifying intensity of an emotion on a thermometer). All of these adaptations served to enhance patient engagement across therapy sessions.

More work is needed to ensure that telehealth can adequately address the unique barriers to treatment for female Hispanic

youth with PTSD. Although these case studies do demonstrate feasibility and initial clinical improvements, several other steps are needed. First, it is imperative to continue to assess barriers to treatment access and completion among this population and to assess if telehealth delivered by Spanish-speaking clinicians addresses these barriers adequately or if other adaptations are needed to service delivery. Further, a clinical trial would be necessary to determine if telehealth-based treatment is as good as clinic-based treatments for this particular population, consistent with adults and veterans (e.g., Acierno et al., 2016). These case studies represent an important first step in determining how to best address the mental health needs and barriers in access to care of trauma-exposed female Hispanic youth.

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Establishing Priorities for Lesbian, Gay, Bisexual, and Transgender Health Disparities: Implications for Intervention Development, Implementation, Research, and Practice

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HEALTH DISPARITIES REFER to diseases, disorders, or comorbid combinations thereof that are not equally distributed across a population. In public health, they may also signify differences in the physical environment, access to health care, utilization or quality of health care, or health status (Carter-Pokras & Baquet, 2002). Traditionally, understudied and underserved populations are most vulnerable to these disparities. In recent years, there has been increased attention to the health disparities experienced by sexual and gender minorities (SGMs; i.e., lesbian, gay, bisexual, and transgender individuals and families) and the need for more research to address and reduce these disparities. For instance, in 2011 the National Institutes of Health commissioned the Institute of Medicine to review the existing state of the literature on SGM health disparities and to make recommendations for research priorities. Further, in 2016, the director of the National Institute on Minority Health and Health Disparities formally recognized SGMs as a health disparity population (NIMHD, 2016). This designation signifies a recognition of the high disease burden and continued barriers to care among SGMs as well as a commitment by NIH to marshal resources to advance the health of LGBT Americans.

As the knowledge base on SGM health disparities grows, it is important for psychologists and other health care providers to have up-to-date information on these disparities, their causes, and evidence-based approaches to address them in clinical practice. With that in mind, the goals of this article are: (a) to summarize and synthesize the empirical literature on mental health and substance use disparities among SGMs; (b) to provide a brief review of the disproportionate rates of stress and trauma among SGMs as they relate to health disparities; (c) to guide readers on extant evidence-based psychosocial interventions for SGM clients; and (d) to orchestrate recommendations for research, clinical practice, and public health to improve the health of SGM clients. A comprehensive review of all health disparities experienced by SGMs is beyond the scope of this article. We have focused our synthesis of the literature and recommendations on mental health and substance use problems because psychologists and other mental health professionals are most likely to encounter these presentations in clinical settings. We acknowledge that SGMs are also at increased risk for physical health problems inclusive of sexual health disparities (e.g., gay/bisexual men and transgender women are at increased risk for HIV; sexual minority women are at increased risk for obesity). Readers are referred to recent reviews of the empirical literature on HIV (Batchelder, Safren, Mitchell, Ivardic, & O'Cleirigh, 2017; O'Cleirigh, Magidson, Skeer, Mayer, & Safren, 2015) and physical health conditions (Simoni, Smith, Oost, Lehavot, & Fredriksen-Goldsen, 2017) among SGMs. We hope a greater awareness of these clinical presentations within the context of minority stress will guide psychologists and other health professionals toward a more tailored clinical assessment in support of providing culturally competent care.

To help guide readers, our review of health disparities is divided into two sections: mental health and substance use. Within each section, we review studies that have compared SGMs to heterosexual and cisgender individuals and then provide more nuanced information on specific subgroups of SGMs (namely bisexual and transgender individuals). Historically, research on SGMs has combined bisexual individuals with gay and lesbian individuals and largely neglected gender identity minorities. Emerging research suggests that bisexual individuals are at increased risk for mental health and substance use problems compared to both heterosexual and gay or lesbian individuals, and that gender minorities are at particularly high risk for these negative health outcomes. As such, it is important for psychologists and other health professionals to be aware of the high burden of disease that differentially affects specific subgroups of SGMs.

Mental Health Disparities Among SGM populations

There are significant mental health disparities experienced by SGMs relative to their heterosexual and cisgender peers, including mood and anxiety disorders, body dysmorphic and eating disorders, and other psychiatric comorbidities (see Blosnich, Foynes, & Shipherd, 2013; Boroughs, Krawczyk, & Thompson, 2010; Brown & Jones, 2016; Cochran, Balsam, Flentje, Malte, & Simpson, 2013; Cochran, Sullivan, & Mays, 2003; Feldman & Meyer, 2007; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Marshal et al., 2008; Safren & Heimberg, 1999; Shipherd, Mizock, Maguen, & Green, 2012). A meta-analysis found that rates of mood and anxiety disorders were approximately 2 to 3 times higher among sexual minorities compared to heterosexuals (Meyer, 2003). Similarly, another meta-analysis found that rates of past-year suicide attempts were 2 times higher among sexual minorities compared to heterosexuals and rates of lifetime suicide attempts were 4 times higher among gay and bisexual men compared to heterosexual men (King et al., 2008). There is some evidence that these disparities depend on how sexual orientation is measured. One study found that lesbians had higher odds of mood and anxiety disorders

compared to heterosexual women; however, women who reported exclusive same-sex attraction or sexual behavior had lower rates of these disorders, suggesting some link between orientation/identity and psychopathology (Bostwick, Boyd, Hughes, & McCabe, 2010). This finding was unique to women in that disparities were more consistent across different dimensions of sexual orientation for men (i.e., the rates of most disorders were higher for gay men compared to heterosexual men regardless of identity, attraction, and/or behavior).

Accumulating evidence suggests that rates of mental health problems are particularly high among bisexual individuals. One study found that bisexuality was generally associated with increased rates of mood and anxiety disorders for women and men (Bostwick et al., 2010). Bisexual women had higher rates of most disorders compared to heterosexual women and lesbians. Although bisexual men had higher rates of most disorders compared to heterosexual men, findings were less consistent for comparisons with gay men. For example, men who reported sexual behavior with both women and men had higher rates of all disorders compared to gay and heterosexual men; however, men that self-labeled as bisexual had similar rates to gay men, suggesting some link between orientation/identity and psychopathology. Numerous studies have corroborated these findings that bisexual individuals are at increased risk for mental health problems (Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002), including suicidality (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Jorm et al., 2002). A particularly striking example of this risk is that 18.5% of bisexual individuals had seriously considered suicide in the past year compared to 4.2% of gay or lesbian individuals and 3.0% of heterosexual individuals (Conron et al., 2010). Although findings sometimes differ across dimensions of sexual orientation such as identity or behavior, it is clear that bisexual individuals represent a unique health disparities.

