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the Behavior Therapist

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MESSAGE FROM THE EDITOR

The Past, Present, and Future of *the Behavior Therapist*: A Message From the Editor

Richard LeBeau, *UCLA*

PLEASE ALLOW ME to introduce myself. My name is Richard LeBeau and I am a clinical psychologist at the University of California, Los Angeles, where I also did my graduate training. As of January 1, 2020, I have officially taken over from Dr. Kate Wolitzky-Taylor as Editor of *the Behavior Therapist* (*tBT*). There are two primary reasons that I am deeply honored to have been selected for the role. One is my longstanding commitment to the organization. The other is the long line of brilliant and dedicated researchers and clinicians who have preceded me in the role, including my dear friend and colleague Dr. Wolitzy-Taylor.

My introduction to ABCT came in 2007 at the 41st Annual Convention in Philadelphia (which is coincidentally where we will be returning for the 54th Annual Convention later this year). I still remember how overwhelmed I was coming face to face with leaders in the field whose work I admired and what an impostor I felt like presenting my poster. Since that time, ABCT has been a consistent and welcoming professional home for me, one I immensely enjoy returning to each year right at the start of the holiday season. As I prepared for my new role as editor, I did a great deal of reflecting on ABCT as an organization and this publication in particular. I was particularly struck by the

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the Behavior Therapist

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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, Richard LeBeau, Ph.D., at **rlebeau@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.

realization that, with this issue, *tBT* enters its 43rd year of publication. It is an institution almost as old as ABCT itself. I am deeply humbled to think about the luminaries who have graced this journal's pages before me.

The present issue features several articles centered on the broad topic of engagement. The first set of articles present empirical data on various aspects of improving treatment engagement, including getting individuals to initiate treatment following the initial referral and how to enhance patients' willingness to engage with technology in conjunction with treatment. The second set of articles are reflection pieces covering the thought-provoking invited addresses and invited panels that were major highlights of ABCT's 53rd Annual Convention in Atlanta this past November. But first, I kick things off with a brief overview of what *tBT* is, who makes it happen, where it is headed, and how you can become involved.

What Is *tBT*?

tBT is one of three journals published by ABCT (*Behavior Therapy* and *Cognitive and Behavioral Practice* being the others). It is unique in that it is freely available online and directly mailed to all active ABCT members. The journal publishes a broad range of articles that are relevant to our membership. These articles take many forms, including original research, reviews, commentaries, educational and descriptive pieces, news items, spotlights on exceptional individuals and organizations, and even humor. *tBT* also provides a platform for various important figures within the organization (including current President Martin Antony and Executive Director Mary Jane Eimer) to communicate directly with the membership. Ultimately, *tBT*'s goals are to inform the large and diverse membership of ABCT about what the organization is up to as well as the latest developments in our field more broadly.

Who Is Behind *tBT*?

It takes a large team of dedicated and creative individuals to keep a journal running. Chief among this team is the Associate Editorial Board, a group of 18 researchers and clinicians who volunteer their time and expertise to solicit articles from colleagues, organize special issues, conduct peer reviews, and generate articles of their own. Our current Board has a tremendous diversity of specialty areas, including (but certainly not limited to) dissemination and implementation, the development and evaluation of novel psychological interventions, the reduction of mental health disparities, child development, intimate relationships, interpersonal violence, experimental psychopathology, and neuroimaging. Additionally, there are three individuals who are instrumental to the continuation of *tBT*: ABCT Director of Communications David Teisler, ABCT Managing Editor Stephanie Schwartz, and *tBT* Editorial Assistant Resham Gellatly. Their knowledge and support have been invaluable as I transitioned into this position. Last, but certainly not least, there are all of those who write content for *tBT* and its many loyal readers.

Where Is *tBT* Headed?

My primary goal for my 3-year editorial term is to keep up the tradition of high-quality, informative, and relevant content that has been the hallmark of *tBT* since its inception. I have three additional goals for the journal. The first is to increase *tBT*'s visibility and desirability as a publication outlet for original research being conducted in our field. The second is to increase membership engagement with *tBT* by expanding the digital presence of its contents and increasing the involvement of ABCT's many Special Interest Groups. The third and final goal is to continue publishing thought-provoking special issues. My predecessor, Dr. Wolitzky-Taylor, truly raised the bar with the exceptional special issues she oversaw on topics like diversity and inclusion, pseudoscience, and stigma. I am thrilled to report that we have numerous special issues already planned, including one on clinical psychologists as advocates for marginalized populations and another on the latest developments in the assessment and management of suicidality.

How Can You Be Part of *tBT*?

In order for *tBT* to continue to grow and move forward, it is essential that the ABCT membership get involved. We encourage submissions of numerous kinds (see above) from individuals at any developmental level, including students. We want to hear your thoughts, both about the content that you read in *tBT* and the content that you wish to see in it. If you have feedback you would like to share, content you would like to contribute, or questions about the journal, please do not hesitate to email me at rlebeau@ucla.edu. (Note: Instructions for submitting articles to *tBT* can also be found in each issue as well as on the ABCT website.)

I am very excited to have the opportunity to help deliver original research, insightful commentaries, and organizational news to you over the next year three years and hope that many of you will join me in the process.

. . .

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ABCT PIONEERS SERIES

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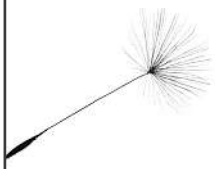

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Russell Barkley
Tom Ollendick
Gail Steketee

From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better

Mary Jane Eimer, *Executive Director*

WE JUST COMPLETED the 53rd Annual Convention, in Atlanta. Overall the convention went smoothly, and the feedback has been very positive, with the exception of unacceptable behavior exhibited by a few attendees. Having our convention attendees feel safe, welcome, and valued is a top priority to leadership and staff. Therefore, over the coming year, the Convention and Education Issues Committee will work with staff to develop a Convention Code of Conduct and clear procedures for what to do if attendees witness or feel harassment of any sort during an ABCT-sponsored event. We will also partner with the Philadelphia Marriott Downtown Hotel and future venues to ensure quick communication when the need arises. I assure you that harassment at any ABCT-sponsored event is unacceptable, and your leadership and staff will work to ensure this does not happen.

The Board of Directors met Thursday, November 21, and had a very productive meeting. A few highlights include:

1. President Antony and Immediate Past President Bruce Chorpita will develop a KPI (Key Progress Indicators) template that coordinators, committee chairs, and editors can use when reporting to the Board. Given the amount of information the Board digests prior to one of our meetings, KPIs will go a long way in communicating the essential progress being made. The Board is well aware that straight-up numbers as a guage to success are not always appropriate or meaningful.

2. Membership will focus this year on clinical psychology and Psy.D. programs while keeping a close eye on how we can better serve our master-level and social work members. We will also address the needs of our clinical members.

3. We rely on you to help spread the word on the advantages of being an ABCT member. We are always looking for members to serve as an ABCT Ambassador, and we would welcome you as an Ambassador. We encourage members in a variety of settings to participate in this program. If interested, please contact Rebecca "Becca" Skolnick, Ambassador Committee Chair, at rskolnick@mindwellnyc.com and copy me, mjeimer@abct.org. Thank you for consideration in getting more involved in ABCT.

4. This was the first year in a good long time that we offered child care. It was heavily subsidized by ABCT to make it a go. The leadership wants to continue the experiment in Philadelphia, promoting it heavily and aiming for it becoming a self-sustaining program. But this works only if there is a demonstrated need.

5. Brian McGrath, our financial advisor from Boenning and Scattergood, updated the Board on our investments over the past year. Our portfolio is socially responsible. Even so, we had a very good year with our short-term investments, far exceeding market averages. As is no surprise, we get the bulk of income in the fall and early winter from membership, publications, and the Annual Convention. The money is invested, and the interest earned is one component of our operating income. We transfer money back as we need it over the course of the year. Like many organizations, dues income alone does not cover our operating expenses.

6. Speaking of Mr. McGrath, one of the many advantages of our relationship with Boenning and Scattergood is that you can contact him to review your own personal portfolio and develop a financial plan that would include guidance on repaying student debt, saving for mortgages, college tuition for your offspring, or your retirement—all areas of Mr. McGrath's expertise. ABCT members are not charged a service fee for consultation or providing a formal Financial Plan called the ENVISION Plan. You can reach Mr. McGrath at 610-832-5292. Be sure to mention that you are an ABCT member.

7. I've been given the go-ahead to hire two new staff: an Outreach and Continuing Education Manager and a Membership and Marketing Manager. This will bring the ABCT Central Office force to 10 and help us address the strategic plan in a more robust manner.

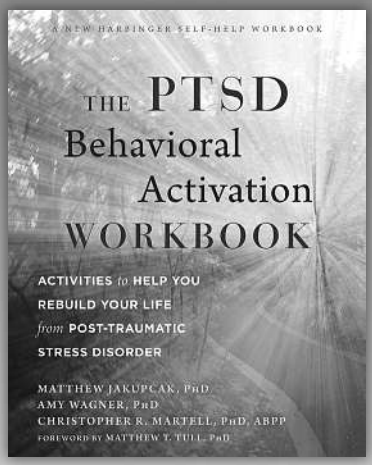
8. The Board approved in principle staff's proposal for a new database system that will have new modules and a better user interface and allow members to update our numerous directories in real-time. The Finance Committee has asked for some more financial information before signing off. Hard on the heels of the database will be a redesign of our website. The leadership and staff understand the importance of keeping pace with technology. There are a host of technology upgrades that I will address in future columns.

9. Staff are working in earnest to develop General Data Protection Regulations (GDPR) and Canada's Personal Information Protection and Electronic Documents ACT (PIPEDA). There are expensive penalties if we are audited and found not to have policies in place or appropriate privacy fields in our AMS. ABCT, as a North American organization with a global reach, including in the European Union, needs to evaluate and address our ongoing privacy practices, IT systems, and third-party/vendor agreements as they relate to GDPR and PIPEDA requirements. This will also impact how we instruct our Special Interest Groups to maintain data on their members.

10. Have you taken a look at our listing of Self-Help Book Recommendations? The Board just accepted another 15 books for inclusion on our website.

11. The Board recently appointed the Task Force to Promote Equity, Access, and Inclusion, co-chaired by Sandra Pimentel, Shireen Rizvi, and Laura Seligman. The main objective of the task force is to provide data and recommendations to assist the Board in ensuring that all members and potential members have equal access to the professional benefits offered by ABCT. Board was informed that the task force had a booth in the exhibit hall to solicit feedback and will hold a meeting during the convention. Additional task force mem-

ESSENTIAL RESOURCES for YOUR PRACTICE



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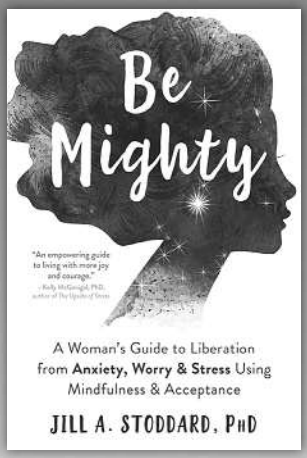

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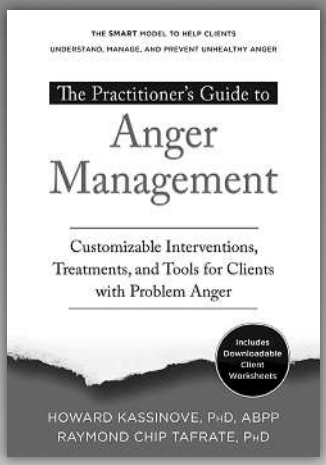

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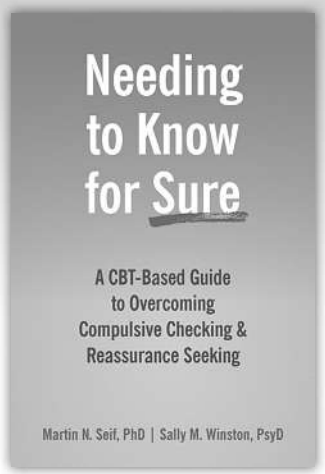

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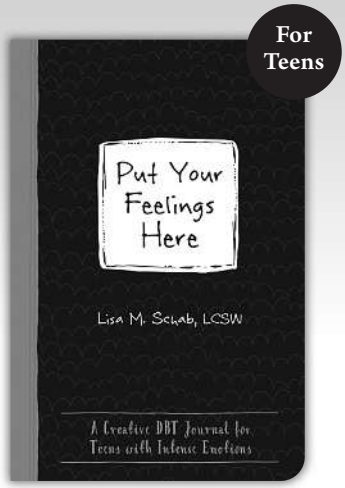

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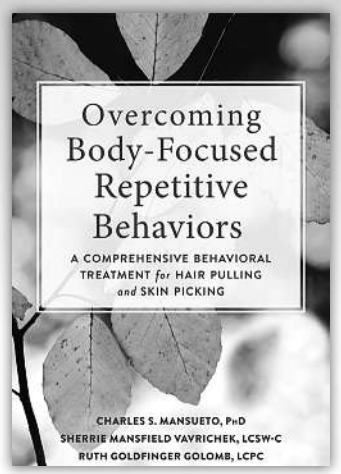

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bers represent various SIGs and include: Anu Asnaani, RaeAnn Anderson, Sierra Carter, Ryan DeLapp, Brian Feinstein, Christine (Cho) Laurine, Christina López, and Jae Puckett.

Your new Board just held its first meeting December 9, where they determined the 2020 priorities and action items and reaffirmed our 8 strategic initiatives. I will be covering this in more detail over the coming months as we focus on plans for the June Strategic Planning Retreat.

Postconvention wrap-up for ABCT staff is another busy season: minutes, thank-you letters, orientation for new members to governance, closing our fiscal year, updating our stats from membership and the convention, and a whole host of other details.

The results are in! Congratulations to Laura Seligman, our 2020–2021 President Elect, and Carolyn Becker Black, our 2020–2023 Representative-at-Large and liaison to Membership Issues. Our two bylaws changes were approved by the membership. And, by moving the election to November, we increased voter participation to 28%, up from 21%. Thank you to those that voted.

I'm writing this column in early December. But I can't let this opportunity go without thanking you for making ABCT your professional home. Wishing you and yours a terrific holiday season and a Happy New Year! Until next time!

. . .

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ORIGINAL RESEARCH

Military Sexual Trauma Survivor Preferences for Provider Gender and Associations With Mental Health Evaluation Attendance

Minden B. Sexton, *VA Ann Arbor Healthcare System, University of Michigan Medical School*

RaeAnn E. Anderson, *Kent State University, University of North Dakota*

Diana C. Bennett, *New Mexico Veterans Affairs Healthcare System*

Edward J. Thomas, Rachel B. Broman, Sarah K. H. Richards, *VA Ann Arbor Healthcare System*

MILITARY SEXUAL TRAUMA (MST) refers to sexual assault or severe sexual harassment experienced during military service. A recent meta-analysis indicated 13.9% of veterans endorsed MST (38.4% of women and 3.9% of men; Wilson, 2018). Although MST is more common in female veterans, given the gender imbalance in military service, men represent a sizable proportion of MST survivors receiving Veterans Health Administration (VHA) care (Kimerling, Street, Gima & Smith, 2008). Despite nationwide screening efforts and free treatment provided to MST survivors, MST care tends to be underutilized (Kimerling et al., 2015). Approximately half of recent female veterans who are eligible for MST-related care access it (Calhoun et al., 2016). Literature among civilian sexual trauma survivors (Kantor, Knefel, Lueger-Schuster, 2017) as well as MST survivors (Turchik, Bucossi, & Kimerling, 2014; Turchik et al., 2013) suggests that lack of knowledge, stigma, and gender-related issues are large barriers to care. In particular, during the past decade, the U.S. Department of Veterans Affairs has explicitly recommended veterans' preferences for provider gender be assessed and accommodated whenever possible (VHA, 2018). However, there is limited research to date on survivor preferences and whether these are related to treatment-seeking behaviors. For instance, it is possible that articulation of a preference may be associated with more serious consideration of treatment or other factors relevant to engagement. The goal of this study was to investigate the provider gender preferences of male and female U.S. veterans seeking treatment for mental health concerns associated with MST and the association of provider gender preferences with initial visit attendance.

Gender Issues and Barriers to Treatment Seeking

Trauma survivors often report intense shame and stigma regarding their experiences (Aakvaag et al., 2016). These emotions are related to increased symptom severity (Aakvaag et al., 2016; Tangney, Wagner, & Gramzow, 1992) and decreased treatment seeking (Kantor et al., 2017; Sable, Danis, Mauzy, & Gallagher, 2006). Embarrassment and stigma can be exacerbated for survivors of sexual trauma (Aakvaag et al.), particularly men (Sable et al., 2006). Sexual assault survivors often question their sexuality, masculinity/femininity, self-worth, and relationship functioning after their traumas. For veterans with MST, the unique characteristics of military culture, such as placing high value on masculinity or prioritizing appearances of strength, may further hinder treatment seeking through increased stigma (Bell, Turchik, & Karpenko, 2014; O'Brien, Keith, & Shoemaker, 2015). Finally, men often experience sexual violence under different circumstances than women and may experience different clinical outcomes (Anderson, Cahill, & Delahanty, 2016; Davies, 2002). Trauma-relevant contextual aspects including the increased likelihood of MST perpetration by men, gender-relevant strain, and perception that female clinicians may be less challenging to discuss sensitive issues may relate to care-seeking decisions among survivors (e.g., Bell et al., 2014; Elder, Domino, Rentz, & Mata-Galán, 2017; Monteith, Gerber, Brownstone, Soberay & Bahraini, 2019). Thus, facilitating care for MST survivors necessitates sensitivity to gender-related issues and potential patient preferences.

