ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

the Behavior Therapist

ISSN 0278-8403 Volume 48, Issue 1 | January 2025

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Published by the Association for Behavioral and Cognitive Therapies | 305 Seventh Avenue, New York, NY 10001

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the Behavior Therapist Volume 48, Issue 1

ORIGINAL RESEARCH | **Reflective Training: A Tool to Help Diverse Learner Groups Scale-Up Therapy Skills**

David L. Roberts, *UT Health San Antonio, Long School of Medicine*

Logan Bruntmyer, *Texas Tech University*

Casey L. Straud, *UT Health San Antonio, Long School of Medicine, and University of Texas at San Antonio*

Casey Thornton, Austin W. Lemke, Jason E. Schillerstrom, *UT Health San Antonio, Long School of Medicine*

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The authors declare no conflicts of interest.

Correspondence to
David L. Roberts, Ph.D., Department of Psychiatry & Behavioral Sciences, UT Health San Antonio, 5788 Eckhert Road, San Antonio, TX 78240
Robertsd5@uthscsa.edu

Demand for counseling and psychological interventions is significantly outpacing other sectors of the U.S. economy (Bureau of Labor Statistics, 2024), due in part to increased recognition of mental illnesses and to increased recognition of the role that patients' health behavior choices play in all areas of medicine. In addition to counselors and psychiatrists, *nonspecialist providers*, like primary care providers and community health workers, are being called on to provide specialized interventions, such as Motivational Interviewing (Brandford et al., 2019) and suicide risk assessment and safety planning (Labouliere et al., 2021).

Unfortunately, it has proven expensive and logistically challenging to scale-up training in delivery of counseling and psychological interventions (Hepner et al., 2018). To build skill requires distributed practice, corrective feedback over time, and assessment of behavioral skills. Arranging these training elements typically requires healthcare providers to contract with a trained assessor and/or content expert, to obtain patients' written consent to record treatment sessions, transmitting session recordings in a HIPAA-compliant manner, and an hour or more of an expert rater's time to evaluate and provide feedback on each recording. This process is logistically challenging and prohibitively costly for routine use in community settings.

Reflective Training (RT; www.reflectivetraining.org) was developed to be an affordable, scalable alternative to help beginners and nonspecialist healthcare providers build mastery in counseling and psychological interventions. RT uses a task-sharing model (WHO, 2008) in which nonexpert peer coaches lead flexibly scheduled, web-based training sessions. In these structured sessions, learners practice skills and learn to track others' skill use in videotaped role-plays. RT is made to be adapted for use with a range of counseling approaches, so far including Motivational Interviewing (MI; Miller & Rollnick, 2023), cognitive behavioral therapy (CBT; Beck, 2011), suicide risk assessment and safety planning, crisis counseling (Dangwung et al., 2024), solution-focused therapy (de Shazer, 1985), behavioral activation (Cuijpers et al., 2007) and dialectical behavior therapy skills (DBT; Linehan, 2014).

To streamline the processes of skill assessment and giving corrective practice feedback, RT peer coaches complete a simplified web-based rating scale, called a Feedback Form (FF), based on 7-minute role-plays that learners record over webcam.

FF scoring is an objective tool for coaches to provide learners with corrective feedback and empirically based suggestions for future practice. Additionally, coaches teach this FF assessment method to all RT learners, who use it to track skill use in role-plays as a form of modeling-based training. From an implementation standpoint, the FF's web-based format means that coaches and learners who achieve reliability in FF scoring can easily and quickly rate any other learners' role-plays, providing a fast, scalable, and cost-effective method for objectively tracking learners' counseling skills over time and providing corrective feedback and suggestions for future practice.

RT has been developed over the past 5 years through an iterative process of implementation, learner feedback, and modification within a range of student and professional provider groups. These provider groups have included community health agency staff (n = 37), psychiatry residents (n > 80), medical students (n > 25), nurse case managers (n > 18), counseling, psychology and social work interns in community health agencies (n > 40), peer support specialists (n = 6), private practice psychotherapists (n = 4) and occupational therapists (n = 2).

In the current proof-of-concept study, we conducted an initial evaluation of the reliability of RT's FF measure of counseling skill. We measured the FF's reliability among experienced psychologists to estimate the maximum expectable reliability of the web-based measure. We then evaluated the FF among RT coaches to estimate its practical or "real world" reliability among those who use it day-to-day. And last, we tested the FF's reliability among naive healthcare students to estimate the minimum training requirements for a nonspecialist to generate reliable ratings of learner skill use. After estimating the reliability of the FF, we examined the effects of RT training on learner skill acquisition over time using FF ratings of learner skill as the outcome measure.

Methods

Setting and Participants

This study was conducted in an urban health-sciences university setting. Participants included RT learners and FF raters. Learners comprised two successive cohorts of first-year psychiatry residents (n = 23 and 21) participating in program-required didactic seminars on CBT and MI. Raters included three tiers: (1) *Specialists* in behavioral ratings of therapy skill comprised two licensed psychologists with experience in CBT and MI (who also are authors of this study: DR and CT[1]); (2) *RT coaches* comprised three MA-level counselors who had completed a 12-hour course of RT in the MI Training Area, had functioned as an RT coach for at least 6 months, and had completed an average of 18 previous FFs before this study began. Notably, the coaches had familiarity with CBT, but no training or experience completing CBT FFs prior to this study; (3) *Non-specialists* comprised two medical students and one undergraduate, all with no previous experience in MI, CBT, RT or completing behavioral rating scales.[2]

Assessment: The Feedback Form–CBT version (FF-CBT)

The FF is a brief, web-based behavioral rating scale of the counseling skills used by a provider in a 7-minute recorded role-play. The FF is used by both RT peer coaches to assess learner skill and RT learners as modeling-based learning. All RT users read the

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[1]A third specialist's scoring was excluded from the study when it was determined that they had followed an earlier version of the FF scoring protocol, which had minimal scoring anchors and called for ratings to be based on a single viewing of the role-play video.

[2]This educational research project was granted exempt status by the UT Health San Antonio Institutional Review Board. All learners were informed that their data would be analyzed for educational research and were given the option to remove their data from analyses.

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FF's three-page coding guide and complete 1-hour of FF training as part of RT orientation.

The FF is divided into three sections: Microskills, Relational Balance, and Specialized Skills. The first two sections are designed to measure generic counseling skills and are identical across FFs used in all training areas, while the Specialized Skills section assesses skill use within a specific training area (CBT, DBT, MI, etc.). In the Microskills section, the rater uses behavior tallies to track instances of the role-play provider using open questions, closed questions, reflections, affirmations/validations and "cautions" (provider utterances that convey an excessively controlling or judgmental stance). This section is rooted in the well-established microskills approach to training and practice in counseling (Ivey et al., 2017).

The Relational Balance section of the FF is adapted from principles of MI (Miller & Rollnick, 2023). It comprises two 1–10 scales that are scored based on the entire 7-minute role-play. Client Motivation rates the client from "Very unmotivated" (1) to "Very motivated" (10) and Provider Directiveness analogously rates the provider's stance from "Highly following" (1) to "Highly directive" (10).

The third section of the FF is Specialized Skills, which lists between 15 and 30 skills specific to the training area of the form. For example, the CBT-FF lists 15 Specialized Skills, including *developing a behavioral experiment* and *cognitive restructuring/reappraisal* while the MI FF lists 17 Specialized Skills, including *reflecting change talk* and *querying extremes*. Each time during the role-play that the provider attempts one of the listed Specialized Skills, the rater enters a timestamp (e.g., 2:45). The rater does not judge the quality or completeness of the skill attempt. In a typical 7-minute role-play, the rater identifies between 0 and 6 attempted Specialized Skills.

After each FF is completed and submitted, the RT website uses FF data to compute the learner's success in meeting six standard goals and pushes this information to the learner, along with their coach's practice suggestion, which is based on the learner's success in meeting role-play goals. Role-play goals vary by training area and are guided by each area's theoretical framework. For example, the goals for MI (cf. MINT, 2008) are as follows:

1. More open than closed questions
2. At least as many reflections as total questions
3. At least one affirmation or validation
4. Avoid cautions
5. Provider Directiveness score is within two points of Client Motivation score
6. Attempt at least two Specialized Skills

A Total FF Score (range: 0 to approximately 8[3]) is computed as the sum of the number of goals 1–5 that were achieved plus 0.25 for each Specialized Skill used.

Procedures

- *Reliability of FF Assessment*

All raters (specialists, coaches and learners) completed basic RT FF training, including reading a two-page glossary of CBT Specialized Skills before completing ratings. In addition, the students were given an additional 1-hour didactic session on CBT concepts. Eight of the 46 7-minute CBT role-plays that our learner participants completed

[3]The measure's ceiling is not exact because learners theoretically could use up to 20 or more specialized skills in a role-play, but practically we have never observed more than 9.

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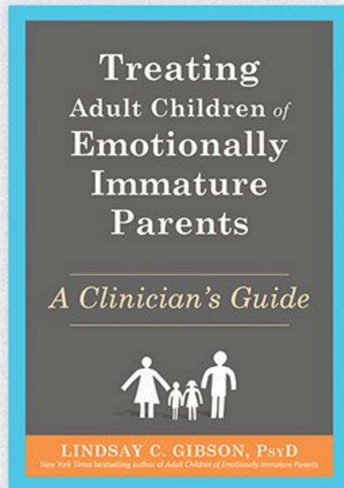

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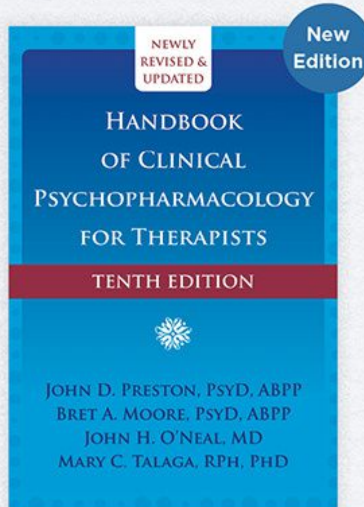

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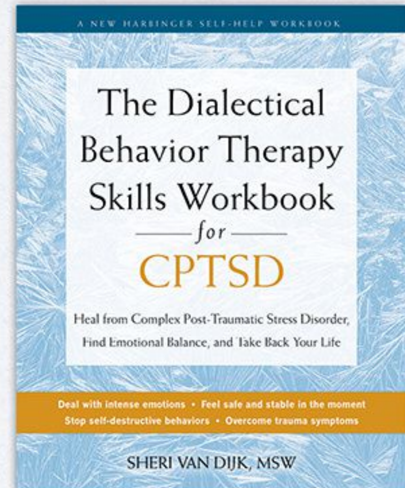

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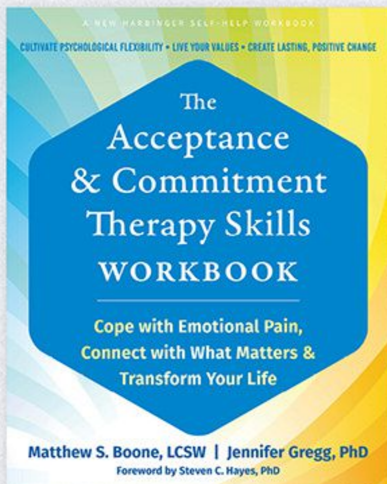

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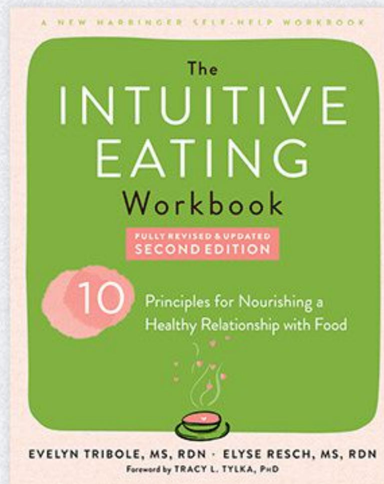

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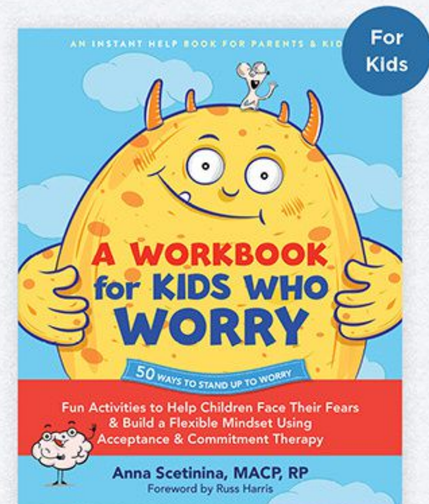

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Table 1. Interrater and Test-Retest Reliability Alphas of the FF-CBT

Variable (*n* = 8 rated role-plays)	Test-retest ICC	Inter-rater ICC					
		Specialists (*n* = 2)		Coaches + Specialist (*n* = 4)		Students + Specialist (*n* = 4)	
	Avg.	Sing.	Avg.	Sing.	Avg.	Sing.	Avg.
Microskills							
Open Questions	0.97	0.84	0.92	0.77	0.93	0.83	0.95
Closed Questions	0.99	0.82	0.90	0.83	0.95	0.59	0.85
Reflections	0.99	0.99	0.99	0.89	0.97	0.70	0.90
Affirmations/ Validations	0.99	0.67	0.80	0.29	0.55	0.29	0.62
Cautions	0.99	1.00	1.00	*	*	*	*
Relational Balance							
Client Motivation	0.67	-0.07	-0.14	0.09	0.28	0.25	0.58
Provider Directiveness	0.82	-0.16	-0.37	0.11	0.32	0.38	0.71
Number of Specialized Skills	0.83	0.26	0.41	0.36	0.69	0.27	0.60
Summary Score							
Total FF Score	0.99	0.91	0.95	0.30	0.63	0.33	0.66

Note. Avg. = Average Measures, Sing. = Single Measures; * = Unable to compute due to too many items with zero variance. Alphas interpreted as: > .50 = acceptable; > .70 = good; > .90 = excellent.

as part of their CBT RT training were selected as the stimuli for reliability ratings.