Gender identity minorities also experience high rates of mental health problems. Data from a U.S. national longitudinal cohort study demonstrated elevated rates of clinically significant depression and anxiety symptoms among gender identity minorities (52.0% and 37.5%) compared to cisgender females (27.0% and 31.2%) and cisgender males (25.1% and 15.2%; Reisner, Katz-Wise, Gordon, Corliss, & Austin, 2016). A recent review provided robust support for health disparities among transgender individuals (Reisner, Poteat, et al., 2016), including rates of depression as high as 64.0% based on a screening tool (Nemoto, Bödeker, Iwamoto, & Sakata, 2014) and 36.0% for a major depressive episode (Pitts, Couch, Croy, Mitchell, & Mulcare, 2009). Results of the 2015 U.S. Transgender Survey, which included nearly 28,000 transgender and gender nonconforming individuals, indicated that 39.0% had experienced serious psychological distress in the past month (compared with 5.0% of the general population), 40.0% had attempted suicide in their lifetime (approximately 9 times higher than the general population), and 7.0% had attempted suicide in the past year (approximately 12 times higher than the general population; James et al., 2016).

Substance Use Disparities Among SGM Populations

Sexual minorities are also at increased risk for substance use problems (Green, Bux, & Feinstein, 2013; Green & Feinstein, 2012; Marshal et al., 2008; Woodford, Krentzman, & Gattis, 2012), which is often first observed in adolescence, rendering them at greater risk for developing a substance use disorder later in life (Marshal et al., 2008). This is particularly evident for nicotine dependence (Blosnich, Lee, & Horn, 2013; O'Cleirigh, Elsesser, King, Ehlinger, Bradford, Grasso, under review; Tang et al., 2004), such that sexual minorities have 1.5 to 2 times the odds of cigarette smoking as heterosexuals (Blosnich, Lee, et al., 2013; Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007; Lee, Griffin, & Melvin, 2009; Stall, Greenwood, Acree, Paul, & Coates, 1999; Tang et al., 2004), which explains their increased risk for asthma, some cancers, and cardiovascular disease (Diamant & Wold, 2003; Heck & Jacobson, 2006; Landers, Mimiaga, & Conron, 2011; Lehavot, Rillamas-Sun, et al., 2016; McNair, Szalacha, & Hughes, 2011). Sexual minorities are also at increased risk for alcohol and other drug use and dependence (Lehavot & Simoni, 2011; McCabe et al., 2009). Some studies indicate that alcohol use may be more problematic for sexual minority women, while illicit drugs may be more problematic for sexual minority men (Cochran, Ackerman, Mays, & Ross, 2004). For instance, both recent and lifetime rates of alcohol use and intoxication are higher among sexual minority women compared to sexual minority men (Cochran et al., 2004; Cochran, Keenan, Schober, & Mays, 2000).

There is also evidence that bisexual individuals are at particularly high risk for substance use problems (for a review, see Green & Feinstein, 2012). Data from a U.S. population-based study demonstrated that bisexuality was generally associated with increased substance use and dependence for women and men (McCabe et al., 2009). For instance, past-year rates of heavy quantity drinking, alcohol dependence, marijuana use, and other substance use were higher among bisexual women compared to lesbians and heterosexual women. For men, past-year rates of alcohol dependence and other drug use or dependence were higher among bisexual men compared to heterosexual men. Although past-year rates of alcohol dependence and other substance use or dependence were similar for bisexual and gay men, rates were higher for bisexual men that did not identify as bisexual, compared to gay men. There is also evidence that bisexual women may be less likely to quit smoking (O'Cleirigh et al., under review).

High rates of substance use have also been documented among transgender individuals. Data from the 2015 U.S. Transgender Survey indicated that rates of marijuana use, other illicit drug use, and prescription drug misuse were higher among transgender individuals compared to the general population (James et al., 2016). For instance, 29.0% of transgender individuals had used marijuana, other illicit drugs, and/or misused prescription drugs in the past month, which is approximately 3 times the rate of the general population. In contrast, rates of problematic alcohol use (e.g., binge drinking) and cigarette use were only slightly higher among transgender individuals compared to the general population. Other studies have corroborated the high rates of substance use among transgender individuals. For instance, in a sample of 452 transgender adults, rates of recent substance use were high, including 47.0% for binge drinking, 39.6% for marijuana use, 19.0% for other illicit substance use, and 10.8% for poly-substance use (Keuroghlian, Reisner, White, & Weiss, 2015). There is also some evidence that transgender individuals may be more likely to smoke than cisgender individuals (Grant et al., 2011) and that methamphetamine is more likely to be the primary substance used by transgender women compared to cisgender women at public substance use treatment facilities in

San Francisco (Flentje, Heck, & Sorensen, 2014).

Stress and Trauma Exposure

A prevailing theoretical model for understanding SGM health disparities is minority stress theory. This theory proposes that SGMs experience unique stressors related to their stigmatized social statuses and these stressors contribute to negative health outcomes such as mental health and substance use problems (Meyer, 1995, 2003). Since its inception, scholars have developed additional models that build upon this theory to advance our understanding of SGM health disparities. For example, Hatzenbuehler (2009) proposed the psychological mediation framework that describes the processes through which minority stress influences health (e.g., by contributing to difficulties regulating one's emotions and social/interpersonal problems). More recently, researchers proposed the health equity promotion model, which highlights the need to consider heterogeneity and intersectionality (defined as a dynamic interaction of multiple distinct identities, e.g., gender, race, ethnicity, sexual orientation, gender identity, etc.; Cho, Crenshaw, McCall, 2013) among SGMs, structural and environmental influences on health, health-promoting (e.g., resilience) and adverse pathways to disparities, and a life course development perspective (Fredriksen-Goldsen et al., 2014). Together, these theories provide a comprehensive framework for understanding why SGMs are disproportionately affected by negative health outcomes and for identifying targets for evidence-based interventions to reduce these health disparities.

Some of the unique stressors that SGMs experience are discrimination related to their sexual orientation or gender identities, the internalization of negative societal attitudes about SGMs, and having to make decisions about whether or not to disclose their identity to others. In addition to the unique stressors that SGMs experience, they are also disproportionately affected by types of stress and trauma that can also affect heterosexual and cisgender individuals (e.g., childhood sexual abuse, intimate partner violence, and bullying). Although a full review of stress and trauma exposure among SGMs is beyond the scope of this article, here we highlight several key findings. Katz-Wise and Hyde (2012) reviewed 138 studies on victimization among sexual minorities and found that 41.0% experi-enced discrimination related to their sexual orientation and sexual minorities reported higher rates of 16 out of 18 types of victimization compared to heterosexuals (e.g., verbal harassment, sexual harassment, abuse by family members, physical assault, and sexual assault). Sexual minorities also experience developmental traumas at disproportionate rates. For instance, gay and bisexual men have dramatically higher odds of reporting childhood sexual abuse compared to heterosexual men (9.5 and 12.8, respectively). Similarly, lesbian and bisexual women also have higher odds of reporting childhood sexual abuse compared to heterosexual women (3.4 and 5.3, respectively; Sweet & Welles, 2012). Sexual minorities are also at an increased risk for intimate partner violence (Edwards, Sylaska, & Neal, 2015) and being bullied (Boroughs, 2014).