The treatment needs and preferences of male sexual trauma survivors are greatly underresearched in comparison to women

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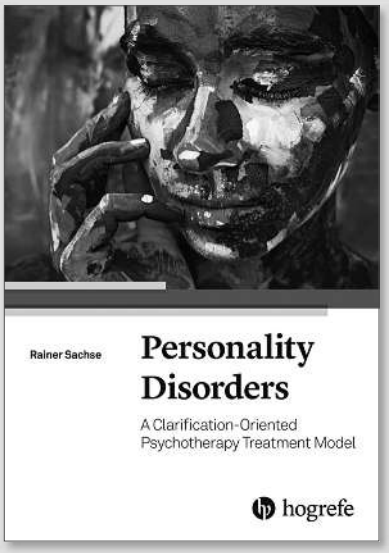

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(Donnelly & Kenyon, 1996; Lowe & Rogers, 2017; Peterson, Voller, Polusny, & Murdoch, 2011) and rape myths regarding male survivors continue to abound in spite of legal and policy improvements (Lowe & Rogers). Of the limited research available on gender and MST treatment, one study of over 4,000 veterans who screened positive for MST found the most powerful factor influencing the receipt of MST-related care was gender; male veterans utilized any type of MST-related care less frequently than female veterans in the 1-year period following a positive screen (Turchik, Pavao, Hyun, Mark & Kimerling, 2012). Thus, understanding the provider gender preferences of both men and women MST survivors may potentially facilitate care, for example, by increasing awareness of VHA system needs for men and women mental MST-skilled health providers.

Complicating this picture, some research suggests PTSD symptoms and psychological distress associated with any diagnosis may increase MST-specific treatment seeking (Calhoun et al., 2016; Kantor et al., 2017), while other research suggests shame and stigma are primary barriers to treatment seeking for people with PTSD (Kantor et al.). Some research suggests female veterans with MST were more likely to endorse PTSD symptoms than their MST-exposed male counterparts (Kimerling et al., 2007), although this finding has less support among veterans seeking mental health treatment for MST-related conditions (Sexton, Raggio, McSweeney, Authier, & Rauch, 2017). Including PTSD symptom consideration may be helpful for understanding both MST survivors gender preferences for providers and attendance at treatment.

Gender Issues and Treatment Preferences

Although national VHA policy and clinical tradition recommend accommodating requests for provider gender when possible, there is a mismatch between such recommendations and available data. Research examining therapist-patient gender match tends to show few, if any, significant effects (Lambert, 2016). Research on patient-provider gender match rarely accounts for the gender preferences patients may have. Rather, these studies focus on post-hoc matches or mismatches of gender regardless of patient preferences. Further, this research has rarely included veterans who, due to the unique characteristics of military culture, may have different attitudes and preferences regarding gender issues and treatment (Bell et al., 2014; O'Brien et al., 2015). Further, given the complex relationships between sexual assault trauma, overrepresentation of males among MST perpetrators, and sexual assault and care-seeking stigmas that may influence recovery from trauma among veterans, it may be that therapist gender preference rather than gender matching is critical for engagement in mental health care. Continued research focused on the gender preferences of treatment-seeking veterans endorsing MST appears warranted.

Within veteran populations, research shows facilitating treatment preferences improves treatment satisfaction, completion, and outcomes (Lindheim, Bennett, Trentacosta, & McLear, 2014) and is consistent with veteran-focused care models. Both quantitative and qualitative research demonstrates female veterans perceive VHA sites that provide gender-sensitive treatment modalities as more accessible and welcoming (Kimerling et al., 2015; Koblinsky, Schroeder, & Leslie, 2017). For example, female veterans interested in intimate partner violence (IPV)-related care consider the availability of female providers an important facilitator of treatment (Iverson et al., 2016). This data is likely relevant to understanding women seeking MST-specific treatment; female veterans with MST histories often perceive VHA as unwelcoming (Kehle-Forbes et al., 2017). However, much less is known about treatment outcomes and treatment preferences among those seeking care for MST-related conditions (Turchik & Wilson, 2010) compared to patient groups defined by diagnostic status (e.g., veterans with PTSD), female veterans as a whole (Kimerling et al., 2015), or reports related to MST survivors that do not incorporate men.

Despite the prevailing clinical wisdom on gender preferences and VHA policy, only two qualitative, small sample studies researching provider preferences in MST survivors have been published to date. Turchik et al. (2013) interviewed 20 male veterans who had not previously received MST-specific mental health care. Of these, 50% indicated they would prefer a female clinician, 25% preferred a male clinician, and 25% denied a preference. Notably, this study purposefully recruited a sample of male veterans who had screened positive for MST and had utilized some type of VHA care, but had not received any MST-specific care. In a parallel study with 9 female veterans of whom 55.6% had attended at least one MST-related visit during the past 2 years, 67% of women preferred female providers and the remainder had no preference (Turchik, Bucossi, et al., 2014). These preliminary results suggest gender preferences may be quite salient for this population and that preferences may vary by patient gender. However, the small sample size makes it difficult to discern the stability of these rates. Moreover, the use of a non-MST-treatment utilizing male population and women with mixed MST-specific treatment utilization limits our ability to generalize these findings to the needs of those actively considering initiation of MST-specific care. In order to further assess issues related to potential gender-specific needs within liaison to care, Turchik and colleagues expanded on the results of gender-related findings with male veterans (Turchik, Rafie, Rosen, & Kimerling, 2014). They examined changes in the utilization of mental health care of 153 male veterans following receipt of male-tailored educational materials. Although the materials were reviewed positively, they did not yield an increase in MST-specific mental health utilization.

Current Study

Prior research with MST treatment seekers shows that, similar to IPV treatment seekers, the gender of the provider is an important concern for patients (Turchik et al., 2013; Turchik, Bucossi, et al., 2014; Turchik, Rafie, et al., 2014). Extant literature suggests male and female MST survivors show a predominant preference for female providers, yet these small sample studies primarily involved qualitative research with veterans not specifically seeking MST-related mental health care. Additionally, none of these studies accounted for potential PTSD symptoms that may prompt treatment seeking or may confound gender-related results. Thus, further research investigating MST survivors' gender preferences using quantitative methods with a larger sample is important for informing VHA policies and practices to optimize MST-related care. The aims of the study were to (a) evaluate MST survivors' gender preferences among a larger sample of veterans accepting referrals for MST-specific care, while accounting for posttraumatic stress symptom screening severity, and (b) to examine relationships between identified preferences, if any, and attendance at consultation appointments with and without controlling for posttraumatic stress disorder screening severity.

Method

Participants

Participants were all 197 veterans endorsing MST who requested referrals for MST-specific mental health care from their VHA clinicians at a Midwestern VHA during an 18-month period between 2015–2016.

Procedures

As part of VHA standard practices, veterans utilizing health care are screened for MST histories and PTSD symptoms at primary care and other medical visits. For veterans who screened positive, hospital clinicians offered to place consultations to initiate referrals to MST specialists. In addition to MST screening visits, hospital staff were also able to refer to the service based on clinical care needs that may arise after screening or when veterans were more actively interested in pursuing MST-specific care. The MST consultation service at this VHA was embedded within a PTSD specialty clinic with ability to liaison veterans into outpatient services, such as PTSD interventions, general mental health services, substance use disorder interventions, or behavioral medicine care, following assessment of needs and preferences.

At the time of consultation placement, veterans were asked their preferences (if any) for the gender of their assessing and treating clinician(s) consistent with the local and national policy recommendations. The Military Sexual Trauma Coordinators (MSTC) at the study hospital (one man and one woman) received all consults and facilitated scheduling for a diagnostic evaluation and treatment-planning interviews, hereafter referred to as the MST evaluation, either at the primary outpatient mental health service or through telemental health to the veteran's home or regional community-based outpatient clinics. Veterans seen in Primary Care Mental Health Integration or the Women's Health Clinic had consultation appointments scheduled prior to leaving the screening visit. In cases we were unable to reach a veteran through the above strategies, the MSTC contacted providers associated with upcoming medical visits throughout the hospital to attempt to schedule. Individuals that did not attend initial appointments due to cancellation or no-showing were also contacted, at a minimum, twice by phone and once by mail to attempt to reschedule. Courtesy appointment reminders were sent through the mail or by phone in the week prior to the appointment. Gender preferences were accommodated in all instances and veterans were aware this preference would be honored prior to their appointment. The MSTC monitored whether consultation evaluations were attended and cross-checked this information with the medical record. The hospital's Institutional Review Board approved the processes and procedures involved in this research. As part of a retrospective evaluation of information collected within the purview of standard clinical care at the hospital, the board waived participant consent requirements.

Measures

Military Sexual Trauma Mental Health Screen and Consultation Instrument. Veterans were screened verbally with the fol-

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lowing items either as part of mandated lifetime screening generally completed in primary care visits, or elsewhere in the hospital when MST was reported: "While you were in the military did you receive uninvited and unwanted sexual attention such as touching, cornering, pressure for sexual favors, or verbal remarks?" and "While you were in the military did someone ever use force or the threat of force to have sexual contact with you against your will?" Veterans who indicated "yes" to either of these items were then asked whether they were interested in speaking to a provider for MST-specific care, and affirmative answers triggered a referral to an MST specialist. Providers generating consultation requests for the MST team were required to select whether the veteran preferred a male clinician, female clinician, or had no preference in order to submit the consult to the service.

Primary Care-PTSD Screen (PC-PTSD). The PC-PTSD (Prins, Ouimette, & Kimerling, 2003) is a four-item screen developed based on *Diagnostic and Statistical Manual of Mental Disorders IV-TR* (American Psychiatric Association, 2000) PTSD symptoms for rapid use in medical settings. The assessment cues for potentially traumatic events, and past-month endorsement of three or more symptoms (e.g., having nightmares, trying hard to avoid thoughts and situations related to the event) is considered a positive screen indicating further attention to the assessment and management of PTSD may be warranted. The PC-PTSD has been psychometrically supported for use with active-duty service members and veterans (Bliese et al., 2008; Calhoun et al., 2010; Ouimette, Wade, Prins, & Schohn, 2008).

Table 1. Veteran Demographic, Service, and PTSD Screening Characteristics (N = 195)

Characteristic	% or Mean	*SD*
Age	44.92	13.37
Women	73.6%	
Caucasian	69.2%	
African American	24.4%	
American Indian	2.3%	
Latina/Latino	1.7%	
Married	26.6%	
Service Branch		
Air Force	15.2%	
Army	49.3%	
Marines	5.1%	
Navy	30.4%	
Service Era		
Vietnam	14.7%	
Post-Vietnam	20.6%	
Persian Gulf	24.1%	
OIF/OEF/OND	40.6%	
PC-PTSD	2.01	1.75

Notes. OIF/OEF/OND = Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn; PC-PTSD = Primary Care PTSD Screen.

Data Analysis

Demographic characteristics were assessed with descriptive statistics as appropriate. Associations between patient gender, provider gender preference, and evaluation attendance were examined using chi-square analyses. Logistic regression was used to evaluate the potential main effects of patient gender, gender preference, and PC-PTSD and the interaction of patient gender and gender preference with evaluation attendance. Phi coefficients were used to characterize the magnitude of significant effects. All analyses were performed with SPSS 24.0.

Results

Participant Characteristics

One hundred ninety-seven veterans had consultations placed for care during the study. Only 1% (n = 2; one man and one woman) of veterans expressed a preference for a male provider and, thus, these two cases were removed from further analyses due to the small sample size of this group. Regarding the remaining 195 participants, they were primarily women (73.3%). Veterans identified as Caucasian non-Hispanic (68.7%), African American (23.1%), American Indian (2.1%), Latino or Latina (1.5%), or another ethnoracial group/biracial/did not identify (4.6%). The average age was 45.2 years. Men comprised approximately a quarter of those seeking MST-specific treatment (26.4%), notably lower than the representation of males within the MST-positive population receiving any services at this VHA (44.5%). Most were not married, and a variety of service eras and branches were represented. See Table 1.

Gender Preferences

Overall, 47.2% of participants requested a female clinician, with the remaining having no gender preference. Among female veterans, 53.5% requested a woman in contrast with 29.4% of men. The patient gender difference in provider gender preference was significant (χ^2 = 8.75, df =1, p = .003). The magnitude of the effect was small-to-medium (Φ = .213). The PC-PTSD was not associated with gender preference (t = 0.129, df = 158, p = .890).

Gender and Gender Preference Associations With Evaluation Attendance

The rate of attendance at MST-specific evaluation appointments was 73.6%. Attendance rates were 74.6% and 70.6% for women and men, respectively. This difference was not statistically significant (χ^2 = 0.32, df =1, p = .573). Specific to gender preferences, requesting a female provider was associated with an 80.2% attendance rate while those indicating no gender preference demonstrated a 67.6% attendance rate. This comparison was statistically significant (χ^2 = 3.91, df =1, p = .048) though the magnitude of the effect was small (Φ = .142). See Figure 1.

Given the significant relationship between patient gender and provider gender preference observed, we evaluated whether the predictive utility of provider gender preference on attendance could be improved with incorporating patient gender, the interaction of patient gender and gender preference, and PC-PTSD scores into the model. Logistic regression found patient gender (p = .549), the patient gender and preference interaction (p = .378), and PC-PTSD scores (.962) did not improve the model (χ^2 = 4.83, df = 3, p = .185).

Discussion

To our knowledge, the current study was the first to examine how veterans' preference for provider gender is related to attendance at MST-specific mental health evaluation visits. Further, whereas women were more likely to articulate a preference for female providers, having a preference for a female provider (versus no gender preference) was associated with greater likelihood to attend visits, while female gender of the veteran was not.

Approximately half of women and one third of men articulated a preference for female providers. However, our results were only partially consistent with those reported in previous research with smaller samples of veterans who were not seeking MST-specific mental health care (Turchik et al., 2013; Turchik, Bucossi, et al., 2014). Regarding female veterans' preferences, our results roughly parallel Turchik's interviews with women; 50% of veterans in this

study requesting female providers in contrast with 67% in Turchick, Bucossi, et al. (2014). Our results differ more substantially from Turchik et al.'s (2013) study of male veterans. Our study identified a notable majority of male veterans (69.6%) did not have a preference for provider gender in contrast with 25% in the qualitative study; the qualitative report indicated 50% of male respondents preferred a female and 25% a male, and we observed 29.4% of men requesting a female provider and only a single male veteran requesting a male clinician. There may be several reasons for these discrepancies. First, the Turchik studies were based on a very small number of participants, a history of MST-related mental health care was an exclusion criterion for men, and a sizeable minority of female veterans were not treatment seeking. In contrast, our study focused exclusively on those who requested or accepted referrals for MST-specific mental health care. It may be that the observed variability reflects differences between active MST treatment seekers and non-treatment-seekers or greater consideration of preferences when accepting an evaluation opportunity. In addition, it may be that male veterans who prefer male clinicians may have additional, unresearched factors that reduce willingness to even accept an MST-related consultation. Further research evaluating intersections between veteran gender and military culture with other aspects of diversity would be illustrative.

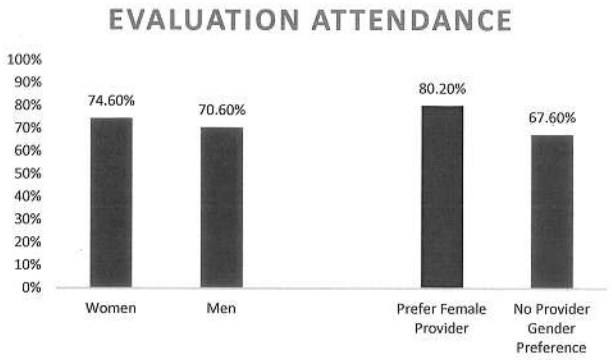

Figure 1. Evaluation attendance by veteran gender and preference of provider gender

The overall attendance rate for the MST evaluation was encouraging. However, nearly a quarter of veterans were lost to care between the placement of the consultation and the evaluation, despite the frequent outreach contact provided by the hospital to establish first visits and reschedule missed appointments. Our study found veteran gender was not associated with completion of evaluations, though those who requested a female provider were more likely to attend than those who indicated they did not have a provider preference. It is possible that those who select a provider gender preference may be less likely to be in precontemplative or contemplative stages regarding engaging in treatment and that active selection of a provider characteristic signals greater consideration

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of readiness for care entry (Norcross, Krebs & Prochaska, 2011).

