Behavioral and Cognitive Therapies in Psychiatric Rehabilitation for the Schizophrenia Spectrum: Finding the Forgotten Stepchild

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ABCT ASSOCIATION *for* BEHAVIORAL *and* COGNITIVE THERAPIES

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PRESIDENT'S MESSAGE

Engaging Our Stakeholders

David F. Tolin, *The Institute of Living*

AS I WRITE THIS COLUMN, the 54th ABCT Annual Convention has just wrapped up, and our pivot to a virtual meeting seems to have gone extremely well. I'd like to express my deepest gratitude to the ABCT central office staff who made it happen, with a special thanks to Stephen Crane, our Convention Manager, for his exceptional work. We had 2,334 attendees; I'm particularly happy that of those, 225 were nondoctoral clinical professionals attending their first ABCT convention, suggesting that our efforts to expand our tent are working. Although I have not yet been able to review all of the attendees' comments about the convention, the anecdotal information I've received thus far suggests that our attendees were particularly appreciative of the increased emphasis on diversity in our offerings. Here I want to acknowledge the tremendous efforts of the 2020 Program Chair, Shannon Wiltsey Stirman, and the Associate Program Chair, Daniel Cheron. Know that 2021 Program Chair Gregory Chasson, Associate Program Chair Elizabeth Katz, and I have every intention of continuing, and even expanding on, their work and vision for a convention that embraces diversity in all its manifestations.

I'd also like to thank our immediate Past-President, Martin Antony, for his steady lead-

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convention 2021

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.

ership during a turbulent year. The year 2020 brought us COVID-19, an increased focus on systemic racism, and a disputed election. Throughout the year, Dr. Antony managed to keep ABCT on track, addressing timely topics in his presidential columns and guiding us toward a more conscientious and inclusive future. He has left some very big shoes to fill.

As you may have read in a previous issue of *the Behavior Therapist,* 2020 also brought a strategic retreat, which occurs every 3 years (Antony, 2020). Facilitated by consultant Jeff De Cagna, this meeting included the Board of Directors, coordinators, and senior staff. Among the many topics of discussion was a challenge to think of who our stakeholders are, and how to best engage with those stakeholders. Britannica defines a stakeholder as any individual, social group, or actor who possesses an interest, a legal obligation, a moral right, or other concern in the decisions or outcomes of an organization. Thus, for ABCT, our stakeholders are any individuals or organizations who have a vested interest in what our organization does and the decisions we make.

For us to engage with a stakeholder does not necessarily mean that the stakeholder must become a member of ABCT. That is one way to engage—and I am broadly in favor of expanding our membership—but it is not the only way. Rather, the aim of stakeholder engagement is to build some kind of mutually beneficial relationship. Central to the process, therefore, is starting (or continuing) conversations with various groups in order to explore how ABCT can best meet their needs. In this column, I will discuss several (though certainly not all) of our prospective stakeholder groups. I do not claim to have the solution for how best to engage all of these stakeholder groups; rather, my hope is to start a discussion on the topic.

Our members are, of course, our primary stakeholders. At present, there are 2,938 of us. That number is down from prior years, likely due to diminished attendance at the virtual convention. This link between membership and convention attendance highlights the fact that our main way of engaging members has historically been through the Annual Convention, but that is certainly not the only way. Indeed, during the strategic retreat, the idea that "ABCT is primarily the ABCT Convention" was identified as an orthodox belief that potentially holds us back from a richer relationship with our members. So how else can we build a mutually beneficial relationship with our members—both full members and students? One ready avenue is our 41 Special Interest Groups (SIGs), which can provide a smaller and more topically focused group with which our members can interact. To join a SIG, visit the "For Members" section at www.abct.org. In addition, members wishing to work on behalf of the organization can join one of a number of committees, including (but not limited to) the Continuing Education Committee; Academic Training & Educational Standards Committee; Research Facilitation Committee; Awards & Recognition Committee; Self-Help Book Recommendation Committee; Dissemination, Implementation, & Stakeholder Engagement Committee; Public Education & Media Dissemination Committee; Membership Committee; and Social Networking Media Committee. If you're interested in learning more about, or joining, a committee, email our Executive Director, Mary Jane Eimer (mjeimer@abct.org). Furthermore, we are in need of members who would like to review 2021 convention submissions; for more information, email abstractsubmission@abct.org.

ABCT is also working to increase engagement with our members from traditionally marginalized groups. Our members who represent ethnic, racial, sexual, or gender minorities should know that they have a welcoming and inclusive professional home in ABCT, and those of us in leadership should continuously strive to make it so. Recently, the Task Force to Promote Equity, Inclusion, and Access, chaired by Drs. Sandra Pimentel, Shireen Rizvi, and Laura Seligman, recommended specific steps for ABCT to consider in order to better engage with, and meet the needs of, our members and prospective members from these groups. The Board of Directors is currently discussing their suggestions, and a report on their work is forthcoming in a future issue of this newsletter.

The list of stakeholders, however, does not end with the membership. Practicing clinicians in the community constitute another important group that has an interest in, and can contribute meaningfully to, ABCT's activities, with or without ABCT membership. Although our full members mostly (91%) have doctoral degrees, we should be mindful of the fact that the APA Commission on Accreditation is now working towards accrediting master's degree programs in health service psychology (HSP), comprised of clinical, counseling, and school psychology programs (Commission on Accreditation, 2020). We would be well served to enhance our relationship with these master-level clinicians. Our journal *Cognitive and Behavioral Practice* provides a unique potential for a two-way communication, in which we can both provide information to, and solicit information from, these stakeholders. There is a unique opportunity here for us not only to disseminate information about evidence-based CBT, but also to hear back from these clinicians about how our treatments are working in their practices, and what might improve uptake and efficacy of the treatments. This strategy of two-way communication is consistent with prior recommendations for the dissemination of evidence-based practices (e.g., Goldfried et al., 2014). One area of our work that I'd particularly like to highlight is our continuing education program, which I hope to prioritize during my term as President. ABCT is well poised to provide educational workshops that appeal to practicing clinicians, regardless of whether they are ABCT members. And again, because dissemination is best conceptualized as a dialogue, rather than a lecture, ABCT should solicit input from these stakeholders about their training needs. We should further explore engaging these clinicians as presenters, not just as consumers, as I am sure there is much that they can teach us while still maintaining a strong ABCT "brand."

We should also consider how best to engage training programs. This includes not only our strong existing relationship with clinical psychology Ph.D. programs, but also counseling psychology programs, Psy.D. programs, MSW programs, and master's-level HSP programs. Given our increasing emphasis on diversity and inclusion, we may wish to reach out in particular to programs housed in historically Black universities, universities with largely Hispanic/Latinx students, and organizations of underrepresented students. Conversations with directors of clinical training at these institutions would help us understand how to create a mutually beneficial relationship.

Another stakeholder group that deserves our attention—companies and other organizations with a vested interest in the work of ABCT—includes health insurance companies, administrators of large mental health systems, schools, the judicial system, and our colleagues in publishing. Funding agencies such as the National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration

(SAMHSA) are also important stakeholders, and ongoing dialogue with these agencies is critical.

Finally, a list of ABCT stakeholders would not be complete without individuals with lived experience of behavioral health problems. Certainly they stand to benefit from the work that ABCT does, and our resources such as the fact sheets (which are now expanding to YouTube videos) and Find a CBT Therapist search engine on our website are a great start. However, we would likely benefit from increased dialogue with, and input from, those with lived experience.

As we think about engaging stakeholders, we need to consider how we articulate to those stakeholders what our organization is about. Our current mission statement was carefully crafted and provides a thorough description of our aims. However, at 101 words long, it may not be the optimal message for rapid communication with certain stakeholders, especially when "bandwidth" is limited. As the leadership discusses how ABCT can interact with various stakeholders and the relationships we could build, we are considering a statement of simplified purpose that is not intended to replace the mission statement, but rather will serve as a shorthand way to communicate to prospective stakeholders ABCT's reason for being that reflects its most important work:

> *ABCT promotes the use of science to understand and treat human problems.*

The Board is continuing to address this simplified purpose, along with guiding principles and critical outcomes. In future columns I will describe additional proposals from the strategic meeting. In the meantime, I welcome your comments and questions. Please feel free to email me at david.tolin@hhchealth.org.

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No conflicts of interest or funding to disclose.

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AT ABCT

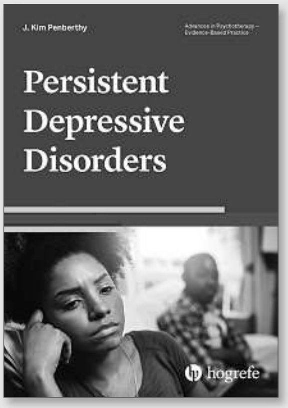
From Your Executive Director: What Your Leadership and Staff Are Working on to Serve You Better

Mary Jane Eimer, *Executive Director*

WE DID IT! ABCT offered its first virtual convention, and the majority of our attendees were satisfied, according to evaluations and feedback. Thank you Shannon Wiltsey Stirman, Program Chair; Daniel Cheron, Associate Program Chair; and all of our members for accommodating the extra effort required by the Cadmium system, the additional time required to prerecord or record "live!," and being flexible. Staff are coming down the home stretch in reviewing and editing the 40 Zoom-based webinars.

Thank you, President Antony, for producing an opening ceremony and shaking things up by presenting your Presidential Address Wednesday evening. And thank you to Katharina Kircanski, our Convention and Education Issues Coordinator, who presented an orientation session for our virtual format and worked closely with our committee chairs: Brian Baucom, AMASS; Samantha Farris, Institutes; Courtney Benjamin Wolk, Master Clinician Seminars; Cole Hooley, Research and Professional Development Seminars; and Christina Boisseau, Workshops (mini and 3-hour ticketed). Special thanks to Abby Adler, our Local Arrangements Chair, who helped staff in identifying appropriate audiences for our virtual format and helped organize our first virtual Saturday-night party. And thank you to an outstanding Program Committee who reviewed the submissions. It does take many dedicated and generous members to develop the content for our Annual Conventions. Your service to ABCT is greatly appreciated.

I also want to acknowledge our amazing staff, who took on added responsibilities, learned new systems, white-knuckled our opening sessions, and faithfully came to the office each day to monitor sessions, answer the constant ringing phones to help members and nonmembers renew, join, register, gain their access code, and manage this year's process to earn continuing education credits. Kudos and a sincere thank you to my colleagues: Stephen Crane, Convention Manager, for learning how to put on a virtual convention and stay on top of Cadmium complex program; Dakota McPherson, Membership and Marketing Manager, and Veronica Bowen, Membership Services Assistant, for applying their technical skills in helping sort out a few glitches; David Teisler, Director of Communications, and Amanda Marmol, Administrative Secretary, for monitoring a livestream channel and staffing the phones; Stephanie Schwartz, Managing Editor, for her graphic design skills that grace the platform and our website; Kelli Long, Bookkeeper, for nurturing the staff even while she keeps our books in GAAP-approved order; and, of course, Tonya Childers, our Convention Registrar, who was never off the phone and was totally focused on answering questions and solving numerous problems to get our attendees in sessions as quickly as possible. Yours truly also handled several Zoom webinars and monitored a live stream. We also hired 3 temps to help monitor the concurrent sessions. Clearly, it was a team effort.



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Advances in Psychotherapy – Evidence-Based Practice
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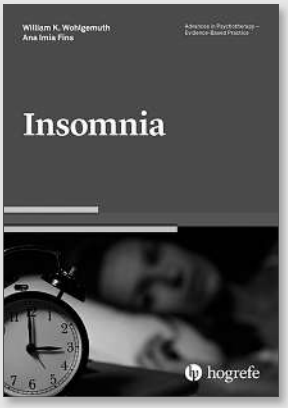

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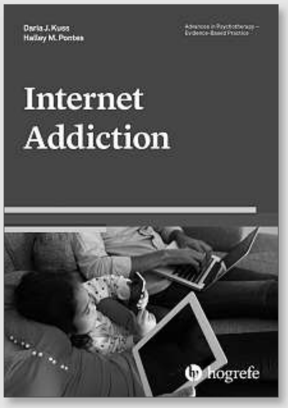

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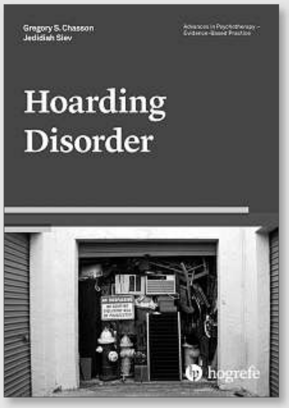

Gregory S. Chasson
Jedidiah Siev
Advances in Psychotherapy – Evidence-Based Practice
Hoarding Disorder
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And then . . . we were hitting our stride with membership renewals, donations to our awards programs, and convention registrations, when *bam*! — a hacker compromised our online store, making fraudulent charges on some members' credit cards. We apologize for the inconvenience and thank our members and convention attendees for their good will and understanding as we sorted out and addressed the problems. We contacted the FBI, FTC, and US Secret Service, the latter of which has jurisdiction over cyber-crimes. Both the FBI and FTC recommended that those whose cards were used to make reports to the FTC and to give and get information from any of the three major credit bureaus. Among those compromised credit cards we were made aware of, the individual cardholders have been contacted by our Director of Communications, David Teisler. He has given formal statements to the FBI and FTC and has spoken with an agent at USSS. We are well aware we are not the first organization they have heard from and it is a long line of organizations ahead of us for further follow-up.

This was an insidious hack—it left no trace. in the past, our systems show an anomaly, but not this time. We are also aware that our firewalls are fighting daily against brute-force attack. We shut down our e-store and had our consultants and staff work to find the problem and determine the solution(s). We understand the need for our membership and professionals to trust our system. So we upgraded systems, added security, and reopened the store, monitoring transactions there and on our merchant portal. As you know from past columns, we are migrating to a new platform in April. There is an awareness of optics and the cost; but we wanted you to have a fully functioning system in the intervening 4 months. We all know that hacking has increased world-wide during the pandemic. All of us are monitoring our credit card usage and bank accounts with a closer eye. staff continues to come to the office, but we are back to a staggered scheduled due to the increased number of COVID cases in NYC, so calling us with your information is still an option in addition to mailing in a check. We're here to facilitate things for you.

Now is the time to look forward. Work is already under way in planning for the November 18-21, 2021, convention in New Orleans' Hyatt, a new venue for us. The portal to submit ticketed sessions opens January 4 followed closely by the general call for papers on February 8. Program Chair Chasson is working with leadership and staff on what an ABCT hybrid meeting would offer.

President Tolin has laid out the broad topics the ABCT leadership intends to address over the coming year. Each standing committee and think tank has a staff liaison to ensure clear communication that runs both vertically and horizontally. Time spent is a precious commodity and we want all of our volunteers to feel their time has been spent in meaningful ways during their service at ABCT. As President Tolin mentioned in his column, many of our committees appreciate more participation from our members. You can contact the chair directly or you can write to me with your interest and skill sets and I can help you identify a committee or two that would benefit from your participation. Feel free to write to me at mjeimer@abct.org.

A top priority for staff over the past year that is continuing in the new year is transitioning to a more robust database system that is fully integrated with a more user-friendly website. Our goal is to have more individual transaction history (capturing the conventions and CE credits), indicating the Special Interest Groups joined, address and email changes updated in real time across various directories available on the web, the ability for staff to update the annual election records directly rather than sending to a third party, and capturing more demographic and biographic information to help ABCT be mindful of our goals for equity, inclusion, and access. In addition to our web editors Regine Galanti, succeeded by Laura Payne, and Associate Web Editors Shelley Avny, Nicholas Crimarco, Courtney DeAngelis, and Miriam Korbman, many of our members have been tapped into service to help us. We have focused on the rather long list of specialties and exploring how professionals and the public use our site and what they might want in the future. We also are expanding our cyber security coverage.

It is no secret that these are turbulent times for you, our members. Thank you for those who have already renewed your membership. For those that have not, I do hope you will do that now. ABCT is a member-driven organization with over 20 standing committees, three journals, two think tanks, and over 40 Special Interest Groups. We are expanding our webinar program to provide quality and diverse presentations and the ability to earn continuing education credits from our live and recorded offerings. We are here for your 24/7—and we are more than our Annual Convention. Don't make this your last issue of *tBT*, dropped from our list serve or your favorite SIG, cut loose from your professional home.

And as mentioned earlier, let us hear from you. A new year brings new goals, aspirations, and hope. I wish you and yours a very happy and healthy new year with COVID-19, one hopes, rapidly becoming a distant memory.

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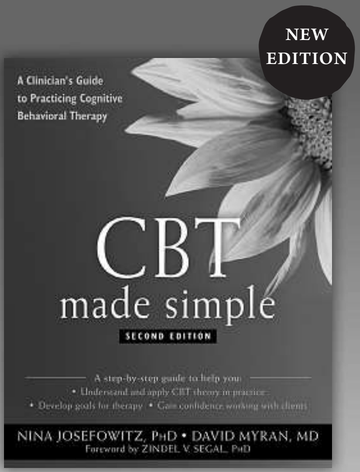
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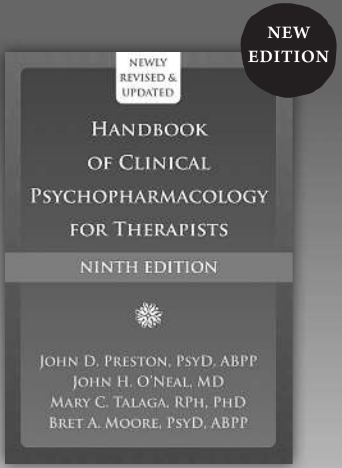
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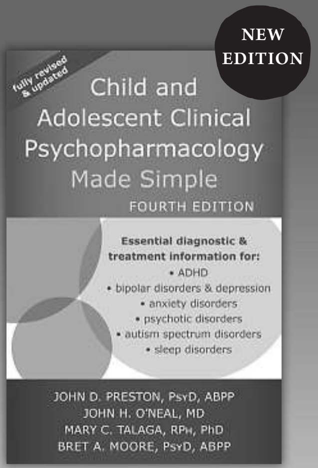
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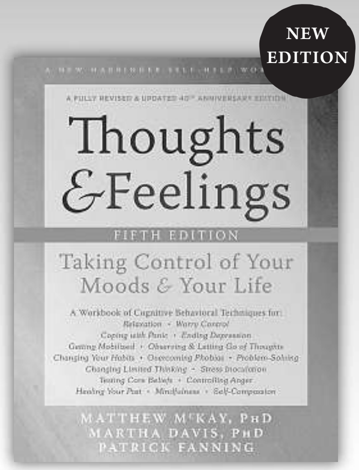
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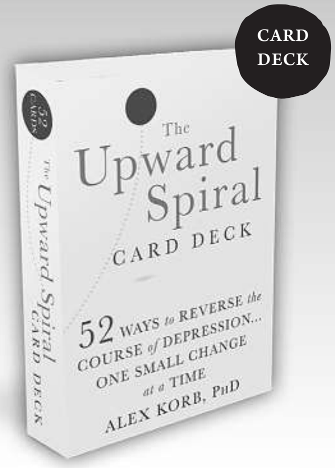
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The Upward Spiral
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52 WAYS to REVERSE the COURSE of DEPRESSION... ONE SMALL CHANGE at a TIME
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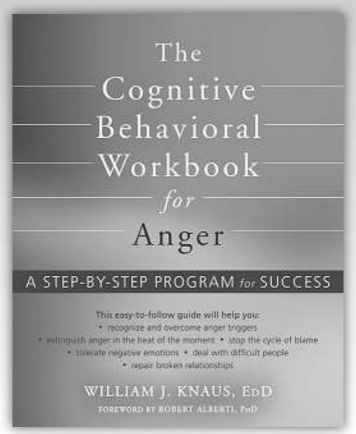
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A STEP-BY-STEP PROGRAM for SUCCESS
WILLIAM J. KNAUS, EdD
FOREWORD BY ROBERT ALBERTI, PhD

Open Pilot Trial of a Single-Session Consultation Service for Clients on Psychotherapy Wait-Lists

Jessica L. Schleider, Jenna Y. Sung, Amanda Bianco, Adam Gonzalez, Dina Vivian, and Michael C. Mullarkey, *Stony Brook University*

THE DEMAND FOR MENTAL HEALTH services dramatically exceeds the number of available providers, rendering months-long waits for therapy the rule, rather than the exception, facing treatment-seeking individuals. In the United States, wait-times for outpatient psychotherapy often span weeks to several months (Blech et al., 2017; Steinman et al., 2015), and waiting for care can itself may cause harm. Longer wait-times are linked to worsening mental health symptoms (Steinert et al., 2017), even when compared to "no treatment" conditions (where individuals do not expect to receive future care (Furukawa et al., 2014), along with smaller symptom improvements and greater odds of premature dropout once treatment is accessed (Reitzel et al., 2006; Swift et al., 2012). Thus, there is a need for efficient, sustainable service-delivery models that enable quick access to treatment for as many patients as possible. Offering interim, low-intensity supports to treatment seekers may help mitigate adverse effects of waiting for longer-term care. To explore this possibility, we tested the acceptability, feasibility, and short-term effects of a solution-focused single-session consultation service, offered to individuals waiting for therapy at two outpatient clinics with mean wait-times of 2 to 6 months.

What Are Single-Session Interventions and Why Deliver Them?

Single-session interventions (SSIs) are defined as "specific, structured programs that intentionally involve just one visit or encounter with a clinic, provider, or program" (Schleider et al., 2020). SSIs may serve as stand-alone programs (e.g., where no other treatment is accessible, as is true for many individuals with mental health needs; Kazdin, 2019) or as adjunctive supports within existing care systems (see Hoyt et al., 2018, for examples of both application types). Evidence supports both applications. SSIs have reduced anxiety, depression, self-harm, and interpersonal challenges, among other psychosocial concerns (Cartwright-Hatton et al., 2018; Davis et al., 2012; Hymmen et al., 2013; Ranney et al., 2017; Schleider et al., 2019). A meta-analysis of 50 randomized trials found a significant, positive effect of SSIs on mental health problems, versus control conditions, at post-intervention ($g = .32$; Schleider & Weisz, 2017)—an effect comparable to that observed for longer-term therapies lasting 16 weeks on average ($g = .46$; Weisz et al.). SSIs may also improve treatment expectancies, which predict subsequent engagement and response (Swift et al., 2012; Thiruchselvam et al., 2019; Wu et al., 2020). For instance, relative to a placebo control, a 15-minute, online SSI teaching that emotions are malleable strengthened adults' beliefs that therapy could be effective (Schleider & Weisz, 2018).

Because SSIs may improve both symptoms and treatment expectancies, delivering an SSI *when individuals initially seek therapy* might augment expectancies for change, capitalize on motivation, and prevent symptom increases while waiting for longer-term care. Hoyt and colleagues (2018) note that SSIs may confer at least three structural benefits if integrated into traditional outpatient clinics: (a) SSIs increase access to immediate support, providing patients with meaningful therapeutic interactions at just the right moment (when they are first compelled to seek support); (b) SSIs may reduce risks of delayed treatment (or prevent overtreatment, as an SSI may be sufficient to address certain patients' needs); and (c) SSI services could provide a valuable clinical training opportunity to trainees, given that weekly therapy is infeasible in many clinical settings (e.g., inpatient clinics, schools, primary care). As such, it is important to identify SSIs best-suited for flexible, broad use across diverse clinical settings—especially SSIs that are easy to implement, requiring minimal training to deliver.