Rates of stress and trauma are especially high among transgender individuals. In the 2015 U.S. Transgender Survey, transgender individuals reported that because of their gender identity they were verbally harassed (46.0%), physically attacked (9.0%), or sexually assaulted (10.0%) over the past year, with 47.0% being sexually assault in their lifetime and 54.0% experiencing intimate partner violence in their lifetime. Similarly high rates have been reported in other samples of transgender individuals. For instance, one study found that 78.0% of transgender individuals reported being harassed, 35.0% reported being physically assaulted, and 12.0% reported being sexually assaulted at school (Grant et al., 2011). Testa and colleagues (2012) also found high rates of physical violence (38.0%) and sexual violence (27.0%) among transgender individuals, with the majority reporting that at least one incident was due to their gender identity or expression. More recent reports from a community health center identify transgender patients at greater risk of intimate partner violence, with transgender women and transgender nonbinary individuals being particularly vulnerable (Valentine, Peitzmeier, King, O'Cleirigh, Marquez, Presley, & Potter, under review). Transgender individuals also have higher rates of unemployment and job discrimination (e.g., being denied a job, being fired from a job) relative to the general population (Grant et al., 2011; Lombardi, Wilchins, Priesing, & Malouf, 2002).

Thus, mental health and substance use disparities together with increased exposure to trauma and individual and institutional level stress provide an opportunity for psychologists and other health professionals to intervene using evidence-based approaches. We next move to review the extant evidence-based treatments developed for SGM populations.

Evidence-Based Treatments for Mental Health and Substance Use Problems Among SGMs

The American Psychological Association has published guidelines for clinical practice with LGB clients as well as transgender and gender-noncomforming clients (APA, 2012, 2015). These guidelines provide recommendations for tailoring mental health treatment to be sensitive to the unique needs of SGMs and all mental health professionals are encouraged to follow them. In general, they emphasize the need to reflect on one's own attitudes toward SGMs, to have appropriate knowledge about sexuality, gender, and how these aspects of a person's identity can influence their life experiences and health, and to use this information to inform assessment and treatment practices. In addition to these guidelines, several case reports have been published describing the successful implementation of cognitive-behavioral therapy for mental health problems among sexual minorities (Kaysen, Lostutter, & Goines, 2005; Safren & Rogers, 2001; Walsh & Hope, 2010). These tend to focus on gay men or lesbians, but in an exception, one case report described a cognitive-behavioral group intervention used to help a young bisexual man manage stress, reduce substance use, and reduce condomless sex (Smith et al., 2015).

In recent years, there has been increased attention to developing and adapting interventions to help sexual minorities cope with stigma-related stress and improve their mental health. For instance, Pachankis and colleagues developed the ESTEEM intervention (Effective Skills to Empower Effective Men), a 10-session, sexual minority–affirmative transdiagnostic cognitive-behavioral intervention for gay and bisexual men focused on reducing mental and behavioral health problems (e.g., depression, anxiety, substance use, condomless sex). As described elsewhere (Pachankis, 2014), the intervention targeted minority stress processes (e.g., internalized stigma, rejection sensitivity, sexual identity concealment) and universal risk factors (e.g., emotion regulation, hopelessness, isolation, unassertiveness). A randomized controlled trial of the intervention demonstrated significant reductions in depression, alcohol use problems, and

condomless sex compared to a waitlist control condition (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). Further, gay and bisexual men with higher levels of internalized homonegativity (IH) evidenced greater gains from the intervention (Millar, Wang, & Pachankis, 2016). Those with higher implicit IH had greater reductions in depression, anxiety, and condomless sex while those with higher explicit IH had greater reductions in heavy drinking. Only 5 of the 63 participants sampled were bisexual suggesting more work is needed to generalize these findings, found to have preliminary efficacy, beyond gay men.

There is also evidence that technology can be used to treat depression among sexual minorities, which has far-reaching implications for meeting the health care needs of sexual minorities in rural areas, those who do not have access to traditional health care, and those who are not comfortable disclosing their sexual orientation to health care professionals. Lucassen and colleagues (2015) adapted a computer-based cognitive-behavioral intervention for depression so that it could be used to address the unique needs of sexual minority youth. The intervention (Rainbow SPARX) taught standard cognitive-behavioral strategies (e.g., behavioral activation, cognitive restructuring), but applied them to the stigma-related stressors that sexual minorities experience. The intervention was also adapted by developing new content to teach the youth about the social influences on mental health for sexual minorities and to promote resilience by developing a positive view of one's sexual minority identity. A preliminary test of the intervention in a sample of 21 sexual minority youth found that it led to significant reductions in depression and these gains were maintained 3 months after treatment.

Green and Feinstein (2012) reviewed the literature on substance use disparities among sexual minorities and found only six treatment outcome studies from 1996 to 2012, each focusing on gay and bisexual men. Culturally affirming adaptations of motivational interviewing (Morgenstern et al., 2009), contingency management (Shoptaw et al., 2005), and cognitive-behavioral therapy (Shoptaw et al., 2008) have been used to treat alcohol and substance use in SGM populations with mixed findings. Recently, a pilot emotion-regulation treatment based on the Unified Protocol (Barlow et al., 2010) was found to reduce substance use at 3-month follow-up in a sample of 13 HIV-positive men (Par-

sons et al., 2016). Senreich (2010) found that gay or bisexual men who participated in SGM-specific groups had better substance use outcomes. Other treatments in development are addressing substance abuse and other health sequelae linked with childhood sexual abuse and bullying (Batchelder, Boroughs, Safren, & O'Cleirigh, 2016). However, SGM-specific treatment was determined by participant self-report and thus results should be interpreted with caution; only 7.4% of the treatment options listed as "SGM-specific" on the Substance Abuse and Mental Health Services Administration (SAMHSA) directory truly had competencies developed or tailored specifically for SGM populations (Cochran, Peavy, & Robohm, 2007). Beyond gay or bisexual men, "The Last Drag" is a SGM-specific intervention based upon an American Lung Association intervention that has shown initial efficacy (Eliason, Dibble, Gordon, & Soliz, 2012).

At present, many of the SGM-specific treatment studies have significant limitations (e.g., inadequate comparison treatment, length of follow-up window, sample size). Additionally, most of the interventions have focused exclusively or primarily on gay men and there is an urgent need for testing intervention efficacy in more diverse samples of SGMs, especially women, bisexuals, and transgender individuals. Although interventions have been developed to reduce HIV risk among transgender women (e.g., Operario et al., 2016; Taylor, Bimbi, Joseph, Margolis, & Parsons, 2011), there has been a lack of attention to the development of interventions to address stigma and improve the mental health of transgender individuals. In addition to the APA guidelines referenced above, several resources exist to inform the delivery of culturally competent health care (e.g., Coleman et al., 2012; Singh & dickey, 2017) and substance use treatment (e.g., Lombardi & van Servellen, 2000) to gender-identity minorities. In the absence of specific efficacy data regarding mental health and substance use interventions for transgender individuals, mental health professionals are encouraged to become familiar with guidelines and recommendations related to transgender-affirmative treatment. With several needs identified, we next move to outline recommendations for research, clinical practice, and public health/policy.

Recommendations

To help guide readers, we have organized our recommendations into three themes: research, clinical practice, and public health and policy.