The current study has a number of strengths. Our sample included all veterans for whom an MST-related mental health consult was placed within the studied time frame, with sufficient numbers of both male and female veterans, which may improve the generalizability of our findings. Further, the utilization of participants actively seeking care clarifies potential preference differences in those seeking treatment in contrast to samples included in the limited previous research.

Although we used a sample of treatment-seeking veterans that should be highly generalizable, we were limited in the number requesting a male provider. We were also unable to follow up with those who did not attend to determine what factors may have contributed. We were limited in our ability to collect other variables that may have influenced attendance, such as readiness for treatment, psychosocial stressors, or history of treatment seeking outside of our VHA clinic. Although we included PC-PTSD score, this is only a screening measure, and full indices of symptom severity were unavailable for those who did not attend the appointment. Further, our participants were limited to veterans who disclosed MST to their provider and accepted a mental health referral for care. Of particular importance to our study, it should be noted that continuing research identifies that male veterans, in particular, may be less apt to disclose MST through national VHA screening procedures (Bovin et al., 2019)

There are likely a variety of factors influencing gender preference and these underlying characteristics remain poorly understood. For instance, an individual's history of treatment experiences or contextual aspects of the assault, such as the gender of perpetrators, may be important factors in determining when an individual would request a provider of a certain gender (Turchik et al., 2013). Empirical examination of these and other factors are clear next steps in furthering our understanding of role of gender preference in treatment outcomes for MST survivors. A greater understanding of these factors will allow providers to better facilitate treatment engagement. It was further surprising that scores on the PC-PTSD screen did not improve the fit of our models. Although PTSD is only one of several common outcomes following trauma, one might anticipate that those reporting greater past-month stress would be more likely to present for care. Further attention to aspects of clinical care management and engagement in the context of MST with elevated PTSD symptoms would be illustrative and may identify additional pathways to assist survivors who are screening positive for current stress. Additionally, future work should examine how gender preference may relate to use and completion of evidence-based psychophamacology and psychotherapy resources for MST-related conditions as well as potential relationships with clinical outcomes. Previous work has identified that a gender match between patient and clinician is not, itself, related to psychotherapy retention for PTSD treatment, and in fact a gender match for male patients may be a negative predictor of treatment retention (Shiner, Westgate, Harik, Watts, & Schnurr, 2017). This suggests the relationship between patient and clinician gender is complex and gender preference may be more important than gender match. However, the relationship between patient-provider gender preference match and clinical outcome has not been previously evaluated with MST survivors. Although certainly not all MST survivors have mental health symptoms significant enough to warrant treatment, future studies are also needed to determine ways in which more veterans with active MST-related symptoms can be engaged in care and to identify barriers to accepting a referral for treatment.

Implications for Policy or Practice

It is recommended that VHA mental health service teams ensure composition of sufficiently trained staff in MST and trauma-focused care such that preferences can be honored whenever possible. There may be a subpopulation of male veterans who would prefer a male clinician (as evidenced in Turchik's study of non-treatment-seekers) who are, as yet, declining mental health referrals for MST. Further, the percentage of veterans in this study expressing no preference for provider gender may serve to allay misconceptions that veterans will reject male clinicians for MST-focused interventions.

The observation of more limited use of care by male veterans, even after controlling for PTSD symptoms reported at screening, is concerning as significant efforts have been made during recent years to raise awareness of MST services and address barriers for male veterans at a national and local level. At the local level, male-specific brochures about MST and associated care were disseminated throughout the hospital and a male MST Coordinator was available during this time. Nationally, the VHA requires service providers to receive MST training to augment skills when identifying and treating survivors that incorporates awareness of MST and its relationships to physical and mental health and facilitated sensitive screening, referral, and appropriate care related to their service role (VHA, 2018).

Given that a positive MST history is associated with increased hospital service utilization (e.g., Mercado, Wiltsey-Sterman, & Iverson, 2015), our results support the notion that additional research on barriers to treatment, particularly for male survivors, is needed. A qualitative study by Turchik et al. (2013) identified common barriers to treatment seeking for male survivors of MST include unhelpful beliefs about masculinity, sexuality, and gender roles that may be specific to men; these challenges are often more pronounced in military populations (Bell et al., 2014; O'Brien et al., 2015). It is possible that some of these impediments may be addressed through conversations with veterans at the time of MST screening and referral for treatment. However, as non-mental-health providers commonly conduct these screenings, additional training may be for such clinicians to reduce potential barriers to disclosing MST (e.g., Andersen & Blais, 2018) and accepting referrals for treatment.

In addition, further hospital utilization mapping of the care trajectories of mental and non-mental-health VHA use for male veterans with MST is advised to identify the degree to which MST-related care may be indicated and augment policies to better target issues associated with nonengagement in care. For instance, MST screening is generally conducted during first visits with primary care providers. It may be the case that, as veterans increase familiarity with care providers and establish trusting relationships over time, they may be more open to consideration of MST-specific care through VHA. Currently, MST screenings and associated consultation questions are designated as a single lifetime clinical reminder. It may be helpful to consider, for those with lifetime positive screens, to have reminder mechanisms in place to inquire about interest in care liaison on a recurrent basis or to consider repeat screenings to better capture those that may be more likely to have false negatives on MST screens when newly entering the VHA system.

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ORIGINAL RESEARCH

Increasing Behavioral Health Appointment Attendance Using Warm Handoffs in an Integrated Primary Care Setting

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ONLY 21% OF CHILDREN and adolescents who require behavioral health (BH) services receive them, with Latino and uninsured children even less likely to receive such services (Kataoka, Zhang, & Wells, 2002). Additionally, children enrolled in Medicaid are less likely to utilize mental health services than children enrolled in fee-for-service insurance plans (Cook et al., 2004). In traditional care models, patients with BH concerns who seek help rely predominantly on their primary care physicians (PCPs) for treatment (Bluestein & Cubic, 2009; Hemmings, 2000). This reliance on PCPs as a source of mental health care has arisen in large part due to the barriers patients face in accessing services. For example, a study conducted in 2009 identified a shortage of mental health providers, as well as health plan network barriers, as major impediments to service provision within a sample of pediatricians (Cunningham, 2009). In an attempt to mitigate these barriers, the field has moved toward integrating dedicated BH providers directly within primary care offices in order to provide better care to patients who would not seek it elsewhere. This emerging model of integrated health care treats a wide spectrum of patient needs in diverse patient populations by integrating an additional form of treatment within a primary care or hospital setting (Blount, 1998). Integrated care provides a potential avenue for BH services to reach children in racial minority, low-income, or uninsured populations who are otherwise unlikely to receive treatment, since providers are available on site.

One of the unique features of integrated care settings is the ability to conduct warm handoffs (WHOs), the practice by which one provider introduces the patient to another provider, in person, in order to initiate the transition of care. This process differs from the standard referral method in which PCPs provide referral information for an outside specialty provider and instruct patients to schedule an appointment separately from their primary care visits. WHOs allow PCPs to introduce the patient to the BH provider immediately upon discussing behavioral concerns during their medical visit. WHOs can vary in length from brief introductions that last only a few minutes to longer interactions that turn into the first billable BH session, thereby making immediate treatment possible. This provision of same-day care mirrors the primary care model, in which patients can make an appointment as soon as they feel sick and reduces a significant barrier to patients' access to care in traditional models—appointment waiting lists (Cunningham, 2009).

There is a dearth of research examining WHOs and the few published studies have examined adults. Much of the research has

focused on integrated inpatient hospital settings (Richter et al., 2012), and primary care research has predominantly studied WHOs among adult patients with specific concerns, such as depression and substance use (e.g., Apostoleris, 2000; Cohen et al., 2015; Horevitz, Organista, & Arean, 2015; Pace, Gergen-Barnett, Veidis, et al., 2018). A poster published by Apostoleris in 2000 found that among 100 adult patients, 76% attended their first session when given a WHO, compared to 44% who did not receive a WHO. Horovitz, Organista, and Arean (2015) investigated the relationship between WHOs and treatment engagement for Latino adults with depression (*N* = 431) and found that, overall, WHOs were not directly associated with increased patient attendance versus a standard referral; however, Spanish-speaking Latinos attended follow-up at a higher rate than English-speaking Latinos following a WHO. Additionally, a 2018 multivariate analysis of adults referred for various behavioral health concerns in primary care found WHOs did not correlate with an increase in attendance rates and that the most significant predictor of attendance was the time between referral and first appointment (Pace et al., 2018).

The aforementioned studies suggest two gaps within the literature. First, there is a contradiction in findings among the published studies on the effect of WHOs on attendance that further highlights the need for a more robust study of WHOs, particularly in integrated BH care settings and among diverse populations. Second, there is considerably less research related to pediatric patients (Briggs et al., 2016). However, pediatric integrated care is especially necessary, as childhood and adolescence are critical periods for the development and establishment of healthy behavior patterns, which in turn have a vast impact on future health outcomes (Campo, 2012). Integrated care models are also uniquely positioned to reduce barriers to care even further via the ability to conduct WHOs and improve access to immediate patient care for behavioral health concerns.

Current Study

In 2014 Montefiore Medical Group (MMG) established its own integrated health care system, the Pediatric Behavioral Health Integration Program (BHIP), which incorporates pediatric psychologists and psychiatrists (BHIP providers) into pediatric primary care practices. BHIP utilizes a population-based approach to universally screen for behavioral symptoms and treat patients with mild to moderate issues (e.g., anxiety, depression, ADHD, trauma) within a short-term treatment model, typically lasting 4–6 sessions. BHIP's integrated care setting means that the patient's PCP is located in the same building, often the same hallway, as the BHIP provider, which allows for an easy referral process and transition of care.

MMG has leveraged its large-scale integrated health program to produce the only extant research on pediatric WHOs. Among the first 1,164 pediatric patients referred at eight practices in the first 6 months of the program, 63% attended at least one behavioral health session when given a WHO, compared to only 53% who attended without a WHO (German et al., 2015). While the findings reported in this poster were very promising, they were not the primary analysis of the study and contained some methodological flaws the present study attempted to improve. In particular, the initial descriptive study included a small number of patients who were not expected to return for a BHIP session because they were directly referred out for a higher level of care before the onset of BHIP treatment. Additionally, patients who received a WHO and were able to be seen for an initial appointment on the same day were coded as having attended at least one session, which may cloud the effect of the WHO itself. The present study attempted to better operationalize these variables in order to reduce this noise and investigate potential moderating factors.

Table 1. Participant Demographics

Demographics	% Medicaid or Uninsured	Number of Patients Age 6-18
Practice-wide demographics		
Site A	74	4,727
Site B	79	4,313
Site C	78	5,440
Patients referred to BHIP	*N* = 982	
Age in years, mean (*SD*)	14.9 (3.73)	
% Age groups (in years)		
4 to 6	9.4	
6 to 9	41.5	
10 to 13	23.9	
14 to 17	21.4	
18 to 21	3.8	
% Female	48.2	
% Race		
Black/African-American	35.0	
White/Caucasian	6.6	
Asian	1.8	
Other	48	
Unknown	8.8	
% Ethnicity		
Hispanic	50.9	
Non-Hispanic	42.5	
Unknown	6.6	
% Preferred Language		
English	87.9	
Spanish	10.6	
Other	1.5	
% Insurance		
Medicaid	70.2	
Commercial	27.6	
Uninsured	2.2	

The primary aim of the current study is to investigate the impact of WHOs on attendance for pediatric patients and whether this effect is moderated by the variables that prior external research has shown correlates with dropout/nonattendance, such as patients' race (Shimotsu et al., 2015), ethnicity, preferred language (Horevitz et al., 2015), gender, insurance coverage (as a proxy for socio-economic status), and age (Neal et al., 2018). Given that integrated care settings strive to make BH services more universally accessible to all patients, the current study sought to investigate if receiving a WHO at the time of referral further increased access to BH care across demographic groups within a diverse pediatric integrated care population.

Method

Participants

Our study sample includes all (n = 982) pediatric patients (6–21 years old) who were referred to BHIP at three MMG primary care practices from January 1 through December 31, 2016. The three primary care practices were selected for their full-time staff of pediatric providers and their role as teaching clinics for pediatric residents within MMG. All three clinics serve demographically similar populations: all have a high percentage of patients with Medicaid, as well as large African American and Hispanic populations (for demographics, see Table 1). The sample does not include referrals to off-site BH treatment for patients who need a higher level of care and thus were not intended to be treated within BHIP. There were no additional exclusion criteria for participants in this sample.

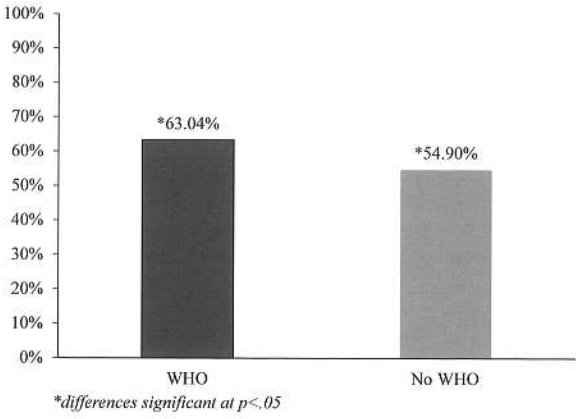

Figure 1. Attendance to behavioral sessions compared between patients who did or did not receive a WHO

Procedures

The referral process at BHIP typically begins with the PCP identifying a BH concern and making a referral to the BHIP clinician within the patient's medical appointment. The PCP may attempt to coordinate a WHO at this time, usually by calling the BHIP provider's extension or knocking on their door. If unable to do a WHO, the BHIP provider then follows up with the patient over the phone to make contact and schedule an initial appointment. If the BHIP provider is able to do a WHO, they will make this initial contact within the medical appointment. Our independent variable (IV), WHOs, were defined as a meeting between the patient and the BH provider on the same date as the referral (0 = referral without WHO, 1 = referral with WHO). Session attendance, the dependent variable (DV), was defined as the patient's return to the clinic to attend at least one session with the BHIP provider after the referral date (0 = no sessions, 1 = one or more sessions). For patients who received a WHO that lasted 15 or more minutes, attendance to the second session with the BHIP provider was used to determine attendance. Demographic covariates, including insurance, ethnicity, race, and gender, were coded from the electronic medical record via chart review by trained research assistants.

The data were collected from patient databases maintained by the BHIP provider at each site. These files track the date of every referral made to each BHIP provider, the provision or absence of a WHO, the session dates, and the number of sessions each patient attended. Research assistants verified this data by conducting chart reviews to confirm the documentation of a WHO and BH session attendance in MMG's electronic medical record.

Covariates

Patient race was coded as 1 = Black/African American, 2 = White /Caucasian, 3 = Asian, 4 = other. Ethnicity was coded as 1 = Hispanic, 2 = Non-Hispanic, 3 = other. Preferred language was coded as 1 = English, 2 = Spanish, 3 = other. Gender was coded as 1 = female, 2 = male. Insurance coverage was coded as 1 = Medicaid or uninsured, 2 = commercial insurance. Age was coded categorically as 1 = child (ages 12 and under), 2 = adolescent (ages 13–21).

Analysis

The data were analyzed using binomial logistic regression via SPSS (24.0). A stepwise analysis was conducted, first modeling the IV on the DV, then adding covariates, then adding the interactions between the covariates and IV. The final model only includes the significant covariates and interaction terms in order to retain power and minimize standard error (Aiken & West, 1991; Bernerth & Aguinis, 2016). The adjusted and unadjusted analyses provided similar patterns of findings. Bivariate correlations were run and were not found to be significantly related to attendance.

Results

Results from the logistic regression suggest that patients who received a WHO were more likely to attend at least one session than patients referred by their PCP without a WHO (b = .35, SE = .15, p = .02; see Figure. 1). Specifically, patients who received WHOs were 42% more likely to attend a subsequent session compared to patients who did not receive a WHO (OR = 1.42). The pattern of findings remained constant after the addition of covariates (race, ethnicity, gender, age group, language, and insurance) to the model, which showed a 37% increase in attendance for patients with WHOs compared to those without (OR = 1.37; see Table 2). Analyses did not provide evidence that the relationship between receipt of a WHO and session attendance varied by race, ethnicity, gender, age group, language, or insurance status.

Out of the 982 patients that were referred to BHIP included in this sample, 553 of them attended at least one session. Among those referred only 24% (n = 161) of them received a WHO. The modal number of sessions attended by all patients referred to BHIP in the entire sample was 0. When comparing the modal number of sessions attended by WHO status, however, patients who received a WHO attended 1 session compared to 0 sessions attended by those who did not receive a WHO.