To estimate the interrater reliability of the FF-CBT our two specialists' ratings (8 x 2 = 16) were entered into a two-way random effects Intraclass Correlation Coefficient (ICC) model. We computed Average Measures (k = 2) alphas to estimate the FF-CBT's optimal reliability and Single Measures alphas to estimate the reliability of using a single rater's FF scoring as the basis for learner evaluation. We used this same approach to estimate the interrater reliability of coaches' FF scoring, entering the three RT coaches' ratings along with the ratings of the primary specialist (DR; 8 x 4 = 32; k = 4). This same model was used again to estimate reliability for the three students (8 x 4 = 32; k = 4).

The test-retest reliability of the FF was evaluated by having the two psychologist specialists rate the same eight CBT role-plays 2 months after their initial scoring. We computed test-retest reliability within the same ICC model used to compute inter-rater reliability but computed Average Measures exclusively.

- *Change in Learner Skill Use*

We used a quasi-experimental design to compare change in counseling skill in the two cohorts of psychiatry residents who received successive iterations of the RT training package. Both cohorts participated in a course including a 1-hour weekly seminar on MI concepts, followed by a 1-hour RT "lab" in which they completed practice exercises and used the FF to rate peer role-plays. Cohort 1 completed 12 weeks and Cohort 2 completed 9 weeks. Participants recorded 7-minute role-plays at Week 2, midpoint, and posttraining.

Cohort 1 provided posttraining feedback to the research team, which was used to improve RT for Cohort 2. Most notably, learners stated that practicing role-plays with

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their peer learners was less useful than practicing with coaches because fellow learners were “too easy” and did not foster skill use. Therefore, for Cohort 2, all role-plays were conducted with standardized patients and standardized role-play topics. For all MI training, in the first role-play the standardized patient exhibited elevated resistance to create opportunities for learners to practice “rolling with resistance” specialized skills; in the final role-play, the standardized patient exhibited elevated motivation to create opportunities for learners to practice “evoking change talk” specialized skills.

Complete week-2 and posttraining data were available for 39 of the 44 learners because 4 learners from Cohort 1 and 1 learner from Cohort 2 did not complete the posttraining assessment. The two cohorts showed the same rate of attendance and of performance on weekly assessments of their knowledge of MI didactic content. To evaluate the learning impact of RT in general and of any differences between the two versions of RT used in the two cohorts, we conducted a 2 (Group: Cohort 1 vs Cohort 2) x 2 (Time: baseline versus posttraining) repeated measures ANOVA using specialist ratings of learners’ Total FF Score as the outcome variable.

Results

Reliability of FF Assessment

Reliability analyses are summarized in Table 1. For interrater reliability, Single Measure alphas are included alongside Average Measures in order to estimate the feasibility of using single FF ratings as the basis for learner evaluation. Alphas are interpreted as: > .50 = acceptable; > .70 = good; > .90 = excellent.

Total FF Score showed excellent Single Measures interrater and Average Measures test-retest reliability when used by specialists, and acceptable Average Measures interrater reliability when used by coaches and students. Among individual items, Microskills variables generally showed high reliability across groups, while Relational Balance and Specialized Skills showed variable reliability.

Change in Learner Skill Use

Results of the 2 (Group: Cohort 1 vs Cohort 2) x 2 (Time: Week 2 versus posttraining) repeated measures ANOVA on FF Total Score are as follows. There was a significant Main Effect for Time, $F(1, 37) = 21.93$, $p < .001$, a significant main effect for Cohort, $F(1, 37) = 5.02$; $p < .05$, and no effect for the Time × Cohort interaction ($F = 1.94$; ns; Figure 1). Examination of means confirmed that the main effect for Time was driven by improvement from Week 2 to posttest. The main effect for Cohort was driven by Cohort 2’s greater performance across timepoints compared to Cohort 1.

Post hoc paired samples *t*-tests showed that both cohorts increased significantly in Total FF

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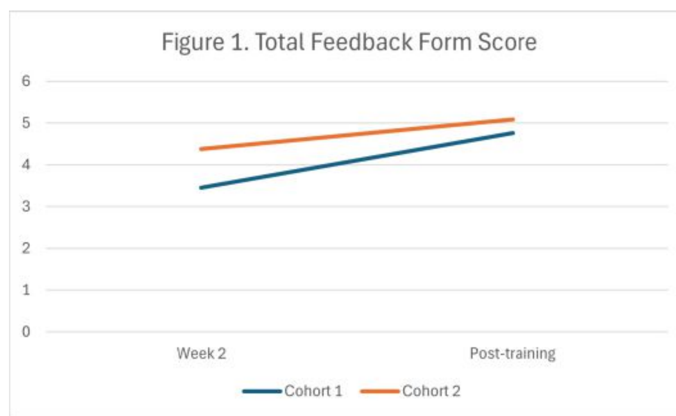

Score over time. Cohort 1 improved significantly from Week 2 (m = 3.45) to posttest (m = 4.76; $t = 4.94$; $p < .001$) and Cohort 2 also improved significantly from Week 2 (m = 4.38) to posttest (m = 5.09; t = 2.07; $p < .03$).

Discussion

This proof-of-concept study provides initial support for the interrater and test-retest reliability of RT's Feedback Form method of assessing counseling skill, as well as initial evidence for the efficacy of RT in improving learners' intervention skills in the targeted training area (Motivational Interviewing).

Reliability of FF Assessment

The FF Total Score showed good to excellent single measures interrater and test-retest reliability when used by specialist clinical psychologists. This means that FF ratings from a single specialist can be used reliably to assess learner skill and to provide corrective feedback. Psychologists' Single Measure estimates also reached good to excellent reliability on all three objective microskill items (open questions, closed questions and reflections). However, psychologists' reliability on Number of Specialized Skills used, Client Motivation and Provider Directiveness was lower, failing to reach adequate single-item reliability even in Average Measures. This finding is not surprising given that all three items are judgment-based and the FF uses a streamlined coding guide with limited rating anchors. To achieve reliability on these items likely will require more detailed scoring guidance.

As expected, compared to specialists, coaches and students showed lower interrater reliability. In particular, both groups' Total FF scores only reached acceptable Average Measures reliability. Thus, it appears that FF ratings from coaches and students may provide a useable estimate of learners' skill performance, but only when used in aggregate. As with specialists, current findings suggest that these groups likely would benefit from more detailed scoring guidelines. However, we are cautious of increasing the amount of time learners are asked to spend mastering the FF method because it is not yet known how or if FF training contributes to improved learner skill, and feedback across learner groups suggests that FF scoring is not a preferred aspect of RT for learners, and so increasing FF training may decrease learner engagement.

It is notable that the students' reliability was not lower than the coaches'. This indicates that the coaches' sheer volume of experience using the FF did not confer greater scoring reliability and that naive students can be trained within 3 hours to reach a sim-

ilarly acceptable level of reliability. A major contributor to students' good reliability was their performance on the objective microskills variables. This highlights the value that objective ratings of provider behavior can bring in comparison to judgment-based ratings, which require more learner time and knowledge to master.

It is not yet known whether FF ratings of provider skill use correlate with patient outcomes. However, previous similar research has found that ratings of counseling performance significantly predict patient outcomes, while providers' performance on a knowledge test do not (Singla, Puerto Nino, et al., 2023).

The relatively strong performance of naive students here also is consistent with previous research using task-sharing models with students (e.g., Kilpela et al., 2014), which shows that with appropriate training students can reliably take on psychoeducation and assessment roles traditionally reserved for specialists. These findings suggest that task-sharing methods may contribute to RT being a cost-effective approach of acquiring and honing specialized psychotherapy skills.

A limitation of the current findings is that coaches' and students' reliability likely is influenced by the fact that both groups had very limited previous knowledge of CBT and received only approximately 2 hours of CBT exposure as part of this study. Because the RT model requires that all learners (and coaches) within a training area complete knowledge-based learning prior to starting RT, it is likely that both coaches and learners in routine RT practice would exhibit higher FF reliability in their active training area than what was observed in the present study. To address this, we currently are conducting a follow-up study of coaches' and learners' reliability within their active training areas.

Change in Learner Skill Use

Regarding the effects of RT on learner skill use, both cohorts improved significantly from Week 2 to posttraining in Total FF score. This finding is consistent with previous research showing that new nonspecialist learners can be taught to competently deliver psychological interventions (van Ginnekin et al., 2013), and that this can be accomplished through informational training followed by deliberate practice and corrective feedback (Chow et al., 2015). Findings also revealed a main effect for group such that Cohort 2 performed significantly better at both Week 2 and posttest. Given that the cohorts showed similar attendance and informational learning, it is likely that this difference is attributable to the addition for Cohort 2 of the standardized patient and standardized role-play content in skill assessment.

Cohort 1's complaint that peer role-play patients were "too easy" is supported by data showing Week-2 Client Motivation FF ratings being significantly higher in Cohort 1 ($m = 5.24$) than in Cohort 2 ($m = 3.73$; $p < .001$). This likely contributed to Cohort 1's lower Week-2 performance because peer role-play partners did not exhibit sufficient resistance to enable learners to use the "rolling with resistance" skills that are central to MI. In contrast, the standardized patient used with Cohort 2 exhibited greater resistance at Week 2, enabling learners to incorporate more skill use into the role-play. At posttest, the "easy" peer patients continued to exhibit high motivation for change in Cohort 1 ($m = 6.85$) and the standardized patient deliberately increased their motivation ($m = 5.30$). This enabled both learner groups to employ "evoking change talk" skills at a higher level—which is consistent with both groups showing strong posttest performance. Thus, in addition to providing initial support for the efficacy of RT, these findings also support the use of standardized patients and standardized role-play focus in RT to maximize learner skill growth. In light of these findings, we have integrated the task of

portraying a standardized patient into the role of the RT coach to maximize feasibility of RT.

The current findings have spurred several future directions for the study of RT. First, we are studying whether enhanced training and an expanded coding guide improve reliability across rater groups, especially in ratings of Client Motivation, Provider Directiveness, and Number of Specialized Skills used. Second, it is unclear whether completing FFs contributes to learners' skill development. We are examining associations between learners' reliability in FF ratings and their improvement in skill use. Third, the validity of the FF has not been established, including defining scoring cut-offs that have real-world significance. To address this, we are currently examining the convergence between FF ratings of learner skill and external criterion measures of this domain. Last, we are examining the feasibility and scalability of RT outside of academic training environments. This includes projects training counselors in a homeless clinic, a statewide network of nurse case managers in a managed care organization, mental health peer support specialists and church-affiliated nonspecialist helpers. We also are collecting data on the efficacy of RT in training areas other than MI, including CBT, crisis counseling, and behavioral activation.