SSIs for Individuals Waiting for Therapy: A Solution-Focused Approach

Although many existing SSIs might be usefully integrated into existing clinical settings, we opted to test a novel "single-session consultation" service (Schleider, 2020; full intervention protocol accessible at osf.io/xnz2t/ and draws heavily from principles of Solution-Focused Brief Therapy; SFBT; Bannink, 2007; De Shazer, 1985). SFBT is focused on identifying and mobilizing a patient's present goals, hopes, and strengths (i.e., a strengths-based, patient-centered approach as opposed to a deficits-focused, therapist-driven approach). Interventions based on SFBT have guided single-session clinical services internationally, though few such services exist in the United States (several exist in Canada, New Zealand, and Australia; see Hoyt et al, 2018, for case examples). Given its emphasis on *present hopes, patient strengths*, and *concrete strategies*, SFBT fits naturally into a single-session format. Therapists help patients identify the tools and capacities they already possess to solve a problem at hand, and to take steps, however small, toward a future in which that problem is less influential. SFBT asserts that all people possess inner resources to solve life's challenges; that one does not need to know what caused a problem (e.g., via comprehensive clinical assessment) to begin solving it; and that the client is expert in their life and best positioned to address their problems (de Shazer, 1985).

We designed the Single-Session Consultation (SSC) as a flexible, SBFT-based program for use with adolescents and adults, regardless of problem type or severity. Using the SSC, therapists help clients identify (1) a specific, modifiable problem (and associated "hope" for their SSC session); (2) the "smallest-possible step" they can take toward overcoming their problem; and (3) a personalized Action Plan, drawing on their inner abilities and external resources to help them enact this smallest-possible step. This process aims to empower the client, helping them realize and mobilize their existing resources to cope more effectively. Notably, the SSC is designed to be delivered by therapists with *any level* of clinical training, from trainees to seasoned professionals, and training is approximately 90 minutes in length (Schleider, 2020). Thus, the SSC is designed for immediate scalability across diverse settings.

Present Study

This open pilot trial examined the feasibility, perceived acceptability, and short-term effects of the SSC service, which was offered to clients on waiting-lists at two outpatient clinics at Stony Brook University across a 6-month period. At both of these clinics, wait-times for psychotherapy average 2 to 6 months. Preregistered hypotheses were as follows (see https://clinicaltrials.gov/ct2/show/NCT04069832):

1. Clinically relevant constructs of hopelessness and perceived agency (primary outcomes) will significantly improve from pre-SSC to immediately post-SSC.
2. SSC participants will view the program as acceptable and useful in addressing their clinical needs, indexed by mean ratings of at least 3.5 out of 5 across the five items (each rated on 1–5 Likert scales) on the "Consultation Feedback Form" developed for this study (available at osf.io/zwphv).
3. The SSC will show feasibility as a service provision model based on patient attendance (i.e., >50% of patients offered the SSC service will elect to receive it, and >75% of clients who schedule an SSC will attend, which would reflect a substantially lower "no-show" rate than average for community-based mental health clinics, where 40-60% of scheduled sessions are attended (Lefforge et al., 2007; Oldham et al., 2012).
4. Clients' overall psychological distress will significantly decrease from baseline to 2 weeks after their SSC.

Last, to explore whether SSC might provide sufficient clinical care for some subset of clients, we documented patients' choices about whether to remain on (or remove themselves from) clinic wait lists 2 weeks after their SSC.

Method

Procedure

All clients 13 years or older who inquired about outpatient therapy services at two outpatient clinics (described below) from September 2019 to February 2020 were offered an SSC. Prospective clients completed a brief phone screen to collect contact information, a brief summary of their primary reason for seeking services, and an abbreviated risk assessment to determine appropriateness for outpatient therapy (versus emergency services if imminent risk is present). If emergency services are not required, clients were placed on clinic wait-lists (estimated at 2–6 months). Clients were then informed of the SSC service and invited to take part in a one-time, face-to-face consultation with a trained clinician while waiting for treatment. Clients expressing interest in the SSC were scheduled for a session within 2 weeks of this invitation, choosing among 6 to 8 preexisting SSC appointment times (1–2 session options per weekday). Clients received confirmation emails shortly after scheduling and 24 hours before their session. Prior to scheduling, clients were informed that the cost of an SSC is identical to the cost for a single session of psychotherapy (between $20 and $65, per the clinics' sliding fee schedules).

Participants were asked to arrive 30 minutes prior to their SSC to complete baseline questionnaires. Upon arrival, after providing informed consent to take part in the SSC trial, participants self-reported overall psychological distress, levels of hopelessness, and levels of perceived agency at baseline. Participants then took part in their 1-hour SSC with a trained clinician. Immediately after the SSC, participants again self-reported levels of hopelessness and perceived agency, along with feedback on the session's acceptability. Participants were then contacted via phone for a two-week follow-up assessment, wherein they again self-reported overall psychological distress and received the option of *remaining on* or *removing themselves from* the clinic waitlist for therapy. Clinic staff attempted to contact SSC recipients up to 3 times for their follow-up call. If no response was received, clients were considered unresponsive and were automatically removed from the clinic waitlist, per both clinics' standard policies.

Clinical Settings

This trial took place at two mental health clinics affiliated with Stony Brook University, the Leonard Krasner Psychological Center (KPC) and the Mind-Body Clinical Research Center (MBCRC). The KPC is the training facility for students in Stony Brook University's clinical psychology doctoral program. Student clinicians provide a variety of evidence-based assessments and therapies, including outpatient services for children, adolescents, and adults under the supervision of licensed psychologists. The MBCRC, housed in the Department of Psychiatry at Stony Brook Hospital, provides evidence-based adult outpatient mental health services and is staffed by predoctoral and postdoctoral trainees, social workers, and clinical psychologists.[1]

Inclusion Criteria

All English-speaking adolescents (age 13+) and adults on waitlists for outpatient therapy services at the KPC and MBCRC received invitations to take part in this study. Child clients < age 13 were not eligible to take part in this study, as the SSC was designed for use with adolescents and adults. Due to unusually low rates of service inquiries from prospective adolescent clients during the recruitment period, all participants in this study were adults (> 18 years). Informed consent was obtained prior to study initiation with each participant.

Therapist Training, Supervision, and Fidelity

Six advanced doctoral student clinicians from the KPC and three postdoctoral clinicians from the MBCRC attended a 90-minute SSC training, led by the first author (JLS). This training provided background information on single-session and solution-focused therapeutic techniques; a step-by-step walkthrough of the SSC program protocol; an overview of potential challenges (and recommended solutions) faced by SSC providers; and guidelines for addressing imminent risk during an SSC session. Clinicians in this study were advised to utilize standard clinic procedures to assess risk in participants reporting non-zero suicidal ideation at pre-intervention. If risk to the client was deemed imminent, clinicians were instructed to prioritize risk management and triage over SSC completion. Although several participants in this study (26.67%) reported passive suicidal ideation at pre-intervention, risk was assessed and deemed imminent in none of these cases, and all of these clients engaged successfully in the SSC.

To promote clinician fidelity, therapists received a step-by-step guide to delivering the SSC in its intended format (available here: https://osf.io/r5gk3/) and an "Action Plan" worksheet to be completed jointly with clients during the SSC (available here: https://osf.io/7jt6m/). The Action Plan is designed to impose a uniform, linear structure onto each SSC while generating a personal coping plan for each client. Action plans were successfully (at least 80%) completed for all SSC sessions in this study, suggesting fidelity to the intended format. Additionally, all SSC sessions delivered at the KPC (23 of 30 in this study) were video-recorded for supervision purposes and viewed in full by the first author (JLS). Consistent with the successfully completed Action Plans, recordings suggested therapists' fidelity to the SSC structure.

Single-Session Consultation Overview

The SSC is designed to last approximately 1 hour, although a session may last 30–90 minutes, depending on clinical setting, client needs, and therapist availability. Below we summarize the key tasks within an SSC. A more comprehensive description of the SSC and its delivery, including example responses to client concerns, strategies for incorporating strengths-based language throughout the intervention, and solutions to common problems, is available in the open-access SSC manual: https://osf.io/tua4h/.

After briefly assessing readiness to engage in the SSC (i.e., assessing imminent risk, which takes precedence over the SSC if present), the SSC therapist briefly introduces the purpose and parameters of the SSC; sets client expectations (i.e., this session will not become a long-term therapeutic relationship; it is simply a means of providing short-term support while you are waiting for services); praises the client for taking initiative to engage in the SSC; and introduces the Action Plan, which will guide the session's structure and will be completed jointly over the upcoming hour. Next, the client is asked to identify their top problem in the present moment (which led them to seek services), along with their top hope for today's session (framed as a discrete, tangible step they would like to take towards a future where their top problem is more manageable). If needed, the therapist redirects the client to identify a top problem and commensurate top hope that is modifiable—i.e., changeable via personal effort. Examples for ways to reframe "external" top problems to relatively "internal" alternatives are noted in the SSC manual.

Next, the clinician poses the "miracle question," a common SFBT technique: *Imagine that a miracle occurs overnight; while you are sleeping, your reason for seeking services has completely disappeared. When you wake up, how will you know that there has been a miracle? What will you do, think, or feel differently?* The therapist supports their client in crafting as vivid a description as possible of their "miracle day" wherein their top problem is absent. Next, the therapist asks the client to rate, on a 1-to-10 scale, "how close they are to [their] miracle day" at the present moment, with "10" representing their problem having disappeared entirely, and "1" representing their problem being at its worst (completely incapacitating). The remainder of the session is dedicated to crafting a personalized Action Plan, geared towards

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[1] There were no significant differences across clinics in uptake of the SSC when offered, but a larger number of clients at the KPC (versus the SSC) were offered the SSC, as there were more staff members available at the KPC to assist with recruitment calls for this study. We were unable to examine differences in outcome by clinic, as only 7 individuals completed the SSC at the MBCRC; thus, results of statistical tests would have been uninterpretable.

helping the client “move up by just one point on your Miracle Day scale”—for instance, if a client rates themselves at a “4 out of 10” in terms of closeness to their miracle day, their plan is geared towards supporting them in reaching a “5 out of 10.” The Action Plan includes up to three concrete things that the client can do (including where and when they will do those things) to increase their miracle day scale rating by a single point. Therapists encourage the client to choose Action Plan strategies reflecting small steps they have taken before (e.g., based on times when their miracle day scale rating was slightly higher than today’s rating), drawing on the client’s existing strengths, habits, connections, and coping skills as heavily as possible. Clients are also guided to identify two people or community resources that can help them implement their plan. Once the Action Plan is constructed, the client is asked to identify an inner obstacle that may keep them from following through with their plan: a “thought, feeling, or bad habit that could get in the way” of carrying out the Action Plan as intended. Upon identifying an inner obstacle, the client is asked to generate a “phrase, thought, or action to help them overcome their inner obstacle.” The therapist works with the client to help them generate an inner obstacle that feels personally important, and to craft a way to overcome it that “rings true” to them.

Upon ending the SSC, the therapist takes a few moments to write a personalized note to their client at the bottom of the Action Plan worksheet. This note is written in the second person (using “you” pronouns) and identifies two specific reasons why the clinician personally believes that the client is capable of following-through on their action plan, based on their own observations during the SSC. The client receives a copy of their action plan, including the note from their clinician, at the SSC’s conclusion. Clients are also provided with a list of referrals to local emergency services and crisis hotlines and textlines, should they require immediate support before beginning psychotherapy.

Measures

State Hope Scale
(SHS; Snyder et al., 1996)

The SHS is a 6-item self-report measure of agentic, goal-directed thinking. Respondents rate 6 items on a Likert scale from 1 (*definitely false*) to 8 (*definitely true*). Higher mean scores reflect a greater sense of personal agency (i.e., personal capacity to pursue and sense of having attained goals). Scores range from 1–8, with higher scores reflecting greater perceived agency. The SHS was administered at pre-SSC and immediately post-SSC. Internal consistency was α= 0.86 and 0.92 at pre-and post-SSC, respectively.

Beck Hopelessness Scale-4
(Perczel Forintos et al., 2013)

The brief, 4-item BHS asks respondents to report agreement with 4 items on a 0–3 scale. Higher scores reflect greater hopelessness; scores range from 0–12. The BHS-4 was administered at pre- and immediately post-SSC. Internal consistency was α= 0.87 at both pre- and post-SSC.

Brief Symptom Inventory-18
(BSI-18; Derogatis, 2001)

The BSI-18 assesses self-reported psychopathology and distress. It was selected as the primary outcome measure for this study because it is brief, normed on a national U.S. sample of adults, and inclusive of multiple domains of psychopathology (depressive symptoms, anxiety symptoms, somatic symptoms). Respondents rate endorsement of 18 physical and emotional complaints on a 0–4 Likert scale. The total sum score yields an additional total distress score (range: 0–72). Higher scores indicate higher levels of overall psychological distress. The BSI-18 was administered pre-SSC and at 2-week follow up. Internal consistency was α= 0.85 and 0.90 at pre- and post-SSC, respectively.

Consultation Feedback Form

The consultation feedback form, designed for this trial and administered at post-SSC, contains 5 items rated on a 1 (*Not at all*) to 5 (*Very much*) Likert scale, reflecting endorsement of a series of statements about the SSC (e.g., "Did you find the consultation helpful in addressing your concerns?" and "How hopeful are you that the action plan will be useful?" Higher scores indicate greater perceived usefulness of the SSC. Internal consistency was α= 0.86.

Sample Size Justification

We were interested in obtaining precise estimates of feasibility and acceptability outcomes; client satisfaction ratings; and changes in proximal intervention outcomes to aid in the planning of a larger-scale efficacy trial. A sample of 30 participants was sufficient for these objectives, per guidelines for pilot study-planning proposed by Joulius (2005) and Whitehead et al (2016).

Analytic Plan

Per preregistered analyses, we ran two 2-tailed paired samples *t*-tests to assess whether participants’ hopelessness and perceived agency significantly improved from pre- to post-SSC. A pre-post difference with $p < .05$ indexed a significant change, in either case. We next examined Consultation Feedback Form scores; mean scores of >3.5/5 on each item indicated that

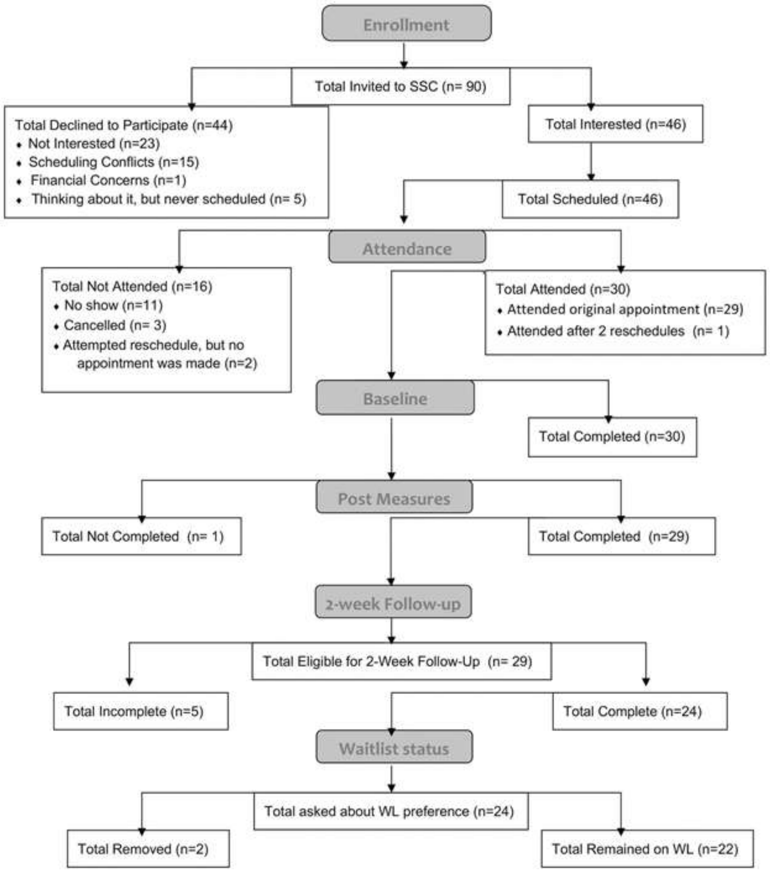

Figure 1. Modified CONSORT diagram illustrating participant enrollment, attendance, and retention patterns

participants found the SSC *more than somewhat acceptable* along all dimensions examined. To gauge service model feasibility, we first divided the number of waitlisted individuals who accepted the SSC invitation by the number of people who received SSC invitations; we then divided the number of people who attended their scheduled SSC by the total number of who scheduled an SSC. An "accepted SSC invitation" rate of >50% and an "attended scheduled SSC" rate of >75% suggested the SSC's feasibility as a service delivery model in these clinics. Last, we ran a 2-tailed paired samples *t*-test to test whether participants' psychological distress (BSI-18 scores) significantly ($p < .05$) reduced from pre-SSC to follow-up.

For paired-samples *t*-tests, the false discovery rate (FDR) was applied to identify potential false-positive results. *Q*-values were computed for *p*-values from *t* tests using an online calculator applying Benjamini and Hochberg's (1995) approach (www.sdmproject.com/utilities/?show=FDR). Results were considered significant if FDR corrected $q < 0.05$.

Results

Anonymized data and code for all analyses are available here: https://osf.io/xnz2t/

Descriptives and Feasibility

Of the 90 treatment-seeking individuals invited to take part in an SSC, 46 (51.11%) expressed interest in receiving one and scheduled an SSC appointment (see Figure 1). Among those who did not schedule an SSC, 23 (25.56%) noted they were not interested; 15 (16.67%) were interested but had conflicts with available SSC time-slots; 1 (1.11%) was interested but cited financial challenges; and 5 (5.56%) expressed possible interest but did not ultimately schedule an SSC. Among those who scheduled an SSC, thirty (65.21%) attended; 11 clients no-showed (with no additional clinic follow-up), 3 explicitly cancelled their SSC, and 1 failed to attend their scheduled session after rescheduling twice. These attendance patterns met our preregistered benchmark for feasibility in terms of interest (>50% scheduled an SSC among those invited) but not for attendance (>75% attendance among those scheduled). Rates of SSC session attendance were within-range of previously reported rates of outpatient therapy attendance in U.S. mental health clinics, where portions of scheduled sessions missed by clients ranges from 40 to 60% (Gopalan et al., 2010; Lefforge et al., 2007).

Table 1 displays demographic characteristics of SSC recipients, who were 31.2 years of age on average (range: 18 - 70) and 73.33% female. At baseline, 8 of 30 participants (26.67%) endorsed recent or current suicidal ideation (i.e., thoughts of suicide were present in the prior 2 weeks), and baseline BSI General Severity Index scores (M = 23.97) reflected mean t-scores > 63 — the established cut-off for "clinically-significant psychological distress" (Derogatis, 2001).

SSC participants presented with a diversity of "top problems." Most commonly, top problems involved interpersonal distress (e.g., loneliness; wanting to cope more effectively with a break-up; loneliness), uncontrollable or generalized worry, depressed mood, sleep disturbances, or academic stress.

Did SSC Recipients Report Improvements in Hopelessness, Agency, and Psychological Distress?

SSC recipients reported significant pre-to post-intervention increases in perceived agency, $d_z = 1.43$, $t(26) = 7.42$, $p < .001$, $q < .001$, and a significant decrease in hopelessness, $d_z = 1.11$, $t(26) = 5.75$, $p < .001$, $q < .001$, with large effect sizes for both primary outcomes. Per common language effect size estimates (Lakens, 2013), hopelessness showed a 86.59% chance of being lower at post- versus pre-intervention, and agency showed a 92.36% chance of being higher at post- versus pre-intervention.

Psychological distress from baseline to 2 weeks post-intervention significantly decreased, with a medium-to-large effect, $d_z = .72$, $t(23) = 3.52$, $p = .002$, $q = .002$. Psychological distress showed a 76.40% chance of being lower at follow-up relative to baseline. Additionally, two of the 24 participants who completed the 2-week follow-up assessment voluntarily removed themselves from their waiting-lists after receiving the SSC, citing reduced perceived need for treatment.

Did SSC Recipients Find It Acceptable?

Participants perceived their SSC sessions as highly acceptable. On a scale from 1 (*not at all*) to 5 (*very much*), participants rated their sessions as "helpful in addressing their concerns," *M*(*SD*) = 4.31(0.76) and as having "helped them develop an action plan to address their concerns," *M*(*SD*) = 4.55 (0.78). Participants generally rated themselves as "hopeful that the action plan will be useful," *M*(*SD*) = 4.07 (0.80), and "motivated to use their action plan," *M*(*SD*) = 4.24 (0.79). All but one of the participants (96.67%) reported that they would "mostly" or "very much" recommend the consultation service to others, *M*(*SD*) = 4.72(0.52). Additionally, several SSC recipients provided positive written feedback about their experience. As examples: "I didn't expect to feel this differently after a single consultation. It's a big relief"; "Great communication, the consultation didn't feel rushed. Everything was patient and led to a new revelation/idea/goal that was set"; "I feel very positive about my plan and I am excited to begin trying it out. Thank you." Other study participants provided either neutral written feedback (e.g., "thank you") or no written feedback. No participants provided negative written feedback on their SSC.

Table 1. Demographics, Individuals Attending an SSC Session

	Full Sample *M* (*SD*) or (%)	KPC Sample *M* (*SD*) or (%)	MBCRC Sample *M* (*SD*) or (%)
N	30	23	7
Age	31.2 (14.9)	26.3 (11.2)	47.0 (15.1)
Sex			
Male	8 (26.7%)	7 (30.4%)	1 (14.3%)
Female	22 (73.3%)	16 (69.6%)	6 (85.7%)

Note. KPC (Krasner Psychological Center); MBCRC (Mind Body Clinical Research Center). Due to the KPC's and MBCRC's transitions to telemental health services in April 2020, data on participants' race/ethnicity (stored on paper documents in both clinics) were inaccessible to the researchers at the time of data analysis for this manuscript.

Discussion

This open pilot trial tested the feasibility, perceived acceptability, and short-term effects of the Single-Session Consultation, a 1-hour solution-focused intervention for adults on waiting-lists for outpatient psychotherapy. Clients who completed the SSC reported significant pre- to post-intervention reductions in hopelessness (d_z = 1.43) and perceived agency (d_z = 1.11), along with significant reductions in psychological distress from pre-intervention to 2-week follow-up (d_z = 0.73). SSC recipients viewed the intervention as highly acceptable, per preregistered benchmarks. Regarding feasibility, attendance patterns met our preregistered benchmark with respect to client interest (51% of those offered an SSC elected to receive one, above our 50% benchmark) but not attendance (65% of those who scheduled an SSC attended one, below our 75% benchmark). Overall, results suggest the SSC's potential utility among high-symptom, treatment-seeking individuals.