Discussion

The results of the present study suggest that the practice of conducting a WHO for a newly referred pediatric patient was positively related to their attendance to subsequent BH sessions, regardless of the

patient's demographic profile. Patients who received a WHO at the time of referral were more likely than patients who did not receive a WHO to come back to at least one session with the BH provider and attended a higher modal number of sessions. Further, WHOs appear to be beneficial to all pediatric patients, even after factoring in variables that previous research have found to correlate with attendance, such as race, ethnicity, gender, age group, language, and insurance coverage (Horevitz et al., 2015; Neal et al., 2018; Shimotsu et al., 2015). Interestingly, these findings are inconsistent with some of the studies on WHOs for adult patients. Unlike the Horevitz et al. study on depressed adult Latino patients, the current study did not find attendance differences based on language. Although the present study found that demographic covariates did not moderate the effect of WHOs as hypothesized based on the literature, this should be viewed as a positive. One of the main purposes of integrated care is to increase access to care for all patients, particularly for underserved populations like the patients in our study sample. It is encouraging to find that WHOs have the potential to further increase access to BH services for all pediatric patients, including racial minorities and uninsured patients who have historically had limited access to BH care.

These findings produce two main implications for clinical practices that are capable of implementing WHOs. First, because patients who receive WHOs are more likely to come back to attend a session, psychologists in integrated care settings should make an effort to conduct a WHO for all newly referred patients when possible. This represents a unique opportunity for the PCP and BH provider to work together to increase the likelihood that their patient will follow up on the referral and access the BH services they need. WHOs also present the possibility for immediate access to care if the practice is able to facilitate same-day sessions. Second, providers need to make the most out of any face-to-face interaction that they have with patients at the time of referral. Given that the overall modal number of BH sessions attended by patients in this study was 0, the only interaction most patients had with the BH provider was at the time of referral. As a result, the WHO should not only introduce the provider and the program to the patient, but it should also demonstrate to the patient the potential usefulness of BH treatment, and even provide some initial intervention. A client-centered technique, such as motivational interviewing, during these initial interactions is one way in which a provider can develop a relationship with the patient by allowing the patient to feel understood by the provider, thereby increasing their readiness for change (Miller & Rollnick, 2013). Making this first meeting productive, even if that meeting lasts for fewer than 15 minutes, encourages the patient to view the provider as a source of aid and support. Providers may find it helpful to frame this first in-person interaction through the lens of "If this is the only time I meet with this patient, what do I want them to gain from this experience?"

Unfortunately, it is not always possible to conduct a WHO for every patient. In our study, for example, only 24% of the

Table 2. **Logistic Regression Analyses**

	Attended Behavioral Health Follow-up Appointment				
	Wald test (*df*)	*B*	*SE*	*P*	*OR*
Covariates (*reference group*)					
Race (*Black/African-American*)	3.05 (3)			.38	
White/Caucasian	.25 (1)	-.16	.30	.60	.85
Asian	.26 (1)	-.26	.51	.61	.77
Other	1.30 (1)	.27	.24	.26	1.31
Ethnicity (*Hispanic*)	2.06 (2)			.36	
Non-Hispanic	1.90 (1)	.31	.23	.17	1.37
Other	.08 (1)	-.16	.55	.78	.86
Preferred language (*English*)	3.71 (2)			.16	
Spanish	.37 (1)	.16	.26	.54	1.17
Other	3.28 (1)	-1.12	.62	.07	.33
Commercial Insurance (*Medicaid*)	1.83 (1)	.21	.16	.18	1.24
Female	.09 (1)	-.04	.14	.76	.96
Children (*12 and under*)	.32 (1)	.09	.15	.57	1.09
Predictors					
Received a WHO	3.47 (1)	.31	.17	.06	1.37

Note. The pattern of results was the same with and without covariates.

referred patients actually received a WHO. A primary impediment to the coordination of a WHO derives from the likelihood that an integrated BH provider is already in session with another patient. This creates a unique dilemma for BH providers in primary care settings and requires the establishment of clear guidelines for when and how to conduct a WHO without compromising the care of an existing patient. Further investigation is needed regarding how patients and BH providers perceive these practices to affect their care.

There are several limitations to this study that are important to consider. First, as this was a retrospective observational study without randomization, causality cannot be concluded. However, the results suggest that WHOs may be an effective and feasible method to increase access to care and warrants further rigorous study.

Additionally, this study was unable to examine the range of methods employed by BH providers during a WHO. Exploring the content of these WHOs would have required the BH providers to enter detailed notes about the encounter into the electronic medical record and for the research team to conduct a thorough chart review and qualitative analyses; however, such a process was not feasible for the present study. All BHIP providers in MMG practices are trained in how to conduct WHOs, including using techniques such as motivational interviewing. Further research into maximizing the benefits of a WHO is a necessary next step, as is creating a standardized best practice for executing WHOs.

Second, although there are likely individual differences between referring PCPs regarding WHOs that may also impact patient attendance, such an analysis was beyond the scope of this study. For example, individual PCPs may differ in the manner in which they request a WHO or in their reasoning behind requesting a WHO versus only placing a referral for a particular patient. A related limitation is the absence of data on the number of WHOs requested by PCPs, which would be beneficial in better understanding the process and feasibility of increasing the rate of WHOs. Though MMG's electronic medical record system does require PCPs to record referrals made to integrated BH providers, it does not currently provide a reliable mode to track PCPs' requests for WHOs.

Finally, the present study did not examine patient perceptions regarding WHOs. Because this was a retrospective study, we were not able to collect qualitative data that could reveal the factors that might have influenced a patient's decision to come back, the patients' perceptions of an in-person, presession meeting with the BH provider, or the effect a WHO might have on an existing patient's experience in a session. Patient preferences may also play a role in whether the PCP requests a WHO at the time of referral. Surveying patient perspectives might offer insight into the underlying mechanisms that cause WHOs to be effective in increasing attendance, thereby influencing the development of a standardized WHO procedure.

The present study is one of the first to examine the benefits of WHOs for pediatric patients. WHOs were found to be an influential factor in increasing pediatric patients' attendance to their first BH session. The results suggest that BH providers should (a) prioritize conducting WHOs and (b) treat the WHO encounter as if it were the only time they could interact with this patient. Since the field of integrated pediatric primary care is quite new, there is still much to learn regarding the maximization of its benefits.

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ORIGINAL RESEARCH

Implementation of Technology-Driven Comprehensive Physical Health Assessment in an Anxiety Specialty Clinic: Preliminary Pilot Study Findings

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Physical Health in Anxiety Disorders

Anxiety-related disorders are associated with poor physical health, including cardiovascular disease (Celano, Daunis, Lokko, Campbell, & Huffman, 2016), metabolic syndrome (Hung, Liu, Hsiao, Yu, & Chu, 2014), lower physical activity (Nyrop et al., 2017), and poor sleep (Jansson-Fröjmark & Lindblom, 2008). Poor physical health, in turn, contributes to substantial psychological and economic burden in individuals with anxiety disorders (Ten Have et al., 2016). Despite the association between poor physical and psychological health, physical health is rarely addressed in anxiety treatment.

Effect of Physical Health Interventions on Psychological Outcomes

Physical health interventions like exercise are associated with improvements in quality of life and reductions in stress and alcohol use (Edwards & Loprinzi, 2017). Exercise performs comparably to antidepressant medications in reducing symptoms of depression (Kvam, Kleppe, Nordhus, & Hovland, 2016). Multiple reviews and meta-analyses have demonstrated the positive benefits of physical activity on depression and anxiety (e.g., Hartescu, Morgan, & Stevinson, 2015; Peluso & de Andrade, 2005). Pilot research demonstrates the promise of using a physical activity intervention, informed by the use of a wearable device (Fitbit), for women with an alcohol use disorder and depression (Abrantes et al., 2017). Thus, the efficacy of physical health interventions on mental health has been well-established and may be aided by the use of technology.

Effect of Anxiety Interventions on Physical Health Outcomes

Cognitive behavioral therapies (CBT) are the most empirically supported treatments for anxiety (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) and are associated with improved physical symptoms in patients with medical complications (Coughtrey et al., 2017; Wroe, Rennie, Sollesse, Chapman, & Hassy, 2017). In a review of 12 randomized trials of psychosocial interventions for pediatric cancer, psychosocial interventions (which included cognitive, behavioral, psychoeducational, and social treatment components) were associated with improved physical symptoms and reduced procedural pain (Coughtrey et al.). Similarly, in adults with Type 2 diabetes, a diabetes-informed CBT intervention was associated with improved dietary and glycemic control compared to traditional CBT treatment for diabetes (Wroe et al., 2017).

Less is known about the effect of CBT on physical health in patients with anxiety disorders without medical complications. In a large randomized trial of patients with anxiety disorders in primary care, CBT was

associated with significantly greater improvements in physical functioning compared to a control comparison (Niles et al., 2013). However, this study did not include physical activity, illness, or sleep as outcome variables. CBT plus a walking intervention resulted in comparable improvements in physical activity relative to CBT plus education for patients with anxiety disorders (Merom et al., 2008). In both CBT groups, one-third of patients reported improved physical activity, which was associated with greater improvements in anxiety and depression. Thus, CBT alone may be sufficient to increase physical activity in some patients with anxiety disorders, though more research is necessary on this topic.

Measuring Physical Activity in Anxiety Disorder Treatments

In order to determine the effect of anxiety disorder treatment on physical health, reliable and valid indicators of physical health are necessary. Of the general population with access to the internet, up to 64% report using or being interested in wearable devices (KARIM Project, 2014). Thus, these wearable devices may provide a unique opportunity for objective assessment of physical health. This is an important area for future research because the field of mental health largely relies of self-report indicators of both physical and psychological symptoms, which have important limitations. While Fitbit is one well-validated measure of physical activity (Adam Noah, Spierer, Gu, & Bronner, 2013; Fulk et al., 2014; Lee, Kim, & Welk, 2014), many of the consumer-marketed wearable devices, including Fitbit, have limited validation for measuring sleep (Meltzer, Hiruma, Avis, Montgomery-Downs, & Valentin, 2015; Montgomery-Downs, Insana, & Bond, 2012; Russo, Goparaju, & Bianchi, 2015). Nevertheless, these devices are widely marketed with claims ranging from "Sleep better and live well … automatically track your sleep" (Fitbit) to "Expert at helping you fall asleep faster" (Withings) (cf. Russo et al., 2015). Excitement about wearable devices from the general population (Dolan, 2014), from mental health subsamples (Abrantes et al., 2017), and insurance companies (Olson, 2014; KARIM Project, 2014) has resulted in many patients presenting to mental health treatments already using wearable devices for measuring sleep and physical activity (Baron, Abbott, Jao, & Mullen, 2017). However, little is known about patient use of wearable devices in a naturalistic mental health treatment center, or about patient and clinician perceptions of the utility of such wearable devices. One prior study of an insomnia treatment in college students provided Fitbit Flex Devices to all participants (Baroni, Bruzzese, Di Bartolo, Ciarleglio, & Shatkin, 2017). However, "extensive device failure" prevented an analysis of outcome data from the Fitbit (Baroni, Bruzzese, Di Bartolo, & Shatkin, 2016).

Yet another strategy for measuring physical health is through the use of ecological momentary assessment (EMA), or text message inquiries about symptoms and functioning. EMA has been widely studied in the context of mood disorders, eating disorders, and schizophrenia (Gravenhorst et al., 2014). Some data suggest that the quality of data collected through smartphones exceeds that of traditional paper-and-pencil methods of data collection (Bardram et al., 2013). One study incorporated EMA into CBT for youth anxiety (Wallace et al., 2017); however, rather than monitoring continuously, participants completed 5 days of EMA monitoring through phone calls (i.e., not through text messages). To our knowledge, EMA has not been incorporated as a measure of physical health for patients receiving CBT for anxiety disorders in a naturalistic setting.

Current Study

The goal of the current study was to provide preliminary pilot data on the implementation of a wearable Fitbit device coupled with EMA in a naturalistic sample of patients receiving CBT for anxiety-related disorders. This pilot study data was part of a larger ongoing randomized controlled trial comparing assessment as usual (AAU; computer-delivered surveys and laboratory assessments) to enhanced assessment (AAU plus EMA, Fitbit, wellness check assessment). For the current study, only preliminary data from the use of the Fitbit and EMA on 10 participants who completed qualitative interviews in the enhanced assessment condition are presented. The first goal was to report on the use of the Fitbit device and the frequency of completion of EMA assessment. The second goal was to identify common themes of participant perspectives toward the Fitbit and EMA assessment. The third goal was to evaluate clinician perspectives toward the collection of Fitbit and EMA assessment as well as reported barriers to and facilitators of use of the data collected in treatment planning.

Table 1. **Demographic and Clinical Information**

Gender (% Female)		80
Age (*SD*)		28.70 (6.86)
Ethnicity	White	8 (80)
	Hispanic/Latino	1 (10)
	Black	1 (10)
Education *n* (%)	High school diploma/GED	2 (20)
	Associates Degree	2 (20)
	Bachelor's Degree	4 (40)
	Graduate Degree	2 (20)
Employment Status	Employed full time	6 (60)
	Unemployed	2 (20)
	Student	2 (20)
Principal Anxiety Disorder	Posttraumatic Stress Disorder (PTSD)	3 (30)
	Obsessive Compulsive Disorder (OCD)	2 (20)
	Panic Disorder	2 (20)
	Generalized Anxiety Disorder (GAD)	2 (20)
	Specific Phobia	1 (10)
Weeks in Study (*SD*)		5.64 (3.44)

Methods

Participants

Participants (n = 10) were treatment-seeking adults at the Center for the Treatment and Study of Anxiety (CTSA) in

Philadelphia, PA who received a principal diagnosis of a *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) anxiety-related disorder. See Table 1 for demographic information.

Clinicians were either master's-level clinical psychology doctoral students (n = 3), postdoctoral fellows (n = 3), or licensed doctoral-level psychologists (n = 1).

Measures

Fitbit assessment. Participants were provided with a Fitbit Alta HR device to monitor pedometer ratings number of steps taken and number of minutes slept. The device also captured calories burned, heart rate, and a variety of other indices not included in the current study.

EMA. Text message inquiries were delivered through Twilio technology (Twilio Cloud Communications; http://twilio.com), which was synced with the Way to Health Platform (https://www.waytohealth.org/; described below). Questions were taken from the Patient-Reported Outcomes Measurement Information System (PROMIS; Cella et al., 2007). In the current study, the following adult short form assessments were used each week: Emotional Distress-Anxiety–Short Form 4a (4 items, rated on a 1 = *never*, to 5 = *always*, point Likert scale), Emotional Distress-Depression–Short Form 4a (4 items, rated on a 1= *never*, to 5 = *always*, point Likert scale), Sleep Disturbance–Short Form 4a (4 items, rated on a 1 = *very poor*, to 5 = *very good*, point Likert scale), Social Isolation–Short Form 4a (4 items, rated on a 1 = *never*, to 5 = *always*, point Likert scale), Global Health–Physical 2a (2 items, rated on a 1 = *poor*, to 5 = *excellent*, point Likert scale), Physical Function–Short Form 4a (4 items, rated on a 1 = *unable to do*, to 5 = *without any difficulty*, point Likert scale), and Self-Efficacy for Managing Emotions–Short Form 4a (4 items, rated on a 1 = *not at all confident,* to 5 = *very confident,* point Likert scale). Each question was preceded by a prompt to: "Please rate the following question on this scale about how you have felt in the past 7 days."

Acceptability. Brief (5–10 minute) qualitative interviews were completed with participants. Two participants were unavailable for completion of these qualitative interviews, resulting in 8 interviews. These assessments used open-ended queries about participant perceptions of satisfaction, palatability, and agreeability of each component of the assessment. Copious notes were taken during the interviews for review of feedback themes by two of the authors (L.B. and A.A.), and both raters were in full consensus about these identified themes.

Clinicians were asked to rate "On a scale from 1 to 7, where 1 is 'I don't at all like it,' 4 is 'I somewhat like it' and 7 is 'I like it very much,' how much do you like the idea of collecting Fitbit data and text message data from CTSA patients?"

Feasibility. The rate of completion of each of the study measures provided an indication of feasibility. Specifically, the proportion of answered EMA queries out of all delivered EMA queries and the proportion of days in which the Fitbit device captured usable data gauged feasibility.

Clinicians were asked, "On a scale from 1 to 7, where 1 is 'This is not at all feasible,' 4 is 'This is somewhat feasible' and 7 is 'This is very feasible,' how feasible do you think it is to collect Fitbit data and text message data from patients?" Additionally, clinicians were asked about barriers to using the platform, as well as possible facilitators of platform use.

Organizational Portal. The Way to Health platform was used to sync all study data. Only clinicians had access to the Way to Health platform for the current study, and patients could not view their data in the portal.