In sum, this study provides initial evidence that the RT training package can be used to build learner skill in counseling approaches and that this skill improvement can be measured reliably and efficiently through the same integrated web-based RT training platform. Our ongoing research is furthering psychometric evaluation of the FF method and evaluation of the effectiveness of RT in a range of different learner groups studying in diverse training areas.

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STUDENT FORUM |

Advising Discerning College Students About Psychotherapist Career Options: Unpacking the Alphabet Soup of Graduate Training and Licensure

Thomas G. Plante, *Santa Clara University and Stanford University School of Medicine*

Many of our psychology college students wish to become psychotherapists (Farber et al., 2005; Hill et al., 2013). Becoming a psychotherapist has been a popular career choice for psychology majors for decades (Huynh & Rhodes, 2011; Kottler, 2022). The popularity of psychotherapy as a career option is likely only to increase, given the recent attention to mental health troubles among youth in particular and the reduced stigma of seeking mental health professional help (Bommersbach et al., 2023; Cullen, et al., 2020; Weisz et al., 2019). Many celebrities with a great deal of media attention and social media followers have recently admitted to mental health struggles and have discussed the many benefits of psychotherapy. Furthermore, the U.S. Surgeon General has offered several unprecedented recent advisories highlighting the increased numbers of people with mental health concerns and the need for more professionals to serve those in need (Ferrari, 2016; Hoffman et al., 2017; Office of the Surgeon General, 2021).

However, given all of the attention mental health problems and treatment options have received in recent years, our students are easily confused and are often misinformed about the best path forward in pursing graduate training and then licensing as a psychotherapist. In my over 30 years of teaching psychology undergraduates, it has often become a daily ritual for me to meet with confused students and try to help them discern their path forward following college to become licensed psychotherapists. While there are many resources available to help guide interested students, including books, websites, journal articles, and so forth (e.g., Sayette & Norcross, 2024), one can easily experience an overload of information as well as too many distracting details that can only add to confusion for students trying to make decisions about their post-college graduation plans that are suitable for them. The purpose of this brief article is to help both students and their faculty advisors better understand options for graduate training leading to licensure as a psychotherapist in a brief, simple, straightforward, and direct manner.

Before a fruitful and productive discussion about graduate training and career options can begin, it might be helpful to introduce students to a structured strategy for decision making and discernment using the four Ds (i.e., discovery, detachment, discernment, and direction; Plante, 2017, 2024). The four Ds originated from the work of St. Ignatius of Loyola, the founder of the Society of Jesus or the Jesuits, 500 years ago, but has been adapted to use with secular and modern audiences (Burton et al., 2023; Plante, 2017, 2024; Tan, 2023).

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The author declares no conflicts of interest.

Thomas G. Plante
ORCID: 0000-0001-5314-2991

Correspondence to
Thomas G. Plante, Ph.D., Department of Psychology, Santa Clara University, Santa Clara, CA 95053
tplante@scu.edu

The Four Ds of Decision-Making

Discovery refers to an understanding of one's gifts, talents, and desires. Asking students about what they are interested in, compelled by, and talented in provides a richer understanding of their gifts and desires to thoughtfully consider when advising them about potential career possibilities. *Detachment* refers to avoiding the subtle and not-

so-subtle influences of society, peers, parents, and others who may have strong views or agendas for their career paths and decisions. This might include practical matters such as likely income, prestige, or following the footsteps of their family members in business, medicine, law, and so forth. Students are asked to at least temporarily detach from these influences to help determine their own desires and goals. *Discernment* focuses on reflecting on what provides consolation versus desolation when considering various graduate training and career options. For example, students might feel more engaged by and comfortable with certain career pathways than with others. Finally, *direction* speaks to next steps in decision-making where specific issues and questions can be addressed to develop clarity and a game plan about what to do next. The four-D process will help to prepare students for specific questions that can assist them in determining their best path forward to reach their educational, career, and professional goals.

Three Critical Questions for Psychotherapist Career Path Discernment

The path to becoming a psychotherapist is especially confusing for many as there are so many possibilities and tracks to consider (Karazsia & Smith, 2016; Landrum, 2018; Protivnak & Yensel, 2017; Schatz & Ansburg, 2020). Students, and often faculty advisors, can easily be perplexed by the "alphabet soup" of options and potential directions (e.g., MFT, LCSW, LPC, PhD, PsyD). This confusion can be simplified by asking students to answer a few basic questions in a particular order to help them narrow their options and select the one that is most likely to meet their needs, desires, and goals. Following the four-D process, I would suggest starting a conversation with these three important questions:

Question 1*: Do you want to be a psychotherapist only and thus have no interest in conducting research, teaching at the college or university level, or conducting psychological assessments such as neuropsychology testing, cognitive or intellectual assessment, and personality or psychopathology assessment?*

If students answer "yes" to this question, then they may be interested in a master's-level degree and licensure as a social worker (i.e., LCSW), marriage and family therapist (i.e., MFT), or licensed professional counselor (i.e., LPC). Since licensure occurs at the state, and not federal, level, students should check to be sure that the pathway that they choose is licensable in the state (or states) that they likely will settle in when they complete their training. Most states offer licensing in all of these areas but some states will license MFTs but not LPCs while other states will license LPCs but not MFTs. Checking with the state licensing boards in the states of interest would be advised before applying to graduate programs, especially when applying to graduate programs in states other than the one the student is most interested in settling in when their graduate training program is completed.

Master-level training programs are generally not very selective or competitive and so students with various grade point averages and backgrounds, including with diverse academic majors not in psychology, may be able to enroll in many of these training programs. The training programs will likely cost money, with private schools being generally much more expensive than public ones. Additionally, few scholarships are typically available to offset costs. Since these training programs usually take only about 2 years of study to complete compared with the longer length of time that it takes to complete an undergraduate or a doctoral degree, the costs may be more manageable. In most states, a post-degree internship year of supervised training experience is needed before one is eligible

for licensure. This post-degree internship often includes a modest stipend.

Question 2: *Do you want to be a psychotherapist who also conducts psychological assessment such as neuropsychological testing, forensic evaluations, cognitive or intellectual assessments, and personality and psychopathology evaluations?*

If students answer "yes" to this question, then they should pursue a doctoral degree (PhD or PsyD) at either a university or at a free-standing professional school setting. If students are not interested in research or teaching at the college or university level and want to focus primarily on clinical applications such as psychotherapy and psychological or neuropsychological assessment, then they might focus their graduate school search attention on either PsyD programs or any of the doctoral degrees offered at free-standing professional schools.

Like master-level training programs, free-standing professional schools, unaffiliated with universities, tend to be generally nonselective in their admission processes and thus students with diverse college academic performance and with different academic majors can often be admitted to these doctoral training programs. Additionally, students who are older and perhaps have had other careers or family obligations are welcome to apply to most of these training programs too. Free-standing professional schools tend to depend on tuition dollars for their operations at a much higher percentage than universities and so class sizes tend to be larger and tuition costs can be high as well. Few scholarships are generally available for most students, with some exceptions for minority students. Since doctoral programs take 4 or more years to complete, the costs of training can be very high, especially at these nonuniversity-affiliated, free-standing professional school graduate programs.

Question 3: *Do you want to be a psychotherapist who not only conducts psychotherapy and psychological testing but also conducts research and potentially has interest in teaching at the college or university level?*

If student answer "yes" to this question, then they likely want to direct their graduate school search attention to PhD programs in university settings only. These programs are generally highly competitive and thus excellent grades, test scores, and previous research and clinical experience is strongly advised prior to submitting an application for admission. Additionally, applying broadly to many schools across the country is usually needed as well to increase the probability of receiving an invitation to enroll in at least one of these programs. Some graduate training programs require applying to a particular faculty member's laboratory or research group while others require a more general admission application procedure without specifically indicating which faculty member the student hopes to work with. Some programs are very research focused, with little attention to clinical training, while others are more balanced with equal attention to both clinical and research training and experiences. A close review of each graduate program's informational material as well as speaking to current or recent students and faculty might be helpful to determine if the program fits the applicant's needs and desires.

Earning a PhD from a university in an accredited clinical or counseling psychology program provides students with the most career options and opportunities in that these graduates can later pursue careers in clinical work such as psychotherapy and psychological testing but also pursue careers in research, teaching, consultation, or a combination of all of these options. However, students who have little interest in research might be disappointed with these university-based PhD training programs if they are primarily interested in becoming clinicians. A significant advantage of PhD programs

offered in university settings is that typically research or teaching fellowships are available so that the financial costs to students tend to be much lower (and might even be completely free) compared to other graduate training options (i.e., terminal master's degrees, PsyD degrees, or degrees from free-standing professional schools).

Once these three questions are presented and answered, it might be helpful for students to consider several other common issues and questions about graduate training leading to professional licensure before making their decision about which programs to apply to.

Important Additional Considerations for Psychotherapy Career Path Discernment

Specialization Training

Students often wonder if they need to enter a graduate training program with a clear specialty in mind. Perhaps they are considering focusing their graduate training attention on children, adolescents, families, adults, or the elderly. Maybe they are interested in particular diagnoses such as eating disorders, depression, anxiety, trauma, autism spectrum disorders, or major psychopathology such as schizophrenia. They may wonder about particular professional training methods such as dialectical behavior therapy, trauma-informed therapy, or working with particular subgroups such as BIPOC (i.e., Black, Indigenous, People of Color) clients. Some training programs require students to select a specialty or subspecialty interest during the application process, while others do not. Since interests can change over time and also might change after students obtain advanced training and experiences in the field, it is recommended to secure a broad and diverse education in order to make a more informed decision about specialization later in one's training program and career.

Interstate Training

Students often wonder if they can complete their graduate training in any state. Since each state has its own requirements for licensing, they should be mindful of individual state requirements in whatever state (or states) they hope to settle in once they complete their graduate degree and seek state licensure. Typically, there are mechanisms in place to be licensed across state lines, but glitches can easily occur when different states have different requirements for licensure. One recent development for psychologists that offers some degree of helpful licensure reciprocity between states is PsyPact (Taube et al., 2023; Younggren et al., 2022). More than 40 of the 50 states are now members of PsyPact that offers a pathway to be a recognized licensed provider in multiple states once licensure is secured in one of the PsyPact states.

Overseas Training

Some students wonder if they might complete their graduate training in another country. This is not recommended, unless they are considering Canada since educational and licensing requirements overseas often do not closely match those of the United States. Thus, students may complete graduate training overseas only to realize that getting licensed in the U.S. after they graduate results in many insurmountable obstacles. If students wish to work in the U.S. when their graduate training is complete, they would be best served if they complete their graduate training in the U.S. as well. Canada is the one exception as their training program requirement mostly match those in the U.S.

Applying for a Terminal Master's Degree First Before Working Towards a Doctoral Degree

Often students wonder if they should apply for a terminal master's degree first and

then decide later if they want to continue their graduate training to earn a doctoral degree. The problem with this plan is that many doctoral degree programs will not recognize all of the classes taken as part of a terminal master's degree program and they may not accept some or all of the credits earned. Thus, for most students, it is likely best to decide if they wish to pursue a terminal master's degree program leading to a masters-based licensure or a doctoral degree program leading to a doctoral-based license.

Degree Programs and Licensure Titles Can Be Misleading

Students often are confused by what degree programs and licensure titles allow them to actually do in clinical practice. For example, someone who has a license as a marriage and family therapist (i.e., MFT) can do marriage and family therapy, but they also can conduct individual therapy, group therapy, and couples' therapy where the couples they are working with are not married. A licensed clinical social worker can do individual, couple, group, and family therapy as well as case management and advocacy work. The critical issue is that professionals must stay within their lane of professional training, supervision, and competence and not deviate or dabble in areas that they have no or little training or expertise (American Psychological Association, 2017). Both legally and ethically, professionals need to maintain competence and work in the areas of practice that they are adequately trained in, regardless of the title of their degree or license.

Required Training Does Not End With the Degree, and Post-Degree Training Is Necessary Before State Licensure

Students may assume that once they earn their graduate degree, they have fully completed their training and are ready for state licensure. Almost all states require at least 1 year of post-degree supervised training experience before eligibility for state licensure. Thus, students must complete an internship or post-degree fellowship under the supervision of licensed professionals before they are allowed to sit for most state licensing exams. A modest living stipend is usually provided for this post-degree year of supervised training and experience.