Our study, though preliminary, suggests that a novel SSI may help fill gaps in existing services. Given the shortages of mental health providers and needs to expand service access across numerous settings, the SSC might prove helpful within and beyond outpatient mental health clinics. Providers in hospital and primary care settings, where time with patients is limited, may find the SSC's self-contained structure useful. Therapists in this study included both pre- and postdoctoral clinicians, suggesting the SSC's ease of delivery after a 90-minute training. Of course, these possibilities require further study in diverse contexts and populations. We have thus made SSC materials freely available, including SSC training slides, the intervention protocol, the Action Plan, and the Consultation Feedback Form used in this study (https://osf.io/xnz2t/), which we hope spur further tests of the program's potential.

Some aspects of our results warrant further consideration. For instance, due to logistical constraints, we were able to offer clients only a handful of time-slot options for SSC appointments, and those appointments were available in-person only. Walk-in clinics, teletherapy options, and other approaches conferring more flexible scheduling capacity could yield broader SSC interest and improved attendance. Although the SSC attendance rate in this trial (65%) compares favorably with session attendance rates in outpatient mental health clinics nationally (40–60%), alternative delivery models could further boost the SSC's accessibility and uptake—and in turn, its feasibility for clinics to provide.

Separately, most clients in this study chose to remain on their respective therapy waiting lists after completing an SSC. Notably, we do not view this as evidence that the SSC was ineffective. This sample was composed of treatment-seeking adults with no prior knowledge of the SSC, who contacted clinics specifically in pursuit of weekly therapy; thus, their continued interest in this type of treatment is unsurprising. Indeed, the fact that two participants perceived no need for therapy after their SSCs suggests its potential utility, for some, as a stand-alone intervention. As is discussed elsewhere (Schleider et al., 2020), most SSIs may operate as either stand-alone or adjunctive supports, depending on context, setting, and clinical need. This prospect should be explored in future, larger-scale trials of the SSC as a stand-alone support and as a means of enhancing client motivation and engagement once therapy begins.

This study has important limitations. Results of any nonrandomized pilot trial are preliminary. Further, this pilot trial had a relatively brief follow-up period compared the average waiting time for psychotherapy at the participating clinics, and

Table 2. Means, Standard Deviations, and Effect Sizes

	M (*SD*)
Agency	
Pre-SSC	26.30 (8.73)
Post-SSC	19.48 (8.04)
d_z [95% CI]	1.43 [0.88, 1.96]
Hopelessness	
Pre-SSC	5.37 (3.59)
Post-SSC	2.78 (2.50)
d_z [95% CI]	1.11 [0.62, 1.58]
Psychological Distress	
Pre-SSC	25.83 (11.24)
2-weeks	18.00 (11.83)
d_z [95% CI]	0.72 [0.26, 1.16]

a subset of participants were lost to attrition (though no differences emerged in baseline psychological distress levels between participants who did versus did not complete the follow-up assessment). Nonetheless, it is notable that treatment-seeking individuals often report stable or worsening symptoms while waiting for therapy, yet participants in this trial reported symptom reductions 2 weeks post-SSC. Future randomized trials are needed to determine the longevity and robustness of effects observed in this study. Separately, due to the SSC's brief format (and its omission of a formal assessment, which might have lasted longer than the intervention itself), data on participants' diagnostic profiles were unavailable. We thus cannot comment on the SSC's utility as a function of problem type. Anecdotally, study authors (upon viewing video-recorded SSC sessions) and SSC therapists observed that some conditions rendered the program more challenging to deliver. Examples included traumatic brain injury (resulting in memory impairment) and an eating disorder (resulting in medical problems)—both noted spontaneously by SSC recipients during sessions (these two clients were referred to specialty services following their SSCs). At the same time, several clients reporting clinically elevated psychological distress and suicidal ideation engaged successfully in the SSC; thus, clinical severity alone does not appear to preclude acceptability, but formal investigation is needed as to whether the SSC's utility varies by clinical profile.

Overall, results support the Single-Session Consultation's acceptability in a high-symptom, treatment-seeking adult sample. SSC recipients reported improvements in hopelessness, perceived agency, and psychological distress while waiting for longer-term treatment. Both pre- and post-doctoral therapists successfully delivered the SSC following a brief, 90-minute training. Future studies will help gauge the SSC's best-fit applications and potential contraindications.

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LITERATURE REVIEW

Behavioral and Cognitive Therapies in Psychiatric Rehabilitation for the Schizophrenia Spectrum: Finding the Forgotten Stepchild

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ALAN BELLACK famously characterized schizophrenia as cognitive behavioral therapy's "forgotten stepchild" in his 1985 Association for Advancement of Behavior Therapy (later renamed the Association for Behavioral and Cognitive Therapies) presidential address, a characterization that largely rings true today (see Snyder et al., 2016). At ABCT's 52nd Annual Convention in 2019, the president of the ABCT Psychosis and Schizophrenia Spectrum Special Interest Group (PASS-SIG), Dr. Jerome Yoman, co-organized a panel discussion, including senior serious mental illness (SMI) expert panelists (i.e., Drs. Shirley Glynn, Kim Mueser, David Penn, Steven Silverstein, and Will Spaulding), and moderated by one of the authors of this article (Dr. Charlie Davidson). This panel commemorated 50 years of behavioral and cognitive therapies for schizophrenia spectrum disorders (SSDs). It was a lively panel discussion regarding the state of SMI/SSD treatment research (emphasizing effective SSD interventions) and concerns that mental health practitioners and trainees unfamiliar with SMI view SSD as too severe, too distinct, or even too risky to treat (see Combs et al., 2006, for an overview of SMI misconceptions and recommendations).

We pause here to address stigma and related factors that too often preclude an individual with SSD from receiving any type of care (Corrigan, 2004; Corrigan et al., 2014). Rates of institutionalization have rapidly declined since the 1950s, but rates of criminalization of mental illness and accompanying incarceration have increased (e.g., individuals with a mental illness are 50% more likely to receive a jail sentence for a misdemeanor conviction), as are rates of homelessness, and lack of insurance coverage in SSD (Davis et al., 2012; Hall et al., 2019). Individuals with SSD also experience stigma at alarming rates from the general population (Gerlinger et al., 2013) and from primary and mental health care providers (e.g., increased social distancing, stereotyping, and attribution of mental illness; Mittal et al., 2014). However, as our health care systems are increasingly pushed towards more efficient integrated care, clinicians and researchers are more likely than ever to encounter individuals with SSD, a history of psychosis, or psychosis secondary to another condition. A move towards inclusive care for individuals with SSD can decrease barriers to treatment, increase access to medications and effective psychosocial treatments, and combat stigma through increased interactions and visibility of recovery (i.e., if individuals have access to better treatment, providers see more individuals with SSD doing well and modify misconceptions that perpetuate stigma). The present article is a call for clinicians and researchers to reevaluate what they may have learned about SSD. Given the low prevalence rates of SSD, these misconceptions are perhaps not surprising and are likely the result of unfamiliarity rather than ill intentions. To this end, the present review provides a brief background on SSD, an overview of effective behavioral and cognitive treatments, and summarizes integrated services needed to provide truly integrated care for individuals with SSD.

Background

Before proceeding further, we offer a couple of simple definitions. The term "schizophrenia spectrum disorders" encompasses a range of diagnoses including schizophrenia, schizoaffective disorder, and psychosis not otherwise specified, which are diagnosed by the presence of at least one of the following: delusions, hallucinations, disorganized thinking, disorganized or abnormal motor behavior, and negative symptoms (e.g., diminished emotion expression and avolition; American Psychiatric Association, 2013). The term "psychosis" is used to describe conditions that affect the mind where there has been some loss of contact with consensus reality and typically includes symptoms from the aforementioned domains (National Institute of Mental Health, 2019). For this article, we will focus on schizophrenia spectrum disorders (hereafter referred to simply as "SSD") to focus our review of publications and treatment guidelines. Psychotic symptoms exist on a spectrum and are observed across diagnoses with varying severity (e.g., positive symptoms in schizophrenia, grandiosity in bipolar disorders, superstitious beliefs in obsessive compulsive disorder, nihilistic delusions in severe depression, and concern for constant watch by others in social anxiety disorder; see Guloksuz & van Os, 2018). Another term used throughout this review, serious mental illness (SMI), is a term typically associated with mental health policy. It was originally used in federal policy discourse to denote people with SSD and other comparably disabling conditions. For present purposes, "SMI services" refers to people with SSD.

Prevalence and Costs of SSD

Prevalence rates of SSD are relatively low, around 0.5% to 0.75% (Moreno-Küstner et al., 2018; Wu et al., 2006). Yet, SSD remains one of the most impairing and costly diseases, consistently ranked as the 15th leading global cause of years lost to disability (the third leading mental illness diagnosis) since 1990 behind major depression and anxiety disorders, which have prevalence rates at least 10 times greater than SSD (Global Health Metrics, 2017; Greenberg et al., 2015; Remes et al., 2016). An individual diagnosed with SSD will have a life expectancy, on average, 14.5 years shorter than their cohort members, and premature mortality rates exceed triple that of the general population (Hjorthøj et al., 2019; Olfson et al., 2019). One of the misconceptions of premature mortality in SSD is that these deaths are due to suicide, when, in fact, the majority (more than 85%) of these premature deaths are due to natural causes such as cardiovascular diseases (most common), cancer, diabetes, influenza, and pneumonia (Olfson et al.). Actual causes of death in this population seem to reflect a sedentary low-socioeconomic lifestyle and social disadvantage often related to disability rather than violence or substance use. Only one in seven deaths in SSD is related to unnatural causes and suicide makes up only 25% of those deaths with a global prevalence rate of 8.9% in SSD populations (Global Health Metrics, 2017; Walker et al., 2015). In short, suicide and substance use are serious risks for people with SSD, as with other mental illnesses, but they do not account for the much lower life expectancy and substantial impairments observed.

Equally striking are the substantial economic costs associated with SSD. While the prevalence of SSD is less than 1%, annual national economic costs related to direct health care, nondirect health care, and indirect costs (e.g., unemployment, caregiver costs) total around $155 billion (Cloutier et al., 2016). Compared with depressive disorders, with a prevalence rate more than 20 times higher (20.6% prevalence, $210.5 billion estimated economic costs), and anxiety disorders, with a prevalence almost 30 times higher (28.8% prevalence, $46.6 billion estimated economic costs), the economic costs of SSD are staggering (Devane et al., 2005; Greenberg et al., 2015). From both a human life and economic perspective, improving treatment and outcomes for individuals with SSD remains one of our toughest and most pressing challenges as mental health providers and clinical researchers.

Risk of Violence in SSD: Stigma and Misperceptions

Similar to misconceptions regarding SSD and mortality, misconceptions also exist around SSD and risk of violence to others. Despite widespread media attention, reviews of epidemiological data robustly demonstrate that most individuals with SSD are never violent towards others (Swanson et al., 2015). Globally, individuals with SSD were shown to have a 9.9% risk for engaging in violence compared with 1.6% in the general population; however, the meta-analysis presenting this finding cautioned against significant heterogeneity in reports and emphasized the need to examine predictors of violence comorbid with SSD rather than SSD as a stand-alone risk factor (Fazel et al., 2009). For example, this meta-analysis found that elevated rates of engaging in violent behavior may be better explained by substance use. Rates of violence were higher among people with substance use disorder but not SSD (seven times higher than the general population) than among people with comorbid substance use and SSD (five times higher than the general population).

A large prospective study also shed light on the misconceptions surrounding the relationship between SSD and rates of violence (Sariaslan et al., 2016). This study found that it may be more prudent for clinicians to screen for high-risk characteristics more broadly (e.g., recent stressful life events, injury-related events such as self-harm and traumatic brain injury, substance use) rather than screening out individuals with SSD and denying them access to care and research opportunities (Sariaslan et al.).

Considering recent large-scale findings, clinicians and researchers alike are encouraged to rethink excluding individuals from clinical care or research based solely on a diagnosis of SSD. Instead, we advocate for a shift towards more accurate and inclusionary practices such as screening for violence risk factors more broadly (e.g., head injury, PTSD, homelessness, and substance use; Elbogen et al., 2008) and emphasizing individual protective factors (e.g., engagement in treatment, social support) when deciding if a person is an appropriate fit for the risk and liability capabilities of a treatment or research setting. For example, studies may consider excluding individuals based on the level of specific symptoms that may prohibit safe or effective engagement in the intervention (e.g., high scores on hostility, mania, suicidality; see Himle et al., 2019, for an example) rather than an SSD diagnosis.

We pause briefly to reiterate that while there is some evidence for slightly elevated risk of violence in SSD, individuals with SSD and SMI are far more likely (2.3 to 140.4 times higher than the general population) to be victims of criminalization, highlighting that victimization seems to be a greater public health concern among SSD populations than perpetration (Choe et al., 2008; Maniglio, 2009). These rates of victimization are associated with substance use, homelessness, and more severe symptomatology—factors that can be addressed and alleviated if individuals have access to effective treatments and social supports.

Psychosocial Treatments for People With SSD

For organizing research, policy, and practice, behavioral and cognitive therapies are often categorized as psychosocial treatment, in contradistinction to pharmacological (drug) treatment. There have been systematic efforts to identify best practices in the psychosocial treatment domain for SSD, including behavioral and cognitive therapies, e.g., the Patient Outcomes Research Team (PORT; Dixon et al., 2009), Mueser et al. (2013), and the National Institute for Health and Care Excellence in the United Kingdom (NICE; Kuipers et al., 2014). These efforts are comparable to broader efforts to identify and disseminate evidence-based practices in health care more generally and are meant to address persistent difficulties in dissemination of new treatments for SSD (Spaulding & Sullivan, 2016). The following section briefly summarizes these efforts, leading to a current agenda for developing and disseminating practices of known effectiveness. This review is a primer and by no means meant as an exhaustive review of evidenced-based treatment recommendations for SSD. The following sections review psychosocial treatments with consensus across widely disseminated practice guidelines and a focus on services psychologists are uniquely trained to provide (i.e., Dixon et al.; Kuipers et al.; Mueser et al.). Psychosocial Treatments summarizes approaches to specifically target symptoms and functioning related to SSD on an individual level (e.g., CBT), while Integrated Care reviews approaches that target concerns related to or comorbid with SSD symptoms, often in a broader context (e.g., trauma, substance use, family therapy, and supported employment).

Before we begin, it is important to recognize that different psychosocial treatments for SSD target different dimensions of the disorder. Historically, there is a focus on targeting hallucinations and delusions. This focus can ignore impairments in functioning, particularly interpersonal and broader social functioning, which tend to be more disabling and more subjectively distressing to individuals with SSD (e.g., Halverson et al., 2019, Van Rooijen et al., 2019). The rise of the recovery movement, a consumer movement that favors a broader concept of functional recovery (Treichler & Spaulding, 2017), parallels the focus of modern behavioral and cognitive therapies and other psychosocial treatments that address a much broader scope of treatment targets (e.g., symptom management, interpersonal problem-solving, occupational functioning, family relations).

Antipsychotic medications are effective first-line treatments to resolve acute psychotic episodes in the short term and may suppress persistent psychotic symptoms in the longer term. However, effects are heterogeneous across individuals (Citrome & Stroup, 2006), with estimates that half of individuals demonstrate “minimal improvement,” indicated by a 20% reduction in symptoms, while less than a quarter of individuals demonstrate “good improvement,” indicated by a 50% reduction in symptoms (Haddad & Correll, 2018). Rarely are antipsychotic medications alone enough to fully restore premorbid functioning. Additionally, medication benefits target positive symptoms (e.g., hallucinations, delusions, acute behavioral disorganization) with limited effects for negative symptoms (e.g., anhedonia, amotivation) and impairments in interpersonal and social functioning (Haddad & Correll). The latter are significant predictors of functional outcomes in SSD (Fusar-Poli et al., 2015; Nielsen et al., 2015; Sergi et al., 2007). The relative limitations of psychopharmacological treatment for SSD have been an important impetus for development of behavioral and cognitive therapies.

Social Skills Training

Social skills training is a behavioral approach utilizing role-modeling, rehearsal, and corrective feedback to improve skills related to everyday functioning and social interactions and can be administered in individual or group formats. For example, a therapist and client may take turns role-playing how to socialize at an upcoming family event. The therapist may recommend and model different strategies and then switch and have the client try preferred actions while receiving feedback during and after the role-play (e.g., recommending increased eye contact during a greeting to seem more engaged). This approximates methods used for clients with other diagnoses who have social skill deficits but less severe disability. Contemporary social skills training can also target deficits in social perception, social cognitive processes and social anxiety (e.g., Mueser et al., 2013), as well as overt behavior, and is designed to facilitate generalization of new skills to diverse settings and context, and to promote development of a social support network. A recent meta-analysis on skills training supports the PORT (2009) and Mueser and colleagues recommendations, with findings demonstrating improvements in negative symptoms, general psychopathology, and social outcome measures with improvements maintained during follow-up periods (Turner et al., 2018).

Cognitive Behavioral Therapy

CBT treatment research in SSD has been prolific albeit somewhat fragmented and divergent. One direction has focused on positive symptom reduction, using techniques collectively identified as cognitive behavioral therapy for psychosis (CBTp), with demonstrated efficacy reducing positive symptoms (e.g., Turner et al., 2020). Another direction is based on the attribution-focused techniques associated with the work of Aaron Beck and is typically described as recovery-oriented cognitive therapy (e.g., Grant et al., 2014). More direct attention to the cognitive processing deficits of SSDs are also incorporated in conventional group and dyadic CBT modalities, such as social skills training and cognitive process interventions (e.g., Order et al., 2010; Granholm et al., 2016). CBT modalities that directly address motivation, such as motivational interviewing (MI) and acceptance and commitment therapy (ACT), are especially applicable to individuals with SSD, and have an evidence-base for that purpose (e.g., Fiszdon et al., 2016). Therefore, a “CBT” treatment designation in SSD may range widely across studies.

Outcome analyses of CBT for SSD have not always kept up with the diversification of purposes, techniques, and treatment targets. Bighelli and colleagues (2018), in a meta-analysis of over 50 studies, found that CBT for SSD is associated with reductions in positive and negative symptoms and improvements in functioning and quality of life. However, a recent Cochrane review of 36 randomized controlled trials found no added benefits of CBT to standard care (e.g., antipsychotic medication regimen) compared with other psychosocial treatments, often requiring less resources (e.g., social skills training groups; Jones et al., 2019). This conclusion was based on a range of outcomes including symptom reduction, rates of rehospitalization, and emphasized average endpoint scores for functional outcomes rather than individual domains of functioning (e.g., interpersonal functioning, daily living skills). It is also important to note that Jones and colleagues rated most studies as “low” in quality. Reliable meta-analytic studies require inclusion of more rigorous treatment studies and greater sensitivity to the heterogeneity of CBT as applied to the heterogeneous treatment targets associated with SSD.

One final note regarding CBT and SSD. CBT is recommended as an "add-on" treatment for SSD by the National Institute of Mental Health (NIMH) and the National Institute for Health and Care Excellence (NICE; Jones et al., 2019). This is an unfortunate terminological relic of a past era in which symptom reduction was considered the most important outcome (rather than functional recovery). The term "add-on" also ignores the importance of improved symptom management in individuals with symptoms refractory to drug treatment (i.e., symptom reduction does not meet a clinically defined "good response" but symptoms are stable and overall functioning is improved).

First-Episode Psychosis

A clinical practice guideline for treating schizophrenia perhaps less known to practitioners outside of SMI specialty care is the need for distinct and comprehensive coordinated care programs specifically for individuals experiencing first-episode psychosis (FEP). Typically, the designation of "FEP" is used to refer to individuals with SSD experiencing illness onset within the past three to five years. Individuals in the early stage of SSD present with unique treatments needs (e.g., emphasis on low-dose psychopharmacological treatments to minimize side effects and decrease nonadherence, delivery of services in a group setting with other young persons, family involvement, emphasis on school and work functioning; for a brief review see Mueser & Cook, 2014), and interventions addressing these unique treatment needs show improved outcomes and reduced symptoms (Kane et al., 2016).

FEP programs today trace back to the work of Dr. Patrick McGorry and his group in Australia and their work with the Early Psychosis Prevention and Intervention Centre (EPPIC; McGorry et al., 1996). EPPIC was the first comprehensive program targeting early detection and intensive treatment of psychosis with novel treatment components including family therapy, vocational rehabilitation, and peer support. The success of EPPIC in Australia prompted a roll-out of programs in the United States emulating the EPPIC model (Breitborde & Moe, 2016). Two of the most well-known FEP studies in the United States include the large-scale randomized controlled trial, Recovery After an Initial Schizophrenia Episode (RAISE) initiative (Kane et al., 2015) and the large-scale implementation study OnTrackNY (Bello et al., 2018). The RAISE Study implemented a treatment recovery program of coordinated specialty care called NAVIGATE, which comprises medication management, individual and family therapy, and supported employment and education. The NAVIGATE model emphasizes shared decision-making, resiliency, psychoeducation, and CBT methods. The RAISE Study randomized 34 clinics around the country to deliver NAVIGATE or traditional community care from 2010–2014. Results demonstrated the NAVIGATE model improved quality of life, decreased symptoms, improved involvement in work and school and increased treatment retention (Kane et al., 2016). This model of coordinated specialty care is also cost-effective and efficacious, demonstrating improved outcomes compared with treatment as usual (Correll et al., 2017; Rosenheck et al., 2016). Since the inception of RAISE, clinics around the country have adopted this model of recovery, and the availability of FEP clinics is rapidly growing (Azrin et al., 2016). It should be noted that the dissemination of RAISE was spearheaded by Dr. Robert Heinssen at NIMH, who founded the SIG in 1990 and was its chair until 1996; his advocacy and policy work with congress resulted in the Consolidated Appropriations Act of 2014 that provided funding to support the implementation of evidence-based programs for individuals with SSD.

These psychosocial treatments are based on recommendations from consistent findings of large-scale studies (either large sample sizes or a large combined sample of smaller studies). Therefore, a quick note is warranted that this is by no means an exhaustive list of efficacious psychosocial treatments for SSD (other effective psychosocial treatments that may be of interest to readers include therapies targeting neurocognition, social cognition, and metacognition). As researchers and clinicians continue to develop and disseminate new treatments, more information is continually made available on which to base more definitive clinical practice recommendations. Readers are also cautioned that SSD is a heterogeneous diagnosis and therefore a "one size fits all" approach risks policy reforms advantageous to a majority at the expense of a significant minority (Spaulding et al., 2010). New treatments will invariably create subsets of individuals with refractory forms of SSD that do not respond to these new treatments, which can lead to further stigmatization (Spaulding et al.). Treatment recommendations impact administrative decisions and "too often, administrators perceive mental health services to be like commodities like pork bellies and iron ore—generic and invariant in quality and cost-effectiveness" (Spaulding et al., p. 5). Therefore, clinicians and researchers are advised to carefully consider the effects of advocating for novel and "tried and true" interventions alike.