Research

The studies on SGM health disparities are not uniform in their measurement of sexual orientation or gender identity. For example, while some studies measure sexuality across multiple dimensions using several items across the spectrum of sexuality (e.g., attraction, behavior, identity), others simply use one item to categorize participants on their identity or orientation (Ridner, Topp, & Frost, 2007). Most research conflates birth sex with gender identity and even when gender identity is examined, nonbinary identifications are not always included. These operationalization and measurement differences may result in divergent estimates of the health disparities experienced by SGM populations. We strongly recommend all researchers who conduct research on human subjects to include demographic questions on sexual orientation and gender identity, regardless of whether or not the research itself focuses on SGM populations. For best practices for asking questions about sexual orientation, refer to the report published by the Williams Institute (2009). This will enable researchers to describe the compositions of their samples so that psychologists and other health professionals can draw reasonable inferences about the extent to which findings are likely to generalize to SGM populations. Further, collecting these data can facilitate research collaborations, such that SGM health researchers can utilize existing data to answer questions that might otherwise go unanswered. For researchers whose work focuses on SGM health disparities, a comprehensive assessment of sexual orientation and gender identity can facilitate a nuanced approach to examining these disparities. A growing body of research indicates that discrepancies between dimensions of sexual orientation are associated with poorer health outcomes (Schick, Rosenberger, Herbenick, Calabrese, & Reece, 2012) and multiple changes in sexual identity over time are associated with negative health outcomes (Ott et al., 2013). As such, we encourage researchers to consider the fluidity of sexuality and the diverse ways in which people's attractions and behaviors may or may not align with their identities.

As highlighted throughout this article, some subgroups of SGMs are at higher risk for mental health and substance use problems than others. As such, it is critical to consider SGMs as heterogeneous rather than as a single group. Researchers are moving forward with new initiatives to stimulate health research specific to bisexual women and men. For example, a collaborative effort called the Bisexual Research Collaborate on Health (BiRCH) was formed in 2014 to address the gaps in bisexual health research and to raise public awareness (The Fenway Institute, 2014). There are numerous other demographic characteristics that influence SGM health disparities, such as age, race/ethnicity, disability status, and veteran status. For example, health disparities affect sexual minorities across the lifespan, ranging from adolescence (Coker, Austin, & Schuster, 2010; Marshal et al., 2008) to later in life (e.g., over 50; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Wallace, Cochran, Durazo, & Ford, 2011).

With growing recognition of the disparities in mental health, substance use, and stress affecting SGMs, there is an urgent need for more research on the development, adaptation, efficacy testing, and dissemination of interventions to improve the health of these populations. In line with our recommendation for more empirical attention to subgroups of SGMs, there is a particular need for intervention development for lesbian, bisexual, and transgender individuals. At this point, there is not enough evidence to draw conclusions about whether or not existing interventions adequately address the unique needs of these populations. Given the multiple health problems affecting these populations, transdiagnostic interventions (e.g., ESTEEM; Pachankis et al.) have great potential to improve the overall health and wellbeing of SGMs. Additionally, in order to reach a wide range of SGMs, including those who may not present for mental health treatment, future research should consider the delivery of SGM-affirmative interventions in diverse settings (e.g., primary care, community centers) and using technology (e.g., computer-based interventions, mobile applications, telehealth).

Clinical Practice

In order for these disparities to be reduced, psychologists and other healthcare professionals will play an instrumental role in creating change by leading efforts in research, advocacy, and clinical practice. Although providers will have limits in their ability to address the structural or societal influences on SGM health disparities, graduate and medical school training programs that adapt cultural competencies around issues of SGM health will equip the next generation of clinicians to counteract disparities. SGM health providers also need to feel safe in "coming out" during their training and professional years (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). All providers, irrespective of their own sexual orientation or gender identity, can stay abreast of the literature in this area and can seek practicum, residency, fellowship, or continuing education related to sexual and gender minority health (see Hope & Chappell, 2015; Matza, Sloan, & Kauth, 2015). Several health professions have guidelines suggested or established to help clinicians provide care to these populations, such as Pediatrics (Levine, 2013), Psychiatry (Adelson, 2012), and Psychology (Boroughs et al., 2015). Together with more general guidance provided by NIH, a burgeoning evidence-base is being established to assist health care professionals indirectly address these population-based disparities in their clinical work (Alexander, Parker, & Schwetz, 2015). The dissemination of new research in the form of best practice guidelines should provide clinicians with a needed resource to integrate into their extant skills in working with SGMs across a variety of practice settings.

Thus, SGM individuals, couples, and families may present with a psychological disorder(s) to mental health or medical professional, or they may seek counseling services related to issues of stigma, discrimination, victimization, or coming-out issues. With a continually decreasing average age of coming-out (see Grov, Bimbi, Nanín, & Parsons, 2006), school psychologists, nurses, and counselors in particular may encounter secondary school students seeking counseling and support surrounding their burgeoning identity formation and a need for affirming evidence-based psychotherapeutic interventions. Appropriate referrals should assist those without mental health training to help younger adults with health problems that have implications for mental health. Some early detection models for a first episode of a mental health disorder involve self-medicating through substance abuse.

As these represent some of the most significant modifiable health risk behaviors, an assessment of these vulnerabilities and incorporation of health behavior change goals into a treatment plan may be particularly appropriate for SGM clients/patients.

Training in the provision of psychological services with SGM individuals should include an awareness of these disparities, and the mechanisms by which they increase distress and impairment (Boroughs et al., 2015). Competence in this context requires awareness of the unique vulnerabilities between groups of SGMs such that the role of club drugs, or drugs used in the context of sexual activity, is assessed for among the most at-risk groups while other health risks, such as binge drinking, is assessed for among lesbian and bisexual women.

Public Health and Policy

As noted throughout this article, health disparities do not equally affect all SGMs. Subgroups of SGMs (e.g., bisexual and transgender individuals, particularly transgender nonbinary) are at particularly high risk for mental health and substance use problems. The field of public health needs to recognize this within-group diversity and stratify resources to meet the specific needs of SGM subpopulations. Still, individual-level interventions alone are not sufficient to eliminate SGM health disparities. We need large-scale, population-level interventions to affect the sociopolitical factors that contribute to these disparities. At the time of publication of this article, SGM variables are not reliably included in the U.S. census, making it difficult, if not impossible, to obtain representative samples of SGMs and limiting the generalizability of research findings. The recent removal of some federal public websites (e.g., www.whitehouse.gov, U.S. Department of Labor's official webpage) that contained information about rights and resources for LGBT people further obscures policy in this area and possibly hinders efforts to examine disparities using a scientific and unbiased apolitical approach to the intersection of policy and health (see Itkowitz, 2017).

As described elsewhere, the mental health of SGMs is indirectly affected by social policies that contribute to reduced social and financial resources as well as increased stress and distress in these populations (Hatzenbuehler et al., 2010). SGMs are less likely to have health insurance or to engage in certain preventative care behaviors compared to heterosexual and cisgender individuals, which in turn contributes to their poorer health status (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010). Chronic health problems such as obesity, cardiovascular disease, and HIV that differentially affect LGBT individuals become

more salient with age. The full impact of these disparities may be a greater burden to public health in the near future when the population of older (above age 65) SGM people doubles from its current size in the coming decade (Wallace et al., 2011). Thus, it is imperative that primary care, mental health services, and community resources engage SGM people. The public health implications of these disparities may be improved by an increased focus on SGM health disparities by the NIH and other public health funding agencies. This agenda will support research in this area and allow for demonstration and dissemination of best practices that may greatly impact health disparities for SGM groups going forward (Alexander et al., 2015).