Conclusion

Many college students are interested in becoming psychotherapists but are easily confused about the best path to do so. Since there are many training and licensing options to consider, there are multiple opportunities for confusion, misinformation, and distraction to make the best choice given their interests, skills, and hopes for their future career path. Asking students to first participate in a decision-making process—the four Ds—that highlights discovery, detachment, discernment, and direction before considering three critical questions may help them find the right direction. Thoughtful reflection and discernment about their options may avoid errors in decision-making as well as later regrets.

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ORIGINAL RESEARCH |

Racial Microaggressions and Cultural Intelligence

Monnica T. Williams and Muna Osman, *University of Ottawa, School of Psychology*

Ahmad Alftieh, *University of Ottawa Institute of Mental Health Research at the Royal*

About Racial Microaggressions

As blatant expressions of prejudice have declined over the last several decades, increasing attention has been paid to how more subtle forms of prejudice are enacted in everyday interpersonal interactions, and interest in microaggressions has coalesced in this context. Racial microaggressions refer to the verbal and nonverbal acts that reinforce pathological stereotypes, discriminatory and exclusionary social norms, or communicate inferiority about people of color (Williams, 2020). The term *microaggression* was first defined by Pierce (1970), a Black psychiatrist at Harvard University, as the incessant and subtle offenses that cumulatively have a negative effect on African Americans. Substantial work has been done in the field since that time to define, conceptualize, and examine the effects of microaggressions, which has advanced the research area significantly in conceptual and theoretical clarity (Farahani et al., 2022; Osman et al., 2024). Although researchers have studied racial microaggressions targeting different racial groups, this study will focus on anti-Black microaggressions. Anti-Black racism refers to a set of beliefs, attitudes, policies, and practices that devalue, minimize, and marginalize those presumed to be of Black African heritage; it is connected to all types of racism to the extent that it privileges proximity to Whiteness (e.g., Eurocentric beauty standards) over Afrocentric and other non-White physical features (Comrie et al., 2022). Anti-Black racism is widespread and leads to poor mental and physical health outcomes for Black people (Cénat et al., 2024). As such, this study will examine correlates of individual tendencies to microaggress against Black people.

Understanding the correlates, predictors, and antecedents of microaggressions is essential to enhancing conceptual and theoretical clarity. As a concept, we know racial microaggressions are multifaceted and can be identified based on the context and content of the statement, action, or stereotype (Williams et al., 2021). This includes the power dynamics between the perpetrator and target (Wong et al., 2014), levels of acceptability (Mekawi et al., 2023), and target stereotypes (Mekawi & Todd, 2021). For example, an instructor telling a Black student that she is smart during office hours as part of a general feedback might not be a microaggression; however, it might be if it was said during class with an expression and tone of surprise (Williams, 2021). Similarly, asking an Asian American woman where she is from might not be a microaggression if the motivation is genuine connection over similar life experiences; however, it might be if the motivation is to draw stereotypical conclusions based on heritage and/or assumed immigration status. It is therefore crucial to consider microaggressions in the context in which they are enacted rather than isolating them to specific words, actions, or statements. Established measures of microaggressions, such as the Cultural Cognitions and Actions Scale (CCAS), consider both context and content to ensure a range of microaggressions is assessed accurately in a reliable and valid way (Kanter et al., 2020). This measure has been tested and used in national samples in both the United States and Canada.

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Monnica T. Williams ORCID: 0000-0003-0095-3277

This research was undertaken, in part, thanks to funding from the Canada Research Chairs Program, Canadian Institutes of Health Research award number: CRC-2018-00239 (PI M. Williams).
The authors report no conflicts of interest.

Correspondence to
Monnica T. Williams, Ph.D., University of Ottawa, School of Psychology, 136 Jean-Jacques Lussier, Vanier Hall, Ottawa, Ontario, K1N 6N5, Canada. Monnica.Williams@uOttawa.ca

Consequences and Impact of Microaggressions

Recent surveys document that people of color experience racial microaggressions regularly with negative physical and mental health consequences (Forrest-Bank & Jenson, 2015; Hall & Fields, 2015; Nadal et al., 2014). A study utilizing a large, diverse sample of undergraduate and community participants recruited from a large urban Hispanic-serving public college in the Northeast and various community organizations found that exposure to racial microaggressions negatively predicted mental health outcomes and was associated with an increase in depressive symptoms and negative affect (Nadal et al., 2014). In addition, Blume et al. (2012) found that exposure to microaggressions was associated with higher prevalence of anxiety and binge drinking among students of color attending historically White universities. Further, a study investigating the effects of racial microaggressions among young adults of color found a significant association between increased suicidal ideation and exposure to microaggressions (O'Keefe et al., 2015). This association was mediated by an increase in depressive symptoms among individuals of color experiencing microaggressions. In a recent study by Kuem and colleagues (2023), the authors showed that gendered racial microaggressions significantly increased the likelihood of suicidal ideation by threefold among a sample of 309 adult Asian American women, highlighting its prominent role as a risk factor for suicidal ideation. Similarly, Hollingswood and colleagues (2017) showed that exposure to racial microaggressions leads to increased levels of suicidal ideation, which was moderated by higher levels of perceived burdensomeness among African American college students. Cénat and colleagues (2022) found that racial microaggressions against Black Canadians were common, comprising an integral component of discrimination that contributed to poor life satisfaction and low self-esteem.

In addition to interpersonal interactions, microaggressions can occur in professional, medical, and clinical settings (Williams et al., 2024). For example, microaggressions have been linked to a poor therapeutic alliance when perpetrated by therapists against clients of color (Constantine, 2007; Owen et al., 2014) and a poor working alliance when perpetrated by supervisors against trainees of color (Wilcox et al., 2024). The ubiquity of these experiences across individuals, settings, and over time underscores the pressing need for further research exploring the causes and correlates of microaggressions to better inform our understanding of how they can be prevented (e.g., Brown et al., 2024). Specifically, there is growing interest in the individual differences and situational correlates of the occurrences of microaggressions.

Cultural Intelligence

Research interest in cultural intelligence has grown significantly since it was first introduced. As such, the concept of cultural intelligence has been validated and refined across different social settings, organizations, education institutions, and interpersonal interactions as well as different countries and populations (Wang & Goh, 2020). Cultural Intelligence (CQ) is defined as an individual's capability to function and manage effectively in culturally diverse settings (Earley & Ang, 2003). The development of this construct was based on contemporary theories of intelligence (Sternberg & Detterman, 1986), and it focuses on situations involving cross-cultural interactions that arise due to differences in race, ethnicity, and nationality. Building upon Sternberg and Detterman's multiple-loci theory of intelligence, Ang et al. (2007) further conceptualized CQ as a multidimensional construct in which an individual functions in culturally diverse settings. This includes metacognitive CQ, cognitive CQ, motivational CQ, and behavioral CQ dimensions. Individuals with high CQ are culturally competent and can employ a wide array of cognitive, behavioral, and motivational abilities to adapt and function effectively with individuals and

situations that are culturally different (Ott & Michailova, 2018).

The metacognitive CQ domain reflects the mental processes used to acquire and understand cultural knowledge (Flavell, 1979) that encompasses an individual's ability to plan, monitor, and revise mental models of cultural norms for countries or groups of people (Ang et al. 2007). Evidence shows that individuals with high metacognitive CQ are more likely to question assumptions about culture and adjust their mental modes during and after cross-cultural interactions (Brislin et al., 2006; Triandis, 2006).

The cognitive CQ domain reflects knowledge of norms, practices, and conventions of different cultures, acquired through education and personal experience (Ang et al., 2007). This includes knowledge of basic frameworks of cultural values (Hofstede, 2001) and different cultural systems such as economical, legal, and social systems (Triandis, 1994). Evidence shows that individuals with high cognitive CQ can better understand similarities and differences between different cultures (Brislin et al., 2006).

The motivational CQ domain reflects the ability to exert conscious effort to direct attention and energy towards learning and functioning in situations that are culturally different (Ang et al. 2007). Evidence shows that those with high motivational CQ can direct attention and energy toward cross-cultural situations based on intrinsic interest and have confidence in their cross-cultural effectiveness (Bandura, 2002; Deci & Ryan, 1985).

The behavioral CQ domain reflects an ability to display appropriate verbal and nonverbal actions when interacting cross-culturally (Ang et al., 2007). Evidence shows that individuals with high behavioral CQ are more likely to exhibit situationally appropriate behaviors based on capabilities such as tone, gestures, and facial expressions (Gudykunst & Ting-Toomey, 1988).

Research on cultural intelligence has gained increasing attention within the last 2 decades due to the increase in globalization and diversification among different sectors and organizations worldwide (Fang et al., 2018; Ott & Michailova, 2018; Wang & Goh, 2020). As such, much of the scholarship on CQ has appeared in the organizational behavior and management literature (Afsar et al., 2021; Livermore et al., 2022). Substantial research has been conducted to standardize its definition and the validation of its measurement, as well as investigating how it can be developed and used to predict individual outcomes in intercultural settings (Ott & Michailova). Evidence shows that cultural intelligence is a predictor of outcomes such as cultural adaptation, expatriate performance, global leadership, intercultural negotiation, and multicultural team processes (Van Dyne et al., 2012). A recent study by Genkova and colleagues (2021), investigated a large sample of adults ($N = 1{,}051$) from different European cultures (i.e., Hungary, Czech Republic, Serbia, Germany) and found the cultural intelligence scale (CQS), particularly the motivational aspect, was a significant predictor of lower prejudice across national samples.

Cultural Intelligence and the Occurrence of Microaggressions

It seems logical that having greater cultural intelligence should equip individuals with the skills to adapt their behaviors appropriately in diverse settings and, as such, reduce the biases that lead to racial microaggressions by broadening one's cultural understanding. When people are better able to interact across cultures, it would be reasonable to hypothesize that they are less likely to rely on stereotypes (Ang et al., 2007), which makes them less likely to commit microaggressions. Increasing cultural intelligence may also encourage individuals to reflect critically on their own beliefs and behaviors. This reflection can lead to a more conscious awareness of their own implicit biases, motivating efforts to challenge and change these automatic responses.

By learning about different cultural groups, individuals gain exposure to different ways of life, which can reduce the fear and discomfort that often accompanies unfamiliarity (Earley & Peterson, 2004). This exposure helps normalize diversity and reduces the tendency to view one's own cultural norms as inherently superior. Increasing cultural intelligence also involves developing empathy by understanding the emotions, motivations, and backgrounds of different people (Wang & Goh, 2020). This empathy allows individuals to see beyond superficial differences and recognize shared human experiences, which can significantly lower feelings of animus and reduce the automatic negative associations that lead to microaggressions. As such, we predict that greater cultural intelligence is correlated with a lower tendency to commit racial microaggressions.

To date, there have been no empirical studies of CQ and the propensity to commit racial microaggressions. Ng and colleagues (2022) call for more study into the "specific nature of each CQ factor" (p. 192) to enable the detection and management of unequal social interactions that are too often riddled with microaggressions.

Purpose of this Study

To date, most efforts to understand microaggressions have surveyed stigmatized group members (Nadal, 2011) but have not assessed the degree to which others engage in microaggressive behaviors. One of the few studies that examined this issue found that White students who reported that they were more likely to microaggress were more likely to endorse color-blind, symbolic, and modern racist attitudes (Kanter et al., 2017). Direct focus on the psychology of those delivering microaggressions may improve efforts to develop interventions to educate those committing microaggressions and thereby reduce the frequency and resulting harm caused by these acts.

Research has shown that microaggressions are positively correlated to both racial bias and aggression. Specifically, aggressive tendencies were strong correlates of microaggressiveness (Williams, 2021; Williams et al., 2021). Despite the link between aggressive tendencies and endorsing microaggressions, it has also been theorized that racial microaggressions occur as a cultural faux pas, caused in part by a lack of cultural knowledge rather than racial prejudice (Lilienfeld, 2017; Williams, 2021). Similarly, there has been speculation about the role of dispositional tendencies in negative affect to drive occurrences of microaggressions rather than racial prejudice (Lilienfeld, 2017; Williams, 2020). Research is needed to explore how negative affect, aggressive tendencies, and cultural intelligence, independently or in combination, relate to microaggressive tendencies. Negative affect refers to trait-level tendencies in aversive affective states, encompassing emotions such as anger, fear, anxiety, shame, and disgust (Watson et al., 1988). The link between aggression and negative affect is well-established (Kjærvik & Bushman, 2021), as is their link with racial microaggressions (Williams, 2021).