Procedures

Study procedures were approved by the Institutional Review Board at the University of Pennsylvania. All patients seeking treatment at the CTSA completed an initial intake evaluation with either a supervised master's-level clinician in a doctoral training program, supervised postdoctoral fellow, or a licensed clinical psychologist. At this evaluation, principal, secondary, and tertiary diagnoses were determined using the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), which is a short structured diagnostic interview for DSM-IV and ICD-10 psychiatric disorders with strong psychometric properties (Lecrubier et al., 1997). After completing the MINI, many participants were evaluated with additional measures to confirm their diagnosis, including the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989), the Posttraumatic Stress Scale-Interview (PSS-I; Foa et al., 2016; Foa, Riggs, Dancu, & Rothbaum, 1993), the Liebowitz Social Anxiety Scale-Interview (LSAS; Liebowitz, 1987), and the panic disorder, generalized anxiety disorder, and specific phobia sections of the Anxiety Disorders Interview Schedule (ADIS; Brown, Barlow, & DiNardo, 1994), each conducted at the interviewers' discretion to improve diagnostic specificity. These measures are gold-standard assessments for anxiety-related disorders and have strong psychometric properties (Foa et al., 1993; Foa & Tolin, 2000; Goodman et al., 1989; Liebowitz, 1987; Powers, Gillihan, Rosenfield, Jerud, & Foa, 2012). As part of the baseline evaluation, patients completed self-report questionnaires through REDCap (https://www.project-redcap.org; Harris et al., 2006) on their home computer.

Upon consensus between the patient and evaluator that the patient was appropriate for treatment at the CTSA, patients were offered the chance to participate in the current research study. Participants randomized to the enhanced assessment (EA) condition were provided with the Fitbit device immediately after their first therapy session, at which point their EMA assessments began. They received training from a research assistant in how to use the Fitbit, including charging it and connecting to the application on their smartphone, as well as how to answer EMA questions. Participants were given contact information for the researcher in the event that they had technological difficulties with the Fitbit or EMA. For each day of usable data extracted from the Fitbit device, participants were paid $0.25.

Ecological Momentary Assessment Data Collection. Messages were delivered 7 days a week between the hours of 9 A.M. and 9 P.M. Up to four inquiries were sent daily for up to 20 weeks in the study, or until posttreatment, whichever came first. For each text message response, participants received $0.10. Participants were given a random response window within which they could respond to receive payment for the response (ranging from 55 minutes up to 4 hours), but were not told about the response window in advance to encourage participants to respond as quickly as possible. The Way to Health platform and Twilio were programmed to always inquire about anxiety on day 1, depression on day 2, sleep on day 3, social functioning on day 4, physical health on day 5, physical health functioning on day 6, and emotion management on day 7. The pattern was repeated for 20 weeks, or until the participant completed treatment. The benefit of this standardized question delivery was

Table 2. **Themes About Fitbit Identified From Brief Interviews With Participants**

Theme 1	Positive View Toward the Fitbit	*Example 1*. "Overall I do like the Fitbit and I'm considering buying one after the study. I like that I'm more aware of how much activity I'm doing in a day...It's also helpful for me to see how much sleep I'm getting." *Example 2*. "I do like the Fitbit; I like how it keeps track of my activity and gives me information about my sleep patterns and all of that. I usually wear it every day and every night." *Example 3*. "I love everything about it. I like that it tracks my steps, heart rate and calories. I use it to track my workout. I like how I get to see what type of sleep I've had and how restful it has been. There is nothing I don't like about it." *Example 4*. "I love that it tells me about my sleep and how my heart rate is."
Theme 2	Inconsistent Estimation of Sleep	*Example 1*. "Sometimes there are times that I'm having trouble sleeping where I'm lying in bed and it thinks I'm asleep and I'm not." *Example 2*. "When it comes to my sleep it's overestimating how much I sleep because I have an ongoing problem with waking up and falling back to sleep at night—Fitbit is not catching all of that." *Example 3*. "I don't trust the sleep data. Sometimes the data seems wrong, and sometimes it misses when I'm napping."
Theme 3	Inconsistent Estimation of Physical Activity	*Example 1*. "Sometimes I'm surprised in the distance that it says I've walked, and it might be overestimating." *Example 2*: "In terms of physical activity, I'm a little more active than the Fitbit is saying."
Theme 4	Interference With Sleep	*Example 1*. "I took it off a couple of times at night because the green light on the back makes it hard to sleep with it sometimes; most nights I try to wear it." *Example 2*. "Sometimes I don't like that it's uncomfortable to sleep with it. The little green light underneath is kind of annoying because I can see it at night and it keeps me up." *Example 3*. "It's weird—when I'm sleeping at night it feels like it's tightening because of moving around on my arm."
Theme 5	Concerns With or Overattendance to Heart Rate Tracker	*Example 1*. "Sometimes the heart rate monitor trips me up because I'm not sure how accurate it is. Sometimes it seems higher [on the Fitbit] than it probably is." *Example 2*. "I have a hard time believing that my heart rate is that high all the time. Either I'm really anxious or stressed all the time or it's wrong." *Example 3*. "I like watching how it monitors my pulse rate during different times of the day to see if I'm particularly stressed. It helps me identify if I'm stressed or if I'm about to become stressed."

greater ease in modeling time when conducting analyses. The disadvantage was that the questions were asked in a predictable pattern each week.

Responses that did not match the possible response options received an automatic reply noting: "Sorry, I don't understand. Please rate with format 1–5." Participants who completed treatment early or who dropped out of treatment were asked to return their Fitbit device and the program stopped sending them text messages at that point. Even if participants dropped out of treatment or asked to drop out of the study, the opportunity to complete a qualitative interview for the study was still available. At the time of data extraction for the current study, 1 participant had stopped treatment early due to logistical constraints, and the other 9 participants were actively engaged in treatment. At the time of data extraction and qualitative interview completion, participants were at varying stages of study participation (see Table 1), ranging from 4 days to 72 days of participation (average 39.50, *SD* = 24.11).

Results

Rates of valid responses to EMA queries were high, with only 2 of 1,206 text messages having invalid responses (i.e., responses outside of the 1–5 window). Of all text messages delivered, participants did not respond to 9.8% and responded to text messages outside of the predetermined time window on 4.0% of messages.

In contrast, there was significantly more variability in terms of whether participants wore their Fitbit device. On average, participants had usable Fitbit physical activity data on 57.7% of possible experimental days, though the range was from 15.9–100%. Fitbit sleep data was even more variable in its collection, with data collected on an average of 52.2% of days, with a range from 5.4–83.8%.

In response to participant qualitative interviews, several key themes were identified in terms of reactions to Fitbit data collection, including: (a) generally positive views toward the Fitbit; (b) concerns about inconsistent estimation of sleep; (c) concerns about inconsistent estimation of physical activity, (d) concerns about interference with sleep; and (e) concerns about or overattendance to the heart rate monitor (see Table 2). Additionally, several key themes were identified in terms of reactions to EMA data collection, including: (a) concerns about the repetition of questions; (b) concerns about not having

enough time to respond; (c) perceptions of convenience; (d) interest in the questions and method; and (e) concern with questions querying about the prior week (see Table 3).

In response to clinician surveys ($n = 7$), two clinicians reported having logged into the Way to Health portal to view Fitbit and EMA data since being trained in how to use the portal. One clinician reported logging in once since the initial training for 5–10 minutes, and a second reported logging in twice for 5 minutes. When queried about how much clinicians liked the collection of Fitbit and EMA data, the average score was 5.57 ($SD = 1.22$) out of 7 possible points, where 7 is extremely positive. When queried about the utility of collecting Fitbit and EMA data, the average score was 4.86 ($SD = 0.75$) out of 7 possible points. When queried about the feasibility of collecting Fitbit and EMA data, the average score was 4.43 ($SD = 1.38$) out of 7 possible points. Only one clinician reported having received feedback from their patient on the assessment; this patient reported concerns about the heart rate data collection feature of the Fitbit (as described in Table 2). This concern was reportedly discussed in treatment to ensure that the data was not being used to reinforce checking of physical sensations.

In terms of barriers and facilitators to use of the platform, feedback was consistent across most clinicians. Clinicians identified time constraints and forgetting to log in as barriers to using the platform. One clinician suggested the use of individually tailored EMA questionnaires to promote greater engagement with the platform and to compare against self-monitoring data. Other clinicians suggested that the research team provide feedback from the questionnaires to identify gaps in responsivity or to provide data graphs. Finally, a clinician indicated that the amount of the data was somewhat overwhelming and suggested streamlining the information.

Table 3. Themes About Ecological Momentary Assessment (EMA) Identified From Brief Interviews With Participants

Theme 1	Concerns About Repitition	*Example 1*. "The questions got very repetitive; I noticed that it asked about hopelessness a lot." *Example 2*. "I noticed that it's the same ones over and over again." *Example 3*. "I'm not sure if my responses have become habitual. By now I'm familiar with the questions, so I know more or less what it's asking. I remember how I answered before and that may influence how I respond."
Theme 2	Concerns About Not Being Given Enough Time to Respond	*Example 1*. "A couple of times I got two close together so hadn't had the chance to answer one before I had to answer both." *Example 1*. "A couple of times I got two close together so hadn't had the chance to answer one before I had to answer both." *Example 2*. "There have been a few times where I didn't [answer] right away. That's only happened twice."
Theme 3	Convenience	*Example 1*. "I think it's better than getting an email or a phone call because it's so much more convenient."
Theme 4	Interest in Questions	*Example 1*. "It's interesting to see that my answers will vary from week to week." *Example 2*. "They have been great. They cause me to think about a lot of things that I don't normally [think of]."
Theme 5	Concern With Questions Querying About the Prior Week	*Example 1*. "I don't like that it asks about over the past 7 days. Sometimes I can't remember how I felt over the past 7 days because it will it change a lot. In 10 minutes from now I could be feeling sad even though I'm fine now. I wish there was a way that we could narrow it down more. *Example 2*. "It might be a better gauge to ask about the past 24 hours as opposed to the past week in the questions. Sometimes there's a certain amount of variability within a week where I just take the average and give that; there's probably more variability in questions specifically related to anxiety. There's not variability with physical stuff."

Discussion

This pilot study demonstrated that EMA and wearable Fitbit devices have mixed support for implementation in an anxiety specialty clinic. Completion rates of EMA were high, with participants answering about 85% of text message inquiries shortly after question delivery. Use of the Fitbit was much more variable on both objective and subjective indices. According to an objective index of data transmitted from the device, the Fitbit captured useable data on about 50–60% of possible days in the study. However, the range of useable data was from 16–100% across participants. In subjective qualitative interview, participants generally reported trying to wear the Fitbit on most study days, but occasionally removing the device during the evening. This discrepancy in self-reported versus objectively measured use of the Fitbit may be due to inaccurate reporting or equipment failure.

Data gathered from the qualitative interview revealed general enthusiasm toward the use of the Fitbit. Some participants reported an interest in purchasing the device for their personal use upon study completion. Others reported being interested in the ability to track physical activity and sleep quality. A few participants noted being pleased with some added features of the Fitbit, including the ability to track heart rate and calories burned from exercise.

However, several concerning themes emerged from participant interview, most of which revolved around sleep. First, consistent with prior literature (Kang et al., 2017), several participants raised concerns about the ability for the Fitbit to accurately assess sleep. Specifically, some participants reported noticing that the Fitbit overesti-

mated sleep time by categorizing time spent awake in bed toward minutes slept. This was revealed in interviews both in terms of participants who described sleep-onset insomnia (i.e., difficulty with sleep initiation) and sleep-maintenance insomnia (i.e., waking up in the middle of the night), which participants felt was not always documented accurately. Second, other participants noticed that time spent napping was not categorized as time asleep. Third, several participants identified that wearing the Fitbit occasionally interfered with sleep. Some of these participants described that the green light on the back of the Fitbit device was noticeable, whereas others reported that the device felt tight on their arm overnight. A few participants removed the device at night to avoid disturbance.

Not all participants reported concerns about the accuracy of sleep tracking or inference in sleep. Instead, some participants reported excitement about the ability to track sleep quality. This discrepancy is worth consideration in terms of the potential implications for implementation of Fitbit tracking in anxiety clinics. Prior literature documented that some individuals have initiated treatment for insomnia as a result of inaccurate data from wearable devices (Baron et al., 2017). In fact, some participants may overattend to sleep data in order to perfect the quality of their sleep ("orthosomnia"; Baron et al., 2017). This hyper-focus on perfecting sleep may ultimately backfire and increase anxiety. Additionally, the tendency for wearable devices to overestimate sleep data is especially prevalent in participants with insomnia (Kang et al., 2017). Thus, prior to implementation of wearable devices in anxiety specialty clinics, it may be important to warn participants of the potential inaccuracy of the sleep data to avoid the precipitance of sleep-related anxiety. It may also be important to incorporate the use of sleep diaries to match objective and subjective measures of sleep quality (Monk et al., 1994; Sadeh, 2011).

Another theme identified through qualitative interviews reflected concern about the tracking of heart rate through the Fitbit device. One participant-clinician pair reported that the heart rate monitor was serving to reinforce hypervigilance toward physiological sensations. Another participant noted that the device tended to overestimate heart rate, and that initially the participant was concerned about the meaning of this overestimation. Specifically, the participant worried that the elevated heart rate was indicative of stress or anxiety level. Yet another participant reported using the heart rate monitor as an indicator about the likelihood of impending stress. As individuals with panic disorder have a tendency to overattend to physiological sensations (Schmidt, Lerew, & Trakowski, 1997), this group may be at particular risk for adverse effects of wearable devices that include a heart rate monitor. There may be other populations, such as those with anorexia or bulimia nervosa or with body dysmorphic disorder, that may report adverse effects of Fitbit data due to overattendance to data from the device. In contrast, some populations may benefit from increased attendance to bodily cues, such as those struggling with obesity, wherein the concerns about wearable device tracking may be irrelevant. Future research should identify whether certain principal anxiety or other diagnoses are more strongly associated with concerns about heart rate monitoring (or other indicators) in wearable devices. In addition, these findings suggest the importance of asking patients about the wearable devices that they are already using, as well as about interpretations that patients make about these wearable devices. These conversations may offer an opportunity to provide psychoeducation about the benefits and drawbacks of ongoing physiology recording. Fortunately, several wearable devices do not include a heart rate monitoring component, and may be preferable for implementation in an anxiety specialty clinic.

Just as perceptions of the Fitbit device were mixed, participants reported varied perceptions of the EMA questions as well. Some participants appreciated the convenience of answering questions over text message instead of over the phone. Others reported liking the questions because they encouraged conscious reflection on a variety of domains. In contrast, participants noted that the repetition of the questions may influence their pattern of responding and that they sometimes did not have time to answer one question before the next question appeared. Additionally, participants suggested that narrowing down the time-window for reflection from 1 week to 24 hours would assist in providing more accurate responses.

No participant identified concerns about data security during the qualitative interview. This was somewhat a surprising omission from responses. Data security was discussed at the time of informed consent, including strategies to enhance data security as well as limitations to data security. Perhaps the open conversation about data security alleviated participants' concerns, or perhaps individuals with strong concerns about data security may have refused to learn about the study altogether.

Clinician perceptions of the Fitbit and EMA assessments also varied. In general, enthusiasm for the assessment package was modest, with scores for acceptability, utility, and feasibility ranging from a 4.8–5.4 on a 7-point scale, where 7 reflected extremely positive perceptions. While clinicians reported moderate to high enthusiasm for this assessment, they rarely used data from the assessments in treatment planning. Common barriers identified to the use of this data were forgetting about its availability and lack of time. The lack of clinician engagement with data in this study provides an important barrier to implementation of this assessment strategy in clinical practice. The clinicians offered a few suggestions to increase the palatability of the assessments. For example, a few clinicians suggested that the study team could email weekly summaries of data to the clinicians. Another suggested tailoring the questions to each participant or collecting less data that was more individualized. Therefore, customization and delivery of easily digestible summary information, perhaps in graphic form, may be important features for clinicians in their consideration of incorporating EMA into clinical practice. The more personalization in both data collection and data reporting, the greater the likelihood of utilization. Finally, it might be helpful to engage in problem solving with clinicians about optimal times to access the data.

Rates of utilization of the Fitbit were lower compared to other studies. In one study of behavioral activation for depression, participants were provided with a Fitbit device to wear for 18 weeks of therapy. In this study, participants who found the Fitbit unhelpful were significantly less likely to wear the Fitbit (12 weeks of usage vs. 18 weeks of usage; Chum et al., 2017). However, mean rates of utilization across all participants were not reported in this study. In a small study of individuals with serious mental illness (n = 10), a Fitbit device was worn on an average of 89% (SD = 13%) of study days (Naslund, Aschbrenner, Barre, & Bartels, 2015). In a sample of women with depression and an alcohol use disorder (n = 20), the Fitbit was worn on 73% of study days (Abrantes et al., 2017). It is possible that sample differences may explain lower adherence in the current

study findings, as the current study focused on individuals with a principal anxiety disorder, which was not the focus in other reported studies. This should be explored in future research.