Conclusion

The disparities of health between SGM and heterosexual and cisgender populations are many. The sequelae of these inequities in health and access to care contribute to a significant public health burden affecting the SGM communities and their families. Additionally, bisexual and transgender populations face unique challenges. When aging SGM become multiply marginalized, extra outreach and education may be needed. The IOM research guidelines and the NIH Strategic Plan for SGM Health Research are important frameworks by which researchers can contribute to the reduction of health disparities in the SGM population. Although SGM health disparities remain, recent developments in research, clinical practice, access to insurance and care, societal changes such as increased acceptance of SGM people, and greater attention to this problem by funding agencies support a future where the health disparities reviewed here will improve for all that are affected.

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Spotlight on a Mentor • **Dr. David DiLillo**

The ABCT *Spotlight on a Mentor* program honors excellence in mentorship by highlighting exceptional ABCT mentors nominated by their students and trainees. We are pleased to present an interview with our most recent spotlighted mentor, Dr. David DiLillo. Dr. DiLillo is Professor and Associate Chair of Psychology at the University of Nebraska-Lincoln (UNL), where he has been a faculty member since 2000. He received his Ph.D. from Oklahoma State University in 1997 after completing an internship at the University of Tennessee Professional Psychology Internship Consortium. At UNL, he mentors clinical psychology doctoral students, teaches the core Psychotherapy class, and provides clinical supervision. Dr. DiLillo and his research team study trauma, particularly interpersonal violence victimization and perpetration. This work has been funded by grants from NIAAA, NICHD, and NIMH. Among his many professional activities, Dr. DiLillo finds the mentoring of graduate students to be especially rewarding. He takes pride in helping doctoral students acquire the skills and experiences needed to develop their own program of research. To date, nine of his doctoral student trainees have received F31 NRSA fellowships from NIH. Dr. DiLillo has been recognized with a university-wide award from UNL for excellence in graduate mentoring.

In the many nomination letters submitted in support of Dr. DiLillo, themes of encouragement, support, and learning emerged. Anna Jaffe described her experience working with Dr. DiLillo this way:

Beginning with first advising meeting, David encourages his students to develop an individual program of research by exploring the literature with curiosity, clarifying one's interests, and then focusing on projects that align with those interests… One of his strengths as a mentor is helping students to consider broad long-term goals, while also paying attention to the specific task at hand. David views each task (from a poster abstract to a manuscript) as an exercise and learning opportunity for his students. The care and detail with which he approaches each project has been admirable and inspirational, and also speaks to how invested he is in his graduate students' training.

Dr. DiLillo's nomination letters uniformly praised Dr. DiLillo's developmental approach to mentorship and attention paid to excellence in writing. Anna Jaffe wrote that Dr. DiLillo is skilled in "providing more guidance for newer students and granting independence to students as they progress through the program." Similarly, Michelle Haikalis wrote that "[Dr. DiLillo's] hands on approach during the early stages of training is particularly helpful. For example, in early versions of manuscripts he often shows students his editing process during individual meetings so that they can more thoroughly understand how to improve in their writing." In her nomination letter, Ruby Charak described the way in which she developed mentorship skills herself under Dr. DiLillo's guidance: "By letting me take the lead on meetings with Research Assistants, mentoring undergraduate students during the summer, and taking guest lectures, [Dr. DiLillo] provided me a platform to develop skills on how to supervise and mentor students." Molly Franz commented on the attention Dr. DiLillo paid to his students' writing: "One of David's strengths is his excellent writing ability, which he generously shares by spending many hours each week editing our manuscripts. He does not merely replace our wording, but engages in discussion with us about the art of writing, which has been incredibly helpful to my professional development."

Dr. DiLillo responded to questions from ABCT's Academic Training and Education Standards Committee about his experience and goals as a mentor, as well as his mentorship philosophy and mentorship practices.

For how long have you been a member of ABCT?
I have been a member of ABCT since I started graduate school in 1992.

For how long have you engaged in the type of mentoring that you engage in now?
I have been mentoring doctoral students in the Clinical Psychology Training Program at the University of Nebraska-Lincoln since 2000.

What type of mentor do you aspire to be? Do you have a mentorship philosophy?
My philosophy is to mentor students in ways that will help them discover and reach their own professional goals. I say

"discover" because many students do not have well-defined interests or career plans when they begin graduate school; they simply know that they enjoy clinical psychology. To accomplish this, I try to provide mentees with a wide range of research and clinical opportunities so they can explore their interests, develop competencies, and create a fulfilling career path. Throughout this process, I strive to foster increasing independence. I utilize the developmental concept of "scaffolding," which involves offering students temporary support to assist them in accomplishing new tasks they could not typically achieve on their own. As they acquire new skills, I gradually remove the supportive scaffolding. I find this promotes self-efficacy and autonomy—the ultimate goal of mentoring!

What practices do you engage in that foster your mentorship style?
Mentees in my lab initially participate in one or more team projects, often employing existing datasets, then progress to developing ideas for their own projects. I have weekly individual meetings with mentees throughout their graduate careers. Over time, mentees assume increasing responsibility for project decisions and leadership. We also meet weekly as a lab to discuss ongoing group projects and professional issues relevant to our research. I encourage interaction between mentees—with advanced students orienting newer students to various lab procedures—to foster a culture of support and collegiality in the lab. Students are involved in multiple projects simultaneously and are encouraged to present and publish their work, as well as to seek funding for their research. I also encourage students to affiliate with other labs if they wish—again, so they can discover their own interests. Relatedly, I often help students make connections with other faculty and resources to acquire training experiences that I cannot provide (some recent examples are: training in advanced statistical modeling, ERP assessment, salivary cortisol analysis).

What are your strengths as a mentor?
I try to be a positive role model for mentees. I am committed to them and demonstrate that by spending time on mentoring activities. I am willing to share my knowledge, skills, and experiences

with students. I view mentees as junior colleagues and treat them with respect.

Whom do you perceive to be your most influential mentors? Describe the main lessons that you have learned from your mentors.

I have been influenced by numerous mentors. Among them are:

William D. Murphy – my internship director, who is the embodiment of a scientist-practitioner. I remember Bill conducting a CBT group for adolescent sex offenders, writing an assessment report, and analyzing data for an article—all in one day.

Lizette Peterson – my postdoctoral advisor, who was an absolute dynamo. She showed me that it's possible to balance a productive research career and an active, involved family life. She used to say, "A change is as good as a rest." It's true!

Dave Hansen – my colleague at Nebraska for the past 16 years, and our department chair for 11 of those years. Dave exemplifies professionalism and collegiality on a daily basis. A terrific role model and problem solver!

Note: all these mentors are ABCT members (though Lizette passed away several years ago).

What do you tend to look for in potential mentees?

I look for mentees who are motivated, organized (yet flexible), have a strong work ethic, are eager to learn, and get along well with others. These qualities, along with natural intellectual ability, serve students well in any mentoring relationship.

What advice would you give to other professionals in your field who are starting out as mentors?

A few things come to mind:

- Serve as a role model for ethical behavior and high standards of professionalism.
- Play to your mentees' strengths while challenging them to grow in new areas.
- Be open to your mentees' ideas.
- Make mentoring a priority; follow through with commitments (meetings, deadlines, etc.).
- Spend as much time listening as dispensing advice.
- Don't try to shape mentees in your own image; help them develop and reach their professional goals.
- Take an interest in mentees. Show that you care. Listen with empathy when professional or personal issues arise, while maintaining healthy boundaries.

What do you enjoy doing for fun/relaxation?