We test this hypothesis by exploring the relationship between cultural intelligence and the propensity of people to commit anti-Black racial microaggressions, while accounting for aggressive tendencies and negative affect in a Canadian national sample of White adults.

Specifically, this study hypothesizes: (a) levels of cultural intelligence will be related to microaggressions, such that higher levels of cultural intelligence is related to lower levels of endorsing microaggressions; (b) the domains of cultural intelligence will be related to endorsing microaggression; (c) the domains of cultural intelligence will be related to endorsing microaggressions, above and beyond the effect of aggressive tendencies and negative affect. Finally, to assess the relationships between these constructs we use a hierarchical analysis to demonstrate the incremental contribution of

construct (negative affect, aggressive tendencies, and CQ-Metacognitive, CQ-Cognitive, and CQ-Motivational) in explaining microaggressive tendencies.

Method

Participants

A total of 235 participants were included in this study from a larger diverse sample. Participants were geographically representative across the Canadian provinces.

Table 1. Participant Demographic Information

	Total (n)	Percentage
Gender Identity		
Male	94	40.5 %
Female	138	58.7 %
Non-Binary/Gender Fluid	3	1.3 %
Sexual Orientation		
Heterosexual	209	88.9 %
LGBQ	21	9.00 %
Asexual	2	0.90 %
Not Listed	3	1.30 %
Country of Birth		
Canada	230	97.9 %
Other	5	2.10 %
Hispanic Ethnicity		
Non-Hispanic	230	96.0 %
Hispanic	2	2.20 %
Marital Status		
Married	87	37.0 %
Widowed	8	3.40 %
Separated/Divorced/Annulled	19	8.10 %
Single (Never Married)	71	30.2 %
Living With Partner	47	20.0 %
Religion		
Catholic	110	42.6 %
Christian	49	20.9 %
Muslim	9	0.90 %
Atheist	39	16.60 %
Agnostic	23	9.80 %
Other	19	8.10 %
Language Fluency		
English	112	47.7 %
French	75	31.9 %
Bilingual (English/French)	39	16.6 %
Bilingual (English and another Language) or Other	6	2.60 %
Education Completed		
Grade 12 or less (without graduating)	12	5.10 %
High school diploma, GED, or equivalent	51	21.7 %
Part college	31	13.2 %
Graduated 2 year college	50	21.3 %
Graduated 3 or 4 year university	62	26.4 %
Some post-graduate/professional school	8	3.40 %
Completed post-graduate/professional school	18	7.70 %
Employment		
Employed full-time for pay (over 30 hours/week)	115	48.9 %
Employed part-time for pay (less than 30 hours/week)	18	7.70 %
Homemaker	9	3.80 %
Full-time Student	17	7.20 %
Part-time Student	1	0.40 %
Unemployed temporarily/more than 6 months	19	8.10 %
Retired	39	16.6 %
Receiving public assistance	3	1.30 %
Disabled	8	3.40 %
Other	3	1.30 %

Procedures

Participants were recruited from across Canada using Qualtrics Panels, a web-based survey tool ($n = 825$; 91.4%), supplemented with a smaller number of undergraduate participants from the Integrated System of Participation in Research (ISPR) Student Pool, located at the University of Ottawa ($n = 78$; 8.6%), the world's largest French-English bilingual institution of higher learning. Inclusion criteria were: (1) at least 18 years of age, (2) identify racially/ethnically as Black, White, Indigenous, Asian, or another race, and (3) currently reside in Canada. Exclusion criteria were the inability to read English or French. Only White adults ($N = 235$; M age = 44; SD age = 15.6; Range 12–81) were included for this study.

Measures

The Cultural Cognitions and Actions Scale (CCAS; Kanter et al., 2020) is a self-report questionnaire that measures a White individual's likelihood to commit a common microaggression against Black people. It measures four areas of microaggressive behaviors, which include negative attitudes, colorblindness, objectifying, and avoidance. Respondents are presented with eight different scenarios involving potential Black–White individual or group interactions in which microaggressions might be expressed. Then respondents are asked to rate how likely they would be to say or do each item on a 5-point Likert scale ranging from (1 = *very unlikely* to 5 = *very likely*). The Canadian version of the CCAS was used as a measure of microaggressive tendencies in participants. The Canadian version of this measure was adapted to remove explicit reference to American cultural and political events (Williams et al., 2021). Internal reliability for the total CCAS in our sample was strong ($\alpha = 0.88$).

The Cultural Intelligence Scale (CQS; Van Dyne, 2012) is a self-report measure that consists of 20 items that assess four dimensions of CQ (Ang et al., 2007). This includes: (1) metacognitive CQ; (2) cognitive CQ; (3) motivational CQ; (4) behavioral CQ. The CQ was included to determine if microaggressions might be caused by deficits in cultural intelligence. Items are rated on a 7-point Likert scale ranging from (1 = *strongly disagree* to 7 = *strongly agree*), with 4–6 items on each subscale. The score for each scale is the sum of ratings for its items. Due to a survey error, CQ-Metacognitive was missing two items, and as such consists of only 2 items instead of 4. The two included items were: "I am conscious of the cultural knowledge I apply to cross-cultural interactions" and "I check the accuracy of my cultural knowledge as I interact with people from different cultures." The CQ-Cognitive includes items such as, "I know the cultural values and religious beliefs of other cultures." The CQ-Motivational includes items such as "I am confident that I can socialize with locals in a culture that is unfamiliar to me." The CQ-Behavioral contains items like, "I use pause and silence differently to suit different cross-cultural situations." Internal reliability for each of the four scales in our sample were $\alpha = 0.81$ (CQ-Metacognitive), $\alpha = 0.92$ (CQ-Cognitive), $\alpha = 0.89$ (CQ-Motivational), $\alpha = 0.87$ (CQ-Behavioral).

The Buss Perry Aggression Questionnaire (BPAQ; Buss & Perry, 1992) is a 29-item self-report measure that assesses aggression in an individual. The BPAQ contains four subscales of domains of aggression, including physical aggression, verbal aggression, anger, and hostility. Items are rated on a 5-point Likert scale ranging from (1 = *extremely uncharacteristic* to 5 = *extremely characteristic*). The score for each scale is the sum of ratings for its items, with two items reverse-scored. The total BPAQ is the sum of all scale scores, with higher scores indicating higher aggressive behavior. The BPAQ was included as aggressive tendencies have been linked to the propensity to commit

microaggressions (Williams, 2021). Internal reliability for the overall BPAQ in our sample was excellent (α = 0.94).

The Positive and Negative Affectivity Schedule (Negative Affectivity; PANAS-Negative; Watson et al., 1988) is designed to measure negative affect across different periods of time. Items are rated from 1–5, with higher numbers indicative of greater agreement. Participants were asked to rate items based on how they feel "in general" to quantify affect. As it has been hypothesized that microaggressions may be related to negative affect, the PANAS-Negative was included to account for this potential source of microaggressive behavior. Only the PANAS-Negative was used for this study. Internal reliability for our sample was excellent (α = 0.94).

Analysis

The CCAS was the primary dependent variable for the study, with the four CQ scales as our main independent variables. Bivariate relationships between the subscales and total scores of the study variables were examined through Pearson correlations. Hierarchical linear regression was used to test the predictive relationships between CQ factors, negative affect, aggression tendencies, and cultural cognitions and actions. A hierarchical regression helps to understand the influence of multiple predictors or correlates on a dependent variable. Through a series of nested regressions, we examine the unique contribution of each predictor or correlate at each step. For our analysis, negative affect was entered in step 1, then aggressive tendencies in step 2, and, finally, the significant CQ scales (CQ-Metacognitive, CQ-Cognitive, and CQ-Motivational) in step 3. Given the cross-sectional nature of this study, each step of the regression will include correlates of microaggressive tendencies. Each of the proposed predictors are measured to capture trait or dispositional-level tendencies rather than state or situational-tendencies. As such, we propose negative affect, aggressive tendencies, and CQ as conceptual predictors, temporally preceding, microaggressive tendencies across different situations.

Results

The total score for the CCAS was 45.07 (*SD* 13.71). The mean item score for each CQ scale was M = 4.58 (*SD* 1.23) for CQ-Metacognitive, M = 3.95 (*SD* 1.24) for CQ-Cognitive, M = 4.73 (*SD* 1.16) for CQ-Motivational, and M = 4.03 (*SD* 1.18) for CQ-Behavioral. There were no significant correlations between the CCAS and demographic variables, so these were not included in any models.

Correlational Findings

As shown in Table 2, The CCAS was significantly negatively correlated to CQ-Metacognitive and CQ-Motivational. As predicted, it was also significantly positively correlated to the BPAQ, most strongly related to BPAQ-Physical followed by BPAQ-Anger. The CQ-Cognitive was slightly significantly correlated to the PANAS-Negative. All CQ scales were correlated with each other, as were all BPAQ scales in the expected directions.

Hierarchical Linear Regressions

A series of hierarchical linear regressions were conducted entering negative affect (step 1), aggressive tendencies (step 2), and CQ-Metacognitive, CQ-Cognitive, and CQ-Motivational (step 3). Since CQ-Behavioral was uncorrelated to the CCAS it was not included in the regression. The results of these regressions are summarized in Table 3. For each predictor, the beta is shown for the step where the predictor was entered and the subsequent steps. In general, the betas did not change substantially with the inclusion of additional predictors at later stages.

Table 2. Bivariate Pearson Correlations Between Microaggressive Tendencies, Cultural Intelligence, Negative Affect, and Aggression

	CCAS Total	CQ-Meta	CQ-Cog	CQ-Mot	CQ-Beh	PANA S-Neg	BPAQ (Total)	BPAQ Physical	BPAQ Verbal	BPAQ Anger
CQ-Metacog	-.202**									
CQ-Cognitive	.154*	.296**								
CQ-Motivational	-.207**	.673**	.341**							
CQ-Behavioral	.027	.167*	.395**	.265**						
PANAS-Negative	.159*	.048	.174**	-.127	.041					
BPAQ Total	.229**	-.036	.055	-.159*	.198**	.545**				
BPAQ-Physical	.290**	-.088	.009	-.229**	.189**	.452**	.872**			
BPAQ-Verbal	.110	.062	.080	-.023	.247**	.378**	.815**	.617**		
BPAQ-Anger	.187**	-.024	.046	-.158*	.095	.557**	.911**	.734**	.683**	
BPAQ-Hostility	.174**	-.037	.072	-.102	.180**	.498**	.888**	.636**	.669**	.763**

Note. *CQ: Cultural Intelligence; BPAQ: Buss Perry Aggression Questionnaire; PANAS: Positive and Negative Affectivity Schedule

In step 1, negative affect (PANAS-Negative) significantly predicted CCAS, $F(234) = 6.034$, $R^2 = 0.025$, $p = 0.02$. The total variance explained by negative affect was In step 2, aggressive tendencies (BPAQ) significantly predicted CCAS, $F(234) = 6.640$, $R^2 = 0.054$, $p = 0.002$. In step 3, CQ-Metacognitive, CQ-Cognitive, and CQ-Motivational significantly predicted CCAS, $F(234) = 7.760$, $R^2 = 0.15$, $p < 0.001$. The PANAS-Negative, which was significantly correlated to the CCAS in the bivariate model, lost significance once the BPAQ was included in the regression. Aggressive tendencies (BPAQ) remained significant even after the addition of the cultural intelligence subscales (CQ-Metacognitive, CQ-Cognitive, and CQ-Motivational).