Several important limitations of this study require consideration. First, this is a pilot study with a small sample size of only patients with a principal anxiety diagnosis. Therefore, results may not generalize to other samples, particularly with more mixed diagnoses. Second, participants were compensated for responding to each EMA inquiry and for each day that usable Fitbit data was collected. Therefore, the patterns of use were likely influenced by this compensation, though the compensation was fairly low ($0.10 per EMA response and $0.25 per day with usable Fitbit data). Nevertheless, future research needs to explore the frequency of responding and wearing the device when participants are not compensated in order to make observations about implementation in real-world settings. Two participants could not be reached for a qualitative interview, and therefore their data could not be included. This data may have added additional themes to the qualitative interview responses. In addition, participants were at varying stages of study participation at the time of data extraction and qualitative interview completion in order to allow for an understanding of perspectives across the timing of study participation. This may have altered perceptions about feasibility and acceptability. Clinicians reported extremely limited use of data collected through these assessments. Therefore, their self-reported perceptions of the acceptability, feasibility, and utility of the data may have been altered if they had been required to access the data for a minimal amount of time. However, use requirements would have prevented an understanding of naturalistic use of the data. Finally, clinicians at the anxiety specialty clinic are typically involved in a variety of research projects. Therefore, their perceptions toward this data may be positively biased.

Conclusions

In summary, this pilot study provides preliminary insights into the use of EMA and Fitbit devices in a naturalistic sample of treatment-seeking participants presenting to an anxiety specialty clinic. While patients liked the Fitbit device, they both reported important concerns about the device and demonstrated extreme variability in device use. Similarly, while participants regularly answered the EMA questions, they noted concern about their response accuracy because of the question repetition. Finally, while clinicians were generally supportive of the EMA and Fitbit device use, they almost never accessed the data following the initial training. Therefore, while participants and clinicians may support the use of EMA and Fitbit in treatment planning, much more work is required to seamlessly integrate useful components of these assessments into treatment.

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How to Be an Advocate: Summary of "Realizing ABCT's Mission in a Politicized World"

Presented by Lynn Bufka (Moderator), Anita Brown, Brandon Gaudiano, Megan Gordan-Kane, Lauren MacIvor Thompson, and Laura Seligman

Summarized by RaeAnn E. Anderson, *University of North Dakota*

Erica L. Goodman, *University of North Dakota and Northwestern University*

Danielle Piggott and Sidney Thimm, *University of North Dakota*

Kristin E. Silver, *Durham VA*

Paige Michel, *University of North Dakota*

THIS PANEL WAS ORGANIZED in response to the concerns raised by ABCT members regarding hosting the Annual Convention in Atlanta after the passage of bill HB481, "Living Infants Fairness and Equality Act" (i.e., the Heartbeat Bill). In practical terms, this bill represents an extreme abortion ban, banning any abortion after a heartbeat can be detected—at approximately 6 weeks of gestation. The naming of this bill and rationale for it belies the biology of pregnancy, but we digress.

Many members suggested canceling the convention in Atlanta, given the consequences of this bill for reproductive health—discrimination and a violation of human rights. Yet, other members voiced concerns that canceling the convention obscures the diversity and range of political opinions and values of Georgians. Further, many argued that canceling the convention could ultimately harm those most vulnerable and those with the least political power—people of color and women who work in service industry and tourism jobs. Also not withstanding consideration were the financial costs to the organization for late cancellation. As a partial remedy, this panel was organized with the goal of providing information on how members of ABCT can use the science and values promoted by our organization to create positive change in the world.

Context for the Panel as Laid Out by the Panelists

Dr. Lynn Bufka, Associate Executive Director of Practice, Research, and Policy for the American Psychological Association, framed this proceeding by noting that ABCT as a nonprofit organization has legal limits to advocacy and lobbying: ABCT cannot lobby or advocate for issues outside our specific mission. ABCT cannot engage in direct campaign support. Members, however, can lobby and advocate for issues without limits. And ABCT can advocate for the issues directly within our mission—the enhancement of health and well-being by the application of behavioral and cognitive therapies.

For members who were not present, we will describe who was on stage and in the audience. The panel was comprised of mostly White women but represented a range of roles psychologists can inhabit. Members of other professions with specific expertise in reproductive health were also present (Ms. Gordan-Kane and Dr. MacIvor Thompson). The audience appeared to be primarily White women, and the number of men in the audience seemed lower compared to the number of male members of ABCT.

Historical Context

The panel began by formulating the historical context for HB481, led by legal historian Dr. MacIvor Thompson. Dr. MacIvor Thompson noted that before the 1930s–40s, abortion was not a hot political issue, and many Americans did not have strong opinions about abortion. Much of the current political divisiveness around abortion began when laws were passed with the goal of creating moral order; this prescriptive morality-themed legislation helped shape public opinion. For example, the first abortion-related statutes were not passed until the 1820s, and they were designed to regulate unsafe medications used for abortion. Prior to this, pregnancy was seen as a process wherein a baby did not "exist" until the "quickening"—or the first movements were felt. Indeed, it was news to us as audience members that abortion has been legal longer than it has not. Additional laws were passed in the 1870s, due to xenophobic and racist immigration fears, to ensure that there were not too many abortions of the "correct" babies. Furthermore, it is important to note that women have always sought abortions and therefore suffered the attendant consequences of restrictions to abortion. For example, in 1966 in Georgia 205 women died from self-induced abortions. Black and poor women were overrepresented among those who paid the highest price for lack of abortion and other reproductive care access (see also: the story of Henrietta Lacks). In the pre-Roe era of the 1960s, hospitals formed informal committees to approve applicants for abortions; often the wait times for these committees led to decisions not being made until the second trimester and as many as half of applicants were rejected.

Megan Gordan-Kane of Feminist Women's Health, a clinic that serves as an independent abortion provider in Atlanta, discussed using the reproductive justice framework to provide services and advocacy. The reproductive justice framework was developed by Black women in the 1970s to be more inclusive of the range of needs and contexts in which reproductive rights are exercised. This was in response to prior abortion activism by White women focusing almost exclusively on abortion access. For example, Megan Gordan-Kane remarked that if minimum wage is between $5 and $6 an hour, the legal right to abortion is almost irrelevant because abortion care would be unaffordable (current rates for an abortion in Georgia range between $350–$2,100: abcwomensclinic.com/abortion-costs-in-georgia/). To wit, Georgia currently has one of the highest maternal mortality rates in the United States.

Next, we outline the theme and specific behaviors the panelists recommended for ABCT members who are interested in advocacy.

Advocacy Within Our Various Roles

Go Beyond Publishing

The panel unanimously agreed that it is important for researchers to break out of ivory towers and disseminate their research findings in accessible ways. Producing research papers alone is not enough to tip the scales and create change.

Advocate for Yourself and Your Clients

It was also noted that clinicians play an important role in not only advocating for themselves but also their clients and providing support for clients to advocate for themselves.

Science in Policy

Dr. Seligman noted the importance of using science in policy development, in contrast to HB481 where pseudoscience was allowed significant influence. This was echoed by Dr. Guadiano, who noted that people tend to form opinions based on what they already believe to be true and are strongly influenced by trusted identities, especially in the absence of challenges to those beliefs or identities. In our current era, misinformation is flourishing, and junk science/pseudoscience is rampant. Further, social media has been very effectively co-opted by some advocacy/political groups. As noted by historian Dr. MacIvor Thompson, the relationship between science and law has often been contentious. Knowing this history is important for crafting advocacy strategies.

What We Can Do

Prepare Talking Points, Summaries

Megan Gordan-Kane recommended that psychologists and ABCT in particular have unique skills in being able to make science accessible to legislators and advocacy groups. Indeed, this is something we do for our patients regularly. She recommended preparing bullet points and executive summaries to communicate science quickly and effectively. Legislators, in particular, do not have the time for the nuance and detail that we as scientists value. Rather, they quickly need to know the bottom line. Dr. Guadiano noted this communication style is really the opposite of what we typically do as scientists. Legislators typically want to hear the main point, then discuss implications and supporting details.

Share Personal Stories With Legislators

Megan Gordan-Kane also advocated for sharing personal stories, as these are persuasive and memorable. Share your own experiences, your patients' (with edits to be ethical), and your neighbors' experiences. As pointed out by Dr. Gaudiano, as therapists we spend a good deal of time convincing our patients, with evidence and human connection, to do things they do not want to do. Advocating on a direct level with legislators is therefore entirely in the skill set of most ABCT members.

Have an Established Process for Responding to Issues

Dr. Anita Brown, president of the Georgia Psychological Association (GPA), noted that their group has a public interest committee. This committee reviews any human rights issues that GPA might want to take a stand on, and they have a set five-step process to respond. Consequently, their advocacy is organized as opposed to ad-hoc; there is an existing process that facilitates faster and directed responses to issues. This is in line with their mission to promote human rights and their belief that humans have the right to thrive, not just survive. Dr. Brown recommended developing a similar process and committee for other organizations. Even research labs could have a process like this.

Communicate With Your Legislators

Dr. Brown also noted that all politics are local and knowing your city and state representatives, not just national representatives, is important. Similar to Megan Gordan-Kane, she noted that given our training, we are speaking a different language than legislators; yet, our science is our greatest strength, and communicating the science is important. Know your legislators, their positions, and their values, and direct brief communications to them based on that information. Dr. Bufka noted that we may be inclined to wait until the science is "complete" and we have more information; but even if the science is not complete, we can still advocate against legislation that is inconsistent with our professional ethics and values. As Dr. Bufka said, "we don't have to know everything to have something worth saying," because we have knowledge that others, including legislators, do not have. Dr. Seligman echoed this, noting our training as scientist-practitioners is unique, even compared to other scientists and health care providers. The bar for science communication cannot be knowing everything, as that would result in legislation completely devoid of science.

Shape Contingencies

Dr. Seligman advocated for understanding the contingencies of political behavior, which are probably reinforced by polls rather than by facts or science. Thus, taking action that can influence public opinion and therefore polls can be effective in shaping the contingencies for legislators. For example, sharing findings on Twitter and writing editorials can help shape public knowledge and opinions around science.

Never Stop Learning and Being Educators

Dr. Brown prompted that we are never done learning (indeed, that is why we do continuing education) so you can start advocacy at any time. Some suggested thinking of advocacy as a professional competency. There are resources available to learn and practice these skills—such as through the National Alliance on Mental Illness. Similarly, as educators, we should be clear on communicating sources and not valuing all sources equally.

Do Not Be Afraid to Be an Expert

Ms. Gordan-Kane reminded the audience that we are experts in mental health! Do not be afraid to own that role and share your knowledge. The opposition often does not care about science, so do not let them hold the stage.

Question and Answer

An intriguing question raised by an audience member was, "How do I, as someone who lives in Berkeley, California, change the mind of rural Georgians?" The panel urged this questioner to consider that there probably is local work they can do, and to encourage legislators (or provide reinforcement, to use ABCT parlance) when they are doing things you agree with. Finally, one can always do work on the federal level.

Finally, a bigger picture issue is ensuring that ABCT and the professional field as a whole is getting and generating the best information—are we increasing equity, getting funding for behavioral science, etc.? Is the education and training required in our field affordable and feasible for marginalized populations? The panel agreed these are important issues. As a brief response, Laura Seligman announced the newly formed ABCT Task Force to Pro-

mote Equity, Access, and Inclusion; she further encouraged members to contact members of the task force or email ABCTequity@gmail.com.

Conclusion

Finally, remember your motivation to engage in advocacy. As Dr. Bufka said, being part of the conversation is important. If we do not engage, we risk being left out of the conversation entirely: "If you're not at the table, you're on the menu" (Megan Gordan-Kane). ABCT members have the skill set to be effective advocates, we simply need to step up to the table.

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CBT Medical Educator Directory

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

Visit the directory to submit your name or to connect with CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. Detailed inclusion criteria appear.

visit http://www.abct.org
Resources for Professionals
Teaching Resources
CBT Medical Educator Directory

NEWS

The Public Health Takeaway at ABCT 2019: Discussions at an Invited Panel With Dr. Sonja Schoenwald

Arthur R. Andrews III, *Institute for Ethnic Studies, University of Nebraska-Lincoln*

THIS YEAR'S CONFERENCE centered in part around a theme of "extending the social impact of cognitive behavioral science." To do so, we must look beyond our standard approaches to therapy and critically consider how we might arrange public mental health based on scientifically grounded, cognitive-behavioral principles. To this end, the conference this year hosted an invited panel titled "Increasing Impact of Cognitive Behavioral Therapies: Why Public Health?" moderated by Dr. Sonja Schoenwald. The panel highlighted how improved public health focus could be achieved through interfacing with the Centers for Disease Control (CDC) and aligning ourselves in a similar public health orientation. Although an increasingly common refrain, it would seem that we still infrequently consider how cognitive-behavioral approaches could be used to improve population mental health outside of individual-focused, one-on-one formats that last at least 30 minutes per session (Kazdin, 2019). This panel and its associated background readings (Aarons, Sklar, Mustanski, Benbow, & Brown, 2017; Auerbach, 2016; Kazdin, 2019) offer fresh reminders of the need to creatively apply cognitive behavioral strategies beyond the 1-hour session.

As the first speaker, Dr. Ileana Arias, the Principal Deputy Director at the CDC, raised the question of how we make change at the population level. It is, after all, part of the CDC's mission to shift an entire population. As outlined by Kazdin (2019), this ought to be the goal of mental health interventions as well. Dr. Arias noted that a population shift can and should occur through a variety of means, including by the aggregation of individual change. The extension that we may at times neglect is the contextual and environmental changes that move health for numerous individuals. While Dr. Arias couched this primarily in the critical arena of policy change, we may also consider the social media and social network (e.g., friends and family) approaches recommended by Kazdin and others. In this way, we create change in the digital and social environments. At the same time, numerous examples abound that teach us how policy often affects behavior in more effective ways than individual intervention (e.g., smoking). Dr. Arias noted there is now a significant interest at the CDC for conducting similar work on the mental health side. This includes an evolving focus on well-being at the CDC that encompasses the understanding that well-being is not the sum nor simply the result of physical health indicators.

To align ourselves with the CDC as individual researchers, clinicians, or as an organization, Dr. Arias provided examples from her own experience. She noted that she initially came to the CDC working on violence prevention and continued to be struck by the clarity of vision reflected in the CDC awards that is uncommon in academia. She stated that its focus is always population-based and action-oriented, with every award granted to teams based on the changes in health outcomes their projects had achieved. These awards reflect the CDC's overall mission of improving health. This kind of focus begins with surveillance and is less theory driven. "Theo-

ries do not exist at CDC, only numbers," she said. For cognitive behavioral therapists, I imagine this may sound strange, but it belies the key to a public health approach. Though not explicitly mentioned in the panel, this would likely be similar to the already-embraced community-based participatory research (CBPR) in which a community may dictate the research needs (Minkler & Wallerstein, 2011). The researcher's job in both cases is to reverse engineer the solution that will address the public or community mental health need. Dr. Arias recommended starting with the desired end-state and creating a logic model to arrive at the potential solution. The CDC can then guide communities with identified needs towards the evidence-based intervention with an emphasis on sustainability. It is in that process of giving feedback to these CDC efforts and creating outcomes-oriented science that we have the most opportunities to interface with the CDC or align ourselves in a similar public mental health fashion.

Dr. Richard Purdy next spoke and addressed more of the ways in which we could interface with CDC and how to approach a public mental health focus. Similar to Dr. Arias, Dr. Purdy used his career trajectory to begin highlighting how to advance public mental health and the role of the CDC in doing so. He explained that in one of his earliest jobs, he transported adolescents to therapy and marveled at the change that occurred, which he later discovered had occurred through CBT. He spoke frequently of his mentor, Dr. Michael Roberts at the University of Kansas, and his admiration of the CDC for its public health focus. Dr. Purdy linked this admiration with his own fascination with systems. At the time, he frequently pondered the same question that we continue ask now: How do we get change to more people? This question lies at the heart of the recommendations by Aarons and colleagues (2017) to consider how our interventions can be used by others. It also encouraged Dr. Purdy to consider how we move whole populations beyond the use of individual aggregation. He began to wonder if policy was an answer and worked in a local congressional office where he learned more about the impact of policy. From there he discussed his move to the CDC and the freeing experience of focusing on the mission of the CDC and serving the public good. It seemed this service might resonate with many of us at ABCT, especially as Dr. Purdy discussed the mission of applying good science to advance the public well-being.

The question-and-answer portion connected many of the themes and appeared to provide a clearer pathway for cognitive behavioral approaches in public mental health. Much of this portion focused on the necessary components of dissemination and implementation. This included challenges when including experiential evidence in a continuum of evidence that the CDC uses. This experience recalled the importance of applying cognitive behavioral approaches to understanding a clinician's use of a given intervention. While not explicitly stated, this may fit the dissemination and implementation work that has begun to incorporate techniques similar to exposure or cognitive restructuring when training clinicians. Though not necessarily specific to a cognitive behavioral approach, the need for experiential evidence also resembles the need for approaches like CBPR. In both cases, the broader community, who will use or receive an intervention, should have a voice in continuum of evidence, especially as we consider who will have access to a particular intervention and how it will be used. In so doing, we should consider who has a voice and who is represented in any continuum of evidence, both of which impact whether our innovations expand or ameliorate the yawning care gaps and disparities.