Integrated Care

Psychiatric Rehabilitation

Psychiatric rehabilitation was arguably the first integrated approach to treatment in SSD and still serves as a paradigm for systematic integrated care. It is notable that most or all empirically supported treatments integrate easily within a larger psychiatric rehabilitation program. It is broader than a "treatment" modality. This approach derives from the same roots as modern behavioral therapies, including its conceptual basis in social learning theory, individualized functional assessment, use of evidence-based interventions for specific purposes, emphasis on patient perspective and values, and objective evaluation of progress toward operationalized outcomes (Spaulding et al., 2003). Psychiatric rehabilitation emphasizes the importance of a multimodal approach to assessment and treatment and balances pharmaceutical levels of intervention with behavioral, cognitive, and socio-environmental levels as well as conceptualization of SSD as a disability to be overcome rather than an incurable disease. Central to the approach of psychiatric rehabilitation is the idea that a diagnosis of SSD reflects impairment across multiple domains. Prior to the deinstitutionalization of SSD in the 1950s, psychiatric rehabilitation involved integrated, interdisciplinary teams, able to target impairment on multiple levels. However, this integrated approach became more difficult after deinstitutionalization. While large-scale health care systems still implement integrated programs of care with success (e.g., Veterans Health Administration; Goldberg & Resnick, 2010) community care has become increasingly specialized and compartmentalized so that today there is a need to restore the integration factor to community-based care.

Specialized packages of evidence-based integrated services, such as RAISE, can be conceptualized as contemporary models of psychiatric rehabilitation for first-episode psychosis (FEP). And, while the effectiveness of the integrated RAISE model was previously discussed in the context of FEP, there is also strong support for the efficacy and sustained durability of integrated care for more chronic SSD compared with treatment-as-usual (e.g., Malm et al., 2003; Schöttle et al., 2013).

Family Therapy

Recommendations from both PORT and the RAISE initiative highlight the importance of family support interventions to improve outcomes for individuals with SSD in both early and chronic stages of illness (Dixon et al., 2009; Dixon et al., 2018). SSD is marked by a change in functioning (e.g., loss of job, withdrawal from school) and family members become integral sources of support, ranging from assistance with daily activities to active participation in treatment. Family therapy can range from a modest amount of education for family members about the nature of SSDs and the requirements for recovery to the behavioral interventions that comprise behavioral family therapy (BFT). In addition to information about the disorder, BFT involves functional analysis of particular behaviors that cause family stress and conflict, identification and change of beliefs and attitudes that drive reactions, strengthening collective problem-solving and communication skills, and negotiating normal developmental transitions complicated by the onset of psychosis (e.g., Mueser & Glynn, 1999). Family therapy is shown to decrease frequency of relapse, increase treatment adherence, decrease social impairment, and improve family member outcomes such as perceived burden of caregiving and well-being (Claxton et al., 2017; Pharoah et al., 2010; Weisman de Mamani et al., 2014).

Trauma

The role of trauma in SSD is also worthy of mention here. Roughly 30–60% of individuals with SSD endorse a history of trauma and/or meet diagnostic criteria for PTSD (Mauritz et al., 2013). Theoretical models propose that PTSD worsens the severity and course of SSD through direct effects (e.g., overarousal, reexperiencing trauma) as well as indirect effects (e.g., substance abuse, retraumatization, poor working alliance with care providers), and PTSD in SSD is linked with more severe depression, higher rates of stigma, and treatment underutilization in both early and chronic SSD highlighting the importance of interventions targeting trauma (DeTore et al., 2019; Mueser et al., 2002; Mueser et al., 2004). While many SMI clinicians are familiar with evidence-based trauma interventions, these treatments (e.g., cognitive processing therapy, prolonged exposure) require specialized training and structured sessions, which may not be feasible or accessible during regular group or individual sessions. Individuals with SSD may be underrepresented participants in exposure-based therapies due to perceived risk based on stigmatized misperceptions; however, evidence-based trauma interventions such as prolonged exposure have been shown to be safe, effective, and feasible with individuals with SSD (De Bont et al., 2016; Van Den Berg et al., 2015). These findings suggest individuals may benefit from work with both their primary SMI provider and participation in time-limited (e.g., often 8 to 12 sessions) trauma interventions with clinicians trained in evidence-based treatments.

Substance Use

Both PORT and RAISE recommendations highlight the need for psychosocial treatments addressing co-occurring substance use, and a comprehensive review of the literature suggests around 42% of individuals (22% in women) with SSD have a co-occurring substance use disorder (Hunt et al., 2018). This problem exploded in the wake of deinstitutionalization. Similar to PTSD, many SMI clinicians have experience assessing and treating substance use, but there is an urgent need for providers with expertise in substance use and misuse to deliver this treatment to SSD populations. The feasibility and efficacy of integrating treatments targeting substance use in SSD is well-established (e.g., Drake et al., 2004; Lubman et al., 2010). However, more research is needed to recommend specific interventions. Current evidence suggests optimal outcomes are achieved with effective antipsychotic medication regimens and addiction-based psychosocial interventions; however, the definition of "addiction-based psychosocial interventions" is broad (Crockford & Addington, 2017). Currently, best-practice recommendations emphasize an integration of substance use treatment with mental health services, a low-stress and harm-reduction approach, enhancing motivation, CBT to improve interpersonal and coping skills, supporting functional recovery (e.g., improving quality of relationships and supported employment), and engagement of an individual's social network (Mueser & Gingerich, 2013). As with SMI treatment generally, integrated treatment appears crucial when substance use is co-occurring.

Supported Employment Services

The unemployment rate in SSD is alarming, with some estimates as high as 58% (Cloutier et al., 2016) despite consistent support across decades of research demonstrating that individuals diagnosed with SSD want to work (Crowther et al., 2001). This statistic is also troubling considering meta-analytic evidence illustrating the success of employment interventions with competitive job placement and retainment (Carmona et al., 2017). Today, recommendations for vocational rehabilitation focus on supported employment and are based on the Individual Placement and Support model, which emphasizes collaborative job searches for competitive jobs informed by client preferences (Khare et al., 2016). Recommendations for successful supported employment also highlight the need to integrate cognitive remediation to improve cognitive abilities necessary for successful job performance (Lystad et al., 2017; McGurk et al., 2017). Despite improved outcomes (e.g., Schennach et al., 2012), access and awareness of these important services remain limited. The importance of supported education and employment in SMI treatment also highlights the general importance of multidisciplinary teams in integrated care; occupational therapists, social workers, and other professions are often crucial to an individual's recovery (e.g., Kuipers et al., 2014).

Concluding Remarks

This review is a primer and by no means meant as an exhaustive review of SSD generally, evidenced-based treatment recommendations, or efficacious integrated services for people with SSD. Although the present review focuses on services psychologists are uniquely trained to provide, several other modalities are often critical elements of effective and integrated treatment (e.g., Assertive Community Treatment, Cognitive Remediation). Contrary to public perceptions that SSDs are permanent and only amenable to medications, evidence of recovery and the foundations of these psychosocial approaches have been around for half a century (Allyon & Azrin, 1968). Our hope in presenting this primer is to increase awareness, combat stigma, provide exposure to helpful literature and resources, and perhaps encourage clinicians to participate in care of individuals diagnosed with SSD, thereby increasing accessibility to treatment. Individuals with SSD are underserved in our communities but there is vast potential for improvements in quality of life, meaningful relationships, and competitive occupational pursuits. Moreover, in our personal and professional experience, working with these individuals and their families is immensely rewarding, as we perform our roles as mental health providers and clinical researchers.

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CLINICAL PRACTICE FORUM

A Call for Compassion: Evidence-Based Strategies for Working With Autistic Clients Without Co-occurring Intellectual Disability in Therapy

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AUTISM SPECTRUM DISORDER is a lifelong neurodevelopmental condition that affects approximately 1 in 54 eight-year-old children in the United States (Maenner, 2020) and is characterized by distinct social and communication challenges in tandem with restricted interests and/or repetitive behaviors (American Psychiatric Association, 2013). The last decade of clinical research has illuminated that mental health concerns are highly prevalent and may present differently in autistic people compared with the general population (e.g., Hollocks et al., 2019). Few providers, however, receive training in working with autistic clients (Maddox, Crabbe, Beidas, et al., 2019; Maddox, Crabbe, Fishman, et al., 2019). As such, there is a need for training in working effectively with autistic people among mental health providers. It is important for providers to have a foundational knowledge of and comfort in working with autistic people. This article is intended to provide concepts relevant to the aforementioned knowledge and comfort.

While mental health providers are often taught to view autism through the lens of the medical model—as a disorder to be prevented or cured—the social model provides another perspective. The social model of disability identifies that challenges arise from the person-environment fit (Goering, 2015). The neurodiversity, or autism rights, movement, driven by autistic self-advocates, seeks to highlight the strengths and talents of autistic people and to celebrate autism as natural biological variation (Jaarsma & Welin, 2012; Kapp et al., 2013). Congruent with this, labels of "high" and "low" functioning do not accurately reflect unique strengths and differences of autistic people. This, along with the incongruence between functional abilities and intelligence in autism, has led to autistic self-advocates and researchers alike to recommend that we stop using these terms (Alvares et al., 2019; Kapp, 2018). In addition, many autistic self-advocates have voiced their preference for identity-first, as opposed to person-first, language, highlighting that autism is a core component of their identity (Kapp et al., 2013). In this paper, we use identity-first language (i.e., "autistic client") to respect this stated preference. In the therapy setting, we recommend that providers explore each client's preference.

Competence in Working With Autistic Clients in Therapy

The high rates of mental health concerns among autistic people (Hollocks et al., 2019; van Steensel et al., 2011), coupled with mental health providers' reports of limited knowledge, experience, competence, and confidence in working effectively with this population (Maddox, Crabbe, Beidas, et al., 2019; Maddox, Crabbe, Fishman, et al., 2019), leave many autistic people without access to adequate mental health care (Crane et al., 2019). In fact, autistic people may be turned away by professionals who feel they lack expertise in working with this population (Lipinski et al., 2019). Commensurate with this, a lack of training in neurodevelopmental disorders was recently identified as a concern among health providers generally (Morris et al., 2019), and autistic adults feel as though mental health providers are not well-trained in working with autistic people (Camm-Crosbie et al., 2018). For instance, one autistic adult stated:

> The biggest difficulty in getting the support I need is the lack of understanding of autism. Even after

> decades of research, many institutions still don't have the first clue in dealing with such a condition . . . (Camm-Crosbie et al., p. 5)

The lack of competence in autism and resulting dearth of mental health services for autistic people presents an immediate and urgent need for mental health providers to receive adequate training to develop competence in working with autistic people and to implement treatments effectively for this population.

In this paper, we provide a brief overview of the literature on the prevalence, assessment, and treatment of the most commonly identified co-occurring mental health concerns in autism to provide context and operational definitions for the reader. Thereafter, we provide a set of strategies, guided by the treatment literature for this population, that mental health providers may draw upon in their work with autistic clients. The focus here is on psychotherapy; however, the strategies below will likely prove helpful to psychiatrists and primary care physicians as well as psychologists, counselors, social workers, and other mental health providers.

Co-occurring Mental Health Concerns in Autism

As described above, autistic people commonly experience co-occurring mental health concerns. Historically, diagnostic overshadowing—when the salience of one disorder limits consideration or recognition of another disorder (Matson & Williams, 2013)—resulted in these co-occurring symptoms going undetected. In fact, prior to the current diagnostic manual (DSM-5), autism and attention-deficit/hyperactivity disorder (ADHD) could not be diagnosed together (American Psychiatric Association, 2013). Recently, there has been more widespread recognition of these co-occurring mental health concerns in autism. The areas with the most established lines of evidence are co-occurring ADHD and anxiety, in particular among youth. Recently, more attention has been paid to co-occurring depression and suicidality, and a new area of focus is co-occurring posttraumatic stress disorder (PTSD). This research on etiology, mechanisms, and measurement has led to improved identification of mental health concerns among autistic people and prompted a burgeoning line of research on treatment strategies for these clinical presentations. Of note, in assessing co-occurring mental health concerns, we encourage clinicians to utilize measures that have been created for or validated with this population, when possible, as the literature suggests these tools may function differently among autistic people (Cassidy et al., 2018a, 2018b; Hoover, 2015; Magiati et al., 2017; Schiltz et al., 2019; Yerys et al., 2017).

Co-occurring ADHD

The combined prevalence of ADHD and autism is strikingly high. Estimates range from 12–86% of autistic youth meeting criteria for ADHD, depending on the subtype examined (Gadow et al., 2005; Lee & Ousley, 2006; Mattila et al., 2010). In the general population, the estimated prevalence of ADHD is 5% of children and 2.5% of adults (American Psychiatric Association, 2013; Polanczyk et al., 2007). As neurodevelopmental disorders, the functional presentation of ADHD and autism may be closely intertwined, and thus, core symptoms must be considered carefully. In particular, attention to a person's behaviors within the social context is crucial, as endorsement of a symptom may be related to social difficulties inherent to autism versus inattention or impulsivity pertaining to ADHD (Yerys et al., 2017).

In addition to psychopharmacology, treatments for ADHD rely heavily on behavioral strategies for parents of children (e.g., Chronis et al., 2004), and cognitive-behavioral approaches for adults (Goode et al., 2018). While few studies have evaluated nonpharmacological treatments specifically designed for children with combined autism and ADHD (Antshel & Russo, 2019), parent training programs have been tested among parents of autistic youth and disruptive behaviors, demonstrating preliminary evidence for symptom improvement (e.g., Bearss et al., 2013; Lecavalier et al., 2017). Unstuck and On Target is an intervention designed to improve executive functions among autistic children—which are additively compromised among children with combined autism and ADHD (Antshel & Russo, 2019). Unstuck and On Target has been shown to improve higher-order executive functions, including problem-solving and organization among autistic children (Cannon et al., 2011; Kenworthy et al., 2014).

Co-occurring Anxiety

The estimated rate of co-occurring anxiety among autistic youth is approximately 40% (van Steensel et al., 2011). This is in contrast with just 7.1% in the general population (Ghandour et al., 2019). Less is known about rates of anxiety among autistic adults, but estimates are approximately 33–50% (Hollocks et al., 2019; Uljarević et al., 2019; White et al., 2018). Importantly, anxiety symptoms may be difficult to tease apart from autism symptoms and/or may present differently in autistic people compared with the general population (Kerns et al., 2014). Thus, careful assessment is crucial due to the intricacies of disentangling the two syndromes (American Psychiatric Association, 2013; Kerns, Rump, et al., 2016; Spain et al., 2018).

Researchers have developed several interventions to address co-occurring anxiety, and studies have demonstrated their efficacy, mostly among autistic youth. These interventions include: Facing Your Fears (FYF; Reaven et al., 2012), Behavioral Interventions for Anxiety in Children with Autism (BIACA; Storch et al., 2013; Wood et al., 2009, 2015), and the Multimodal Anxiety and Social Skills Intervention (MASSI; White et al., 2009, 2013). Delivery of these interventions varies from group-based (FYF), individual (BIACA), or a combination (MASSI). Although treatment programs differ in delivery modality and session content, common components are evident. In particular, these treatments are based in cognitive-behavioral theory and employ techniques commonly used to treat anxiety in the general population (i.e., relaxation, exposure with response prevention, cognitive restructuring). A recent randomized clinical trial examining Coping Cat (Kendall, 2006)—an intervention designed to treat anxiety disorders in youth—and BIACA found that both interventions were efficacious at reducing clinically elevated anxiety, compared to treatment as usual, although BIACA showed some additional benefits (Wood et al., 2019). Manuals for Facing Your Fears and Coping Cat are available for purchase, and training in BIACA is publicly available online.

Co-occurring Depression and Suicidality

Co-occurring depression occurs at rates of approximately 22–72% among autistic youth, depending upon age and IQ (Mayes et al., 2011), compared to only 3.2% in the general population (Ghandour et al., 2019). Among autistic adults, estimates indicate a current and lifetime prevalence of 23% and 37%, respectively (Hollocks et al., 2019). Depression may be linked with social challenges common among autistic youth and adults, including perceived group affiliation, loneliness, and social support (Hedley et al., 2017, 2019; Hedley, Uljarević, Foley, et al., 2018; Hedley, Uljarević, Wilmot, et al., 2018; Hedley & Young, 2006; Uljarević et al., 2019). Within the past few years, suicidality has been identified as a highly prevalent concern among autistic adults (Cassidy, Bradley, Shaw, et al., 2018; Cassidy et al., 2014; Hedley et al., 2017; Hedley, Uljarević, Foley, et al., 2018; Hirvikoski et al., 2019; Kirby et al., 2019), and qualitative research has concerningly identified these adults receive little support for suicidal ideation and self-harm (Camm-Crosbie et al., 2018). As yet, few tools have demonstrated strong psychometric properties in capturing co-occurring depression or suicidality (Cassidy, Bradley, Bowen, et al., 2018a, 2018b), and careful assessment is merited given that some symptoms of depression can be conflated with autism (e.g., temper tantrums in children, social interest versus anhedonia among youth or adults; American Psychiatric Association, 2013).

Despite the high co-occurrence of depression and links with self-harm (Hedley, Uljarević, Wilmot, et al., 2018) and suicidal ideation (Hedley et al., 2017), there is considerably less empirical evidence on the treatment of co-occurring depression compared to anxiety (White et al., 2018), with much of it focused on autistic adolescents and young adults. Evidence indicates that group-based cognitive-behavioral therapy (CBT) (McGillivray & Evert, 2014; Santomauro et al., 2016) and mindfulness-based therapy (Sizoo & Kuiper, 2017; Spek et al., 2013) show modest and comparable improvement in depressive symptoms among autistic adolescents and young adults (Sizoo & Kuiper, 2017). It has been theorized that a mindfulness-based approach might offer treatment gains similar to a traditional CBT approach when addressing depression in autism (White et al., 2018). Unfortunately for our autistic clients currently suffering with this presentation, much remains to be learned about efficacious treatment for co-occurring depression and suicidality across the lifespan.

Co-occurring PTSD

Autistic people are more likely to experience traumatic events (Brenner et al., 2018; Kerns, Newschaffer, et al., 2015; Mandell et al., 2005) and adverse childhood experiences (ACEs) than the general population (Berg et al., 2016; Hoover & Kaufman, 2018; Rigles, 2016), placing them at an elevated risk for developing co-occurring PTSD (Roberts et al., 2015). Assessing PTSD among autistic youth and adults may be challenging, as recent literature suggests that PTSD symptoms may present differently among autistic people than in the general population (Haruvi-Lamdan et al., 2018; Hoover, 2015; Kerns, Newschaffer, et al., 2015). Adding to this challenge, there is a lack of validated PTSD measures in this population (Hoover, 2015), however, a recently developed interactive trauma-scale (Hoover & Romero, 2019) shows promise, boasting satisfaction among autistic youth and good psychometric properties (internal consistency and validity). More research is needed to clarify the presentation of co-occurring PTSD symptoms in autism for accurate diagnostic assessment.

In terms of treatment for co-occurring PTSD, much of the research is in its early stages and, while promising, it is too soon to identify which treatments are efficacious. Single case and case series design studies have pointed to preliminary evidence for the effect of CBT in this population (Carrigan & Allez, 2017; Weiss & Lunsky, 2010). Researchers have also put forth recommendations for modifying the treatment of co-occurring PTSD (Peterson et al., 2019; Stack & Lucyshyn, 2019); these include cognitive, behavioral, and affect regulation strategies shown to be efficacious for autistic people.

Implications for Providers

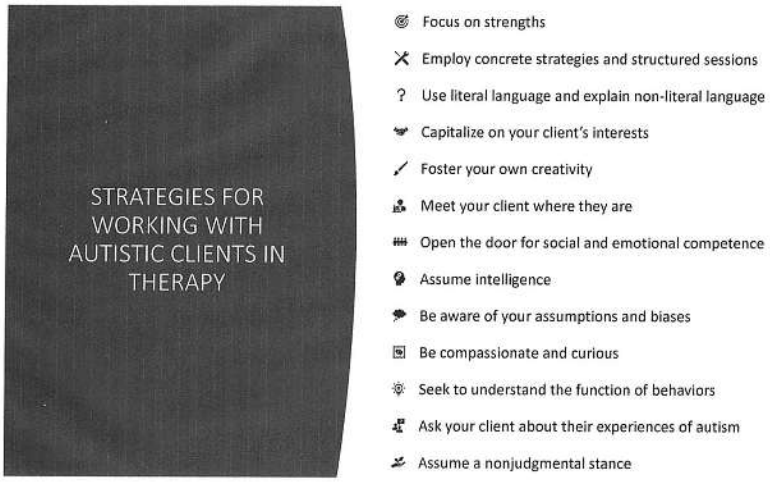
Co-occurring mental health concerns are highly prevalent and often challenging to accurately assess among autistic people, yet there is burgeoning evidence for successful treatment of these concerns via interventions designed or modified for this population. Common elements in the treatments described above are well within reach for mental health providers. Recognizing and employing these strategies can help to close a critical gap in the mental health care of autistic youth and adults.

Recommended Strategies for Competence in Working With Autistic Clients

Considering empirical evidence from the field, including the studies of adapted intervention described above, we provide below a set of recommended strategies for working effectively and compassionately with autistic clients without intellectual disability in therapy. *Cognitive-Behavioral Therapy for Adults With Autism Spectrum Disorder* (Gaus, 2019) is an excellent resource, and we encourage readers to review this text as well. Here, we hope to provide broad recommendations that may be utilized in conjunction with treatment modalities including, but not limited to, CBT with autistic people across much of the lifespan. Please note that some of these techniques remain largely theoretical for much of the autism population—as stated above, much work has focused on the treatment of anxiety among autistic youth. For clarity, *strategies that have not been explicitly tested in treatment studies, to our knowledge, are marked with an asterisk*. Please note that the recommendations below assume the provider is non-autistic. Figure 1 lists the strategies described below.

*Focus on Strengths**

When a client initially presents for treatment, we as mental health providers



- Focus on strengths
- Employ concrete strategies and structured sessions
- Use literal language and explain non-literal language
- Capitalize on your client's interests
- Foster your own creativity
- Meet your client where they are
- Open the door for social and emotional competence
- Assume intelligence
- Be aware of your assumptions and biases
- Be compassionate and curious
- Seek to understand the function of behaviors
- Ask your client about their experiences of autism
- Assume a nonjudgmental stance

Figure 1. Strategies for Working with Autistic Clients Without Co-occurring Intellectual Disability in Therapy

identify the client's goals and begin to clarify their strengths (i.e., existing tools for managing their presenting concerns) as well as areas for growth (i.e., ways to intervene). This is especially crucial for autistic clients as they may have been viewed only from the vantage point of their "deficits" their entire lives. When working with autistic clients, providers may inadvertently overfocus on a client's weaknesses and areas for growth. Instead, we want to empower our autistic clients and highlight their natural abilities and the effective ways in which they navigate the world. In this way, we seek to normalize their symptoms and instill hope (Kerns, Roux, et al., 2016). Narratives that "flip the script" about autism may be helpful for providers looking to capitalize on their autistic clients' strengths (e.g., Kaufman, 2019; Tesfaye et al., 2019). For instance, recognizing that autistic people may use different modes of communication but nonetheless demonstrate ability and desire to communicate (Tesfaye et al.), and that strong attention to detail, as commonly seen in autism, may be viewed as a strength (Kaufman).