Discussion

Correlational Findings

Metacognitive and motivational CQ were negatively related to the tendency to commit microaggressions. Recall that metacognitive CQ in this study reflects an individual's confidence that their cultural knowledge will allow them to comfortably interact with different groups of people, while motivational CQ encompasses a person's confidence to adapt and respond flexibly to the challenges posed by differences. As such, these two constructs are highly related ($r = .673^{**}$), whereby one (metacognitive) flows logically into the other (motivational). Notably, these are aspects of cultural intelligence

Table 3. Hierarchical Linear Regression Predicting the CCAS Score

Step		B	Std. Error	Beta	t	p
1	(Constant)	40.376	2.109		19.141	<.001
	PANAS-Negative	0.240	0.098	0.159	2.456	0.015
2	(Constant)	34.732	2.968		11.701	<.001
	BPAQ Total	0.131	0.049	.203	2.663	0.008
	PANAS-Negative	0.073	0.115	0.048	0.634	0.527
3	(Constant)	43.060	5.012		8.592	<.001
	BPAQ Total	0.118	0.047	0.183	2.493	0.013
	PANAS-Negative	0.009	0.114	0.006	0.081	0.936
	CQ-Metacognitive	-0.935	0.469	-0.168	-1.996	0.047
	CQ-Cognitive	0.449	0.124	.243	3.634	<.001
	CQ-Motivational	-0.349	0.207	-0.148	-1.688	0.093

Note. *CQ: Cultural Intelligence; BPAQ: Buss Perry Aggression Questionnaire; PANAS: Positive and Negative Affectivity Schedule.

focused on an increased awareness of a situation's cultural needs.

Cognitive CQ was positively correlated with the tendency to microaggress. Cognitive CQ is a bit different as it describes confidence in knowing many facts about different cultural groups. Although this may seem positive at face value, those who endorse these items may have a false confidence that effectively sets them up to commit microaggressions as they "don't know what they don't know" about those who are different.

The positive relationships between cognitive CQ and microaggressions could represent a lack of what has been termed cultural humility. Cultural humility refers to an orientation that is based on self-reflexivity and personal assessment, appreciation of the other person's expertise on the social and cultural context of their own lives, openness to establishing power-balanced relationships, and a lifelong dedication to ongoing learning. Cultural humility means admitting that one does not know and is willing to learn from minoritized others about their experiences, while being aware of one's own embeddedness in their own culture worldview (Lekas et al., 2020). Based on our findings, it cannot be assumed people know if they have adequate cultural knowledge to interact in a nonharmful manner, and it seems the more certain a person is that they have the requisite cultural knowledge, the more likely it is that they will offend. Notably, this quality (cognitive CQ) was also correlated to negative affect.

The link between cognitive CQ and microaggressions is somewhat at odds with Genkova and colleagues (2021), where most European groups evidenced small but negative correlations between cognitive CQ and a measure of blatant and subtle prejudice. It should be noted, however, that the measures of prejudice used in that study were not about racism or microaggressiveness specifically. Despite similarities between prejudice and microaggressions (Williams, 2020), we found the link between these constructs and cognitive CQ were different.

Finally, we found behavioral CQ was uncorrelated to microaggressiveness, meaning that being conscious of the need to use one's cultural knowledge does not prevent or facilitate the commission of microaggressions. Further research will need to examine the temporal sequence between the domains of CQ and microaggressive tendencies to identify bi-directional relationships over time.

Predictors of Microaggressiveness

As seen in other studies, aggressive tendencies were a robust correlate of microaggressiveness (Williams, 2021; Williams et al., 2021). This relationship remained highly significant even after accounting for negative affect, which became nonsignificant when aggression was included. Because metacognitive and motivational CQ were so highly correlated, motivational CQ became nonsignificant when both were placed in the model, which speaks to the large overlap between these constructs.

There have been few studies focused on how the various facets of CQ may predict behavioral interactions. For example, a study Şahin and Gürbüz (2014) conducted on a large sample of military personnel in Turkey found that motivational CQ and behavioral CQ can significantly predict adaptive performance, which is defined as an individual's capacity to adapt to dynamic and novel work environments (Hesketh & Neal, 1999). This is in line with previous studies showing that CQ mediates the relationship between openness to experience and adaptive performance among undergraduate students (Oolders et al., 2008). Furthermore, several studies examining the impact of cultural intelligence on intercultural negotiation outcomes and effectiveness found that motivational CQ was the best predictor of certain types of desirable interactions (Chen et al., 2010; Imai & Gelfand, 2010; Templer et al., 2006).

Overall, it appears that racial microaggressions are caused by a combination of

aggressive tendencies, false confidence in one's cultural knowledge, and a lack of awareness of the cultural knowledge one applies to diverse interactions. These findings indicate that having greater metacognitive and motivational cultural intelligence, as well as more cultural humility, reduces the commission of microaggressions. Notably, Lekas and colleagues (2020) argue against an emphasis on learning specific information about other cultures (i.e., cultural competence which seems to map onto cognitive CQ) in favor of cultural humility, as focusing on achieving success in cultural competence can detract from humility and intensify power imbalances.

Due to the CCAS's focus on anti-Black microaggressions, this study indicates that White people who think they are culturally savvy are actually less adept in interacting with Black people. It could be that due to pervasive stereotypes about Black people in the media, many White Canadians (much like White Americans) think they are more knowledgeable about Black people—and correspondingly how to interact with them—than they actually are.

Only a handful of studies have examined the relationship between microaggressions and cultural humility, but cultural humility has been found to moderate the relationship between racial microaggression frequency and also the supervisory working alliance between clinical trainees and supervisors (Hook et al., 2016; Wilcox et al., 2024).

Limitations and Future Directions

Despite the inclusion of aggression and cultural intelligence into our model, there remain other factors contributing to the tendency to microaggress. Future studies should include validated measures of cultural humility as a predictor, as well as measures of explicit bias, which have been shown to correlate with microaggressiveness in prior studies (e.g., Kanter et al., 2017). One limitation of our study was the use of a short two-item subscale of metacognitive CQ; future studies should include the full four-item subscale.

Finally, due to the correlational design of our study, directionality of findings is uncertain. It could be that people who are more racist are less interested in improving their cultural intelligence; accounting for the inverse relationship between microaggressive tendencies and metacognitive and motivational cultural intelligence will be important for future studies. Future studies might also examine CQ scores before and after an empirically supported training for reducing microaggressions (e.g., Williams et al., 2020). Such studies might examine these variables in relation to committing other types of racial and cultural microaggressions as well.

Conclusion

Racial microaggressions are a problematic but common occurrence that lead to a host of problems, including distress and poor mental health among people of color, and poor working relationships with aggressors. This is the first study to explore the relationship between cultural intelligence and the propensity to commit racial microaggressions. Aggressive tendencies are a strong predictor of the tendency to commit racial microaggressions, which is not explained by negative affect or lack of cultural intelligence. Aspects of cultural intelligence focused on increased awareness of a situation's cultural needs reduce the tendency to microaggress; however, feeling secure in one's existing cultural knowledge appears to increase the tendency to microaggress. As such, cultural humility may be an important consideration in facilitating harmonious interracial interactions.

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PRESIDENT'S MESSAGE | Change Is Hard but Necessary: Evolving Our Convention to Meet ABCT's Growth in a New Era

Steven A. Safren, *University of Miami*

THE ABCT ANNUAL CONVENTION is a yearly highlight for many of us: an opportunity to come together and share our scientific and clinical innovations, expand our personal and professional networks, reunite with old and new friends, and, most important, engage in critical conversations about the direction of our field.

AABT first began in 1966 as a small organization of 10 clinical psychologists who were focused on establishing behavior therapies as effective treatments for psychiatric conditions, which provided an alternative to psychopharmacology and to psychoanalytic/psychodynamic models. Since the first meeting in 1967 (concurrent with the APA annual meeting), we have grown tremendously—a testament to the decades of valuable science and advocacy advanced by our membership. Our most recent conference, in Philadelphia, was one of our most robust—with almost 4,000 registered attendees presenting on topics ranging from basic science, mechanistic studies, observational and experimental designs, through to efficacy, effectiveness, implementation and dissemination science, and clinical innovations. Our members are from all over the world and represent every type of mental health professional, including social workers, master-level clinicians, and even allied professionals such as psychiatrists, physicians, and nurses. AABT's transformation into ABCT—and its growth/evolution in recent years—has led us to reevaluate some of the practices that have become customary at our Annual Convention. Therefore, to keep up with the evolving needs of the organization, its members, and the field at large, below are some proposed changes.

Oral Presentations

Our current practice of needing to already be connected to colleagues and therefore other papers in a similar topic to present a scientific talk is obsolete. Maintaining this status quo promulgates an "in group/out-group" phenomenon and creates a more difficult system for new and/or prospective attendees to consider ABCT as the outlet for their best work. Additionally, needing to find others with data and presentations in a similar topic can have the side effect of watering down the quality of the science in the oral abstracts so as to meet the overall "theme" of a symposium. This then leads to more oral presentations that are secondary/after-thought analyses from existing data that might not necessarily be the very best work that someone might produce. Hence, the quality of the symposium is reduced because it is organized based on a topic versus on the best science (e.g., it contains some "let's see what I can find" talks). It also might discourage attendees from putting their best science in a symposium because it will only be accepted if enough of the other proposed talks in the group are meritorious enough.

To address this challenge, we are introducing a new mechanism for the 2025 ABCT Convention: stand-alone individual oral abstracts. This will allow attendees to submit and present their best work in the form of a stand-alone oral presentation without having to coordinate with other members in advance to be considered for a symposium. Instead, reviewers on the program committee (please consider joining!) will review by

keywords, and those who submit will have the option of designating their work for an oral abstract and/or poster (if not selected for an oral abstract).

Symposia

To accommodate the oral abstract session, we plan to reduce the number of symposia by approximately half and add a new criterion for acceptance. Symposium submissions must now also include a scientific, conceptual, or clinical rationale as to why these talks should be presented together. Examples of this might be to resolve discrepant findings across more than one study, to address a controversial issue in the field, to showcase an innovative method that other clinical scientists might be interested in learning about and seeing how it might apply to their work, or to gain insight into a new set of findings that need to be presented together for a conceptual, methodological, or specific clinical purpose. Linking talks together just because of a topic area (e.g., general topics like "I have some xyz data lying around, do any of you?") will likely not be considered a sufficient reason on its own for a symposia.

Plenaries

A second upgrade is related to the invited talks. In the past, several "invited addresses" selected by the President and conference chairs on timely topics in the field, with an eye toward the conference theme, were scheduled each convention. However, given the volume of additional conference programming, attendance at these invited addresses was low due to competing demands (e.g., SIG meetings, presentations with a similar topic, planning meetings), despite their timeliness and appeal to a large audience.

To address the competing demands and fully highlight these talks that typically involve state-of-the-science topics, and to foster unity and networking within the conference, we are opting for opening plenaries each morning when no other conference-related activities are scheduled. These will be timely talks, introduced by the President and the conference chairs, that delve into an important theme related to the science and practice of cognitive behavioral therapy.

SIG Meetings

It may be hard to believe, but ABCT now has 44 SIGs! — which makes scheduling at the convention quite the challenge. Our plan for the 2025 Annual Convention is to assign two designated times for SIGs to meet (during which no other conference-related programmatic activities will occur). This will allow for attendees to attend their top two SIGs (or split the time and go to more), without having to sacrifice attending a talk.

Welcome Reception / SIG Poster Session

Finally, we are working on trying to switch the Friday-night SIG poster session into a welcome reception on Thursday evening. This will be the conference kickoff event where we will all gather to socialize, enjoy some beverages, interact with SIG posters and SIG members with areas for each SIG, and start off the conference on a unifying, social, scientific, and positive note.

Theme

The theme of the next conference is "Bridging the Divide: Promoting Rigorous Science and Inclusive Affirming Therapies." As I discussed in the last issue of *tBT* (Safren, 2024), this is a relatively uncertain time with respect to the U.S. governmental influence and potential policies that involve the study of mental health and the practice of mental

health treatment. Accordingly, this will be a particularly important time for us as an organization to be united with respect to highlighting and advancing therapeutic approaches consistent with ABCT's core values, particularly science and diversity.

Stay Tuned

The Program Chairs (Brooke Rogers and Elliott Weinstein) and I are planning feedback Zoom sessions to discuss and further shape all of this with input from membership. We hope you will consider joining and provide us with feedback to help us grow and meet the evolving needs of convention attendees. And, as experts in behavior change, we should remind ourselves—just as we remind our clients—that to address existing concerns we must allow ourselves to try something new, knowing that if it does not work, it can be seen as a learning experience, and we can always go back to how we did things before.

