

the Behavior Therapist

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Message From the Editor

Kate Wolitzky-Taylor, UCLA



IT HAS BEEN A PLEASURE and an honor to serve as Editor of *the Behavior Therapist* for the past 3 years. As my term comes to an end, I have spent some time reflecting on the work that we have published by so many esteemed colleagues and ABCT members. I have enjoyed reading such a variety of types of submissions from the most junior to the most senior members of ABCT, and everyone in between. I hope that you have enjoyed the empirical articles, informative clinical discussions, and thought-provoking commentaries and Letters to the Editor. My goal was to maintain the utility of *the Behavior Therapist* in disseminating new ideas, perspectives, and information for everyone: students to early-career professionals to the most senior members of our field. In addition to the variety of topics our published articles have covered in our regular issues, I hope you have enjoyed reading the many special issues we have published in these past 3 years as much as I have enjoyed working on them. In these special issues, we covered a variety of relevant and timely topics in our field, including diversity and inclusion, stigma in mental health, dissemination and implementation, diverse career settings and diverse settings for CBT delivery, pseudoscience, and radically open DBT. I want to especially thank Trent Codd, Richard LeBeau, RaeAnn Anderson, Sarah Kate Bearman, Alyssa Ward, and Shannon Blakey for their tremendous help with these special issues. I want to also thank Bitu Mesri and Resham Gellatly for their administrative assistance, and the Editorial Board for their behind-the-scenes work. Thank you for always being willing to help out in a pinch, and for all of your inspiring ideas. I am leaving *the Behavior Therapist* in the extremely capable hands of my friend and colleague, Richard LeBeau, and look forward to reading the future issues of *the Behavior Therapist*.

the Behavior Therapist

*Published by the Association for
Behavioral and Cognitive Therapies*

305 Seventh Avenue - 16th Floor
New York, NY 10001 | www.abct.org
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Subscription information: *tBT* is published in 8 issues per year. It is provided free to ABCT members. Nonmember subscriptions are available at \$40.00 per year (+\$32.00 airmail postage outside North America). **Change of address:** 6 to 8 weeks are required for address changes. Send both old and new addresses to the ABCT office.

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The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: <http://www.abct.org/Journals/?m=mJournal&fa=TB>): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Kate Wolitzky-Taylor, Ph.D., at **KBTaylor@mednet.ucla.edu**. Please include the phrase ***tBT submission*** and the author's last name (e.g., ***tBT Submission - Smith et al.***) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

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

Mary Jane Eimer, *Executive Director*



OUR DIRECTOR OF COMMUNICATIONS, David Teisler, and I have just sent out our agenda books for the Publications Committee and the Board of Directors meetings that will occur at the annual convention in Atlanta. It is always one of the happiest days of the year to collect all the reports from our committee chairs, coordinators, editors, and think tank facilitators and share them with your leadership.

It is without question that ABCT is enriched by contributions and skill sets of all our members involved in governance. We work to be mindful of engaging in good governance practices. The Board meets monthly 10 times per year via video conferencing; November is our only annual face-to-face, with the exception of the year we hold our triannual strategic planning retreat. Effort is made to be strategic in our thinking and in our goal setting. Since Michelle Craske was president in 2016, I've asked our presidents to join me at the American Society of Association Executives CEO (Chief Elected and Chief Executive Officer) Symposium. It is a comprehensive program covering board development, good governance practices, what should be included in orientation to ABCT governance, strategic thinking and

planning, and reviewing roles. There is ample time for discussion and to ask very specific questions at the meeting and afterwards. Incoming President Martin Antony and 2019–2020 President-Elect David Tolin just joined me for a session in early November. ABCT is member-driven with high expectations. It is good for our leadership to have time to think about how we do business and what they want to accomplish during their presidency that is in line with our mission and strategic plan.

The convention is a wonderful opportunity to learn about new research, increase your skill sets, and earn continuing education credit. It is also the one time of the year committees, editorial boards, and coordinators get to meet, too. We currently have 23 permanent committees—we just added a new one, Sponsorship, which will report to the Coordinator of Convention and Education Issues. Leadership is good about sunseting committees that no longer serve a purpose and adding new ones when the need arises. It takes a lot of thought, attention to detail, and people power to make ABCT relevant and soar! Taking care of your professional home is serious business.