Employ Concrete Strategies and Structured Sessions

Similarly, providers benefit from utilizing tangible strategies in sessions with our autistic clients, that is, making abstract concepts into concrete tasks or activities (Kerns, Roux, et al., 2016). In particular, the use of visual materials such as videos, images, drawing, and writing, as well as hands-on activities and worksheets, have been found to be efficacious in treating co-occurring anxiety and are recommended (Chalfant et al., 2007; Reaven et al., 2012; White et al., 2013). Depending on the goals of treatment, providers may find modeling skills and in vivo or videotaped practice of skills especially helpful (Reaven et al.; White et al.). We also encourage the use of immediate, direct, and specific feedback for skills acquisition (White et al.). Autistic adults have identified written communication, clearly structured and more slowly paced sessions, and clear expectations to be helpful (Lipinski et al., 2019; Maddox, Crabbe, Beidas, et al., 2019).

Use Literal Language and Explain Nonliteral Language

Autistic people often communicate differently than neurotypical people, both in terms of expressive and receptive language (Kwok et al., 2015). As providers, we may need to be flexible and patient to communicate most effectively with our autistic clients (Kerns, Roux, et al., 2016). On one hand, we may choose to rely on literal, concrete, and direct language (Maddox, Crabbe, Beidas, et al., 2019; McNally Keehn, et al., 2013) while limiting the use of metaphors, sarcasm, and idioms (Kalandadze et al., 2018). On the other hand, because these communication styles are widely used, as rapport is built, we may want to integrate them into treatment. When we do this compassionately, checking in with our clients to ensure we are communicating well (e.g., explaining the meanings of idioms, discussing our intentions when using sarcasm), we provide natural opportunities for bolstering social communication.

Capitalize on Your Client's Interests

Because many autistic people have restricted or circumscribed interests—an interest or intensity of interest that is considered unusual to nonautistic people—and find them especially motivating, incorporating them into therapy can have many benefits (Kerns, Roux, et al., 2016; Maddox, Crabbe, Beidas, et al., 2019; McNally Keehn et al., 2013; Wood et al., 2009, 2015). Interests can be knit into therapeutic materials or activities in sessions, often leading to improved rapport and motivation to engage in activities. Interests may also be used as reinforcement in therapy. That is, clients may earn time engaging in a desired activity or talking about a subject of interest after participating in a therapeutic task. With autistic youth, parents may help employ reinforcement schedules with interests as rewards for desired behavior at home, to aid in generalization of therapeutic work.

Foster Your Own Creativity

Working in mental health requires creativity, and, for providers working with autistic clients, we should feel inspired to foster our creativity to best meet our clients where they are (Kerns, Roux, et al., 2016). The creator of Coping Cat and colleagues have written about the crucial importance of "flexibility within fidelity" (e.g., Beidas et al., 2010; Chu & Kendall, 2009; Kendall et al., 2008), that is, delivering interventions authentically and using strategies that promote engagement in treatment. This may mean augmenting tools used within our practice so that they are more accessible and/or motivating to our autistic clients and relying more heavily on written strategies (Lipinski et al., 2019), images, videos, or cartoons to facilitate therapeutic growth. We also encourage providers to involve your autistic clients in this process—ask what they would find most helpful!

*Meet Your Client Where They Are**

When working with autistic clients, we should not immediately assume that they need or want to work on changing their autism symptoms, such as social skills (Maddox & Gaus, 2018). Through the lens of the medical model, this assumption may occur automatically for providers, and we need to be careful. It is crucial that we curiously and collaboratively develop a treatment plan based on where the client is and what they want to change in their life (Kerns, Roux, et al., 2016). After all, the treatment is the client's, not the provider's, and we must align our intervention with our client's goals, not our own.

Open the Door for Social and Emotional Competence

Social inclusion and acceptance are closely tied to mental health and quality of life for autistic adults (Kapp, 2018). Research has highlighted the interconnected nature of social engagement and co-occurring mental health concerns, including ADHD (Yerys et al., 2017), anxiety (Kerns, Kendall, et al., 2015; Locke et al., 2010), depression (Hedley, Uljarević, Wilmot, et al., 2018), and trauma (Hoover, 2015). Therefore, promoting social understanding and positive social experiences may emerge as treatment targets when working with autistic clients (Kerns, Roux, et al., 2016). In fact, tailored treatments for co-occurring anxiety (i.e., MASSI, FYF, and BIACA) include social skills components that involve didactic instruction and in-session practice. Furthermore, social skills interventions may, in and of themselves, result in secondary improvements in social anxiety (McVey et al., 2016; Schohl et al., 2014), depression, and suicidality (Schiltz et al., 2017). As stated above, not all autistic clients will want social skills intervention. Skills for managing peer victimization, perhaps including advocacy from the provider, parents, teachers, or other important adults or peers, may be helpful, as the social environment—i.e., how others treat autistic people—is linked with mental health for autistic people (Kapp, 2018). Mental health providers may also wish to use their position to help promote inclusion of autistic people in society (see Bölte, 2019).

Emotional competence is a broad term encompassing skills pertaining to the experience of emotions (Saarni, 1999). Autistic people may or may not struggle with skills such as emotion recognition and regulation (Harms et al., 2010; Mazefsky et al., 2013; Nuske et al., 2013); in fact, symptoms of alexithymia may be more likely to predict these difficulties in autism (Cook et al., 2013). Our autistic clients may present with challenges with emotional competence, and these may or may not be areas of desired treatment. Because emotion regulatory processes have been linked with co-occurring mental health concerns—namely, anxiety (Mazefsky & White, 2014)—focusing on these skills may dovetail nicely with treatment.

*Assume Intelligence**

Just as binary categories can prime our brains to ignore varied and unique forms of intelligence among autistic clients, so can implicit biases lead us to unfairly denigrate certain behaviors associated with autism. Our autistic clients may demonstrate behaviors such as repetitive motor movements ("stimming"), echolalia, and/or communication challenges that can misleadingly give the impression of cognitive limitations, when the function or source of these behaviors may or may not be linked with intelligence (Bishop et al., 2006). This implicit assumption can hinder providers having reasonable expectations of clients, pushing clients toward change, viewing clients as unique people, and respecting clients' skillsets and views of the world. It is critical for us to assume intelligence in our autistic clients. For instance, a client's difficulty expressing cognitive experiences verbally does not necessarily indicate lack of a rich inner life (e.g., Jones, 2017). Autistic clients may have insights akin to or exceeding nonautistic clients, though they may struggle to convey these to providers. It would be harmful for a provider to immediately assume, because signs of insight are not clear through verbal language, that they do not exist.

*Be Aware of Your Assumptions and Biases**

Mental health providers are encouraged to consider autism as similar to a minority culture (Maddox & Gaus, 2018; McVey et al., 2017), and, as with any minority culture, providers may have preexisting biases against autistic people that can unintentionally hurt the therapeutic alliance. As providers, we must be aware of these biases in order to effectively challenge them and prevent them from impacting our treatment delivery. Some examples of biases towards the autistic population include beliefs that all autistic people have significant cognitive limitations (Maddox, Crabbe, Beidas, et al., 2019), are savants, are incapable of social lives—including friendships and romantic relationships—cannot feel and/or understand emotions and cannot experience empathy. Such beliefs beget clinical assumptions and decisions that are not based in the reality of the autistic client and, in turn, decrease the chances that effective psychotherapy can take place.

*Be Compassionate and Curious**

Curiosity paired with compassion can solve many clinical conundrums, regardless of a mental health provider's level of training or expertise in autism. Given the heterogeneity in the expression and experience of autism (Masi et al., 2017), our clients are often our best teachers when we want to understand their lived experience and determine how to help them meet their treatment goals. As symptoms of autism become apparent in therapy, we can be most effective by asking the client for their experience of that symptom. For example, if an autistic client mentions confusion surrounding social cues, ask them about their experience of social interactions. Ask about their thoughts, emotions, behaviors, assumptions, fears, frustrations, and goals. Do not assume that they will give a textbook answer; be prepared to trust their answers and adapt your clinical conceptualization and treatment plan appropriately.

*Seek to Understand the Function of Behaviors**

In most forms of therapy, proper assessment of behaviors is crucial to develop empathy for and understanding of a client. This is equally important when trying to help a client change their behavior. When therapists rely too heavily on interpretations, assumptions, or past experiences, they may incorrectly identify the function of a behavior and risk both invalidating their client and delivering an ineffective intervention. Asking clients why they think they engage in certain behaviors, or how they experience those behaviors, can lead to more accurate understanding. Additionally, closely observing behaviors as they occur in session can help to illuminate the possible antecedents and consequences of those behaviors, leading to an understanding of their function. It is crucial to recognize that many behaviors common to autism are not an indication of pathology and may instead reflect a person or a society's discomfort with diversity (Kapp et al., 2019). For instance, repetitive motor movements (or "stimming") are commonly used for emotion regulation by autistic adults (Kapp et al., 2019), and may therefore be a coping strategy to capitalize upon in treatment rather than a behavior to extinguish.

*Ask Your Client About Their Experience of Autism**

Autistic people often experience the world differently than neurotypicals, and it is important to explore this in therapy (Kerns, Roux, et al., 2016). They may have emotional or behavioral reactions to stimuli that would elicit a much different response from a nonautistic person. Therapists who step into the minds of their clients with curiosity and attempt to experience the world through their client's eyes stand a better chance of expressing empathy in therapy. The more curious we are of our clients' experiences, and the more empathic and clinically driven questions we ask them, the better we will be able to understand their emotional and behavioral experiences. This should be balanced with a respect that our autistic clients are not to be expected to teach us about autism (Camm-Crosbie et al., 2018) and we must engage in our own education. Empathizing and understanding can result in flexibly adapting therapy to best suit each client.

Assume a Nonjudgmental Stance

Finally, and perhaps most important, work to foster a nonjudgmental stance in your practice. It is human nature to experience automatic judgments when we encounter new behaviors, cognitions, and emotional expressions, or if an autistic client is struggling with something that a nonautistic therapist believes should be easy. The goal is not to erase our brain's capacity for judging, but to gently acknowledge our judgments and return to a nonjudgmental, empathy-based stance. In doing this, we are being kind to ourselves and ensuring that we can provide the best care for our clients.

Conclusion

Our autistic clients deserve access to high-quality mental health care. They deserve to work with mental health providers who have an understanding of and openness toward neurodiversity, to not be turned away from treatment, nor to be expected to teach their providers about autism. As such, developing competence in working with autistic clients is a necessary component of a mental health provider's training.

The recommendations provided here are based on the current evidence and represent merely a starting point for a mental health provider's training in working with autistic clients. As this area of clinical research continues to develop, and we learn more about the most effective ways to assess and treat co-occurring mental health concerns among autistic people, these recommendations will inevitably change. As with all areas of competence, providers are encouraged to continue to develop their understanding of autistic clients through continuing education, self-study, and compassion in their practice. Fortunately, mental health providers already possess the core skills needed for this important work.

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A Transdiagnostic Approach to the Treatment of Autonomic Dysfunction Associated With Orthostatic Intolerance in Pediatric Patients

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DISORDERS OF AUTONOMIC dysfunction (AD) associated with orthostatic intolerance (OI), such as Postural Orthostatic Tachycardia Syndrome (POTS), are chronic health conditions characterized by symptoms such as dizziness, lightheadedness, nausea, fatigue, and difficulties focusing (i.e., "brain fog"), as well as sympathetic overactivation such as shakiness, palpitations, excessive perspiration, and pain (Jarjour, 2013). These physiological symptoms are commonly associated with functional impairment in major life domains including academics, sleep, physical activity, interpersonal relationships, and activities of daily living (Junghans-Rutelonis et al., 2019). POTS and/or disorders of OI have been associated with significant negative outcomes including psychological distress, academic failure, social isolation, and functional disability (Kizilbash et al., 2014). Functional disability in pediatric patients ranges from mild limitations of activity to severe impairment, with research indicating patients presenting for treatment in a tertiary care setting have moderate to severe functional disability (Kritzberger et al., 2011).

Although POTS has become increasingly recognized and diagnosed by the medical community, additional research is necessary to understand how to effectively treat this condition. It is estimated that 1 to 3 million Americans have POTS (Miranda et al., 2018). Individuals with POTS typically experience the onset of symptoms in adolescence (median age of 13.1 years), oftentimes after an identifiable trigger, typically a viral illness or injury (Johnson et al., 2010). Additionally, most individuals with POTS are female (5:1) and Caucasian (Boris & Bernadzikowski, 2018). Interestingly, most adolescents with POTS are also characterized as being "high achievers," typically receiving excellent grades and being highly successful in multiple extracurricular activities. Although no specific biochemical pattern has been identified in those with POTS and/or disorders of OI, it is hypothesized that the hyperstimulated nervous system of a high achiever may increase the risk of developing neurotransmitter abnormalities (Kizilbash et al., 2018).

POTS and Mental Health

The possible presence of psychiatric difficulties in a pediatric POTS patient is oftentimes a source of contention between the patient and their medical team. Unfortunately, it is not uncommon for providers to convey (purposefully or otherwise) to these patients that their physical symptoms are psychogenic in nature (Junghans-Rutelonis et al., 2019), which can result in patients feeling stigmatized and more resistant to participating in psychological treatment. The relationship between mental health concerns and POTS is complicated by the fact that psychiatric symptoms overlap with AD symptoms associated with OI, particularly those involving sympathetic overactivation. For example, physiological symptoms such as shakiness, palpitations, increased heartrate, excessive perspiration, and lightheadedness can all be symptoms of both POTS and/or disorders of OI and anxiety/panic.

Within adult populations, some research suggests that disorders of AD associated with OI are associated with higher rates of anxiety and depression (Anderson et al., 2014), while other work has not revealed a higher prevalence of psychiatric comorbidities in this population (Raj et al., 2009). Prior research consistently shows youth with somatic complaints, such as chronic pain, demonstrate heightened levels of anxiety and depression (for a review, see Vinall et al., 2016). Given that over half of individuals with POTS report chronic pain, there is reason to believe the high rates of comorbid mental health concerns seen within chronic pain populations may be mirrored among individuals with POTS (Ojha et al., 2011). There is now preliminary evidence that POTS is associated with mental health difficulties in children and adolescents. For example, several studies have documented the strong association between psychological distress, namely anxiety and depression, and POTS for pediatric patients treated in intensive outpatient programs (Bruce et al., 2016; McTate & Weiss, 2016). Although causal conclusions cannot be drawn from these studies, it does make clear that symptoms of POTS, anxiety, and depression cluster together (Kizilbash et al., 2014).

Psychosocial Factors Associated With POTS

Research has identified several psychosocial factors common to youth with disorders of AD associated with OI that support the notion that psychologically informed treatment for this patient population may be useful. For example, there is some evidence youth with POTS and/or disorders of OI may suffer from "somatic hypervigilance," or a tendency to experience mild sensory experiences in an intense or distressing manner (Junghans-Rutelonix et al., 2019). Furthermore, regardless of whether a patient has premorbid anxiety, a common experience of patients with POTS, as well as their parents, is a tendency to experience anticipatory anxiety about engaging in any activities they fear might exacerbate their symptoms, such as attending school, exercising, or going out with friends. These anxieties can be associated with "pain catastrophizing," which involves a tendency to magnify the threat value of pain stimuli, to feel helpless in the context of pain, and be unable to inhibit pain-related thoughts in anticipation of, during, or following a painful encounter (Kizilbash et al., 2018). In response to these fears, youth with POTS may reduce their engagement in daily activities, which is oftentimes supported by parents who frequently engage in accommodating and protective behaviors with children with POTS. This cycle of avoidance can perpetuate and exacerbate symptoms of anxiety, contribute to further deconditioning, and lead to a worsening in functional disability. Those who experience significant functional disability are, in turn, at increased risk of also experiencing symptoms of depression (Kritzberger et al., 2011).

Traditional Treatment of POTS

The American Autonomic Society has published evidence-based guidelines emphasizing the use of nonpharmacologic interventions as first-line therapy for disorders of AD associated with OI, contending that these interventions are most important to long-term outcomes (Stewart et al., 2018). To this end, the Mayo Clinic (2009) has developed a framework (i.e., STEPS) for discussing these interventions with POTS patients. Specific interventions focus on increasing sodium intake (S), taking in extra fluids (T), increasing exercise (E), taking medications as prescribed (P), and promoting engagement in a variety of wellness behaviors (i.e., sleep, school reengagement, setting priorities/goals, and accessing a support system; S).

Together with these nonpharmacologic recommendations, researchers have highlighted the benefits of including psychological interventions when working with this patient population (Johnson et al., 2010). Interventions have typically aligned with the treatment for chronic pain, as these interventions have been widely studied (Eccleston et al., 2014), and there are many similarities in the clinical needs of patients with POTS and those with chronic pain (Bruce et al., 2016; Kizilbash et al., 2014). Effective psychological interventions for chronic pain have included psychoeducation and behavioral strategies that modify lifestyle factors (e.g., sleep, exercise; Lynch-Jordan et al., 2015; Palermo, 2012), cognitive behavioral therapy (CBT; e.g., cognitive modification techniques, behavioral activation, relaxation training, positive patient coping, and activity pacing; Eccleston et al., 2014; Lynch-Jordan et al., 2015; Palermo, 2012), and acceptance and commitment therapy (ACT; e.g., limits of control, focus on experience, values, cognitive defusion, mindfulness, and committed action; Wetherell et al., 2011).

Literature published on effective interventions for pediatric POTS have focused on treating acute patients in intensive multidisciplinary settings (Armstrong et al., 2017; Bruce et al., 2016). While these studies have demonstrated the positive impact of behavioral health supports on psychiatric symptoms and functional disability, these findings are limited by a high dropout rate and an inability to generalize findings to less intensive intervention settings.

Transdiagnostic Treatment of POTS

To date, most interventions for pediatric disorders of AD associated with OI have focused on patients that are significantly disabled and in need of intensive intervention, while less attention has been given to providing services to these patients in an ambulatory setting, particularly within a group-based format. There are many advantages to using a group therapy format with this patient population. First, it is an equally efficacious alternative to individual therapy (Federoff & Taylor, 2001), while also maximizing treatment accessibility in terms of time- and cost-effectiveness (Bastien et al., 2004). A group format also provides increased opportunities for social connections and support for patients and families, which has been reported as particularly valuable for patients with POTS. In fact, there is accruing evidence of the critical role of reducing social isolation and perceived hopelessness for positive health outcomes in patients with chronic medical conditions (Freedenberg et al., 2017). Many teens with POTS, as well as their parents, disclose having negative interpersonal interactions with peers, family, and providers that leave them feeling ostracized and with the impression that others think they are “faking” their illness (teen) or enabling them (parent). A group-based therapeutic approach can help to address these concerns by facilitating increased access to others who understand their symptoms and associated difficulties, reduce social isolation, and contribute to increased feelings of hopefulness.

Historically, youth with chronic medical conditions have been grouped and treated by diagnosis and symptom clusters. More recently, there has been increased appreciation for the commonalities in the needs of patients with chronic medical conditions and their families (Kieckhefer et al., 2014). This closely aligns with recent efforts from the National Institute of Mental Health to develop a transdiagnostic approach to the assessment and treatment of pediatric behavioral health concerns (Rohde, 2012). This innovative approach aims to develop treatment protocols that focus on targeting underlying mechanisms of concern, rather than categorical diagnoses/symptoms (Twohy et al., 2017). This is particularly relevant to pediatric disorders of AD associated with OI, as the symptom presentation, level of functional disability, and presence of secondary symptoms/diagnoses is heterogeneous, although many of the underlying mechanisms responsible for these factors are shared across patients (Johnson et al., 2010). Consequently, a unified treatment targeting shared mechanisms could effectively treat these patients with diverse clinical presentations. Furthermore, developing programs that are informed by a transdiagnostic framework results in a destigmatized approach to mental health (Rohde, 2012), which is particularly important when working with this patient population.

Thus, we developed a 10-week group-based transdiagnostic intervention for teens with disorders of AD associated with OI, most notably POTS (The Restore Program). This intervention targets several candidate transdiagnostic mechanisms commonly implicated in teens with POTS, regardless of the clinical presentation: (1) emotion regulation, (2) information processing, (3) experiential avoidance, (4) parenting behaviors, (5) sleep disturbances, and (6) peer relationships. These mechanisms were chosen based on a review of the literature related to shared mechanisms across emotional disorders and chronic health conditions, such as POTS and chronic pain (Twohy et al., 2017; Ojha et al., 2011). The current study aimed to examine the feasibility and acceptability of this intervention when implemented within an ambulatory care setting.

Method

Procedure

Prior to conducting this pilot study, we received approval from the university’s Institutional Review Board. Patients were primarily recruited through referrals from mental health providers in an outpatient psychiatry clinic and by medical providers in various medical clinics (e.g., neurology, cardiology, and gastroenterology) in a large teaching hospital. All participants received an initial health and behavior assessment and were enrolled in the study if they met all inclusion criteria. Patients were eligible to participate in the study if they were: (a) between the ages of 13–18; (b) had been diagnosed with AD associated with OI or POTS; and (c) had moderate functional impairment and/or were experiencing symptoms of anxiety and/or depression.

Participants

Participants included 25 youth-parent dyads, with teens ranging in age from 13 to 18 ($M = 15.8$). The majority of participants identified as female ($n = 24$; 96%) and were Caucasian ($n = 24$; 96%). While this reflects a highly homogenous sample, these demographic characteristics align with research reflecting who is most likely to be diagnosed with pediatric disorders of AD associated with OI (Boris & Bernadzikowski, 2018). The most common primary medical diagnosis included POTS (*n* = 20; 80%) and dysautonomia associated with OI (*n* = 4; 16%).

Intervention

The intervention used in this study was a 10-session, 90-minute, group-based transdiagnostic psychological treatment developed for teens with disorders of AD associated with OI, such as POTS. Groups were facilitated by a psychologist, a psychology fellow, and a psychology intern. Both teens and parents attended all weekly sessions, meeting separately for the majority of the group, and coming together for a parent-teen exercise at the end of each session for approximately 20 minutes. The joint portion of the group session focused on practicing a skill discussed in both groups (e.g., progressive muscle relaxation) or facilitated collaboration of the teen-parent dyad in discussing effective application of a learned skill into the home/community environment. See Table 1 for a detailed description of each session's focus.

Teen Curriculum

The initial sessions of the teen curriculum focus on promoting treatment engagement and eliciting behavior change through application of motivational interviewing and ACT (i.e., values) techniques, providing psychoeducation about POTS, and reviewing healthy lifestyle behaviors that are critical to the effective management of POTS based on the STEPS acronym (Mayo Clinic, 2009). We modified this acronym to emphasize the importance of pacing and shaping (P and S), as these principles are of paramount importance when discussing how to promote behavior change and appropriately address functional disability. An entire session is devoted to sleep difficulties, as this is a highly common complaint among patients with POTS. A review of sleep hygiene principles is included, as is a description of a stimulus control intervention commonly used to support patients with sleep difficulties. Treatment then shifts to a focus on using relaxation techniques, such as progressive muscle relaxation and visual imagery, to address the hyperarousal of the sympathetic nervous system. The remainder of the curriculum is focused on highlighting the differences between active and passive coping with POTS and promoting the use of a variety of active coping techniques such as mindfulness, cognitive flexibility, and opposite action. Teens are supported in applying these strategies during structured exposures during a final session, as well as problem solving ways to ensure treatment gains are maintained following the ending of the group. Throughout all sessions of the group, group leaders use a combination of providing psychoeducation, facilitating group discussion, and engaging teens in experiential exercises in order to promote understanding of the material. The importance of teens having opportunities to socially connect with one another during group sessions was also found to be highly beneficial.