I enjoy spending time with my wonderful family, socializing with friends, watching sports, and listening to music. ◾

Spotlight on a Mentor • **Dr. Jennifer Read**

The ***Spotlight on a Mentor*** program aims to highlight exceptional mentors among the membership ranks of ABCT. In this edition we present an interview with Dr. Jennifer Read. Dr. Read completed her B.A. at Denison University in Granville, Ohio. She received her Ph.D. in Clinical Psychology from the University of Rhode Island in 2000 after completing her predoctoral internship at the Brown University Consortium. Dr. Read completed an NIAAA-funded T32 Fellowship at Brown University's Center for Alcohol and Addiction Studies from 2000–2003. After this, she joined the Clinical Psychology Department faculty at the University at Buffalo in Buffalo, NY. There, she currently is a Professor of Psychology and the Director of Clinical Training. She mentors Clinical Psychology doctoral students, teaches, and provides clinical supervision at the University's clinic.

Dr. Read's research focuses on the individual and environmental factors that influence heavy and problematic substance use in young adults. This includes factors such as personality, gender, affective state, cognitions, and social influences. Much of Dr. Read's research has examined how trauma and posttraumatic stress may influence or be influenced by substance use, particularly in young adults. With her students and other colleagues, she has published over 100 articles on these topics. Further, with her colleague Dr. Paige Ouimette, she has co-edited a book on the intersection between PTSD and substance use, titled *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*.

Dr. Read was nominated for the Spotlight on a Mentor recognition by research assistants, graduate students, postdoctoral fellows, and colleagues, a testament to her far-reaching talent as a mentor to trainees and collaborators across developmental level. These letters praised Dr. Read as a research and professional mentor, clinical supervisor, and psychopathology professor. Doctoral student Courtney Motschman described Dr. Read's ability to tailor mentorship to each student's needs: "Dr. Read has taught me that being a successful mentor is about meeting students where they are. Some students are stronger than others in certain domains upon entering the program, and her mentorship helps students to develop fundamental skills first, if necessary, before progressing to more advanced skills. This allows every student to improve and grow without feeling overwhelmed or reluctant to ask for assistance."

Common to nearly all of her nomination letters was a description of Dr. Read's practice of requiring that her students set short- and long-term goals for themselves at the beginning of the semester and evaluate progress on these goals throughout the semester. This model was regarded as tremendously influential and effective by Dr. Read's trainees. As articulated by Rachel Bachrach: "These goals helped both Jen and her mentees stay on track so that each of us obtained the individual experi-

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Spotlight on a Mentor interviews are presented by ABCT's Academic Training and Education Standards Committee with editing by Helen Z. MacDonald. If you are interested in learning more about David DiLillo's or Jennifer Read's work as mentors, to learn about other exceptional ABCT mentors, or to add your mentorship profile to the ABCT Mentorship Directory, please visit www.abct.org/mentorship/. Want to nominate a mentor?

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ence necessary to pursue relevant career opportunities after graduation."

Many of Dr. Read's students and trainees described her willingness to devote time to her mentees in a way that conveyed support and respect. Rachel Bachrach wrote, "[Dr. Read's] availability and kindness taught me that mentoring is not just about dictating, but instead a partnership and collaboration between two individuals striving for the same goal. Jen also modeled how to balance work-life and family-life, which I continue to appreciate as a currently working mother. It is extraordinarily helpful to see a woman with a family succeed in academia, as unfortunately, these examples can be scarce." Samuel Meisel reflected similar sentiments: "Although Dr. Read would be deserving of receiving recognition for her mentorship solely based on her ability to help students grow as clinicians, what makes her a truly exceptional mentor is the extra time and effort she puts into her clinical supervising that makes students feel supported, respected, and valued." Lauren Rodriguez also wrote about Dr. Read's availability to her students: "…Jen is unique in that she regularly seeks feedback from her students on her own performance as a mentor. Her accessibility and approachability are two characteristics I have really valued as a first year graduate student… She is truly an inspiration and is someone to look up to and admire. If in my future I am successful, I will be exactly like Jennifer Read."

Dr. Read was widely praised as a clinical supervisor as well as a research mentor. Sharon Radomski described her experience this way: "As a clinical supervisor, Dr. Read challenged me more than any other supervisor I had during my time at UB. She helped me to become more succinct in describing my cases verbally, in my notes, and in my reports. She refined my clinical skills by reviewing tape of my sessions with me (sometimes moment by moment), challenging me to think of a circumstance from multiple perspectives, or encouraging me to consider how my beliefs and values may influence my clinical interactions. I also really appreciated that she introduced me to the role of clinical supervisor by having me provide supervision to a classmate." Jessica Blayney also wrote about Dr. Read's skill as a clinical supervisor: "…Jen promotes flexibility in clinical work, especially with more complex cases. She urges her students to think about the short- and long-term goals for each client. This not only keeps you organized session-to-ses-

sion, but also prevents unnecessary deviation from the treatment plan."

Articulating the sentiments of many of Dr. Read's nomination letters, Gregory Egerton illustrated Dr. Read's model of mentorship using a phrase that she uses in her work with graduate students:

… Jen says … "I work hard for you, you work hard for you, you work hard for me, and we work hard for each other." Despite its simplicity, this quote reflects the essential elements of the mentorship philosophy embodied by Jen in every aspect of her work with her students. First, Jen is an extremely diligent, thoughtful, and hardworking mentor who cares deeply about the welfare of her students ("I work hard for you…"). Second, Jen's thoughtfulness and diligence in her work as a mentor encourages this behavior by her students for themselves and for her ("…you work hard for you, you work hard for me…"). Finally, Jen's relationship to her students is collaborative, cooperative and reciprocal, and is based on the unique connection she shares with them ("…we work hard for each other."). More broadly, this statement symbolizes the openness and supportiveness of Jen's mentorship, and that she truly works with her students.

Dr. Read responded to questions from ABCT's Academic Training and Education Standards Committee about her experience and goals as a mentor, as well as her mentorship philosophy and mentorship practices.

How long have you been a member of ABCT?

I have been a member of ABCT since I was a graduate student, so for about 20 years. The ABCT conference has been a mainstay for me ever since I first started coming in my first or second year of grad school.

For how long have you engaged in the type of mentoring that you engage in now?

I started mentoring doctoral trainees when I came here to the University at Buffalo in 2003. However, I wouldn't say that I've been engaged in exactly the kind of mentoring that I'm engaged in now for 13 years. It's really evolved over the years, and I keep tweaking as I go.

What type of mentor do you aspire to be? Do you have a mentorship philosophy?

I believe that my job as a mentor is to empower students. This involves helping

students to learn what they need to know, to support and guide them as they master various challenges along the way, and to instill in them the confidence that they will need to pursue their interests and ambitions. The best part of being a mentor is to see students come into their own professionally, as they begin to see their own potential, and to know that you have played a role in that evolution.

My philosophy about the mentoring relationship is one that I routinely share with my students. I believe that a successful mentoring relationship is a mutual one, where both the mentor and the mentee are giving and taking in equal parts. If at any point one person is giving or taking too much, it all falls apart. This model also depends on a lot of open communication, so that together you can evaluate how the balance is working, and to make adjustments from time to time, as needed.

What practices do you engage in that foster your mentorship style?

I strive to be very direct and open. I don't want mentees to feel that they have to guess about what I'm thinking or what I expect. I try to be quick to praise students when they've done something well, but I also will be honest with them if I think they've missed the mark. I expect them to do the same for me. This is how we both will be the best we can be.