Our Board this November will spend the bulk of its time addressing the 8 strategic initiatives: Membership and Community Value; Dissemination and Implementation; Innovation and Advancement of Science; Building the Future of ABCT

Through Fundraising; Outreach; Partnerships and Coalitions; Globalization; and Technology. We've made good headway in all areas, but we have turnover in leadership and need to hear their input as well. The focus will be on discussions and sharing, not just reporting updates.

In 2020 we will be holding a Strategic Planning Retreat where the current leadership, including all four coordinators, will meet. The 2020 president-elect (you are voting on that individual as I write) will also be invited. In preparation for the retreat, participants will be asked to complete an environmental scan and address trends. No doubt the membership will be asked to complete a survey or two. I can assure you that our leadership values data in the decision-making process.

The Annual Meeting of Members, which is held every annual convention, is an opportunity for leadership to share their triumphs and progress in their specific area of responsibility. It is also our opportunity to thank those completing their service and welcome those just gearing up. ABCT success is a reflection of governance and staff as a partnership. Be sure to look at the Annual Meeting of Members Minutes in an upcoming issue of *tBT*—it will give you the details of what occurred in 2019.

If you have questions, please do not hesitate to contact us. We value your support and participation. Perhaps you would like to get more involved in ABCT. If that is the case, drop me a line at mjeimer@abct.org and let's see where your interests and skill sets line up. We are committed to making your ABCT experience beneficial and positive.

...

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What Mentors Want in Doctoral Applicants to Research Intensive Labs: Convergent and Divergent Perspectives

Dean McKay, *Fordham University*

Jonathan Abramowitz, *UNC-Chapel Hill*

Michelle G. Newman, *Pennsylvania State University*

Julia D. Buckner, *Louisiana State University*

Jon D. Elhai, *University of Toledo*

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Jesse R. Cogle, *Florida State University*

Bunmi O. Olatunji, *Vanderbilt University*

Jonathan S. Comer, *Florida International University*

IMAGINE YOU ARE MEETING with your psychology professor while attending a traditional college or university. You've been accumulating research experience in your advisor's lab. You might even serve as her lab manager. As such, you seek advice on how you can best improve your credentials to become a more competitive candidate for graduate school in a research-focused doctoral clinical psychology program. Unbeknownst to you, your advisor may struggle with how to best answer your questions, which may include: What skills and experiences should be developed? Do you need additional clinical skills and experiences? Should you pursue a short-term passion now, even if it does not add to your psychology credentials? Will you have a frank conversation about the balance between pragmatic realities (i.e., earning enough to pay rent and sustenance) and necessary objectives (i.e., exposure to pre-professional, but often unpaid or poorly paid, research experiences)? This is just a sampling of topics running through your

advisor's mind as an answer is developed during your meeting. There are some obvious must-haves for successful applicants—high GPA, solid GRE scores, and experience with research during the undergraduate years. But how else can you distinguish yourself from the pack? Your dedicated advisor will want to provide you with the best possible recommendations, but the reality is that these suggestions may not match up well with what your prospective mentors seek in incoming lab members.

The impetus for this article came from a simple question posed to the lead author, coming from an extremely promising student who was torn between two options: pursue a time-limited work experience that was a passion (teach in a different country for 1 year, and earn a good salary) or stay in the United States and garner research experience in a different lab that would complement work she completed during her undergraduate tenure. To fully address this student's inquiry, the lead author put the

following two-part question to the rest of the authors, most/all of whom train their students using a clinical scientist framework (i.e., a good deal of the students' graduate school experiences will concern training in research methodologies, conducting independent research, and writing up empirical findings for publication in peer-reviewed scientific journals):

While we all, no doubt, have lots of applicants with impressive psychology credentials, are there any things that you each look for in applicants that make them "pop" to the top of the heap? In recent years, have there been particularly novel backgrounds in applied experiences that you have valued, or that incoming students have had?

The responses to this query are summarized in this article. In this regard, the nature of the responses reflects the specific skills and background of interest to a unique category of doctoral-level mentors, those who primarily train clinical scientists (i.e., applicants interested in pursuing careers in which research, not therapy, is the primary focus). As you will see, there are several prominent areas of convergence among the respondents, and a smaller set of divergent perspectives. What was remarkable was that among the authors, most of the areas each mentor sought in prospective graduate students overlapped.