Parent Curriculum

Much of the content and structure described in the teen curriculum was paralleled in the parent curriculum, including initial discussion of values (focused on parenting), psychoeducation about POTS, and review of healthy lifestyle habits critical to effective management of POTS (i.e., STEPS and sleep strategies). Throughout these discussions, an emphasis was placed on how parents can effectively promote treatment adherence and functional improvements in their teen, despite their symptoms, through application of principles such as shaping and pacing. Parents were empowered to establish expectations of their teen and use contingency management (e.g., privilege loss, earning rewards) to provide extrinsic motivation for teens to engage in health promoting behaviors. Parents were also taught relaxation strategies, active coping techniques (e.g., cognitive flexibility, mindfulness, acceptance, etc.), and how to support their teens in engaging in exposures. For example, if a teen's exposure was focused on attending a social event they would typically avoid due to fears of worsening their symptoms, parents might provide extrinsic motivations through use of contingency management principles, engage their teen in a discussion focused on promotion of cognitive flexibility, and provide support in using pacing principles in order to successfully participate in the activity. Similar to the teens group, group leaders used a combination of psychoeducation, group discussion, and experiential exercises. The value of parents providing emotional support, encouragement, and ideas to one another cannot be overstated.

Treatment Feasibility and Acceptability

Feasibility and acceptability of the intervention were measured by evaluating the mean number of sessions attended and the percentage of patients considered "treatment completers." Additionally, teens and their parents completed an 8-item self-report measure assessing satisfaction and perceived benefits of their participation in the group. Items were rated on a 4-point Likert scale, with response descriptors varying.

Results

Treatment Feasibility

Of the 25 youth-parent dyads that enrolled in the study, 9 dropped out of the group prematurely (i.e., after 0–4 sessions), resulting in an overall completion rate of 64%. Dropout varied across the three separate groups comprising the study sample, ranging from 1 to 6 per group, and included factors related to cost, level of impairment (i.e., too low to need group or too high to attend), transportation, and difficulty relating to other group members. This completion rate is relatively promising given the difficulty this patient population has with maintaining functioning despite their symptoms. Importantly, participants who completed the group had excellent attendance, missing a mean of 1.3 sessions (range 0–3), providing support for the overall feasibility of this treatment approach.

Treatment Acceptability

Responses from the satisfaction survey suggested that adolescents and parents found the acceptability of this intervention to be quite high. Aggregating across all 8 items, adolescents' overall satisfaction was rated, on average, as 3.3 out of 4, where 4 = *most satisfied*, and parents' average score was even higher, i.e., 3.6 out of 4. Examination of individual items revealed that, on average, adolescents were satisfied overall with the help they received (i.e., 3.4 out of 4, where 4 = *very satisfied*), and they felt the group helped them learn ways to more effectively cope with their AD (i.e., 3.2 out of 4, where 4 = *yes, definitely*).

Free-response items provide further information about adolescents' perceptions at post-intervention: "I've gotten better at keeping up with my goals. I've learned more coping skills and made more friends." "I found many new ways to help with my illnesses and made some good friends." Parents' satisfaction scores demonstrated that they found the intervention helpful and enjoyable. Parents reported that overall, they were very satisfied (3.8 out of 4, where 4 = *very satisfied*), and the group had helped them learn ways to more effectively support their child in coping with their AD (i.e., 3.6 out of 4, where 4 = *yes, definitely*). In expanding on their ratings, parents described, "[The

Table 1. Outline of Treatment Protocol

Session	Teen Goals	Session Content	Parent Goals	Session Content	Teen-Parent Combined
1	Treatment structure/rationale; goals & values	Psychoeducation about POTS; treatment goal setting; identify values	Treatment structure/rationale; psychoeducation about POTS; goals & values	Psychoeducation about POTS; treatment goal setting; identify parenting values	Everyone shares 1 personal value and goal
2	Healthy lifestyle behaviors	STEPS	Parenting strategies to promote teen's wellbeing	STEPS; contingency management	Teens identify 1 STEPS goal. Parents identify how they'll support teens.
3	Sleep strategies	Sleep hygiene; stimulus control sleeping intervention	Parenting strategies to promote teen's sleep; parent self-care	Sleep hygiene; shaping & pacing; diaphragmatic breathing	Teens identify 1 sleep-related goal. Parents identify how they'll support teens.
4	Relaxation	Diaphragmatic breathing; visual imagery	Reducing conflict with teens; mindful parenting	Empathy; mindfulness	Progressive muscle relaxation exercise
5	Coping with a chronic illness	Passive vs active coping; experiential avoidance vs mindfulness; acceptance	Coping with a teen with a chronic illness	Experiential avoidance vs mindfulness; acceptance	Mindfulness exercise
6	Emotional awareness	CBT model of emotions	Emotional awareness and opposite action parenting	CBT model of emotions; double before-during-after (BDA) framework	Complete thought log example
7	Cognitive flexibility	Cognitive restructuring	Cognitive flexibility	Cognitive restructuring	Discuss how to collaborate on cognitive restructuring during upcoming week
8	Cognitive flexibility	Cognitive defusion	Cognitive flexibility	Cognitive defusion	Discuss how parents can support teens in achieving weekly goals
9	Opposite action	Exposure hierarchy; complete exposures	Opposite action	Complete teen exposure	Debrief exposures
10	Relapse prevention	Review all strategies; problem solve possible future barriers	Relapse prevention	Review all strategies; accommodating vs encouraging functioning; shaping and pacing	Teens identify an ongoing goal and parents identify how they'll support teen

intervention] was very empowering. Helped me to help my teen better. Helped her to help herself better." "As a parent, it was incredibly reassuring, comforting, and empowering to meet other parents of teens with POTS. I am much calmer and happier and so is my teen." "Learning how to help her pace herself and build up slowly is very helpful. I feel much more equipped to parent my child with dysautonomia."

Conclusion

The treatment of disorders of pediatric AD associated with OI, such as POTS, continues to be in its infancy, but several consistent themes have begun to emerge: (a) the clinical presentation of this patient population is heterogeneous, while several common mechanisms are shared across patients, and oftentimes is associated with significant functional impairment; (b) symptoms of POTS, anxiety, and depression frequently cluster together; (c) treatment adherence can be problematic for this patient population; and (d) psychological interventions can be helpful in improving functional disability, addressing psychiatric symptoms, and learning ways to effectively manage symptoms of POTS and/or AD associated with OI. Unfortunately, it is not uncommon for patients to report that a medical provider has conveyed to them that their symptoms are "all in their head," which makes the patient much more resistant to the prospect of participating in treatments involving psychological interventions. Furthermore, empirical evaluation of psychological interventions developed for this patient population have typically focused on intensive settings, with little attention having been given to the utility of providing treatment in an ambulatory setting.

The Restore Program was developed in an effort to fill this treatment gap by providing a group-based intervention to teens with AD associated with OI in an ambulatory setting. Development of this treatment protocol was purposefully constructed within a transdiagnostic framework to better account for the heterogeneous presentation of this population, as well as to facilitate reduced mental health stigma by focusing on treatment of underlying mechanisms, rather than psychological symptoms. A group-based format was chosen to capitalize on the therapeutic power of social connection. Qualitative data collected from satisfaction surveys during the pilot study revealed that the opportunity to connect with other teens with POTS was a critical element of treatment that likely positively contributed to treatment outcomes and acceptability of the treatment. Data collected from the pilot study also revealed this treatment approach was both feasible and acceptable to patients and families that participated.

Given the profound negative impact poorly managed POTS can have on a teen's life, it is imperative that effective treatments be available at every level of care. Availability of psychological supports at the ambulatory level of care will assist with intervening earlier on in a patient's clinical course, and hopefully, help to alter the progression of symptoms away from significant distress and impairment. Recent efforts have also been made to integrate psychological supports into ambulatory medical teams treating POTS and/or AD associated with OI, which should continue to assist with reducing mental health stigma and improving access to this critical component of treatment. Future research should be conducted to determine whether The Restore Program is sufficient as a stand-alone intervention in an ambulatory setting, as well as evaluate the feasibility and value added of integrating additional interdisciplinary approaches, consistent with what has been observed in more intensive treatment settings. Evaluation of how this group-based curriculum impacts key treatment targets (e.g., parenting practices, treatment adherence) should also be conducted. Finally, it is recommended that alternative delivery methods, such as telehealth, be considered as another way of improving access to effective treatments for this patient population.

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NEWS

A Summary of Dr. Martin Antony's ABCT Presidential Address

Shannon M. Blakey, *Durham VA Health Care System and VA Mid-Atlantic Mental Illness Research, Education and Clinical Center*

ABCT's 2020 convention differed from previous conventions in ways big and small. The 54th annual meeting was held virtually for the first time, of course, but the multiday meeting also began with what usually occurs late Saturday: the presidential address. Prerecorded a week prior to the ABCT 2020 Virtual Convention, Dr. Martin (Marty) Antony delivered an engaging presentation, titled "CBT in the Era of COVID-19."

After a friendly introduction from the ABCT President-Elect (Dr. David Tolin), current ABCT President Dr. Marty Antony opened his presidential address by discussing the convention theme, "Better Access, Better Outcomes: Enhancing the Impact of Behavioral and Cognitive Therapies." He also acknowledged several ABCT members and staff who were critical to the development and execution of ABCT's first-ever virtual convention on relatively short notice: Dr. Shannon Wiltsey Stirman, Dr. Daniel Cheron, Dr. Katharina Kircanski, Stephen Crane, and the rest of the ABCT staff who all helped to make this year's convention a success (Mary Jane Eimer, David Teisler, Dakota McPherson, Tonya Childers, Veronica Bowen, Amanda Marmol, Kelli Long, and Stephanie Schwartz).

Though the 2020 convention theme was decided prior to the COVID-19 initial outbreak and subsequent global pandemic, a focus on "access and outcomes" remains critically important during the ongoing COVID-19 pandemic. Specifically, there is a critical need to increase access to evidence-based mental health treatments for people who cannot easily access them in traditional settings, and there is still room to enhance outcomes for mental health treatments that have existed for decades. In a mere 65 minutes, Dr. Antony skillfully contextualized the convention's theme within the professional challenges and opportunities associated with the COVID-19 pandemic.

Dr. Antony first discussed the psychology of pandemics, drawing largely from the work of Dr. Steven Taylor, whose timely book on the psychology of pandemics (Taylor, 2020) can help us understand several intra- and interpersonal phenomena salient to many of us today. For example, pandemics are associated with experiences such as uncertainty, confusion, urgency, and unpredictability; disruption in daily routines and the ability to satisfy basic needs; economic, financial, housing, and food instability; social isolation and loneliness; and the death of loved ones. Extreme behaviors such as agoraphobic avoidance, excessive checking, reassurance-seeking, and cleaning rituals typically associated with psychopathology are common among the general public. Dr. Antony highlighted how pandemics strain health care systems and disproportionately affect the poor due to systemic and income-associated environmental variables. He also commented on how pandemics are generally associated with a seeming rise of conspiracy theories, scientific misinformation, anti-science falsehoods, and pseudoscientific claims and "cures"—as well as how certain cognitive-behavioral and motivational interviewing strategies can be used to combat them.

COVID-19 was not the only key event in 2020, however: North America and the world experienced tense political elections, natural disasters (e.g., wildfires, hurricanes) tied to climate change, and murder hornets! Another critical focus of 2020 centered on race-related killings and race-based violence, leading to international discussion around how to address systemic racism. ABCT and several other high-profile organizations (e.g., American Psychological Association, American Psychiatric Association, National Association of Social Workers) released public statements, created task forces and workgroups, and have focused resources toward ending the "pandemic of racism." Dr. Antony acknowledged the interaction between COVID-19 and systemic racism before reviewing research showing how COVID-19 disproportionately affects people from different racial and ethnic backgrounds. Dr. Antony cited research indicating hospitalization rates differ across racial/ethnic groups (U.S. Centers for Disease Control and Prevention) as well as other studies showing that although non-English speakers are less likely to receive COVID-19 tests than English speakers, non-English speakers are more likely to test positive when they are tested (e.g., Kim et al., 2020). He also discussed how ethnic and racial minorities are underrepresented in COVID-related clinical trials, which poses serious limitations and problems for equitably addressing the pandemic (Chastain et al., 2020).

Dr. Antony also addressed several challenges and opportunities related to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles (that's the ABCT mission statement, in case you didn't know!). The COVID-19 pandemic and associated disruption in daily living has brought with it psychological, medical, social, vocational, and economic tolls, which could perhaps be exacerbated by social distancing and quarantine mandates. Moreover, people may be engaging with social media and news outlets more often than normal, which could potentially pose deleterious effects on mental health. Many professionals have also encountered COVID-related distress: the experiences of anxiety, xenophobia, and traumatic stress symptoms, which can be distressing and impairing for many (Asmundson & Taylor, 2020; Taylor et al., 2020). Some investigators argue that COVID-19 and its associated consequences create "a perfect storm" for suicide, although there is presently insufficient evidence that suicidal ideation and/or behavior has changed as a result of the pandemic. Furthermore, although certain mental health conditions seem especially likely to exacerbate due to the pandemic (e.g., obsessive-compulsive disorder [OCD] or depression), not all people with clinical disorders report more severe mental health symptoms or functioning (e.g., Benatti et al., 2020). Thus, as Dr. Antony reminded viewers, it is important not to make overly broad assumptions in our professional roles as clinicians, educators, and investigators.

Next, Dr. Antony discussed to the role of CBT in the era and wake of COVID-19. He began by acknowledging the impressive responsiveness of mental health professionals (including many ABCT members) in generating and disseminating psychoeducational and coping resources for the general public, clinical materials and tools to practitioners, and assessment scales for use in COVID-related research. Dr. Antony pointed to CBT interventions designed to address the needs of front-line workers, including dissemination and implementation efforts to train clinicians and first responders in CBT for COVID-related distress. Cognitive-behavioral and related techniques that might be particularly useful for addressing COVID-related distress include adopting flexible and balanced thinking (i.e., cognitive restructuring), confronting safe-yet-anxiety-provoking situations (i.e., exposure), engaging in pleasant and important activities (i.e., behavioral activation), problem-solving, mindfulness and acceptance-based strategies, relaxation-based strategies, and communication training.

Dr. Antony also acknowledged how the pandemic has pressed clinicians (as well as educators and investigators) to be creative in translating and adapting "usual practice" in light of the real-world constraints on behaviors and situations we may have previously taken for granted (e.g., McKay et al., 2020). Other clinical challenges include discriminating between an adaptive coping behavior and an excessive "safety behavior" (e.g., Thwaites & Freeston, 2005), which can vary over time as public health agencies revise health-related guidelines and recommendations. Beyond simply delivering existing treatments via teletherapy, notable adaptations of CBT referenced by Dr. Antony include CBT for psychosis (Kopelovich & Turkington, 2020), complicated grief (Boelen et al., 2020), social anxiety (Warnock-Parkes et al., 2020), posttraumatic stress disorder (PTSD; Wells et al. 2020; Wild et al., 2020), eating disorders (Murphy et al., 2020), and OCD (Jassi et al., 2020; Krompinger et al., 2020). Additionally, consultation with fellow ABCT members and other professional colleagues can be another helpful strategy for ensuring patients receive the safest, yet also most efficacious, care during this time.

Finally, Dr. Antony turned to what he saw as some potentially positive lasting consequences, as well as general future directions. First, he discussed the Ontario Structured Psychotherapy Program, which focuses on implementing a Canadian province-wide, publicly funded, stepped-care CBT program for depression and anxiety-related disorders (including PTSD and OCD). Informed by the Improving Access to Psychological Therapies (IAPT) program in the United Kingdom, the Ontario Structured Psychotherapy Program draws on teletherapy to increase access to CBT for common mental health problems, and will hopefully contribute valuable scientific knowledge about the utility and therapeutic effects of stepped CBT delivered over virtual platforms. Dr. Antony also expressed what he hoped would be continued research and policy efforts aimed at addressing discrimination and systemic racism.

The year 2020 has certainly been a demanding and unprecedented year in numerous ways, several of which Dr. Antony spoke to in his ABCT presidential address. Dr. Antony—as well as other members of ABCT's Board of Directors, coordinators, committees, and full-time staff—have all worked tirelessly for this organization and its members. If you have not viewed Dr. Antony's presidential address already, you can find it on demand along with hundreds of other ABCT recorded offerings. You can also find COVID-related ABCT content at https://www.abct.org/Information/?m=mInformation&fa=COVID19 and on the ABCT YouTube Channel (https://www.youtube.com/channel/UCUE6712YKqwpnf8UwfGp1kQ).

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NEWS

A Synopsis of Dr. Philip C. Kendall’s Lifetime Achievement Award Address: “Managing Anxiety in Youth: More Action Than Talk”

Amy Sewart and Karla Lopez, *California State University, Dominguez Hills*

AT LAST YEAR’S ABCT convention in Atlanta, Dr. Philip C. Kendall was awarded ABCT’s Career/Lifetime Achievement Award, recognizing his undeniably groundbreaking contributions to the field of cognitive behavioral therapy, specifically in the treatment of child and adolescent anxiety. As a Distinguished Professor at Temple University, Dr. Kendall currently serves as the Director of the Child and Adolescent Anxiety Disorders Clinic, which has served thousands of children over the years and fostered generations of pioneering youth mental health researchers. It would not be hyperbolic to say that perhaps all of us within ABCT are familiar with his work, whether this be through his influential papers (often required reading in graduate programs), through the use of Coping Cat with our child clients, or—for the most fortunate among us—through direct collaboration. Dr. Kendall has been an integral figure in ABCT for several decades, serving as Past President and as Editor of *the Behavior Therapist*.

In his Lifetime Achievement Address, Dr. Kendall provided an overview of his research on youth anxiety, first posing the question, “Do we want to tackle anxiety in youth?” The answer here is an overwhelming yes—research unequivocally shows that failure to treat internalizing problems in youth leads to a host of adult issues, including adult anxiety, depression, substance use, and suicidality. “Do we want to remove all anxiety in youth?” No—rather, we should focus our efforts on giving children the necessary skills to cope with and adaptively manage anxiety. Dr. Kendall highlighted that this requires consideration of how common behaviors that both parents and educators engage in contribute to the maintenance and/or amplification of youth anxiety. These behaviors include (a) an intrusive and controlling style (e.g., “I must know what my child is doing at all times”), (b) the immediate involvement of a mental health professional at the first sign of anxiety (e.g., “My child is anxious about her upcoming spelling test, it’s time to see a professional”), (c) efforts to avoid and escape the experience of anxiety-provoking situations and associated negative emotions (e.g., “My child gets anxious while speaking to strangers, so I just speak for them”), (d) prevention of limited risk-taking (e.g., “My students love soccer, but I don’t let them play during recess. They may seriously injure themselves!”), (e) unpredictable and punitive caretaker behaviors (e.g., inconsistently giving time-out or week-long grounding for similar misdeeds), (f) modeling maladaptive anxious responding, and accommodating (e.g., “Oh my god, a spider!”). These behaviors severely jeopardize the child’s perceived capability to cope with distressing situations and emotions and remove critical learning experiences necessary for the development of adaptive responding.

Next, Dr. Kendall highlighted the essential elements to emphasize during the treatment of youth anxiety, (a) including a strong, collaborative therapist-child relationship; (b) addressing anxious self-talk; (c) ensuring strengthening and generalization of in-session learning through homework, which may be reinforced through rewards; (d) problem solving; (e) psychoeducation regarding emotions; and, critically (f) exposure tasks. Dr. Kendall noted that community-based treatment providers frequently ask, “Wouldn’t exposure to distressing stimuli compromise the therapeutic alliance, an essential element necessary for treatment engagement?” No, research demonstrates that exposure does not rupture alliance.

Also highlighted was Dr. Kendall’s research demonstrating that early, effective treatment of youth anxiety reduces the risk of chronic depressive symptoms and suicidal ideation. No doubt, many of us within ABCT now consider the points mentioned above common knowledge; this underscores the importance and foundational nature of Dr. Kendall's research. The importance of flexibility within fidelity, or adherence to scientifically supported intervention strategies while being flexible in their application, was emphasized as critical. Dr. Kendall's address concluded with outlining necessary future directions in child anxiety research, including research on optimal treatment approaches for nonresponders, improved methods for disseminating evidence-based treatments, increased awareness and destigmatization of child anxiety, early identification efforts, and a more dimensional understanding of childhood psychopathology aligning with the Research Domain Criteria (RDoC). The address concluded with sincere appreciation for his colleagues and students, current and former, and acknowledgment of their critical role in the research above. Dr. Kendall ended his talk by saying, "I'm not done yet." We certainly look forward to new research by Dr. Kendall and colleagues.

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NEWS

Summary of Dr. Luana Marques's Invited Address: "Leveraging Implementation Science and Community-Based Partnerships to Bridge the Science-Practice Gap Among Diverse Populations"

Dana Strauss, *University of Ottawa*

Jade Gallo, *University of Connecticut*

DR. LUANA MARQUES and her lab at the Massachusetts General Hospital (MGH) Community Psychiatry Program for Research in Implementation and Dissemination of Evidence-Based Treatments (PRIDE) strive to bridge the gap between science and practice in diverse communities using implementation science. Dr. Luana Marques started as a clinical psychology intern at MGH in Boston, MA, where she learned from and worked with individuals who developed and tested evidence-based protocols across disorders. This work furthered her interest in serving diverse communities, leading her to begin her current research at a satellite MGH located in Chelsea, a primarily Latinx area. MGH Chelsea is home to many community-led initiatives to combat the high levels of poverty and violence that afflict the area.

Why Is the Science-Practice Gap Important?

After years of working in the ivory tower in psychiatry at MGH, Dr. Marques experienced, firsthand, the gap between science and practice. For example, the majority of the population at MGH Chelsea had acute trauma and a long trauma history. Though the mental health providers were determined to treat their patients, they did not have adequate training in evidence-based protocols for trauma. In fact, she later learned that it takes 17 years for scientific findings to reach practice, and of these, only 14% end up reaching practice (Boren & Balas, 2000; Institute of Medicine, 2006). This meant that it was unlikely that clinicians at MGH were using the most current and well-validated approaches.

Dr. Marques noted that what was happening at MGH Chelsea was not an anomaly, but part of a broader pattern of mental health disparities in which communities of color, particularly Latinx and Black communities, do not have access to high-quality mental health care, and as a result, their mental health needs are not met (Wells et al., 2001). A recent study highlighting disparities in the provision of mental health services showed that in Massachusetts during COVID-19, non-Hispanic Whites used mental health services far more often than Black and Latinx communities despite the disproportionate impact of COVID-19 on racialized and marginalized communities (Yang et al., 2020). Dr. Marques' lab, Community Psychiatry PRIDE, believes that everyone deserves access to high quality mental health care, and they actively work towards this goal.

How to Bridge the Gap

Implementation Science, in combination with community-based participatory research, can help bridge the gap between science and practice. Implementation science is the development of frameworks and guidelines that allow practitioners to tailor mental health research to specific communities. In community-based participatory research, theory meets lived experience as researchers work as equals with community partners to find community-specific solutions to inaccessibility and poor quality of care. To ensure the resulting treatments are respectful, accessible, and relevant, Dr. Marques emphasized that diverse perspectives must be engaged at every level, from community members to staff and from organizations to communities. Researchers need to think about how they can give back to the communities they study, and develop reciprocity and relationships. Dr. Marques often asks her community partners, "How can I be of service?"