After discussing the continuum of evidence, the panel discussed the interactive systems framework (ISF), which comprises three systems: research translation, support system, and delivery system. The panel discussed how each system is necessary for understanding how to approach dissemination and implementation using HIV care as a model that worked mostly well. The approach to HIV care considered the science of the intervention as well as its packaging and delivery. The panel asked us to consider how we package these interventions and how they can be delivered to make a community healthier. The panel highlighted a variety of considerations in making the packaging and delivery more effective, especially from a policy perspective. This includes that we should consider the health impact and future policy levers that our research can influence. It also includes finding ways to making the healthier choice the default choice.

In one of the final exchanges, the conversation appeared to tie together the lessons learned. In response to a question about how to ensure clinicians are trained in evidence-based practice for PTSD, Dr. Arias noted the gap in community knowledge of treatment. She discussed how SAMHSA (Substance Abuse and Mental Health Services Administration) is currently leading the development of standards in trauma-informed care, but that the development of these kinds of standards can be complicated. She then reflected on the importance of always asking yourself, "If I do this, then what?" The CDC and policy makers need for investments to result in something actionable. I took this to mean something beyond a position paper or guidance toward an educational resource about an intervention. Dr. Arias explained this idea further with an example of when she attempted to address the issue of children under 5 years of age receiving psychostimulant medication for ADHD, especially when behavioral interventions are effective. She began setting up a policy to have CMS and Medicaid require behavioral treatment before medication. But then, she asks, "Where are they going to go?" There are massive disparities in care access (e.g., Latinxs receive care at approximately half the rate of Whites) that are compounded by care shortages, given that the majority of people who need care do not receive it (Center for Behavioral Statistics and Quality, 2016). Based on these challenges, Dr. Arias then discussed efforts to expand the providers who can perform treatments for ADHD. The infrastructure first needed to be in place, but the implication was that doing so would require a massive shift in how the infrastructure is organized with a graduate-degree-holding clinician performing all individual services. As a result, she said that she went to national professional organizations to have them train and certify clinicians without needing extensive credentials. As Dr. Arias noted, we have effective interventions, but we still struggle to make them accessible. At this point, I reflected on the presession recommended reading—Kazdin (2019). Specifically, the issue of dissemination and implementation likely entails a variety of strategies: Some may extend the current model of care to more people, while others require breaking from this mold. Overall, this panel seemed to raise issues that point to this multifaceted solution. We are an organization that can and often does lead in the effort to expand care. I look forward to our next conference as we have the opportunity to share knowledge and resources to address these issues under the theme of "better access, better outcomes."

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NEWS

A Summary of Dr. Matthew Sanders' Invited Address: "Transforming the Lives of Children, Parents, and Communities: Accomplishments and Future Opportunities"

Samantha Moshier, *Emmanuel College*

ABCT's 53rd Annual Convention theme was "Wisdom of Purpose and Perspective: Extending the Social Impact of Cognitive Behavioral Science." Few individuals may have been better suited to provide input on this topic than Dr. Matthew Sanders, Professor of Clinical Psychology and Director of the Parenting and Family Support Centre of the University of Queensland. As founder of the Triple P Positive Parenting Program, his work has utilized cognitive behavioral principles to reach millions of children and parents worldwide.

Dr. Sanders opened his invited address by discussing the fundamental importance of parenting support, describing good parenting as "the clean water of child mental health, well-being, and resilience." Research has shown the influence of parenting to be pervasive across brain development, social, emotional, and physical and mental health outcomes. Dr. Sanders argued that parenting support must be central to any public policy focused on improving children's mental health and well-being.

He briefly described the principles of positive parenting underlying the Triple P intervention, which include: creating a safe, nurturing environment; a positive learning environment; providing consistent, assertive discipline; setting reasonable expectations for one's child and oneself; and taking care of oneself. He described the Triple P program as a program focused on teaching parents the tools for personal change, noting that self-regulation is particularly central to building and maintaining effective, nonabusive parenting practices. For instance, effective parenting involves the self-monitoring of one's emotions and behaviors, bringing one's behavior under personal control, having skills and knowledge to develop and carry out a plan, and engaging in reflection that is not overly self-critical and that increases self-efficacy. He also noted that the impact of parenting programs are often underestimated, and have potential to address a range of determinants of health and well-being.

"What do we do when the goal is population-level change?" This question guided Dr. Sanders' address, which shared seven major lessons from large-scale population trials of Triple P. First, effective intervention requires a multilevel system rather than a "one size fits all" approach. Interventions need to be able to scale to varying degrees of intensity that match parents' needs and willingness to participate. Second, a multidisciplinary workforce is needed. Triple P has been exemplary in this area, having provided 8,957 trainings to a range of professionals including psychologists, social workers, educators, and coaches in 29 countries in order to reach over 7 million children. Third, parenting support needs to be inclusive of all parents, and should consider the needs of special groups such as custodial grandparents. Fourth, it should be adapted across cultures to focus on the values, priorities, and culturally appropriate methods of sharing information. Triple P, when adapted to fit the needs of local contexts, has demonstrated acceptability across a range of cultures. For instance, a low-intensity version of Triple P was adapted for use with indigenous Māori families in New Zealand in consultation with tribal elders, practitioners, and parents. This process indicated a need for a low-intensity group intervention that normalized parenting challenges, and Triple P was adapted to meet this need and to use culturally appropriate examples and welcome participants with culturally appropriate methods.

Fifth, programs must be supported by evidence. Dr. Sanders presented an overview of the robust evidence base for Triple P interventions, which includes 175 randomized controlled trials conducted in 37 countries, 95% of which have shown positive effects. In particular, he highlighted the potential for Triple P to lead to

population-level change. Studies focusing on population-based prevention of child maltreatment have been conducted in locations ranging from North Carolina to Ireland, with population-level data showing that Triple P was associated with reduced child maltreatment, improved school outcomes, and better mental health. Triple P has been further supported by cost-effectiveness research, with an estimated benefit of $10.05 for every dollar spent on the intervention.

Dr. Sanders' sixth lesson was multifaceted, focusing on enhancing the reach of parenting support interventions. In order to have sufficient reach, attention must be paid to the communications strategies used to create demand for interventions. Triple P has been promoted with an emphasis on normalizing its services and focusing on the needs of children. Further, there is a need to listen to the changing views of parents, children, and end-users. For instance, Triple P teams have conducted surveys of parents in local communities to assess the "hot-button" issues, and have partnered with local media to distribute these results. Technology can also be used to sensibly extend reach. Triple P has shown positive effects across a range of outcomes when administered in online formats of varying intensity levels. Strategies such as brief phone support, gamification, and social-norm-focused text messages may help to reduce the lower completion rates that are typical of Internet-based interventions. Triple P has also demonstrated effectiveness in formats including self-help books and podcasts. Dr. Sanders cautioned that although parenting advice is widely provided and sought online, an overreliance on the Internet for parenting advice may undermine personal agency within the parenting process.

Reach can also be extended by targeting engagement of parents across multiple contexts. For instance, Triple P has been working with the National Rugby League in Australia to develop a low-intensity program designed to enhance parents' capabilities to support children's enjoyment and participation in sports and reduce negative emotional reactions to game-day events. Currently under development, Active Triple P Online involves a 2-session online program that will be offered to the parents of all players, in addition to an orientation for coaches about the program and a text-messaging program.

Dr. Sanders' seventh and final lesson focused on the importance of sustained organizational support following training. "Enablers" within an organization have the ability to promote sustained use of interventions, which will facilitate lower costs per family and higher return on investment. In particular, organizations can focus on formats that increase the impact of programming and allow for lower costs, such as conducting larger, low-intensity seminars as an alternative to small groups.

In his closing remarks, Dr. Sanders discussed the value and potential of using positive parenting practices to promote global well-being. For instance, the Sustainable Development Goals set by the United Nations may be addressed using principles of positive parenting, including activating a protective parenting stance and mobilizing the family system to change behavior. In partnership with the University of Queensland's Capturing Coral Reef & Related Ecosystem Services, Dr. Sanders has developed the My Family, My Oceans program, a workshop based on Triple P and behavior change principles aimed at helping villagers in Indonesia engage in environmentally friendly practices.

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No conflicts of interest or funding to disclose.

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NEWS

A Reflection on Dr. Vikram Patel's 2019 ABCT Invited Address

Meredith Boyd, *UCLA*

DURING ABCT'S 2019 Annual Convention, Dr. Vikram Patel presented an invited address entitled "Building a Workforce to Deliver Psychological Therapies Globally." Dr. Patel is the Wellcome Trust Principal Research Fellow and Pershing Square Professor of Global Health at Harvard Medical School. He is also an adjunct professor and the joint director of the Centre for Chronic Conditions and Injuries at the Public Health Foundation of India and an honorary professor at the London School of Hygiene and Tropical Medicine. He is a world-recognized leader in disseminating treatments into low-resource settings and was named by *Time* magazine as one of the world's 100 most influential people in 2015. His recent research centers on reducing the burden of mental illness in impoverished areas using existing community resources and workforces.

"With regard to mental health treatment, all countries are developing countries." This striking statement by Dr. Patel highlights that even in well-resourced countries, the difference in access to mental health treatment is vastly outpaced by access to other forms of medical care, despite the immense burden and consequence of mental illness on individuals and society. Although effective interventions for a range of mental illnesses have been delineated through research, translation of these interventions into community settings, where they can benefit those in need, has continued to be a challenge.

Throughout his address, Dr. Patel inspired and called upon ABCT members to consider novel strategies for developing and structuring mental health service systems to address this challenge. In his presentation, he provided examples of ways his research team has used novel strategies to meet the needs of individuals in India who require treatment but have poor access to services. Specifically, Dr. Patel described the implementation of and outcomes from the Healthy Activity Program (HAP), a brief psychological treatment for depression delivered by lay therapists in primary care settings. One of the most promising findings from the HAP study concerned supervision. In traditional models of supervision, an expert supervisor with an advanced degree supports and evaluates more novice therapists. However, results of HAP demonstrated that peer supervisors were as effective as experts when evaluating treatment quality of their supervisees. Additionally, peer supervisors were perceived more positively than expert

supervisors by lay therapists (Singla et al., 2014). Findings from HAP also demonstrated that a reduction in depressive symptoms and functional impairment can be achieved in six to eight treatment sessions delivered by lay therapists (Patel et al., 2017). These promising results suggest that evidence-based psychotherapy can be effectively delivered by lay counselors and effectively supervised by peer supervisors, illustrating the potential for nonspecialist mental health professionals to be trained to provide services at scale, narrowing the treatment gap. Dr. Patel also discussed an exciting new initiative drawing on the use of digital technologies to similarly scale up the mental health care workforce. He provided an overview of an innovative online platform that offers training resources and opportunities for peer supervision, enabling providers anywhere to learn, deliver, and receive support with cutting-edge evidence-based practices for which in-person training and consultation is often not available in underresourced areas in the United States and abroad.

As Dr. Patel emphasized, mental health treatment can be described as much for few and little (to none) for many. Lessons from his team's work suggest ways that mental health workforce training and treatment can be creatively supplemented and altered to increase access to mental health care. His address encourages us to question traditional modes of treatment delivery by addressing the following questions: How can we train the workforce? Who can comprise the workforce? Who can supervise? What is a sufficient dose of treatment? In what settings can treatment be delivered? How can treatments be designed for scale-up?

Dr. Patel's invited address was a highlight of ABCT's 53rd Annual Convention and his message aligned well with the convention theme: "Wisdom of Purpose and Perspective: Extending the Social Impact of Cognitive Behavioral Science." Few have been more visible and successful at raising awareness of the profound need for improved access to mental health services than Dr. Patel, and his message to ABCT members was both thought-provoking and inspiring.

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ABCT AWARDS & RECOGNITION 2019

53rd Annual Convention | November 22, Atlanta

Anne Marie Albano Early Career Award
Jami M. Furr

Outstanding Service
Carmen McLean

Lifetime Achievement: *Philip C. Kendall (pictured with President Bruce Chorpita and Awards Chair Cassidy Gutner)*

Outstanding Training Program
Jesse R. Cougle (center), Director, Florida State University's Clinical Psychology Ph.D. Program (pictured with President Bruce Chorpita and Awards Chair Cassidy Gutner)

President's New Researcher
Jessica L. Schleider

Above, left to right: *Natalie Rodriguez-Quintana,* **John R. Z. Abela Dissertation Award;** *Michael Best,* **Leonard Krasner Dissertation Award;** *Amy R. Sewart,* **Virginia Roswell Dissertation Award;** *Poppy Brown,* **Student Travel Award**

Graduate Student Research Grant
Above, left to right: *Shirley Wang (Hon. Mention) and Colin M. Bosma*

ABCT AWARDS & RECOGNITION 2019

Outstanding Clinician
Cory F. Newman

Distinguished Friend to the Behavioral and Cognitive Therapies
Rod Holland and Philip Tata (center) with President Bruce Chorpita and Awards Chair Cassidy Gutner

ABCT 2019 Champions left to right: *Glenace Edwall, President Bruce Chorpita, T. Lindsey Burrell, Patricia Nygaard, Awards Chair Cassidy Gutner*

Elsie Ramos Memorial Student Poster Awards
left to right: *John McKenna, Cassidy Gutner (Awards Chair), Oliver Johnston, Sara Elkins (member, Awards & Recognition Committee, President Bruce Chorpita, Abel Mathew*

Spotlight on Mentors left to right: *President Bruce Chorpita, Norman B. Schmidt, Genelle K. Sawyer, Elise M. Clerkin, Alisha Wray (member of the Academic Training & Education Standards Committee)*

2020

Call *for* Award Nominations

to be presented at the 54th Annual Convention in Philadelphia, PA

The ABCT Awards and Recognition Committee, chaired by Cassidy Gutner, Ph.D., of Boston University School of Medicine, is pleased to announce the 2020 awards program. Nominations are requested in all categories listed below. Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, Marsha Linehan, Dianne L. Chambless, Linda Carter Sobell and Mark B. Sobell, and Philip C. Kendall. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2020ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line. ***Nomination deadline***: March 2, 2020

Sobell Innovative Addictions Research Award The Sobell Innovative Addictions Research Award is awarded in alternate years. If no suitable candidate emerges in a given year, the call for applications will be repeated until an acceptable submission is received. The recipient receives $1,500 and a plaque. *Nature of the Award*: The award is given to an individual who, through the performance of one or more research studies, has developed a novel and very innovative (1) program of research or (2) assessment or analytic tool or method that advances the understanding and/or treatment of addictions. The emphasis is on behavioral and/or cognitive research or research methods that have yielded exceptional breakthroughs in knowledge. *Eligibility Criteria*: All career stages—the emphasis is on innovation that advances the field regardless of career stage; Candidates must be current members of ABCT; Self-nomination or nomination by others who need not be members of ABCT; Submissions should include the nominee's curriculum vitae, a statement describing the addictions research contribution and why it is novel and advances the field (maximum 3 pages), two letters of support, and copies of publications, web materials, or other documents supporting the innovation and impact described in the nomination.

Evaluation Process: The awardee will be chosen by a committee of three senior researchers with distinguished research records who are members of the ABCT Addictions Special Interest Group. Committee members will forward their recommendation and justification for selecting the awardee to the Awards and Recognition Committee Chair at least 2 weeks prior to the Awards and Recognition Committee April meeting. The Awards Chair will verify that all materials are completed and that the committee agrees with the recommendation. The Awards Chair will forward the materials to the ABCT Board for their approval. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2020ABCTAwards@abct.org. Include "Sobell Research Award" in the subject line. ***Nomination deadline***: March 2, 2020

Outstanding Mentor Eligible candidates for this award are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Previous recipients of this award are Richard Heimberg, G. Terence Wilson, Richard J. McNally, Mitchell J. Prinstein, Bethany Teachman, Evan Forman, and Ricardo Munoz. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to 2020ABCTAwards@abct.org. Include "Outstanding Mentor" in your subject heading. ***Nomination deadline***: March 2, 2020

Outstanding Contribution by an Individual for Education/Training Awarded to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Past recipients of this award include Gerald Davison, Leo Reyna, Harold Leitenberg, Marvin Goldfried, Philip Kendall, Patricia Resick, and Christine Maguth Nezu. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Then e-mail the completed form and associated materials as one pdf document to 2020ABCTAwards@abct.org. Include "Outstanding

Educator/Trainer" in your subject heading. ***Nomination deadline***: March 2, 2020

Distinguished Friend to Behavior Therapy Eligible candidates for this award should NOT be members of ABCT but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent recipients of this award include, Vikram Patel, Benedict Carey, Patrick J. Kennedy, Joel Sherrill, Rod Holland, and Philip Tata. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to 2020ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line.
Nomination deadline: March 2, 2020

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize of $1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Applicants should submit: nominating cover letter, CV, personal statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to 2020ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line. ***Nomination deadline***: March 2, 2020

Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2018. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted, or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the nomination materials (including letter of recommendation) as one pdf document to 2020ABCTAwards@abct.org. Include candidate's last name and "Student Dissertation Award" in the subject line.
Nomination deadline: March 2, 2020

President's New Researcher Award ABCT's 2019-20 President, Martin M. Antony, Ph.D., invites submissions for the 42nd Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. *Requirements*: must have had terminal degree (Ph.D., M.D., etc.) for at least 1 year but no longer than 5 years (i.e., completed during or after 2015); must submit an article for which they are the first author (in press, or published during or after 2018); 2 letters of recommendation must be included; self-nominations are accepted; the author's CV, letters of support, and paper must be submitted in electronic form. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org. Include candidate's last name and "President's New Researcher" in the subject line.
Nomination deadline: March 2, 2020

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

Outstanding Service to ABCT Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to 2020ABCTAwards@abct.org.