Psychology-Relevant Convergence

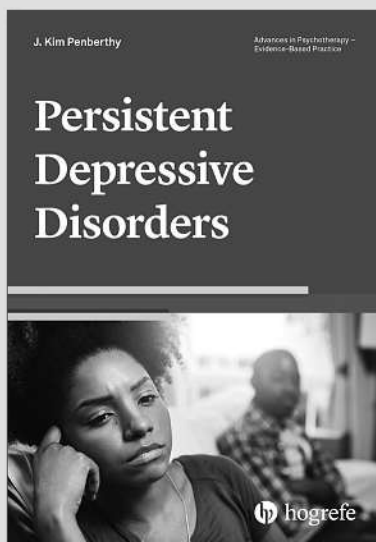
Matching Content Knowledge

Given the emphasis on research in the graduate training conducted by the authors, most (but not all) authors emphasized that experience in the author's area of research was a significant plus. As each of the authors receives dozens of inquiries about joining their lab each academic year, match with the prospective mentor's program of research was cited most frequently as an essential way to demonstrate that commitment. This level of commitment signifies that prospective students are able to think about the topic more deeply through their direct experience, and potentially craft novel investigations that would be part of their doctoral training. Having previous experience is also thought to indicate that prospective applicants have "fire in the belly" about the area of research for the lab to which they are applying. This focus on a particular research area may also emerge from time spent sampling content in different areas of clinical psychology in

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order to gain a clear understanding of where your passions lie. A demonstration of this enthusiasm is evident through an ability to really think about the research area, generate ideas about the limits of the current research, and articulate critiques of existing lines of inquiry. One of us went as far as to note that the prospective applicant should really have a deeper appreciation of the empirical work, and not just a familiarity with review articles or meta-analyses. In short, intellectual curiosity about the topic, and not just rote familiarity, will be more likely to impress your prospective mentor. Behavioral evidence of this knowledge and intellectual curiosity is ideal, and can range from a comprehensive review paper written for a class to authorship on conference presentations or manuscripts, but can also be demonstrated through thoughtful conversations on the topic.

There are a wide range of views on what is required on a CV but most of the authors rely on quality over quantity when it comes to presentations and manuscripts. One of the authors expressed outright skepticism of applicants who have a large number of publications given that it is rare for someone who has not yet launched their career to contribute significantly to numerous articles. Quality research can also be a helpful part of your pre-graduate school preparation for developing predoctoral research grants. In short, concentrate on quality and possibly a couple of papers over sheer numbers. Think, “Can I engage in a meaningful conversation with the prospective mentor about a research topic that we both find interesting and important?”

Personal Familiarity

Now that you’ve identified a list of prospective mentors working in your area of interest, you decide to make contact. In doing so, you would be best advised to have read recent (especially past 5 years) manuscripts in peer-reviewed journals concerning the research conducted by the prospective mentors, and not just know the content area that they publish about or list on their website. You need not stroke our egos and study every written word published by the prospective mentor, but you should be able to demonstrate that you clearly read the research recently conducted in the lab. More generally, you should be armed with questions or comments about the articles that might demonstrate that you have thought deeply about the mentor’s research. By doing this, you’ll also be able to hit the ground running when you are finally accepted and start in some-

one’s lab. You’ll be familiar with the methods and measures germane to the area of work in which you’ll be engaged with that mentor, and will have the knowledge to discuss these approaches competently.

Stay Focused

Suppose you find that a mentor is in a department where there are other faculty members doing work you find interesting. It may be tempting to enumerate several people in your personal statement whose interests line up with yours. Caution is in order when doing this. Although there may indeed be one or maybe two faculty members whose areas are closely related, listing too many signals a lack of focus, which is likely a deal breaker. If you do list multiple faculty members whose labs are of interest, be clear about who is the primary person you want to work with and also provide a rationale for why you are considering multiple faculty members in the program. It is strongly suggested that you contact them to ask whether they are taking a graduate student in a particular year. However, before doing so, check their web pages, as many programs these days post this information and it doesn’t win you any points to be asking when the information is already posted on their website. You want to emphasize a person that you want to work with and who is looking for someone to join their research laboratory.

Statistics Is Essential

Another point of convergence was the emphasis on statistical knowledge. Yes, dear reader, if you are a prospective applicant to any of the labs represented by this author list, your knowledge of statistics is going to be an important metric of whether you get an invitation to interview and/or acceptance offer. One of us even stated that the grade earned in statistics is the only one they looked at when evaluating a prospective applicant’s transcript. Another of us is especially interested in prospective students who are so jazzed about data that the acquisition of a new dataset may cause some loss of sleep in anticipation of conducting analyses, and will take their turn when it comes to the less exciting aspects of research such as data entry. This perspective extends to an emphasis on a general intellectual curiosity about scientific discovery overall, and learning in the broadest sense. The emphasis on statistical knowledge also means you are going to need to know the difference between μ , τ , and δ , and not just how these Greek letters refer to sororities or fraternities. Familiarity with

some statistics software is a particular plus. Knowledge of advanced data analytic approaches, and how to conduct these types of analyses, is not required but will put you in the upper echelon of applicants. Just know that if you document knowledge with statistics, be able to answer questions about them in an interview.