What the Lab Has Done to Bridge the Gap: Three Studies With Diverse Populations

Study 1: Implementation Science Applied to Diverse Populations

Though many of the patients at MGH Chelsea were Hispanic and most had histories of chronic traumatic experiences, there was limited use of evidence-based treatments (EBT) for PTSD among mental health providers, contributing to the existing gap between science and practice. Misguided fears and perceptions surrounding EBT can contribute to therapists' reluctance to learn EBT (Marques, 2020). Dr. Marques and her lab conducted a study where Cognitive Processing Therapy (CPT) was analyzed to refine the training manual to be more feasible for clinicians. Their study used the Replicating Effective Programs (REP) Framework with three main phases: (1) "Pre-Conditions" (addressing barriers and facilitators of CPT at the provider level), (2) "Pre-Implementation" (adjusting the protocol for different cultures; e.g., Latino patients), and (3) "Implementation" (determining the impact of provider modification on patient outcome). They found that provider modifications that demonstrated greater fidelity to the treatment protocol were associated with larger reductions in PTSD symptoms. This research produced a CPT Community manual that is culturally appropriate, feasible, effective, and sustainable (Valentine et al., 2017).

Study 2: Developing a CBT Curriculum for Justice-Involved Youth

The Community Psychiatry PRIDE lab partnered with Roca in Chelsea, a nonprofit that works with young men at high risk for a number of adverse psychosocial outcomes (e.g., incarceration). Roca was using an intervention model to help provide positive outcomes for these young men; however, they were missing a mental health component. They established an evidence-based manual to address this issue, Thinking for a Change (National Institute of Corrections, & United States of America, 2001), but this model failed to engage the participants. After the partnership, a needs assessment found that CBT was perceived as too long, complex, and formal to address the issues facing the young men (e.g., trauma, grief, substance use, anxiety, depression, and emotion dysregulation). Dr. Marques and her team then designed a simple way to deliver and teach CBT skills in small doses that would be engaging and impactful for the men in Roca. This led to CBT being practiced through formal and informal deliveries, as frequently as possible, with paraprofessionals possessing low specialization in mental health, who themselves were like the men they were trying to help. They found that practicing at least one CBT skill resulted in lower risk of unenrolling from the Roca program and increased chances of maintaining a job. This research resulted in an integrated curriculum that provides training and support for staff, can be delivered by paraprofessionals, and fully addresses the needs of the participants while also being sustainable (Marques, 2020).

One Roca participant commented on the skills he learned in the program: "If I'm sad, instead of doing a bunch of drugs, I think it's, like, skill 2 or 3, feel your feelings, ride the wave. I just deal with my feelings without fogging my mind up with anything." Roca Assistant Director, Emily, said, "The CBT can kind of just give us this more concrete way of talking about things that we've already talked with young people about many times, but it gives us, like, a format." Xavier, another Roca participant, reflected, "They teach you how to think in other ways. They teach you how to act in line with your values, and not act on your emotions. If I value being a model citizen and I value being free and not in jail, I'm not going to beat this person up and go to jail tonight." Though the staff had not expected the youth to embrace the CBT-based curriculum, they greatly valued the skills they learned and were able to apply them to their everyday lives.

Study 3: Skills to Support Resilience: A Summer Internship for Chelsea Teens

While less than 1% of the U.S. population and the Massachusetts population contracted COVID-19 during the pandemic, it was contracted by 11% of Chelsea residents. In response to the increased threat of COVID-19 to Chelsea residents, Dr. Marques and her lab developed the Pride Summer Scholars Program, a CBT program adapted for inner-city student youth (Marques, 2020). The Pride Summer Scholars program ran for 4 weeks plus an additional 5th week in which the students completed a final project. It included 150 youths ranging in age from 14 to 18+, and it was taught through virtual learning due to the COVID-19 pandemic. The primary goal of the program was to teach CBT as skills rather than therapy. The youths in the program reimagined CBT as Thoughts, Emotions and Behaviors (TEB), and they learned a new skill each week. They first learned the science of stress and observing the TEB cycle, then, charging up, facing their fears, exploring their thoughts, and they completed a final project.

Results showed that although students expressed differences in the skills they found to be most helpful, most of the students that participated in the program found all the skills helpful, and the majority found the skills helpful to apply to their lives. One student described TEB as allowing students to "learn to control their emotions, not overreact in school, not overreact with their teachers, and as a way for them to become better people in general." The students also believe these skills should be integrated into school curricula to help regulate emotions and generate positive outcomes. Through this study, Dr. Marques and her lab were able to anchor five necessary skills: observe the TEB cycle and create a "pause button"; explore thoughts (i.e., cognitive restructuring); problem solve; charge up (i.e., behavioral activation); and face fears (i.e., exposure therapy). This study demonstrated that these skills can be taught through virtual learning grounded in CBT. In order to bridge the gap between science and practice, CBT must be delivered in such a way that individuals in diverse communities, in this case inner-city Latinx youth, can learn and apply basic CBT to their lives.

Conclusion

Implementation science is a solid foundation on which researchers can conceptualize, develop, and grow their research. It allows researchers to think about the challenges that face diverse communities and ask the questions that are relevant to those communities. Implementation science must be done through equitable partnerships in order to effectively bridge the gap between science and practice and increase accessibility and quality of care.

Mental health care is still largely inaccessible: 20% of adult Americans struggle with mental health (U.S. Department of Health and Human Services, 2016), and mental health professionals make up less than 1% of the U.S. population (Andrilla et al., 2018). Therefore, there is a critical need to train paraprofessionals, particularly in diverse communities, to increase access through innovation.

Dr. Marques's lab at MGH Chelsea, Community Psychiatry Pride, has launched a training institute that provides a basic life skills curriculum, evidence-based training, customized coaching, and access to data anywhere. The goal is to train as many paraprofessionals as possible to make evidence-based mental health care widely accessible and to breach that supply-and-demand gap in mental health care. You can learn more about Dr. Marques's work at her website: drluana.com

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NEWS

Invited Address: Dr. Allison Harvey and Looking to the Next Phase of Transdiagnostic Interventions

Arthur R. Andrews III, *University of Nebraska-Lincoln*

IT SEEMS AS THOUGH each year at ABCT's Annual Convention we see great examples of the potential for broad spectrum interventions that move beyond diagnostic classifications. These approaches fit neatly within the cognitive behavioral framework and mindset as the diagnostic taxons were never rooted in the general principles we see within CBT. Setting aside the debate regarding diagnostic classification systems, Dr. Allison Harvey, a professor of psychology at the University of California, Berkeley, provided another example of the effective and broadly applicable approaches that extend beyond a single diagnostic category and adds to the growing transdiagnostic movement. The target this time? Sleep disruptions.

In her invited address, Dr. Harvey provided the empirically driven and scientifically rigorous rationale for the use of transdiagnostic approaches generally and as applied to sleep more specifically. Most notably, sleep disruptions occur within and exacerbate a host of problem types (e.g., Sarsour et al., 2010). Dr. Harvey centered much of this discussion on her and others' work within bipolar disorder. To the point, sleep disruptions lead to and forecast onset of manic and depressive episodes (Gruber et al., 2011). Further, addressing sleep-related problems improved outcomes for individuals with bipolar disorder (Harvey et al., 2015). Combining this with data regarding the multiple mechanisms for sleep disruption and the mechanisms that maintain appropriate sleep function, she provided an overview of the development of Transdiagnostic Intervention for Sleep and Circadian Dysfunction (TranS-C). TranS-C follows the groundbreaking modularized format Chorpita and Weisz developed for treating emotional and behavioral issues in children and adolescents (Chorpita & Weisz, 2009). Dr. Harvey presented data that at least through initial clinical trials, TranS-C appears effective across a variety of sleep domains, though perhaps less with adolescents. Importantly, her data suggested that TranS-C reduces symptoms of other serious mental illnesses in addition to improving sleep. Dr. Harvey ended her address by noting the importance of translating TranS-C into community-based settings and testing the most crucial aspect of transdiagnostic approaches more generally: expediting uptake of effective mental health interventions and improving standard of care.

Dr. Harvey recounted her path to concluding that transdiagnostic research needed to prioritize implementation. Her story likely felt familiar to many of us at ABCT. She came to realize that her clinic where she tested these wonderful innovations did not represent the broader community. It is now almost cliché to acknowledge that clinical innovations do not reach those who would be most likely to benefit from them and access to such innovation perpetuates the same inequality that we have seen for decades. Dr. Harvey is now moving forward to implement this intervention within community-based settings to test the mechanism that makes transdiagnostic approaches appealing, which is that therapists have to learn fewer treatments to treat a greater number of clients. This has the potential to expand the number of people who can receive evidence-based interventions and at a community-level improves the effectiveness of our interventions. It ties directly to a common public health formula that the overall impact of an intervention operates as a function of its effectiveness, its reach and the fidelity to the intervention when it is translated to a community setting.

I, personally, was relieved to see Dr. Harvey's move toward approaches that consider the overall impact of the intervention and seek to deliver on its promise to expand access to quality mental health. For too long our field has focused on improving interventions without considering who has access to them and how could we design them so that we are producing equity rather than enriching the resources of those who already have access. Moving toward community-based implementation of transdiagnostic interventions for such a cross-cutting problem as sleep is a highly welcome next step. At ABCT, we should be striving to move further down this path. If we are committed to inclusion and antiracism, we must continuously ask for whom and by whom are our interventions designed. Without this, we will always fall short in the full potential of CBT and science-based interventions.

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NEWS

Summary of Eric Youngstrom's Invited Address "Helping Give Away Psychological Science: Bringing the Best of Our Work to the People Who Would Benefit"

Joel Lopez, *University of Connecticut*

PSYCHOLOGISTS AND RESEARCHERS alike dedicate much of their lives to improving the impact of psychological science, which we see in the implementation of new measures, treatments, and frameworks. It became apparent to Dr. Eric Youngstrom that the work of psychologists and researchers often leaks through the current pipeline, never making it to widespread audiences that need the information and resources most. This pipeline Youngstrom speaks of more specifically describes the process from the initial breakthrough in psychological science to the intended benefit to the individual. The leaks in this pipeline Youngstrom speaks of include cost, language, and accessibility barriers that are found around the world. Through discussion of the pitfalls within this process and his proposed open-source methods to limit the information lost along the way, Dr. Youngstrom's presentation falls directly in line with the theme of ABCT's 54th Annual Convention: "Better Access, Better Outcomes."

Dr. Youngstrom envisions a world in which the public has immediate access to materials used by professionals within centralized locations, thereby maximizing potential benefit. A service that Youngstrom sees as foundational for the implementation of this open-access framework is Wikipedia, the world's largest online encyclopedia and 13th most popular website on the internet (Alexa Internet, 2020; Wikipedia, 2020). Youngstrom illustrates his point by comparing the amount of views a "Top 5% Journal Paper" would receive (~3,000 views) to a "mediocre" Wikipedia page, which garners approximately 30,000 views. More specifically, Wikipedia articles on psychological topics generally garner approximately 100,000–1,000,000 views. The sheer amount of material that has come from Wikipedia and subsequent audiences for such material is astounding, as is found within the metrics available on the platform. This underscores the advantage of using Wikipedia alone as a location for professionals and researchers to distribute their work, not to mention other services that are available. While the information and writing found on Wikipedia may not meet the quality standards or rigor expected of academic writing, Wikiversity, a subservice of Wikipedia used by researchers and professionals alike, consists of information of higher quality (Youngstrom, 2018). Youngstrom highlighted that while most of these topics are consistently trafficked on both platforms by humans who can correct misinformation, Wikipedia algorithms determine that the information within psychological science pages tends to be of low quality or infrequently updated.

A solution to this issue comes in the form of a function of Wikipedia that actually allows authors to submit their written work directly to Wikipedia for peer review, allowing the preliminary material to be previewed while undergoing the peer-review process. Additionally, academic material could be co-published through Wikipedia and scientific journals as well, further enhancing the reach that an article could have. Another solution to this issue is that Youngstrom and Dr. Mian-Li Ong developed an organization called Helping Give Away Psychological Science (HGAPS). HGAPS originated as an organization that aimed to keep various psychology-related Wikipedia pages as up-to-date as possible with peer-reviewed content. HGAPS has since evolved into an organization that explores various issues and creatively answers the broader question of how to give away psychological science (Youngstrom & Cotuna, 2020). Other projects developed by HGAPS include the Assessment Center, a self-assessment and triage service that utilizes assessment measures found online for free to collect responses and score responses (HGAPS, 2020). This service allows individuals to undergo self-assessments for various psychological disorders to be used as an indicator for follow-on care. The Assessment Center offers a service for clinicians as well, allowing for a patient's responses to be scored and confidentially shared with the provider online (HGAPS, 2020). The Assessment Center faces challenges in their efforts to effectively accomplish their goal of giving away psychological science; for example, language barriers, translations of measures, and resources are required to acquire highest quality and most up-to-date measures.

Another topic that Youngstrom discussed at length is the idea of Creative Commons. As people develop programs and processes to disseminate the information that has been created, there is an impasse surrounding ownership and rightful compensation for the material that was carefully curated. Traditional ways to distribute a publisher's information came in the form of requesting permission and often providing compensation for the published material. Information that comes from open access journals is, as the name suggests, open to the public for use and distribution. Youngstrom discusses the various Creative Commons classifications and highlights "CC-BY." CC-BY means "Creative Commons by…", as in who the work is attributed to. This classification requires only kudos to the author, thereby negating the fees that are often associated with distributing an author's work. As literature becomes older, it is a simple process to change the distribution classification on the work to CC-BY. This designation would allow organizations to discuss and disseminate the author's work, and Youngstrom takes the audience through an example on how to do this for their own work.

In summary, Dr. Youngstrom fulfilled the intention set forth by ABCT for their 54th Annual Convention with his invited address, and he embodies this with his relentless efforts to streamline the process of bringing psychological science to the public. Youngstrom's high energy and engaging invited address was a highlight to the scheduled presenters in their inaugural all-virtual convention. With the rapid advancement of technology and increased ability for lay-people to access information, Youngstrom believes that the dissemination process should come with ease as there is a more explicit effort to effectively share this information in a mutually beneficial process. Youngstrom is leading the way for developing creative and inexpensive ways to distribute their contributions to psychological science, and urges professional and academic research communities alike to follow suit.

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NEWS

A Summary of Dr. Zindel Segal's Invited Address "Strange Bedfellows Share Mutual Dreams: Increasing Access to Mindfulness-Based Interventions for Mood and Anxiety Disorders"

Samantha Moshier, *Emmanuel College*

ONE OF THE INVITED ADDRESSES at this year's ABCT convention was delivered by Dr. Zindel Segal, a Distinguished Professor of Psychology in Mood Disorders at the University of Toronto Scarborough and a Senior Scientist in the Campbell Family Mental Health Research Institute at the Centre for Addiction and Mental Health. A pioneer in the area of mindfulness meditation interventions, he is one of the founders of Mindfulness Based Cognitive Therapy (MBCT) and has developed a variety of books, online tools, and other resources for patients and therapists alike.

Dr. Segal opened his address by highlighting an unusual commercial that aired on national TV during the election coverage this month: 30 seconds of rain falling on leaves. The ad was sponsored by Calm, a digital application for meditation practice. Dr. Segal described the strong potential for public health intervention arising from this unique advertisement: a message of mindfulness, with direct access (in the form of an app), viewed by tens of millions of viewers. Simultaneously, he noted, concerns come to mind: Is Calm evidence-based? If not, might such advertisements disrupt efforts within our field to disseminate empirically supported mindfulness treatments?

Dr. Segal's address focused on a major gap that exists in the current status of mindfulness-based interventions: limited public reach. For instance, in a review of mindfulness intervention research he coauthored with Dr. Sona Dimidjian (Dimidjian & Segal, 2015), approximately 98% of research was dedicated to basic research, intervention development, and efficacy studies conducted in research clinics. Because meta-analyses (e.g., Goldberg et al., 2018) already provide support for the efficacy of mindfulness-based intervention for anxiety and depression, Dr. Segal argued that focusing on efficacy is likely not the most productive avenue for future research. Instead, he said, the question should be asked: "How can we get clinically robust treatments in the hands of more people?"

Dr. Segal described this as the "challenge of our field" in the coming years and presented three examples of innovative work being done to address this problem. First, with a $100,000 grant for advertising using Google AdWords, Dr. Ricardo Munoz and colleagues (2016) have implemented and evaluated a massive online open intervention for smoking cessation treatment. The intervention website was viewed by hundreds of thousands of individuals and the study enrolled over 7,000 participants, a vast increase in sample size compared to that of the typical randomized clinical trial for a face-to-face treatment. Second, Dr. Andrea Graham and colleagues (2020) have partnered with primary care networks to deliver digital depression and anxiety interventions through a mobile platform, showing how digital tools can be more easily rolled out when relying on patients' existing relationships. Finally, the government of Ontario has responded to the COVID-19 pandemic by offering free mental health resources, including an online CBT program called Beacon Health, an effort that Dr. Segal noted will go far in reducing barriers to care and normalizing the need for mental health treatment.

Acknowledging that these examples are snapshots at the end of a longer journey, Dr. Segal discussed his own experience in making MBCT accessible to a wider audience. He described that in the process of developing MBCT, he had done everything that his graduate training had suggested was required for successful dissemination of a treatment: developing an efficacious therapy, creating a treatment manual and a patient workbook, and publishing in top-tier journals. Yet these accomplishments did not increase the adoption rate of MBCT into public spaces. In order to address this, he and Dr. Dimidjian have developed, evaluated, and implemented a digital MBCT intervention called Mindful Mood Balance (MMB). Their experience of translating an evidence-based face-to-face treatment into a digital intervention offers important lessons for ABCT members with similar goals.

Dr. Segal described that the essential first step of digitizing a treatment is to identify the core elements of intervention that must be captured in order to maintain fidelity. He gave several examples of how he and his team "safeguarded" the core components of MBCT. First, MMB was developed to teach mindfulness in a scaffolded manner similar to in-person MBCT, focusing first on mindfulness of tangible stimuli (activities or physical sensations), and moving on to intangible stimuli (emotions and thoughts). Second, MMB re-created the tripartite learning consisting of experiential practice, didactic learning, and vicarious learning that takes place during an in-person MBCT group. For instance, participants might first complete a 30-minute breath meditation and would then be asked to reflect on their experience through a series of written prompts. Then, they could view a video of an in-person group discussing the same meditation practice that they have just completed, allowing for consolidation of learning. Dr. Segal also described how the online format of MMB allowed for several new ways of teaching the core skills and information: for instance, to encourage a metacognitive relationship to thoughts, MMB contains an exercise in which patients can populate and rearrange a "playlist" of their most frequent automatic thoughts.

Dr. Segal next reported on the recently published results of his randomized trial utilizing MMB to treat residual depressive symptoms (Segal et al., 2020). Exemplifying his earlier point about the need to expand mindfulness intervention research beyond the traditional efficacy study, the trial was conducted among patients receiving usual depression care within the Kaiser Permanente health care system. Patients were 460 individuals with residual symptoms of depression and were randomly assigned to receive either eight sessions of MMB + usual depression care or usual depression care alone. MMB was highly cost-effective and resulted in significantly greater reductions in depressive symptoms, anxiety, and mental functioning relative to usual care alone. Importantly, 60% of patients completed the minimum therapeutic dose of four or more sessions, despite receiving only minimal support from a coach by phone or email.

Dr. Segal concluded his address by discussing how we in the ABCT community can best utilize our skills to help evidence-based treatments reach a broader audience. He emphasized that we have a unique skillset: we are able to conceive of, develop, structure, and evaluate psychological treatments. However, we must step out of our comfort zone to ensure that these treatments don't just "sit on a shelf." To this end, Dr. Segal made two specific suggestions. First, we need to consider partnering with those we may not usually collaborate with. Whether we find ourselves working with computer programmers or E-Learning experts, pursuing collaborations outside of our academic spheres will increase the reach of our treatments. Dr. Segal emphasized that our biggest "zone of influence" in these collaborations is ensuring treatment fidelity. Second, we need to acknowledge the role of commercialization; money must be a part of the conversation because it is required to develop and maintain any digitally based therapy that can reach large numbers of individuals. Relatedly, Dr. Segal noted that outside the traditional academic world, we may need to embrace alternative value sets; for instance, satisfaction survey data may be weighed more heavily than efficacy data for many of our collaborators.

The development of the digital version of MBCT and its subsequent evaluation outside the traditional research clinic is a valuable case study in making evidence-based care more widely available to the public. As Calm's election-day advertising demonstrates, myriad programs have begun to fill the gaps that exist worldwide in access to mental health treatment. Dr. Segal timely message encourages each of us to forge new paths and partnerships in order to ensure that the options reaching the public represent the best that our field has to offer.

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NEWS

Summary of Invited Panel: “Promoting Better, Equitable Access to Evidence-Based Mental Health Services in a Community Behavioral Health System”

Angela Moreland, *Medical University of South Carolina*

THE COVID-19 PANDEMIC has taken the lives of over 300,000 Americans over the past year, with minority groups showing disproportional rates of death at more than 2.7 to 3.3 times that of White Americans (APM Research Lab, 2020). Placing minorities at an even greater disadvantage than nonminority individuals suffering from COVID-19, minority populations have historically experienced greater difficulties accessing both medical and mental health care.

Recent attention has been brought to this significant gap in the experience of COVID-19 among minority versus nonminority populations, which has often been additionally discussed due to conversations surrounding racial injustice and systemic racism that plague our country. As mental health professionals, there is a critical need to bring these conversations into our clinical care and to discuss ways that both COVID-19 and systemic racism impact the clients that we serve, and potentially more importantly, how we respond as clinicians. Led by Dr. Torrey Creed, an invited panel discussion at the 54th ABCT Convention not only brought together brilliant leaders in our field to discuss ways to promote better, equitable access to evidence-based mental health services in our country, but also shared their own experiences and knowledge about essential next steps in clinical care, systems, and policy to address current issues in health disparities to care.

The panel opened with Dr. Creed introducing each of the panelists, which included Dr. Sosunmolu Shoyinka from the Department of Behavioral Health and Intellectual disAbility Services; Hector Ayala from the Hispanic Community Counseling Services; Dr. Amber Calloway from the University of Pennsylvania; Todd Inman from the Mental Heaven Show and Founder of Aristocrat TV; and Dr. Karriem Salaam from Drexel University College of Medicine. The panel had a special focus on Philadelphia, which was the intended site of the ABCT Convention before the pandemic forced it to transition to being a virtual experience. The panelists initially described that Philadelphia has a long history of innovating behavioral health treatments within a recovery-oriented, person-centered system to drive Evidence-Based Practices (EBPs), which helped agencies in Philadelphia to quickly adapt and increase access to necessary mental health services for individuals and families at the beginning of the COVID-19 pandemic. The panelists shared some of their personal experiences during the pandemic, which has been a challenging period for all, but has been especially challenging for minority individuals and families. The panelists then highlighted some of the barriers and solutions that were seen in Philadelphia when the COVID-19 pandemic initially began and how these barriers and solutions have changed over the past year.