Correspondence to Steven A. Safren, Ph.D., ABPP, University of Miami, Coral Gables, FL 33124; ssafren@miami.edu

REFERENCE

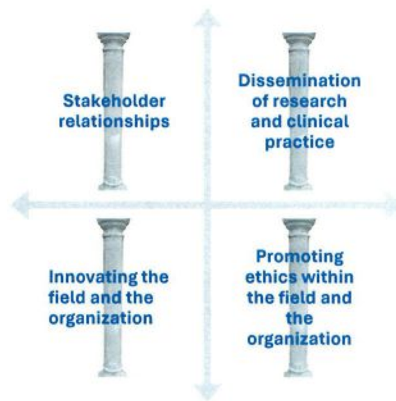
Safren, S. (2024). President's Message: Enhancing Well-Being, Fostering Unity and Advocacy Through Rigorous Science in a Time of Uncertainty. *the Behavior Therapist, 47*, 388-389. https://mydigitalpublication.com/publication/?i=837174&p=28&view=issueViewer ■

CEO'S MESSAGE | **Plodding Forward in Uncertain Times**

Courtney L. White, *ABCT Chief Executive Officer*

FOR MANY PEOPLE in the United States and indeed around the world, the results of the 2024 U.S. presidential election ushered in a new reality. Regardless of your politics, an ideological change in the makeup of the U.S. government invariably comes with shifting national and international priorities, reallocation of government funding and resources, and scrutiny of new and existing government-funded programs. The new administration has made clear its intention to test the boundaries of the efficacy and usefulness of evidence-based science and therapeutic interventions. As a result, many in the scientific community are bracing for an all-out assault on the merits of their work, from censorship, governmental roadblock of their research or clinical practice, and, perhaps most troubling, a potential politically motivated dismantling of important research by way of elimination or deep cuts in essential government funding.

Key NIH institutes such as the National Institutes for Mental Health (NIMH) may see drastic reductions in its budget or onerous governmental mandates on how its funding is to be spent. Many well-thinking scientists and clinicians worry that groups such as the Office of Disparities Research and Workforce Diversity that oversees the important work of research serving sexual and gender minority (SGM) populations may be in the crosshairs of a hard right conservative U.S. government that is diametrically opposed to their existence. There is talk of reallocating some of the federal NIH funding to states, in the form of block grants—a move which would effectively bypass much of the rigorous peer-review guardrails in place for the high-quality research currently being funded by the U.S. Department of Health and Human Services. While most people would agree that governmental waste is real, and a strong argument can be made that the operations of the NIH are overly bureaucratic, it is a truism that drastic and politically motivated changes to the way health care research is currently funded by the U.S. will have deleterious effects on public health by disrupting crucial innovations in the pipeline, and decelerating important scientific progress.



The 4 Pillars of ABCT

Organizations such as ABCT now more than ever have a role to play in protecting vulnerable populations, amplifying invisible voices, and leaning into the idea of equity-focused leadership within the behavioral science space. ABCT has long championed the ideals of quality science, diversity, and innovation and occupies a space at the nexus of their intersectionality. At the recent Board of Directors meeting held in November at the Annual Convention, I challenged the Board not to just look at these ideals as goals, but instead to look at them as pillars, foundational aspects of the very existence of the organization. So, as the organization and the rest of the country plod forward in uncertain political times, always remember our raison d'etre and lean into the idea of the four pillars of the organization:

- *Building and maintaining key stakeholder relationships* — within the ABCT membership; within the scientific community; with the patient and caregiver population; with like-minded organizations and sister societies; as well as with funders and benefactors.
- *Dissemination or research and best clinical practices*. There is a reason why ABCT is seen as the professional home of so many people. ABCT stands at the vanguard of change in the cognitive-behavioral therapy space. Get the word out!
- *Innovating the field and the organization*. Lean into the strengths of the organization, one of which is the critical intellectual brain trust that exists within the ranks. There must be an increased emphasis on ABCT's role in influencing the profession via research advancement, translational science, or clinical practice guidelines.
- *Promoting ethics within the field and the organization*. With arguably the most anti-science U.S. government in recent history taking charge of setting public health policy of the country, groups such as ABCT stand as a bulwark in being authoritative "points of truth." The public, the media, patients and their families, as well as your scientific colleagues will look to ABCT for ethically based, culturally sensitive behavioral science and therapeutic interventions.

Until next time, be well! ■

CE Credits

If you attended the ABCT 58th Annual Convention in Philadelphia (November 14-17, 2024) and purchased the licensed professional rate for continuing education credit, you can now log in to receive your continuing education credits.

Claim your CE credit here:

ABCT 2024 58TH ANNUAL CONVENTION

ABCT ASSOCIATION *for* BEHAVIORAL *and* COGNITIVE THERAPIES

Bridging the Divide | *Promoting Rigorous Science and Inclusive Affirming Therapies*

59th Annual Convention NEW ORLEANS

November 20–23, 2025

Call *for* Abstracts 2025

Enhancing the reach and impact of cognitive and behavioral therapies requires evidence-based solutions across every level of the translational science continuum. To do this, rigorous approaches to the science and practice of cognitive and behavioral therapies continue to need a broader scope of focus to further generalizability, increase translational impact, identify potential moderators of outcomes, and actively reduce threats to psychological well-being due to structural determinants and a general lack of identity-affirmative care. This broader scope of focus includes accounting for contextual, cultural, and diverse factors, as well as solving problems at the intersection of psychology and public health through scientifically rigorous studies ranging from basic science up and through efficacy/effectiveness and ultimately implementation science. Studies that account for structural and or identity-based (e.g. racial, ethnic, sexual and gender minority) factors that lay the groundwork for increasing the reach and generalizability of evidence-based affirmative treatments are therefore particularly encouraged. Examples include:

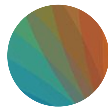
Research at the interplay of public health and behavioral health treatment:

- Studies that address how structural/societal/community-level factors influence the experience of mental health distress and resilience.
- Studies that address important cognitive and behavioral variables across the translational spectrum, including basic science, neuroscience, and experimental paradigm studies that will inform treatment with diverse populations (e.g., sexual and gender minority, race, ethnicity). This might include: (a) studies with populations of interest that extend relevant basic and translational science, or (b) studies that examine important variables such as racism, sexism, homophobia, transphobia, and how that impacts the experience of mental health distress.

Studies of affirmative-based cognitive behavioral therapies with diverse populations:

- While principles of learning theory and cognitive-behavioral therapies are considered universal in humans, this point of view can result in CBT being viewed as too narrow in scope. Diverse populations come with different needs that are affected and influence by situation, context, economic, and health disparities. Studies that seek to better understand how to tailor case conceptualization up and through published treatments addressing these factors, in a person-centered affirming way, are also particularly encouraged.
- Research stemming from newly developed and/or adapted behavioral and cognitive therapy intervention studies aimed at improving outcomes for historically excluded populations or populations experiencing marginalization through chronic systems of oppression (e.g., racism, heterosexism, ageism, transphobia) are encouraged.

- Abstract submission opens: February 10, 2025
- Submission site closes: March 14, 2025



59th Annual Convention
November 20–23, 2025 New Orleans, LA

Call *for* Continuing Education 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, contact the **Workshop Committee Chair, Susan Wenze: workshops@abct.org**

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

- For more information or to answer any questions before you submit your abstract, contact the **Institute Committee Chair, Aleta Angelosante: 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 and Saturday. Please limit to no more than 2 presenters.

- For more information or to answer any questions before you submit your abstract, contact the **Master Clinician Seminar Committee Chair, Samantha Busa: masterclinicianseminars@abct.org**

Research and Professional Development Presentations focus on "how to" develop one's own career and/or conduct research, and/or professional development topics. Presentations should not focus on broad-based research issues. Examples of appropriate topics include (but are not limited to): evidence-based supervision approaches, establishing a private practice, academic productivity, manuscript review and publishing for the general public. Examples of less appropriate topics include: methodological or design issues, or grantsmanship (these presentations may be more appropriate for AMASS). Submissions will be of specific preferred length (60, 90, or 120 minutes) and format (panel discussion or more hands-on participation by the audience). Please limit to no more than 4 presenters and be sure to indicate preferred presentation length and format.

- For more information or to answer any questions before you submit your abstract, contact the **Research and Professional Development Chair, Emily Bilek: researchanddevelopmentseminars@abct.org**

Advanced Methodology and Statistics Seminars (AMASS)
Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday or during the course of the Convention. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

- For more information or to answer any questions before you submit your abstract, contact the **AMASS Chair, Qimin Liu: amass@abct.org**

Submission deadline: ***February 7, 2025 3:00 a.m. EST***

For submission requirements and information on the CE session selection process, please visit www.abct.org and click on "Convention and Continuing Education."

- Ticketed submission opens: Thursday, January 2, 2025
- Ticketed submission closes: Friday, February 7, 2025

Call for Applications FELLOWS

Class of 2025

The ABCT Fellows Committee is pleased to announce that three new fellows were inducted this past year and were acknowledged at the awards ceremony on November 15, 2024. For a complete list of all fellows, please see https://www.abct.org/membership/fellow-members/. ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role.

The Fellows Committee encourages qualified and diverse applicants to apply. We seek diversity in professional background and pathway, as well as in other areas of diversity. It is important that ABCT members have multiple routes to fellow status, and six areas of consideration for fellowship have been identified: (a) clinical practice; (b) education and training; (c) advocacy, policy, public education; (d) dissemination, implementation; (e) research; and (f) diversity, equity, and inclusion. Applicants for fellowship will be asked to endorse in which area(s) they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow; demonstrating outstanding, sustained effort in one area is all that is required and has been the most effective route in successful applications.

Fellow applicants must have full membership in ABCT for at least 10 years (not necessarily continuous), and they must have a terminal graduate degree in behavioral and cognitive therapies or a related area; whatever degree allows licensure and practice for a profession qualifies as "terminal." Obtaining at least 15 years of professional experience following graduation with the terminal degree establishes eligibility to apply for fellowship. We strongly encourage eligible ABCT members from all professions to consider applying for fellow status. Two letters of reference are required, one of which should be from an existing ABCT fellow. If the latter requirement is a barrier to applying, please contact the Chair of the Fellows committee (fellows@abct.org), who will assist in determining how best to handle this requirement.

Letter writers should include detailed, specific descriptions of contributions that are outstanding and sustained. Potential applicants can detail their contributions for letter writers who have agreed to provide a reference. Don't hesitate to sell yourself! The Fellows Committee provides a list of potential activities that would be considered as outstanding and sustained contributions; it can be viewed at http://www.abct.org/Members/?m=mMembers&fa=Fellow. These are only a sample, offered to provide information regarding what the Fellows committee has considered outstanding, sustained contributions, but it is far from exhaustive. If potential applicants believe they have made enduring contributions that are not listed exemplars, please do not let that be a barrier to application. Because members' career paths come with unique opportunities, the committee will be sensitive to the environment in which the prospective applicant is functioning and will weigh the contributions against the scope of the current/primary career.

For more information, please visit the Fellowship application page:
https://www.abct.org/Members/?m=mMembers&fa=Fellow

Deadline: July 1, 2025 is the deadline for applications and letter writers to submit their references for this year.

Applicants will be notified of the decision on their application by October 1, 2025.

Scenes from the ABCT Awards Ceremony

November 15, 2024 | Philadelphia | 58th Annual Convention

Arthur M. Nezu,
Career/Lifetime Achievement

Anne Marie Albano,
Outstanding Mentor

Michael Otto,
Outstanding Researcher

Mark Prince, **Sobell Innovative Addictions Research**

left to right: ABCT CEO Courtney White, ABCT President Sandra Pimentel, **Distinguished Friend to Behavior Therapy** recipients Donna E.M. Bailey and Natalie L. Dallard, and Awards & Recognition Chair Anne Donnelly

Praise Iyiewuare, **Francis C. Sumner Excellence Award** recipient, with ABCT President Sandra Pimentel

Jenna Sung, **Leonard Krasner Student Dissertation Award**

Azure Reid-Russell, **John R.Z. Abela Student Dissertation Award**

Daisy Singla, **Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice**

Olga Revzina, **Virginia Roswell Student Dissertation Award**

Not pictured but still honored

Not all award recipients are pictured in these pages: visit ABCT's Awards & Recognition web pages for the complete listing of ABCT's award winners in 2024.