Nonpsychology Convergence

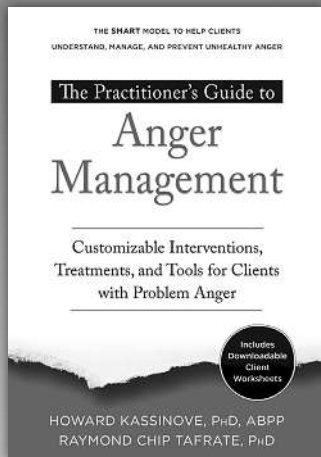
Communications Skills

Now that you see it in print, well, it seems obvious. Being research focused is great and necessary in seeking research-oriented careers, but it also means a good deal of human interaction employing the skills of a clinical scientist. An essential ingredient in your future success as a clinical psychological scientist is being able to effectively articulate your ideas, both orally and in writing, and to be able to work well with others. Indeed, team science is becoming increasingly important and demonstrating you can work effectively with others therefore is key to future success. Additionally, good communication skills will make your time in graduate school far more enjoyable. There are several “products” that can demonstrate this skill. One way is through your academic training, which might include a minor or dual-major in English or communications. You can show off your communications acumen in your personal statement, as well as in your initial exchanges with a prospective mentor. A research paper submitted with your application is another opportunity to highlight your communications brio. You also can demonstrate both oral and written skills through presentation of research at national conferences, and should the opportunity present itself, through lead-authorship on a publication. This last point segues to the next topic.

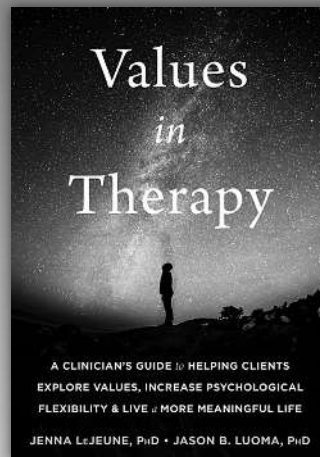
Publications

Increasingly, competitive applicants have one or more publications that have appeared in peer-reviewed professional journals. It has been our observation that for many of these publications the prospective applicant is somewhere in the middle of the author list. As mentioned above, we recognize that the applicant is benefiting from the generosity of the lab mentor. This is not to diminish the contribution of the applicant. It instead is a reflection that the applicant was a contributor in the lab, but may not have contributed significantly to the development of the research idea or the writing. Many of us have met with appli-

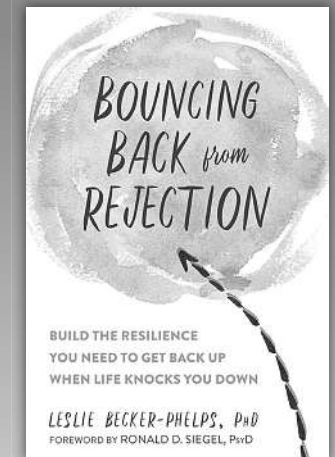
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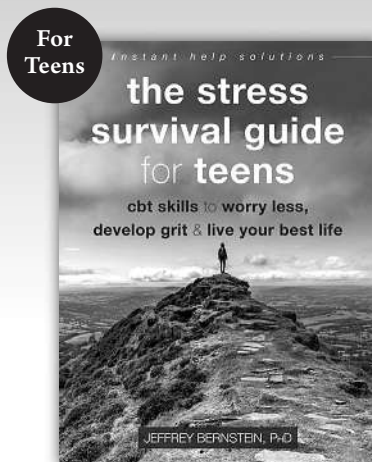
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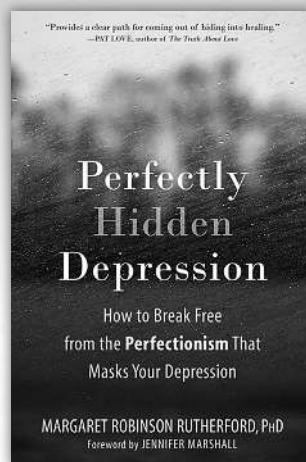
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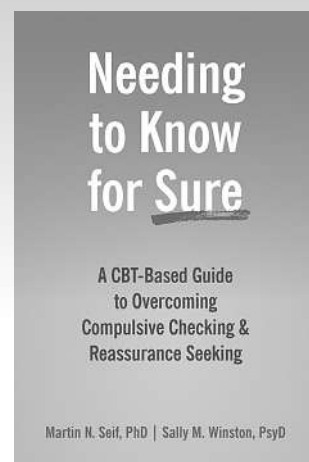
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cants who were hard pressed to describe the research on which they were co-authors. On the other hand, there are some applicants who have contributed significantly as a co-author (i.e., author in the middle of the author list) and have a deep understanding of the paper on which they contributed. Similarly, some applicants even developed research projects and had the opportunity to write the manuscript and publish it as a first-author work. It is difficult to overstate how clearly these latter two scenarios demonstrate good communication skills, as well as a commitment to the topic area, not to mention skill in conceiving and executing a project.