ABCT's 2020 Champions of Evidence-Based Interventions

This award recognizes outstanding individuals who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT. Importantly, the goal of the award is to identify individuals who translate the impact of research into community health and well-being outside of the scope of their job requirements. Individuals who perform this function as part of their normal job (clinical or research) will not be considered for the award. Champions may not be members of ABCT at the time of their nomination.

▶ Potential Candidates

Nominees should demonstrate the characteristics of champions, broadly construed, as recognized in the implementation science literature (see Knudsen, Gutner, & Chorpita, 2019, for examples relevant to ABCT: http://www.abct.org/docs/PastIssue/42n1.pdf). Champions are those individuals who support, facilitate, diffuse or implement the core assets of evidence-based interventions. Champions' efforts expand the scope and impact of evidence-based interventions beyond the reach of researchers alone. They differentiate themselves from others by their visionary quality, enthusiasm, and willingness to risk their reputation for change. Ideal candidates should have demonstrated the following: (1) How the individual has recognized the potential application and impact of evidence-based psychological interventions; (2) How the individual has gone beyond their formal job requirements within an organization to relentlessly promote innovation; and (3) How they actively lead positive social change.

▶ Recognition

Nominees will be reviewed in March, June, and October by the ABCT Awards Committee, and those meeting criteria will be forwarded to the ABCT Board of Directors for approval. Recipients will be notified by the ABCT President, and their names and photographs will be posted on the ABCT website, along with the rationale for their recognition. Each year's champions will also be acknowledged at our annual awards ceremony at the ABCT Convention.

▶ How to Nominate

Email your nomination to **2020ABCTAwards@abct.org** (link to nomination form is on the Champions web page). Be sure to include "Champions Nomination" in the subject line. Once a nomination is received, an email will be sent from staff, copying the Awards and Recognition Committee Chair. The nomination will be reviewed by the Awards and Recognition Committee, and if deemed appropriate for our program, will be forwarded to the ABCT Board of Directors for final approval. Once reviewed and approved by the Board of Directors, the nominee will be contacted directly by the President, followed up with an ABCT staff member for a final review of the copy to be posted on the ABCT website.

Visit our Champions page to see the full listings and descriptions of ABCT's 2018 and 2019 Champions.

abct.org > For Members > Champions

Preparing to Submit an Abstract

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 Programming, 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 Abstract Submission Portal, and the ABCT home page. Attendees are limited to speaking (e.g., presenter, panelist, discussant) during no more than FOUR events. As you prepare your submission, please keep in mind:

• **Presentation type**: For descriptions of the various presentation types, please visit http://www.abct.org/Conventions/?fa=Understanding_The_ABCT_Convention

• **Number of presenters/papers**: For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The total number of speakers may not exceed 6. Symposia are either 60 or 90 minutes in length. The chair may present a paper, but the discussant may not. Symposia are presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.

• **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 degree, ABCT category (if they are ABCT members), and their email address. (Possibilities for "ABCT category" are current member; lapsed member or nonmember; postbaccalaureate; student member; student nonmember; new professional; emeritus.)

• **Institutions**: The system requires that you enter institutions before entering authors. This allows you to enter an affiliation one time for multiple 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 of defined keywords and use one of the keywords on the list. Keywords help ABCT have adequate programming representation across all topic areas.

• **Objectives**: For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the objectives of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Explained data on novel direction in the dissemination of mindfulness-based clinical interventions."

• **Overall**: Ask a colleague to proof your abstract for inconsistencies or typos.

For an in-depth explanation of ABCT's convention program, including the differences among ticketed, general, and special programming, visit us at:

www.abct.org > Conventions & CE > Understanding the ABCT Convention

Questions? FAQs are at http://www.abct.org/Conventions/ > Abstract Submission FAQs

Thinking about submitting an abstract for the ABCT 54th Annual Convention in Philadelphia? The submission portal will be opened from February 13–March 16. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 54th Annual Convention. The deadline for submissions will be 3:00 a.m. (EST), Monday, March 16, 2020.

ticketed sessions

call

54th Annual Convention

November 19–22, 2020 | Philadelphia

for Ticketed Sessions

Workshops & Mini Workshops

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

For more information or to answer any questions before you submit your abstract, email **Christina Boisseau, Workshop Committee Chair, workshops@abct.org**

Institutes

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

For more information or to answer any questions before you submit your abstract, email **Samantha G. Farris, Institutes Committee Chair, institutes@abct.org**

Master Clinician Seminars

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

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

Research and Professional Development

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

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

Conference Theme:

"Better Access, Better Outcomes: Enhancing the Impact of Behavioral and Cognitive Therapies"

Information about the convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2020.

Submission deadline: ***February 14, 2020, 3:00 A.M. EST***

ABCT 2020

Enhancing the Impact of Behavioral and Cognitive Therapies

BETTER ACCESS, BETTER OUTCOMES

54th Annual Convention ••• November 19–22, 2020 | Philadelphia, PA

CALL for PAPERS

Over the past few decades, significant advances have been made in the development of effective behavioral and cognitive interventions for a wide range of problems, and ABCT members have been at the forefront of these developments. Yet, many people have difficulty accessing evidence-based care, and many clients fail to engage in or fully respond to existing treatments. ABCT's 54th Annual Convention will highlight advances in research, clinical practice, and training that feature strategies for strengthening the impact of evidence-based psychological treatments through increasing their reach and improving their effectiveness.

We encourage submissions related to the 2020 convention theme, "**Better Access, Better Outcomes: Enhancing the Impact of Behavioral and Cognitive Therapies.**"

Examples of topics related to the theme include:

- Understanding failures to respond to standard behavioral and cognitive therapies
- Developing new methods for improving outcomes in CBT, and understanding when to use them
- Understanding and targeting mechanisms for better CBT outcomes
- Improving the acceptability of evidence-based interventions to promote engagement among consumers, clinicians, and organizations
- Optimizing CBT cost effectiveness while maintaining and improving quality and outcomes
- Using technology to facilitate the delivery of evidence-based psychological treatments
- Leveraging social media to educate consumers and clinicians about the use of evidence-based treatments and how to access them
- Identifying challenges and opportunities in the implementation of evidence-based practices in large institutions, where clinicians may not be well-versed in CBT
- Addressing system, policy, organizational, and individual-level barriers to implementing evidence-based 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, 2020.**

• • • PROGRAM CHAIR: **Shannon Wiltsey Stirman** • • •

general sessions

Portal opens
February 13, 2020

Deadline for submissions:
Monday, March 16, 2020
(3:00 A.M. EST)

Understanding the ABCT Convention

GENERAL SESSIONS

There are between 150 and 200 general sessions each year competing for your attention. 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. 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 3:00 a.m. ET, Monday, March 16, 2020.
General session types include:

Symposia. *In responding to convention feedback requesting that senior researchers/faculty present papers at symposia, while also recognizing the importance of opportunities for early career, student, and postdoctoral fellows to present their work, we strongly encourage symposia submissions that include a mix of senior and early career presenters.* Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation 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. The total number of speakers may not exceed 6.

Clinical Round Tables. Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Panel Discussions. Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

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 PROGRAMMING

Targeted and special programming 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.

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

Research Facilitation Sessions. Organized by members of the Research Facilitation Committee, these events aim to highlight research resources for those who study or practice behavioral and cognitive principles.

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 40 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.

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.

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. The deadline for these submissions is 3:00 AM ET, Friday, February 14, 2020.

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.

Thinking about submitting an abstract for the ABCT 54th Annual Convention in Philadelphia? The submission portal will be opened until 3 AM EST March 16. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 54th Annual Convention.

Deadline for submissions: 3:00 A.M. (EST), Monday, March 16, 2020

ABCT & Continuing Education

At the ABCT Annual Convention, there are Ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and General sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. See the end of this document for a list of organizations that have approved ABCT as a CE sponsor. Note that we do not offer CMEs. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

For those who have met all requirements according to the organizations which have approved ABCT as a CE sponsor, certificates will be mailed by mid-January following the Annual Convention.

TICKETED EVENTS Eligible for CE

All Ticketed events offer CE in addition to 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 beyond the general registration fee. For ticketed events, attendees must scan in and out, and complete and return an individual evaluation form. It remains the responsibility of the attendee to scan in at the beginning of the session and out at the end of the session. CE will not be awarded unless the attendees scans in and out.

Clinical Intervention Training

One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction. Participants attending a full-day session can earn 7 continuing education credits, and 14 continuing education credits for the two-day session.

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. Participants in the full-day Institute can earn 7 continuing education credits, and in the half-day Institutes can earn 5 continuing education credits.

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. Participants in these workshops can earn 3 continuing education credits per workshop.

Master Clinician Seminars (MCS)

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. Participants in these seminars can earn 2 continuing education credits per seminar.

Advanced Methodology and Statistics Seminars (AMASS)

Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

GENERAL SESSIONS Eligible for CE

There are more than 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. Most of the sessions are eligible for CE, with the exception of the poster sessions, some Membership Panel Discussions, the Special Interest Group Meetings (SIG), and a few special sessions. You are eligible to earn 1 CE credit per hour of attendance.

General sessions attendees must scan in and out and answer particular questions in the CE booklet regarding each session attended. The completed booklet pages must be returned to ABCT central office by the middle of January via e-mail or post.

General session types that are eligible for CE include the following:

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.

Invited Panels and Addresses
Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.

Mini-Workshops
Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long. Mini-workshops are offered on Friday and Saturday and are generally limited to 80 attendees. Participants can earn 1.5 continuing education credits.

Panel Discussion
Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considerations in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

Clinical Round Tables
Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

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.

Symposia
Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation 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. The total number of speakers may not exceed 6.

GENERAL SESSIONS NOT ELIGIBLE for CE

Membership Panel Discussion
Organized by representatives of the Membership Committee and Student Membership Committees, these events generally emphasize training or career development.

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 1,100 and 1,500 posters are presented each year.

Special Interest Group (SIG) Meetings
More than 40 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.

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. These sessions are not eligible for continuing education credit.

Other Sessions
Other sessions not eligible for CE are noted as such on the itinerary planner, in the PDF program book and on the convention app.

How Do I Get CE at the ABCT Convention?

The continuing education fee must be paid (see registration form) for a personalized continuing education credit letter to be distributed. Those who have included CE in their pre-registration will be e-mailed an electronic booklet in advance. Others can still purchase an electronic booklet at the registration area during the convention. The current fee is $99.00.

Which Organizations Have Approved ABCT as a CE Sponsor?

Psychology
ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit.

For ticketed events attendees must scan in and scan out and complete and return an individual evaluation form. For general sessions attendees must scan in and scan out and answer particular questions in the CE booklet regarding each session attended. It remains the responsibility of the attendee to scan in at the

beginning of the session and out at the end of the session. The booklets will be distributed electronically as a PDF and the completed booklet pages must be sent back to the ABCT central offices via e-mail (CECredit@ABCT.org) or post by mid-January.

Social Work
ABCT program is approved by the National Association of Social Workers (Approval # 886427222) for 27 continuing education contact hours. Note: The approval number and unique identifier number along with the social work category will be provided on your approval letter.

Counseling
ABCT is approved by the National Board of Certified Counselors (NBCC) Approved Continuing Education Provider, ACEP No. 5797 and may offer NBCC-approved clock hours for events that meet NBCC requirements. Programs that do not qualify for NBCC credit are clearly identified. ABCT is solely responsible for all aspects of the program.

Licensed Professionals
ABCT is approved by the California Association of Marriage and Family Therapists (CAMFT) to sponsor continuing education for counselors and MFT's, Continuing Education Provider (#133136). The ABCT Annual Convention meets the qualifications for 28 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences. ABCT maintains responsibility for this program/course and its contents.

Continuing Education (CE) Grievance Procedure

ABCT is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. ABCT will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Coordinator of Convention and Education Issues in conjunction with the Convention Manager.

Although ABCT goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the convention staff which require intervention and/or action on the part of the convention staff or an officer of ABCT. This procedural description serves as a guideline for handling such grievances.

All grievances must be filed in writing to ensure a clear explanation of the problem. If the grievance concerns satisfaction with a CE session the Convention Manager shall determine whether a full or partial refund (either in money or credit for a future CE event) is warranted. If the complainant is not satisfied, their materials will be forwarded to the Coordinator of Convention and Continuing Education Issues for a final decision.

If the grievance concerns a speaker and particular materials presented, the Convention Manager shall bring the issue to the Coordinator of Convention and Education Issues who may consult with the members of the continuing education issues committees. The Coordinator will formulate a response to the complaint and recommend action if necessary, which will be conveyed directly to the complainant. For example, a grievance concerning a speaker may be conveyed to that speaker and also to those planning future educational programs.

Records of all grievances, the process of resolving the grievance and the outcome will be kept in the files of the Convention Manager.

A copy of this Grievance Procedure will be available upon request.

If you have a complaint, please contact Stephen R. Crane, Convention Manager, at scrane@abct.org or (212) 646-1890 for assistance. ■

MOVING SOON?

UPDATE YOUR MAILING ADDRESS

To continue receiving issues of the Behavior Therapist
and other important ABCT communications:

✔ Visit www.abct.org
✔ Click "Member Log In"
✔ Update the "Addresses" section of your member profile

Find a CBT Therapist

*ABCT's **Find a CBT Therapist** directory is a compilation of practitioners schooled in cognitive and behavioral techniques. In addition to standard search capabilities (name, location, and area of expertise), ABCT's Find a CBT Therapist offers a range of advanced search capabilities, enabling the user to take a Symptom Checklist, review specialties, link to self-help books, and search for therapists based on insurance accepted.*

*We urge you to sign up for the **Expanded Find a CBT Therapist** (an extra $50 per year). With this addition, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars.*

To sign up for the Expanded Find a CBT Therapist, click MEMBER LOGIN *on the upper left-hand of the home page and proceed to the ABCT online store, where you will click on "Find CBT Therapist."*

For further questions, call the ABCT central office at 212-647-1890.

ABCT

Election Results

Laura Seligman, Ph.D.
President-Elect, 2020–2021

Carolyn Black Becker, Ph.D.
Representative-at-Large and Liaison to Membership Issues, 2020–2023

Both bylaws revisions were accepted.
See our mission and bylaws at www.abct.org

Learn More

about ABCT governance, history, mission:

ABCT.org > About ABCT

- ▶ Mission
- ▶ Bylaws
- ▶ Strategic Plan
- ▶ History of ABCT
- ▶ Membership
- ▶ Governance
- ▶ Contact Us

Meet Our **Featured Therapists**

http://www.abct.org/Help/?m=mFindHelp&fa=ClinicianMonth

Browse our growing collection of featured therapist interviews. In these engaging portraits, clinicians share advice and their personal thoughts on various topics: promoting one's private practice, views on CBT, self-help book recommendations, continuing education activities, waiting-room decore, and how to avoid burnout.

Alan Berkowitz
Larry Cohen
Doreen M. DiDomenico
Ilyse Dobrow DiMarco
Anne Michelle Donnelly
Carol J. Dorfman
Anitra Fay
Nadine Fish
Steven T. Fishman
Arnold Freedman
Seth J. Gillihan
James Gray
Joel Guarna
Wei-Chin Hwang
Angela Klein
Cedar Koons
Harry Lesieur
Cheri A. Levinson
Nehjla Mashal
Patrick McGrath
Paul R. Munford
Charles Melville
Christine Maguth Nezu
Shannon Couture O'Flinn
Terrence Patterson
Phillip Pierce
Erroll Philip
Rebecca Sachs
Gerald M. Stein
Stephen R. Swallow
Gerald Tarlow
Jennifer L. Taitz
Jonathan Kaplan
Katherine Martinez
Melinda White
Reid Wilson
George Wing
Robin Yeganeh

I find that constantly learning something new about my professional work keeps me interested and even fascinated with my work.
—George Wing

Get to know the community.
—Cheri A. Levinson

Anxiety feels much less threatening when you can laugh at it a little bit.
—Ilyse Dobrow DiMarco

Be unapologetic about being a CBT therapist. Take the cases you are comfortable with or can get supervision on, and know your limits.
—Patrick McGrath

CBT can help people get more vibrantly engaged in their lives. At its most transformative, I get to watch someone go from sleep-walking through life to actually living it.
—Nehjla Mashal

the Behavior Therapist
Association for Behavioral
and Cognitive Therapies
305 Seventh Avenue, 16th floor
New York, NY 10001-6008
212-647-1890 | www.abct.org

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This may be your last issue of *tBT*.

RENEW *your ABCT membership before January 31.*

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