Youth Community Leader Award winners *left to right*: Anita FardSanei, Maia Sevin, Colin Benjamin Deibler, with ABCT President Sandra Pimentel

David Teisler receiving the **Outstanding Service to ABCT,** which was awarded to the ABCT central office staff: David Teisler, Stephen Crane, Kelli Long, Stephanie Schwartz, Tonya Childers, Rachel Lamb, Emily Ravaioli, Rachel Greeman, and Maryilyn Brown

Carrie Comeau (*center*), **Champion,** with ABCT CEO Courtney White & ABCT President Sandra Pimentel

Daniel Cheron (*center*), **Champion,** with ABCT's CEO Courtney White & ABCT President Sandra Pimentel

President Sandra Pimentel being honored for her service to ABCT (2023-24), with incoming President Steven Safren

Call for Award Nominations

Awards & Recognition Chair:
Anne M. Donnelly, Psy.D.

To be presented at the 59th Annual Convention in New Orleans

The ABCT Awards and Recognition Committee is pleased to announce the 2025 awards program. Nominations are requested in all categories listed below, including those that might appeal to clinicians, researchers, trainers, and students. Our ABCT community is doing meaningful work, and we encourage you to consider nominating yourself, a student, or a colleague for an award. ABCT values and has committed to supporting individuals from a diverse range of backgrounds with these awards. The Committee also encourages those who have submitted in a prior year and not yet received an award to reapply. If you decide to reapply, please let the Committee Chair know whether you'd like to use your prior submission, and make updates. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Nominate at www.abct.org/awards

Outstanding Clinical Supervisor This is the inaugural year for the Outstanding Clinical Supervisor Award, intended to acknowledge and promote excellence in clinical supervision. Clinical supervision is an essential element in the training of Cognitive Behavioral Therapists. It is one of the most basic ways in which theory and evidence-based interventions are integrated into practice, and plays an essential role in both implementation and dissemination of CBT. Recipients of the Outstanding Clinical Supervisor award from ABCT represent the best that clinical supervision has to offer. This award is given on an annual basis, awarded in even years to a doctoral-level supervisor and in odd years to a master's-level supervisor. This year the award will honor clinical supervisors with a master's degree in their field.

Eligibility Criteria: Candidate must be a current member of ABCT. Candidates must have a master's (odd years) or a doctorate (even years) in their field and have provided clinical supervision to the individual(s) making the nomination. Supervision of psychotherapy: has supervised many graduate students, interns, postdocs, fellows, or residents using empirically supported CBT methods and helped them become effective providers of the best available empirical methods of treatment. Supervision may have been provided on an individual basis or in group format. Please use the nomination form and e-mail nomination materials as one pdf document to ABCTAwards@abct.org Include "Outstanding Clinical Supervisor" in your subject heading. | **Nomination deadline**: March 3, 2025

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. Arthur M. Nezu, Ph.D. is our most recent recipient. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line.
Nomination deadline: March 3, 2025

Outstanding Educator/Trainer This award is given to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Lynn McFarr, Ph.D., is our most recent recipient. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Outstanding Educator/Trainer" in the subject line.
Nomination deadline: March 3, 2025

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 Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University, the Florida State University's Clinical Psychology Ph.D. program, the Beck Institute, and the Penn Collaborative for CBT and Implementation Science, University of Pennsylvania, Perelman School of Medicine. Applications should include a nomination form (available at www.abct.org/awards) and two letters of support. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. | **Nomination deadline**: March 3, 2025

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, and one he vigorously encouraged others to reach for. His penchant for critical inquiry cut across contexts: whether in providing cognitive-behavioral treatment, 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 continuously 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 both achieve this high standard and promote its achievement in others with great skill and kindness. Recipients should be those who also conduct themselves in such a way in their professional lives. This award is 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 3, 2025

The Francis C. Sumner Excellence Award This 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. The award is intended to acknowledge and promote excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional 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. Given on an annual basis, it is 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 (PhD/PsyD/EdD/ScD/MD). 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 recipient will re-

ceive $1,000 and a certificate. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org with “Francis C. Sumner Award” in the subject line. **Nomination deadline**: March 3, 2025

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/her the 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. Please use the nomination form (available at www.abct.org/awards) and e-mail nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and “Albano Award” in the subject line. | **Nomination deadline**: March 3, 2025

Charles Silverstein Lifetime Achievement Award in Social Justice
Members of the Association are encouraged to nominate individuals who have made significant and sustained lifetime contributions to advancing social justice initiatives over many years. This award is given at the discretion of the Board of Directors and is designed to recognize the critical, and often underrecognized, contributions from cognitive and/or behavior therapy (CBT) grassroots activists who are from and primarily work with minoritized and oppressed communities. In very rare instances, the award may be given to allies from the CBT field if nominations arise from minoritized members and their perspective is centered. A key element of this award is recognition that grassroots CBT activists typically have less access to power to directly change systems secondary to structural injustice and oppression. Thus, contributions to advancing social justice by grassroots CBT activists may look different than those of allies, even though grassroots activist contributions are no less important and typically confer increased risk for the individual. Eligible candidates for this award do not need to be a current ABCT member but must have a strong historic connection to the CBT field. ABCT membership at some point in the candidate’s career is desirable. Please use the nomination form (available at www.abct.org/awards) and email nomination materials as one pdf document to ABCTAwards@abct.org. Include candidate's last name and “Silverstein Award” in the subject line. | **Nomination deadline**: March 3, 2025

President’s New Researcher Award ABCT’s 2024-25 President, Steven A. Safren, Ph.D., invites submissions for the 47th 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, innovative work published in high-impact journals; and promise of contributing to cognitive and behavioral theory to advance the field. Scholars who trained in smaller labs or who work in less research-intensive environments are also encouraged to apply, as the quality and potential impact of one’s work, not the number of publications, will be the focus. Requirements: must have had terminal degree (Ph.D., Psy.D., M.D., etc.) for at least 1 year but no longer than 5 years; must submit a recent peer-reviewed, empirical article for which they are the first author; 2 letters of recommendation must be included; the

author’s CV, letters of support, and paper must be submitted in electronic form. Self-nominations are accepted and applicants from traditionally underrepresented backgrounds, or whose work emphasizes community engagement or 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 3, 2025

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 2024. 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 (available at www.abct.org/awards). Email all nomination materials as one pdf document to ABCTAwards@abct.org and include candidate’s last name and “Student Dissertation Award” in the subject line. **Nomination deadline:** March 3, 2025

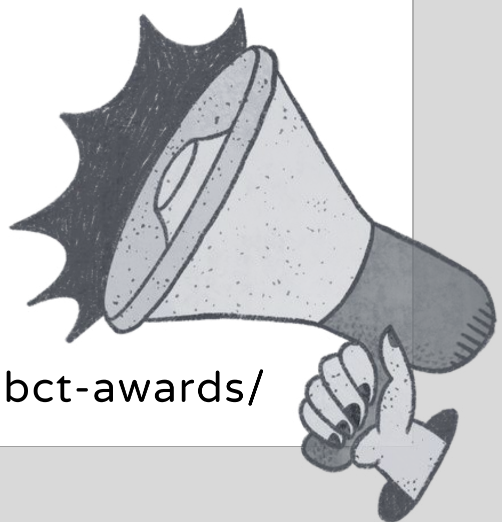
Distinguished Friend to Behavior Therapy This award is given annually to an individual or organization that supports the aims of ABCT in providing awareness, advocacy, or evidence-based behavioral health services in the field of cognitive and behavioral therapies. Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Recent recipients of this award include Bivian “Sonny” Lee III, Founder and Executive Director of Son of a Saint, New Orleans; Connie and Steve Ballmer and the Ballmer Institute; and Community Behavioral Health and The Evidence-Based Practice and Innovation Center, Philadelphia. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include “Distinguished Friend to BT” in the subject line. | **Nomination deadline:** March 3, 2025

Outstanding Service to ABCT This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form (available at www.abct.org/awards). Email the completed form and any supporting materials as one pdf document to ABCTAwards@abct.org. Include “Outstanding Service” in the subject line.| **Nomination deadline:** March 3, 2025

NOW ACCEPTING APPLICATIONS

GRADUATE STUDENT RESEARCH GRANT

ABCT's Research Facilitation Committee is sponsoring a grant of up to $1,000 (plus one honorable mention) to support graduate student research with a clear financial need



APPLICATIONS DUE 3/3/25 TO:

JCARPEN@BU.EDU

For detailed instructions see:
www.abct.org/membership/abct-awards/

ABCT →

Call *for* Nominations

Are you interested in ABCT governance? We are looking for energetic, dedicated, and passionate ABCT members to run for the following two open leadership positions:

ABCT President-Elect (2025–26)

The ABCT President is the official spokesperson of ABCT and presides over the Board of Directors and all governance activities of the organization.

Representative at Large and Liaison to Academic and Professional programs (2025–28)

The RAL works closely with an appointed Coordinator to support and oversee the work of the following committees: International Associates; Academic Training & Educational Standards; Research Facilitation; Awards & Recognition; Self-Help Book Recommendations; and Dissemination, Implementation, & Community Engagement committees.

← To nominate yourself or your colleague for one of these positions, scan the QR code to access the nomination submission form. **Submit the form by Monday, February 3, 2025**

2025 Election Time Line

- **Oct 31, 2024:** nominations open
- **Feb 3, 2025:** nominations close
- **Feb 28, 2025:** names of candidates announced
- **April 1, 2025:** voting opens
- **April 30, 2025:** voting closes
- **May 15, 2025:** winners announced to membership

Webinars

https://elearning.abct.org

ABCT is sponsored by APA, NBCC, CAMFT, & the New York State Education Department to offer CE

upcoming

Matthew Young | Telehealth Parent-Child Interaction Therapy: A Practical Guide for Therapists Jan. 9 > REGISTER

recorded

Richard Heyman | Intimate Partner Violence: Foundations, Assessment, and Interventions

Amber Calloway | Delivering Culturally Responsive Cognitive Behavioral Therapy

Martin M. Antony | Group Cognitive Behavior Therapy With Adults

Ann Steffen | Culturally Attuned Behavioral Activation Across the Lifespan

Carolyn Black Becker | Are You Overlooking Eating Disorders in Your Clients? Moving Beyond the Eating Disorder Stereotype to Reduce Diagnostic Error, Improve Ethical Practice, and Enhance Care

Golda Ginsburg | School-Based Interventions for Students with Anxiety

Alec L. Miller | DBT for Suicidal Adolescents

Robert Leahy | Emotional Schema Therapy: Helping Clients Cope with Difficult Emotions

Jeffrey Lackner | CBT for Irritable Bowel Syndrome: Fundamentals of an Evidence-Based Transdiagnostic Approach

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Visit ABCT's eLearning web pages for many more recorded, CE and non-CE, webinars.

https://elearning.abct.org/

Sanity x ABCT

A collaborative podcast series with Dr. Jason Duncan and ABCT

> episode website

50th Anniversary of Gerald Davison's ABCT Presidential Address
with Dr. Gerald Davison and Dr. Joel Becker

Mary Jane Eimer's Eras Tour: 45 Years of Service
with Mary Jane Eimer & David Barlow

Harms in Therapy | ***with Drs. Ilana Seager van Dyk & Alexandria Miller***

CPT for PTSD | ***with Dr. Patricia A. Resick*** (Episodes 1 & 2)

Starting a Telehealth Practice: What You Need to Know
with Dr. Mary K. Alvord (Episodes 1 & 2)

Parent Child Interaction Therapy | ***with Drs. Kate Gibson & Corey Lieneman*** (Episode 1)

Parent Child Interaction Therapy for Older Children
with Drs. Kate Gibson & Corey Lieneman (Episode 2)

Nonprofit Mental Health Research Careers
with Dr. Shannon Blakey (Episode 1 & 2)

Sleep Health | ***with Dr. Allison Harvey*** (Episodes 1 & 2)

OCD Assessment and Treatment | ***with Dr. Jonathan Abramowitz*** (Episode 1, 2, & 3)

What to Do About Worry | ***with Dr. Robert Leahy*** (Episodes 1 & 2)

Psychedelic Assisted Therapy | ***with Drs. Jason Luoma & Brian Pilecki*** (Episode 1 & 2)

The State of ABCT | ***with Drs. Jill Ehrenreich-May & Sandra Pimentel*** (1 Episode)

SPOTLIGHT ON A RESEARCHER

PRESENTED BY ABCT'S
RESEARCH FACILITATION COMMITTEE

Recognizing Excellence in

1. Early Career Research
2. Mid-Career Research
3. Health Disparities Research

Winners will be featured on ABCT's website, social media, & at the Convention Award Ceremony

Nominate yourself or someone else!

Fine Print: See nomination form at the QR code for eligibility criteria