Related to this, I work to create an environment that fosters a strong working relationship. I want students to feel comfortable enough to tell me honestly when they are struggling, or have concerns, or when something isn't working in our mentoring collaboration. They will only do this if I consistently make open communication the standard, and model it myself. To this end, I try to be approachable and receptive, and to actively solicit constructive feedback.

In collaboration with my students, I engage in both short- and long-term planning for their professional success. Every semester I ask all of my students to make a list of their goals for the semester, their goals for the year, and their long-term plans. We meet to discuss these goals at the beginning and end of the semester and use this time to note accomplishments, to identify barriers to progress, and to strategize about how best to overcome those barriers. We also use these meetings as a time to check in about how things are going more generally. Thinking about short-term progress with

an eye toward longer-term goals really helps to keep us on track for achieving the student's own aspirations and objectives.

I work collaboratively with students. I don't see myself as the boss, or the expert. Some of my best mentoring experiences have been with students who inspired me to take my research in a new direction, or to think about a problem in a different way. I learn a lot from my students, and I value that.

I believe that one of the most important things that I can do as a mentor is to help my students come to trust in their own abilities and judgement. This really guides how I approach working with students in almost any setting, research or clinical. I try to serve as a sounding board, to push a bit, to challenge, to help the student find her or his own view or perspective.

I care about my students as people, and I want them to know that. Even though things are busy for all of us, it's important to check in from time to time to see how things are going, and what s/he is up to—not just in work-wise, but outside of work as well.

I try to portray a realistic view of myself and my professional life. This involves sharing my failures as well as my successes. It's important for students to know that everyone—no matter how accomplished or talented—falls down sometimes. It's OK. You just pick yourself back up and keep trying. I think if I normalize that for them, then they'll have more realistic expectations for themselves and their careers.

What are your strengths as a mentor?

I care about being a good mentor. It's something that is important to me and that I work hard at. I do a lot of reading and thinking about this topic, and often share these endeavors with my students. I get excited about students' ideas and work with them to see those ideas come to fruition. I love when a student comes to me with an idea for a project that they are enthusiastic about, and we work on it together to think through the all of angles, finding a way to make it work.

I invest in my students. What they want for themselves is important to me. I'll work hard to help them achieve their goals. I revel in their successes and feel the sting along with them when they experience disappointment. Your students are only your students for a little while. After that, they are your colleagues, your collaborators, and your friends. It is a long-

term relationship, and the investment in that relationship is an important one.

I think I'm good at recognizing the unique strengths that students bring to the table, and also at helping them to see and appreciate those strengths as well. I also have been successful at combining forces with other students or faculty to maximize on individual strengths and to create really strong and productive collaborations.

I create a positive and enjoyable environment for professional development. People thrive when they are happy and comfortable, and where there is a culture of caring about and helping one another. Everyone in my lab is a part of the team, and we are working together for our individual and shared success. For nearly 15 years, my lab has been an enjoyable and supportive place for students to get intellectually engaged, and to learn and develop. I feel very proud of this.

Whom do you perceive to be your most influential mentors? Describe the main lessons that you have learned from your mentors.

I've learned a lot from and been supported by so many people along my professional career. It's hard to choose just a few.

Mark Wood was my first mentor in the field of addictions when I was a graduate student. He had a profound influence on my early professional development. One of the most important things I learned from him was that you should take your work seriously, but not yourself seriously. He also taught me to set high expectations for myself, and to never give anything less than the best I could do. He was simultaneously my toughest critic and my biggest fan. Both were important and powerful motivators. He passed away not long ago and I think of him often, particularly in my interactions with my own students.

I completed my postdoctoral work at Brown University's Center for Alcohol and Addiction Studies and there I received really good mentorship from so many people. Peter Monti and Tony Spirito in particular were incredibly important to me in helping me think about my own career aspirations, and providing me with resources, support, and encouragement to reach for those aspirations.

What do you tend to look for in potential mentees?

Intellectual curiosity, enthusiasm for the field, academic aptitude, and relevant experience all are important. In addition to these, I've come to believe that it's often some of the personal characteristics that are the most critical to long-term success. Therefore, I also look for someone who is motivated, who is a hard worker, who is persistent, who will both give and take feedback. I also really appreciate students who have a sense of humor. It makes the work more fun if you can laugh from time to time.

What advice would you give to other professionals in your field who are starting out as mentors?

Just be authentic. I think especially earlier in their careers, beginning mentors may feel that they have to project an image of authority or total mastery to their mentees. Instead, my recommendation would be to trust in yourself that you have something to offer. You don't need to create an image.

What do you enjoy doing for fun/relaxation?

My husband and two daughters are my main, go-to people for fun and (sometimes) relaxation. There are other things too, though. I've been a runner my whole adult life and I've found that this is an important source of rejuvenation and mood management. More recently I've also taken up spinning and cycling and I enjoy these a great deal as well. I'm an avid reader and have been in the same book club for 12 years. I also love to travel and have been fortunate to combine some of my work activities with travel to some really interesting places, including Cambodia, Singapore, and Vietnam.

Nomination Form

ABCT's Academic Training and Education Standards Committee is currently soliciting nominations for the Spotlight on a Mentor program. The purpose of the Spotlight on a Mentor program is to highlight the diversity of excellent research mentors within the membership ranks of ABCT. Its goal is to spotlight promising early career mentors in addition to well-established mentors across all levels of academic rank, areas of specialization, and type of institution. Anyone who wishes to nominate a mentor may do so by responding to the questions in the attached document.

Please send completed nominations by May 1 to abctmentor@gmail.com.

NOMINATOR INFORMATION:

    Name of nominator:

    Email of nominator:

    Program (discipline and degree):

    Institution:

NOMINEE (MENTOR) INFORMATION:

    Name of Mentor:

    Position:

    Institution/department:

    Email address:

Tell us about your mentor:

1. What is the context in which you have been mentored by the nominee (i.e., as a clinical supervisor, research advisor, classroom instructor, program administrator)?

2. How would you describe your mentor's unique strengths and/or mentoring style?

3. Please describe any specific practices or strategies your mentor uses that have helped to shape your mentorship relationship and/or your development as a professional.

4. What has this person taught you about the process of mentorship?

5. Please describe any memorable moment(s) in your mentorship relationship with the nominee.

51st Annual Convention

November 16–19, 2017 • San Diego, CA

Call *for* Papers

APPLYING CBT IN DIVERSE CONTEXTS

Program Chair: Jordana Muroff, Ph.D.

As ABCT moves into its 51st year, the frontier of behavioral and cognitive therapies is the broad context surrounding the delivery of these therapies. Woven into the fabric of CBT is close attention to contextual cues when developing hypotheses and treatment strategies for clients. The theories and models of CBT practice are well-defined and many interventions have proven efficacious for subsets of the population. However, we must represent diverse settings and populations (e.g., ethno-racial minorities, LGBTQ, children, older adults) as we examine the social and cultural aspects of CBT research and practice, expand external validity, and maximize CBT benefits. Our scientific knowledge and our perspectives continue to develop and evolve. How do we incorporate new research evidence, models, and methods into effective practice with a very broad reach?