All four of the panelists described the last 9 months as both transformative and challenging. While Philadelphia is a “vibrant city full of diversity,” it is also one of the largest and poorest cities in the United States. All of the individuals on the panel spoke passionately about work being conducted in Philadelphia and their commitment to broad access of EBP among all individuals and families. Dr. Calloway described that getting access to high-quality EBPs into the system in a routine way is challenging in “regular situations,” but that challenge was heightened exponentially during the COVID-19 pandemic. Panel members discussed several immediate changes that were incorporated in Philadelphia to improve access to mental health treatment, which included the city suspending the need for prior authorizations for providers, ability to set up alternative payment methods, the sudden move to telehealth services for mental health, pushing out materials through websites and other platforms, and agencies offering guidance on unique ways to access care.

When stay-at-home orders were initially placed and businesses were forced to close their doors, many agencies began the transition to serving clients solely through telehealth, although this transition was not swift or easy and worked better for some agencies compared to others. Specifically, many agencies did not have the infrastructure in place to quickly adopt telehealth or the policies that accompany the shift to a remote platform. Disparities in the mental health workforce additionally impacted the ability to deliver telehealth during the pandemic, as many clinicians had difficulty accessing the typical needs for successful work and contacting clients, such as email, computer access, or stable internet connection. Because of this, clinicians had to spend extra time in each work day to develop strategies to conduct everyday work activities.

While effort was being made to improve access to mental health services and care during the pandemic, many logistical barriers impeded successful implementation of telehealth. First, many clients did not have access to computers or stable internet connections, forcing a significant amount of time in session being spent providing IT support, which cut into time for delivery of mental health treatment. Panelists described that these barriers have changed over the past year, but that they are consistent and continue to impact equitable access to evidence-based mental health services. In addition, many clients were suddenly faced with multiple additional roles in the household, including working from home, assisting children with remote education, and household responsibilities. Because of these competing roles, many clients had difficulty scheduling sessions during typical business hours or were unable to schedule at all. Many clinicians met this barrier by meeting the client where they were and agreeing to hold the session late at night after the children went to bed, or over the weekend when additional assistance with childcare or other responsibilities was available.

While these methods were helpful, providers in community agencies were coping with many of the same barriers that clients faced, including childcare concerns, furlough from jobs, and loss of income among other stressors. Privacy and space also served as a barrier for both clients and clinicians, as many sessions were conducted from cars, bathroom floors, or closets in attempt to establish privacy on either the clients end or the clinicians end with other family members also working or attending school from home.

Offering a different perspective, Dr. Salaam discussed his experiences as a provider within an inpatient setting during the pandemic. He described that the typical flow of patients did not change with the pandemic under way, as people continued to have the same mental health problems that require inpatient hospitalization, but that the manner in which care was delivered changed in a significant way. Dr. Salaam explained that the way providers dressed, the protective measures taken (PPE gear, face masks), and the canceling of in-person sessions brought on additional stress and often created distance between patients and clinicians. Further, all visitation was suspended during parts of the pandemic, which impacted the critical family and social support that clients need, especially during a time when more stress and anxiety are inherently present. While the impact on patients is clearly seen, stress and anxiety of clinicians was also heightened given the constant worry about getting sick and the additional bandwidth necessary to keep themselves and their families safe. Clinicians work very hard on a daily basis to help patients decrease emotional pain, but it becomes more difficult to provide the needed support when the clinician is constantly thinking about maintaining his/her safety as well.

To provide some insight and next steps, Dr. Creed asked the panel what they feel people have learned from the first 9 months of the pandemic that has been helpful during this new surge. The panelists highlighted that people are dealing with a great deal of change and are not always prepared for it, coupled with the fact that the parameters of the pandemic are consistently changing and can be overwhelming for individuals and families. People are dealing with a great deal of loss, including loss of jobs, loss of income, and isolation, which raises concern for maladaptive coping mechanisms. A main lesson learned provided by the panel included the need for flexibility to address this constant change in parameters and numbers, as well as openness to changes in structure, routine, rules, and everyday life. Additionally, many panel members stressed the importance of support systems and finding unique ways to connect with other people, as well as the emphasis on self-care. While significant suffering and stress have surrounded the COVID-19 pandemic, the silver lining is the enormous improvement in access to care due to leveraging technology and other unique ways to reach individuals and families. As this pandemic continues, it is imperative that we continue to leverage the unique ways we have connected with others while also focusing on the people and populations that are not being reached through traditional mental health services.

Dr. Creed thanked the panel members for their insightful thoughts and experiences, then transitioned to the topic of systemic racism and broadened awareness, posing the critical question of what strategies have been employed to address these issues and what are the important steps moving forward. Dr. Calloway opened the discussing by noting that it is essential that we move beyond the notion that cognitive behavioral therapy and mental health disorders are equal among all individuals, by acknowledging that they do not persist or exist in the same way across people from different identities and cultures. Clinicians across the United States are increasingly having conversations about how to incorporate these differences into care and practice. This power that clinicians hold has the benefit of influencing outcomes and can be very useful for clients, but power with the lack of insight into privilege and differences across cultures can be harmful to clients and the field as a whole. Thus, it is crucial that clinicians increase their knowledge of the lived experience of their clients and not assume that racism is a new concept, although broad awareness might be. Given health disparities in mental health care, minorities often experience myriad additional stressors when compared to nonminority individuals, and clinicians need to understand how these stressors can lead to negative mental health outcomes. Because of this, it is critical to build culturally responsive techniques into every aspect of mental health services, and particularly cognitive behavioral therapy, to ensure that we are considering cultural background and experiences of clients in assessment, case conceptualization, treatment planning, ongoing treatment, and termination.

Given the enormous impact that cultural identification has on all treatment components, it is the clinician's responsibility to invite conversations about cultural background, systemic racism, and experiences, and to critically and carefully examine how they impact treatment. The panelists discussed that successful mental health treatment is built upon rapport with the client, which cannot be built without understand the client's background and experiences.

This invited panel discussion concluded with Dr. Creed asking about next steps and what the panelists would like to see in our field moving forward. The panelists provided several suggestions with the theme revolving around agencies and systems building an infrastructure to specifically focus on systemic racism and making a needed shift within and among clinics to sustain implementation of culturally responsive therapies. This could include adaptation of EBPs to create connection with patients and incorporate cultural experiences and background, but the panel members felt that it was essential to consider the factors discussed in that panel when connecting with clients and delivering evidence-based interventions.

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Summary of Invited Panel “Personalizing Treatment to Improve CBT Outcomes”

Amy Sewart and Amanda Brashear, *California State University, Dominguez Hills*

DESPITE GENERAL IMPROVEMENTS in the efficacy of empirically supported treatments for psychological disorders, both clinicians and researchers continue to be faced with an ever-present problem as old as the field of psychotherapy itself. A significant proportion of patients either continue to experience treatment nonresponse or experience a relapse of symptoms posttreatment. Methods to enhance precision and individualization of evidence-based treatments are critical to the improvement of treatment outcomes. To discuss current approaches aimed at creating more targeted and effective interventions, ABCT 2020 hosted an invited panel entitled “Personalizing Treatment to Improve CBT Outcomes,” moderated by Dr. Michelle Craske, a past president of ABCT and a Distinguished Professor of Psychology at the University of California, Los Angeles.

First, Dr. Jacqueline Persons (Oakland CBT Center) provided her case-formulation-driven approach as a means to enhance treatment response (Persons, 2006). Taking a hypothesis-testing approach to each case, selected interventions are guided by evidence-based theory, ongoing assessment (i.e., measurement-based care), and process monitoring (i.e., homework compliance, working alliance). Current findings suggest that individualized (i.e., “modularized”) applications of empirically supported treatment elements guided by case-formulation-driven principles are comparable to (Persons et al., 2006) or outperform (Lewis et al., 2019; Weisz et al., 2012) standard, manualized treatment protocols. Dr. Rob DeRubeis (University of Pennsylvania) completed this approach in the second presentation, which discussed the use of multivariate models, such as the employment of “prognostic indices”—composite variables of multiple pre-treatment characteristics (i.e., moderators)—as a promising tool for individualized matching to an appropriate level of care (Lorenzo-Luaces et al., 2017). This effort addresses the lack of replicability for single moderators across randomized controlled trials, limitations to multiple moderator analyses with shared underlying constructs, and, hypothetically, dropout through better-matched care.

Next, Dr. Aaron Fisher (University of California, Berkeley) discussed the use of individual-level behavioral data to personalize psychotherapy, wherein individual characteristics inform (a) personalized content and sequencing of modularized, evidence-based treatments and (b) “just-in-time” adaptive interventions. Critically, Dr. Fisher highlighted that nomothetic statistical approaches traditionally used in therapy outcome research, which assess between-group differences, fail to capture intraindividual experiences and outcomes that are essential to treatment personalization (Fisher et al., 2018). With lack of group-to-individual generalizability, Dr. Fisher emphasized the need to create generalizable processes for model derivation and construction that facilitate the reliable creation of personalized models.

Finally, Dr. Greg Siegle (University of Pittsburgh) presented ways in which neuroscience can be harnessed to personalize cognitive behavior therapies to enhance outcomes. Dr. Siegle highlighted that neural predictors of nonresponse (e.g., decreased executive control) are not necessarily targeted directly within cognitive behavior therapies, and methods to intervene upon these predictors through affordable adjunctive training (e.g., cognitive control; Siegle et al., 2014) and “emotion prosthetics” (e.g., a vibrating wrist strap to assist with emotion regulation through an increase in parasympathetic tone) have shown promise in optimizing treatment response.

During the Q&A, important considerations in the implementation of treatment personalization methods were discussed. The panel noted that improving treatment response requires that we also focus efforts on reducing demoralization during therapy and subsequent dropout, and to achieve this requires that we listen to and respect patient treatment preferences—even when this preference is perhaps contraindicated by research indicating who will and will not respond, or what treatment module best maps onto one’s primary presenting problems. The benefits of personalized treatment using a modularized or component-based approach targeted at identified deficits were discussed further, including potential cost-cutting through briefer interventions and perceived translatability and acceptability among real-world settings. At this time, as Dr. Siegle noted, insurance companies do not reimburse for assessments that inform individualized treatment and a shift in what insurance covers as part of psychotherapy is necessary. Furthermore, dissemination of aforementioned technologies is a notoriously long process. Dr. Siegle urged collaboration with industry to increase the rate at which these technologies can be tested within real-world settings. Finally, Dr. Fisher noted that we need to be able to effectively communicate the purpose of assessment methods to patients to reduce perceived burdensomeness and enhance acceptability. In sum, this panel highlighted various promising methods to personalize cognitive behavioral therapies informed by data ranging from self-report to neuroimaging, and through the application of advanced statistical and conceptual models. Efforts presented by these panelists are promising and bring us one step closer to cracking the code of treatment nonresponse and symptom relapse, and, most important, to having the ability to provide every individual psychotherapy that works best for each individual.

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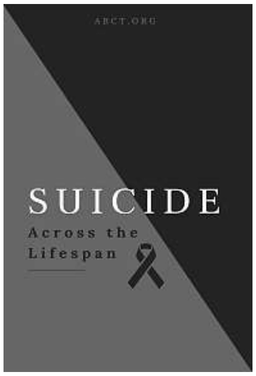
ABCT Launches Inaugural Briefing Books Initiative



To coincide with the its 54th Annual Convention, ABCT launched its inaugural Briefing Books project. The initiative is the brainchild of Emily L. Bilek, Ph.D., ABPP, of the Public Education and Media Dissemination (PEMD) Committee, and David Teisler, CAE, Director of Communications/Deputy Director. PEMD coordinates projects with the Publications Committee and handles press relations for ABCT. The driving force behind the Briefing Books was the desire to provide resources for media and the public who want quick access to materials that explain evidence-based treatments for mental health. In January the committee put out a call to members asking for volunteers to spearhead the project and manage a small team to produce these resources. Fast track to November and the first Briefing Book is available to download on the ABCT website.

The first Briefing Book is entitled *Suicide Across the Lifespan*, with 160-plus pages covering the prevalence of death by suicide in youth (5 to 24 years), adulthood and midlife, and seniors. In addition, death by suicide within sexual and gender minorities and veterans is included, as well as the contributing role of nonsuicidal self-injury, trauma, and disease.

The book's editor and contributing author of the Seniors & Veterans section of the Briefing Book's project, Rita Hitching, MSc., explains the reasoning behind the decision to cover suicide in the first edition: "Our first issue is being released at a time when society is experiencing an unprecedented level of stress. Emotionally demanding circumstances, persistent stress, and depression are strong risk factors for suicide, and when someone ends their own life, the impact is felt by the entire community, and often, long after the event. The global coronavirus pandemic has led to a substantial increase in the number of people experiencing anxiety and depression, and 2020 has highlighted many social injustices and inequities. We felt that by providing evidence-based information that was accessible to all on death by suicide would be very timely."

By design, and with the needs of the reader in mind, flexibility has been built in by providing the option to download the entire book or individual sections. The book, or its sections, can provide useful background information for the busy journalist, as well as supplement the available expertise offered via phone or Zoom conversation by volunteer ABCT subject matter experts through the ABCT office.

Each of the six Briefing Book sections can stand alone, and covers the risk and protective factors, assessment, and treatment of suicidal behavior. Sections are co-authored by ABCT members and leading experts in their field, including Peggy Andover, Ph.D., who contributed to the Non-Suicidal Self-Injury section; Emily Bilek, Ph.D., who wrote the Adults & Mid-Life section; Lily Brown, Ph.D., who wrote the Trauma & Disease section; Mitch Prinstein, Ph.D., and his team Benjamin W. Nelson, Ph.D., Maya Massing-Schaffer, M.A., who penned the Youth section; and Iliana Seager van Dyk, Ph.D., who contributed the section on Sexual & Gender Minorities. The Briefing Books team hope, in future, to write about other topics such as PTSD, stress, gun violence, school shootings, grief, and survivor's guilt, to name a few. ■

ABCT's 55th Annual Convention

November 18–21, 2021 • New Orleans

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 55th Annual Convention in New Orleans? The submission portal will be opened from February 8–March 8. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 55th Annual Convention. The deadline for submissions will be 3:00 a.m. (EST), Feb. 8-March 8.

ticketed sessions

call

55th Annual Convention

November 18–21, 2021 | New Orleans

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 **Tejal Jakatdar, Master Clinician Seminars Committee Chair, masterclinicianseminars@abct.org**

Research and Professional Development

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

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

Conference Theme:

"Championing CBT: Promoting Cognitive and Behavioral Practice and Science in the Context of Public Health, Social Justice, Policy, Research, Practice, and Training"

Information about the convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2021.

Portal Opens: Monday, Jan. 4

Submission deadline: February 8, 2021, 3:00 A.M. EST

ABCT 2021

Hyatt Regency
New Orleans
Hotel

November 18–21, 2021 | New Orleans

CHAMPIONING CBT

Promoting Cognitive and Behavioral Practice and Science in the Context of Public Health, Social Justice, Policy, Research, Practice, and Training

general sessions

CALL for PAPERS

ABCT is proud to announce the 2021 convention theme of *Championing CBT: Promoting Cognitive and Behavioral Practice and Science in the Context of Public Health, Social Justice, Policy, Research, Practice, and Training*.

Sometimes it can feel like swimming against a strong current when advocating for cognitive and behavioral science and practice (i.e., henceforth, "CBT") outside of our close professional circles. The international landscape of mental health prevention, intervention, and training is replete with alternative theories, practices, and interests. The 2021 Annual Convention will place a spotlight on success stories, trials, and lessons learned related to promoting CBT and differentiating it from the other mental health worldviews. In doing so, the ABCT community will come together for a rich discussion that facilitates a core component of the organization's mission to facilitate "the global application of behavioral, cognitive, and biological evidence-based principles." Examples of topics consistent with this theme include, but are not limited to, the following (in no particular order):

- Advocating for the value of CBT in the priorities of major funding agencies and organizations (e.g., importance of promoting cognitive and behavioral science within the NIMH RDoC framework).
- Providing a platform for CBT in the context of social justice (e.g., using cognitive and behavioral science and practice to affect change in prejudice and stigma).
- Encouraging CBT with policymakers to enhance public health through science and practice (e.g., adopting cognitive and behavioral science and practice to reduce unhealthy behaviors, like smoking).
- Promoting CBT priorities in the training of the mental health researchers and practitioners of tomorrow (e.g., encouraging CBT principles as part of establishing training competencies and standards).
- Educating the public about CBT on social media and other public-facing platforms (e.g., impacting public perception of CBT via #CBTWorks).
- Supporting dissemination and implementation of CBT (e.g., integrating CBT principles in a population-level health initiative or system).

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, 2021. The online submission portal for general submission will open on February 8, 2021.

✻ **Deadline for submissions:** Monday, March 8, 2021

• • • PROGRAM CHAIR: **Gregory Chasson** • • •

• • • ASSOCIATE PROGRAM CHAIR: **Elizabeth Katz** • • •

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 8, 2021.
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 1,500 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, Monday, February 8, 2021.

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 55th Annual Convention in New Orleans? The submission portal will be opened until 3 AM EST March 8. Look for more information in the coming weeks to assist you with submitting abstracts for the ABCT 55th Annual Convention.

Deadline for submissions: 3:00 A.M. (EST), Monday, March 8, 2021

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. General session attendees must check in and out and answer evaluation questions regarding each session attended. For those who have met all requirements according to the organizations which have approved ABCT as a CE sponsor, certificates will be available electronically.

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 complete an individual evaluation form. It remains the responsibility of the attendee to check in at the beginning of the session and out at the end of the session. CE will not be awarded unless the attendees checks 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 session attendees must check in and out and answer evaluation questions regarding each session attended.

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 gain access to the CE module. Others can still purchase access at the registration area during the convention.

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 check in and check out and complete an individual evaluation form. For general sessions attendees must check in and check out and answer questions regarding each session attended. It remains the responsibility of the attendee to check in at the beginning of the session and out at the end of the session.

Social Work

ABCT program is approved by the National Association of Social Workers (Approval # 886427222). 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's approval is pending by the California Association of Marriage and Family Therapists (CAMFT) to sponsor continuing education for counselors and MFT's, 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.

Register Now!

Webinar

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

MARCH 12

Cultural Psychotherapy: Concepts, Interventions and Telepsychiatry

— Martin La Roche, Ph.D.

MODERATOR: Janie Hong, Ph.D.

11 am – 12:30 pm Eastern | 10 am – 11:30 pm Central
9 am – 10:30 am Mountain | 8 am – 9:30 am Pacific

During 2020, the twin pandemics of COVID-19 and social unrest exposed significant socioeconomic and racial/ethnic disparities within the United States. Unfortunately, psychotherapy has often reflected these disparities. If psychotherapy is to remain meaningful and credible it needs to be inclusive of the needs and characteristics of all, not just of a privileged few. Cultural Psychotherapy addresses this issue by underscoring how our interventions/relationships and who we are is embedded within socio-economic cultural contexts that confine our relationships and meanings. In this presentation Cultural Psychotherapy's integrative and systematic model is underscored describing its specific applications.

$20 for ABCT members
$30 for nonmembers

CE Credit: 1.5

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2021

Call *for* Award Nominations

to be presented at the 55th Annual Convention in New Orleans

The ABCT Awards and Recognition Committee, chaired by Sara R. Elkins, Ph.D., of University of Houston Clear Lake is pleased to announce the 2021 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 ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line.
Nomination deadline: March 1, 2021.

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, the Charleston Consortium Psychology Internship Training Program, Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University, and Florida State University's Clinical Psychology Ph.D. program. Please complete the on-line nomination form at www.abct.org/awards. Then e-mail the completed form and associated materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. **Nomination deadline:** March 1, 2021.

Outstanding Contribution by an Individual for Research Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions to the literature advancing our knowledge of behavior therapy. Recent recipients of this award include Alan E. Kazdin, David H. Barlow, Terence M. Keane, Thomas Borkovec, Steven D. Hollon, Michelle Craske, and Jennifer P. Read. 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 ABCTAwards@abct.org. Include "Outstanding Researcher" in the subject line.
Nomination deadline: March 1, 2021.

The Francis C. Sumner Excellence Award

The Francis Cecil Sumner Excellence Award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the "Father of Black Psychology," he is recognized as an American leader in education reform. This award can be given on an annual basis, awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree. Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and professional members of ABCT at the time of the nomination. The award is intended to acknowledge and promote the excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional within 10 years of award of the PhD/PsyD/EdD/ScD/MD who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. The Francis C. Sumner Excellence Award is meant to reflect the overarching goal of ABCT supporting its members of color. The recipient will receive $1,000 and a certificate. Please complete the online nomination materials at www.abct.org/awards. Then email the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Francis C. Sumner Award" in the subject line. **Nomination deadline:** March 1, 2021.

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 10 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 ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line. **Nomination deadline:** March 1, 2021.

Michael J. Kozak Critical Inquiry and Analytical Thinking Award

"Clarity of writing reflects clarity of thinking." This statement reflects the overarching goal that Michael J. Kozak sought to achieve himself and that he vigorously encouraged others to reach as well. His penchant for critical inquiry cut across contexts: whether in providing cognitive-behavioral treatment itself, offering supervision of treatment, in scientific inquiry and writing, or in advising investigators about how to put their grant applications in the best possible position for success. Dr. Kozak was always in search of clarity. Accordingly, recipients of the Michael J. Kozak Critical Inquiry and Analytical Thinking Award from ABCT should embody this same spirit in their own work. Michael was able to achieve this high standard and promote its achievement in others with great skill and kindness, so recipients should also conduct themselves in such a way in their professional lives. This award will be given in alternate years. The recipient will receive $1,500 and a plaque. Please complete the online nomination materials at www.abct.org/awards. Then email the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Michael J. Kozak Award" in the subject line. **Nomination deadline:** March 1, 2021.

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 2020. 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 ABCTAwards@abct.org. Include candidate's last name and "Student Dissertation Award" in the subject line.
Nomination deadline: March 1, 2021

President's New Researcher Award

ABCT's 2020-21 President, David F. Tolin, Ph.D., invites submissions for the 43rd 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. Applicants from traditionally underrepresented backgrounds, or whose work advances our understanding of behavioral health disparities, are particularly encouraged to apply. 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 1, 2021.

Graduate Student Research Grant

The ABCT Research Facilitation Committee is sponsoring a grant of up to $1000 to support graduate student research. The grant will be awarded based on a combination of merit and need. Eligible candidates are graduate student members of ABCT seeking funding for an unfunded (including internal sources of funding) thesis or dissertation project that has been approved by either the faculty advisor or the student's full committee. Applications should include all of the materials listed in GSRG Application Guidelines (https://www.abct.org/Resources/index.cfm?m=mResources&fa=GraduateStudentGrant) and one letter of support from a faculty advisor. Please email the application, excluding the advisor letter, in a single pdf to the chair of the Research Facilitation Committee, Shannon Sauer-Zavala, PhD, at ssz@uky.edu. Include "Graduate Student Research Grant" in your subject heading.
Please ask your faculty advisor to e-mail a letter of support separately.
Application deadline: March 1, 2021

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 ABCTAwards@abct.org. Include "Outstanding Service" in the subject line.
Nomination deadline: March 1, 2021.

**For details on all ABCT Awards,
visit our website at www.abct.org**

the Behavior Therapist
Association for Behavioral
and Cognitive Therapies
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