Small Colleges and Competitive Applications

Many of us have had applicants successfully enter our labs after attending small liberal arts colleges that did not have many opportunities for conducting research. There are several ways applicants can address this gap in their training: (a) seek out research opportunities at larger, nearby universities or research institutions—you don't necessarily need to be a student at a particular university/research institute to volunteer or work as a research assistant; and (b) as we stressed above, postundergraduate experience is often crucial. This means finding places to gain research experience after your undergraduate experience, especially if you attended an institution that did not have a wealth of research opportunities available while working on your baccalaureate degree. Remember, if your goal is to enter a research-oriented doctoral program, gaining the necessary research experience either at your undergraduate institution, at a nearby institution while you're in school, and/or following your undergraduate education will help prepare you for the rigors of a research-oriented graduate program.

Time Between Undergraduate and Graduate School

Formulating the long-term plan to attend a doctoral program means cultivating experiences after completing a baccalaureate degree. All of the mentors on this article often prioritize applicants who have a year or more of postbaccalaureate real-world experiences. To be fair, there are surely plenty of applicants who complete their undergraduate work who possess the maturity and sophistication to go directly to doctoral study. But recall the point above that many of the research-oriented doctoral labs seek incoming students who have

familiarity with the methods and measures of that area of expertise. It is unlikely that an applicant coming straight out of their undergraduate will have that background. Maturity is also demonstrated through real-life experiences, which can only be gained through time and effort. Further, doctoral training can be demanding. The additional experience gained in the field will help make your graduate experience less stressful and, thus, more enjoyable. Finally, maturity is challenging to assess, and the stakes for mentors in selecting incoming lab members are quite high; accordingly, postbaccalaureate research experiences can go a long way in assuring potential mentors of your commitment to graduate training in psychological research.

The Importance of Diverse Experiences

One of us has lamented the procession of applicants who have secured interviews for doctoral study who are "psychology automatons." These are extremely bright applicants who are eager to cite research studies in answering questions, even going so far as to steer any questions that are not directly research-related back to the published literature, but who seemingly lack any other experiences. Remember that your career as a psychologist will involve contact with research participants, clients, and community partners who are not familiar with, or interested in, psychology concepts. They need to relate to you on a human level, where a wide range of other activities, cultures, and experiences are more likely to foster the essential common-factor connection that will serve to promote change. Accordingly, to succeed in graduate school you'll need to live in the world and not just in the lab. Be prepared to point out that you have other interests outside psychology.

This point is so central that committing to other interests is a valuable part of an applicant's dossier. Recall that this article came about because a promising student faced a quandary—gain more research experience or pursue a short-term line of work that was a passion. The result from posing the question that sparked the rich discussion leading to this article was that it was recommended to the student that she pursue the work teaching overseas. Gaining unique and interesting experiences are usually not held against a promising applicant who has also acquired the research-oriented skills discussed above. In fact, such experiences contribute to personal and professional development. In short,

being balanced, with knowledge outside psychology as well as within the desired area of study, can broaden your background, foster an appreciation for diverging viewpoints, and may serve to enrich your knowledge of culturally diverse groups and perspectives. Mentors are seeking applicants who bring unique experiences to the lab, and diverse cultural experiences enhance the research conducted, foster innovative thinking among lab members, and are necessary for success in the profession, generally considering the wide range of perspectives that will be encountered in other research and treatment settings.

Diverging Areas

There is a saying that goes something like this: If you ask two psychologists for their opinions, you will get three answers. In this way, it was inevitable that inquiring of this group would lead to some areas that were not necessarily embraced by all.