The theme of ABCT's 51st Annual Convention, "Applying CBT in Diverse Contexts" is intended to showcase research, clinical practice, and training to:

Portal opens
February 15, 2017

- increase our understanding of mental health problems and mechanisms across contexts
- establish or broaden the efficacy and effectiveness of interventions across diverse populations and settings
- disseminate effective cognitive, behavioral, and related treatments across professions

*Deadline
for submissions*:

March 15, 2017

The convention will highlight how our scientific advances inform the who, what, and how of reaching diverse communities with effective treatments.

Submissions may be in the form of symposia, clinical round tables, panel discussions, and posters. Information about the convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2017. The online submission portal will open on Wednesday, February 15, 2017.

*See p. 134
for information
about preparing
your abstract*

Deadline for submissions: 11:59 P.M. ET on Wednesday, **March 15, 2017**

ABCT's 51st Annual Convention

November 16–19, 2017 • San Diego, CA

Preparing
to Submit
an Abstract

Thinking about submitting an abstract for the ABCT 51st Annual Convention in San Diego? The submission portal will be opened from February 15–March 15. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 51st Annual Convention. The deadline for submissions will be 11:59 P.M. (EST), Tuesday, March 15, 2017. We look forward to seeing you in San Diego!

The ABCT Convention is designed for scientists, practitioners, students, and scholars who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions, Targeted and Special Programing, and Ticketed Events.

ABCT uses the Cadmium Scorecard system for the submission of general session events. The step-by-step instructions are easily accessed from the ABCT Abstract Submission Welcome page or the ABCT Annual Convention web page. An individual must LIMIT TO 6 the number of general session submissions in which he or she is a SPEAKER (including symposia, panel discussions, clinical round tables, and research spotlights). The term SPEAKER includes roles of chair, moderator, presenter, panelist, and discussant. Acceptances for any given speaker will be limited to 4. As you prepare your submission, please keep in mind:

- **Presentation type**: Please see below for descriptions of the various presentation types.
- **Number of presenters/papers**: For Symposia, please have a minimum of four presenters ("presenters" include chair(s), papers, and discussant). Symposia may include one or two chairs, but must include only one discussant and between three and five papers. The chair may present a paper, but the discussant may not, keeping the overall maximum at 8. For Panel Discussions and Clinical Round Tables, please have one moderator and between three to six panelists, keeping the overall maximum at 7.
- **Title**: Be succinct.
- **Authors/Presenters**: Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their ABCT membership status: possibilities are current full member; lapsed member or nonmember; post-baccalaureate; student member; student nonmember; new professional; associate member; emeritus. For Symposia, in the first "Authors" section of the submission portal, only list the names of the chair(s), paper presenters, and discussant. In the "Individual Abstracts" section, list the names of the co-authors on each paper presentation (using the "Authors" subsection of "Individual Abstracts").
- **Affiliations**: The system requires that you enter affiliations before clicking on the button to "Save Authors". DO NOT LIST DEPARTMENTS. In the following step you will be asked to attach affiliations with appropriate authors.
- **Key Words**: Please read carefully through the pull-down menu and use one of the existing keywords.
- **Learning Objectives**: For Symposia, Panel Discussions, Clinical Round Tables, and Research Spotlights, write three to five statements of no more than 125 characters each, describing the learning objectives of the event. Sample statements are: Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Presented data on novel direction in the dissemination of mindfulness-based clinical interventions."

Overall: Ask a colleague to proof your abstract for inconsistencies or typos. Abstracts are reviewed based on several criteria including quality, clarity, relevance to ABCT's priorities, relevance to the Convention theme, potential contribution to the field, integration of research, research design and analyses, and SIG sponsorship. Given the large number of high quality submissions across submission types, acceptance decisions are difficult. Please note that decisions to accept/reject submissions are not solely based on Reviewers' ratings. The Program Chair and Committee will consider the full portfolio of the program to ensure diversity of content and presenters when finalizing decisions.

General Sessions

There are between 150 and 200 general sessions each year competing for your attention. An individual must <u>LIMIT TO 6</u> the number of general session submissions in which he or she is a SPEAKER (including symposia, panel discussions, clinical roundtables, and research spotlights). The term <u>SPEAKER</u> includes roles of chair, moderator, presenter, panelist, and discussant. Acceptances for any given speaker will be limited to 4. All general sessions are included with the registration fee. These events are all submitted through the ABCT submission system. The deadline for these submissions is 11:59 PM, Wednesday, March 15, 2017. General session types include:

Symposia

New!

In response to convention feedback requesting that symposia include more presentations by established researchers/faculty along with their graduate students, preference will be given to symposia submissions that include non-student researchers and faculty members as first-author presenters.

Symposia are presentations of data, usually investigating the efficacy or effectiveness of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. No more than 6 presenters are allowed.

Panel Discussions and Clinical Round Tables

Discussions (or debates) by informed individuals on a current important topic. These are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. No more than 6 presenters are allowed.

Spotlight Research Presentations

This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.

Poster Sessions

One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,200 and 1,400 posters are presented each year.

Targeted and Special Programing

Targeted and special programing events are also included with the registration fee. These events are designed to address a range of scientific, clinical, and professional development topics. They also provide unique opportunities for networking.

Invited Addresses/Panels

Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge.

Mini Workshops

Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long.

Clinical Grand Rounds

Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.

Research and Professional Development

Provides opportunities for attendees to learn from experts about the development of a range of research and professional skills, such as grant writing, reviewing manuscripts, and professional practice.

Membership Panel Discussion

Organized by representatives of the Membership Committees, these events generally emphasize training or career development.

Special Sessions

These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years, the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training.

Special Interest Group (SIG) Meetings

More than 39 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.

Ticketed Events

Ticketed events offer educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment.

Clinical Intervention Training

One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction.

Institutes

Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday, and are generally limited to 40 attendees.

Workshops

Covering concerns of the practitioner/educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees.

Master Clinician Seminars

The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees.

Advanced Methodology and Statistics Seminars

Designed to enhance researchers' abilities, they are 4 hours long and limited to 40 attendees.

Continuing Education

Visit http://www.abct.org/conv2016/?mn=21&fn=CE_Credit

ABCT 50th Anniversary Album P L A Y I T F O R W A R D

Jon Abramowitz, Ph.D. • Jon Comer, Ph.D. • Aaron Fisher, Ph.D. •
Elizabeth Hall, Ed.D., Ph.D. • Steve Hayes, Ph.D. • Jon Hershfield,
MFT • David Juncos, Psy.D. • Reed Kendall • Sam Kramer, MA •
Adam LaMotte, M.A. • Jaimie Lunsford, B.S. • Steve Mazza, M.A. •
Tony Puliafico, Ph.D. • Jose Soler-Baillo, M.A. • Dennis Tirch, Ph.D.
• Tim Verduin, Ph.D. • Jerome Yoman, Ph.D., ABPP

To celebrate the 50th anniversary of
ABCT, **Play It Forward** has released a
compilation album featuring 14 songs
written and performed by ABCT mem-
bers. Proceeds go to the ABCT student
research grant and travel award funds.

Those who donate at least $10 will
receive a CD in the mail in addition
to the digital download

Now available for download

All donations go to ABCT

MINUMUM DONATION: $5.00

ABCT 50
50th Anniversary Album
PLAY IT FORWARD

ABCT 50

donate here! https://www.playitforward.com/projects/14