Letters of Recommendation

Obviously, you'll seek out letters from professors and researchers who can comment on your skills and abilities. The quality of the letter is outside your control. However, what a few of us noted was that the letters should not be "cookie-cutter," but instead reflect your unique qualities, your excitement about the topic, and how you stand out from the broader applicant pool. On the other hand, letters of recommendation are notoriously unreliable, and so although an important point of consideration by some, they are not necessarily emphasized in the evaluation of an applicant's materials by all mentors.

No Prior Experience Necessary

We know this will seem confusing, but a couple of us noted that there have been occasions when we have accepted into our labs applicants who had no prior experience in the areas of our work. For this atypical route to work, the areas emphasized above must be truly superlative, particularly research and statistical acumen in other research areas.

Intangibles

There is a frank reality here: matching with a lab is kind of like matching with a partner. Labs have personalities, and you are seeking to join this group, most concretely for a period of around 6 years, but really your relationship with this group will be the longest professional relationship of your career. One of us emphasizes to their

students when meeting with prospective applicants to watch for applicants that may be difficult to work with. Other labs are very hierarchical in nature, where contact with the mentor may be less frequent. Still others have a very formal structure. Knowing which will work for you is an essential part of seeking a lab, and mentors will also be on the watch for how you might best match with the lab.

Conclusions

Finding the right mentor and preparing for application to a research-oriented clinical psychology doctoral training lab requires the accumulation of a specific set of skills and knowledge. The areas highlighted in this article represent the perspectives of a small but diverse group of researchers all engaged in research on anxiety and related conditions, and as a result might reflect biases common to that subspecialty within clinical psychological science. We recognize that the perspective offered in this article might present a daunting list of qualifications necessary to gain entry to graduate school. Unfortunately, the reality is that there are a lot of

applicants and a small number of spots in each of our respective programs, and this is true for the majority of research-focused doctoral programs. On this note, we want to provide an additional word of encouragement. Each of us has had students apply to our labs, or go through the application cycle, more than once and land in a competitive doctoral program after two or even three tries. If this is something you want, do not despair if it doesn't work out the first pass. You will likely gain valuable lessons in the process and should seek guidance from a trusted mentor on how to become a more competitive applicant when the time comes to reapply.

Prospective applicants seeking training in other areas of specialization (and those interested in pursuing careers more focused on conducting clinical services such as assessment and/or psychotherapy) are encouraged to ask their advisors whether the suggestions highlighted here are applicable to other disciplines in psychology. It is our collective perspective that our recommendations for how to best prepare a competitive application to a research-oriented lab will generalize to labs conducting research focused on other spe-

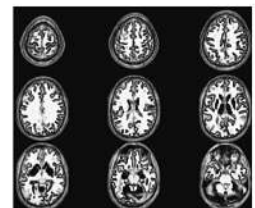
cializations. Further, getting into research-oriented doctoral training programs in clinical psychology is an honor and privilege, and while at the outset 6 years will seem like a long time, it will pass quickly. Being positioned to maximize the learning experiences from the diverse faculty at the program as well as from your mentor sets the stage for a successful career. While we are confident the perspectives offered here are valid for other areas of graduate study, we would nonetheless recommend applicants view the perspectives outlined here as a starting point, with the understanding that ultimately every applicant possesses unique characteristics that may make them attractive to prospective mentors. And with this, we also wish you the absolute best of luck!

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No conflicts of interest or funding to disclose.

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Maximizing Opportunities During the Doctoral Internship in Professional Psychology: Recommendations for Current and Future Trainees

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THE DOCTORAL INTERNSHIP in professional psychology is a major requirement for degree completion and licensure. Grounded in supervised training in clinical service delivery, the clinical internship year¹ provides complementary learning experiences such as research involvement, didactic seminar attendance, and professional development activities. Due to its placement at the end of the graduate training sequence, internship is often described as a capstone experience of the doctoral degree (Lamb, Baker, Jennings, & Harris, 1982). Yet the internship might be better regarded as a keystone experience of graduate training, considering its catalyzing role in the integration of skills across nine professional competency areas² (McCutcheon, 2011). Today, the Association of Psychology Postdoctoral and Internship Centers (APPIC) operates the internship Match, a computerized system in which over 4,000 students in clinical, counseling, and school psychology programs are paired with over 700 internship sites (McCutcheon & Keilin, 2014).

Despite the stressors associated with applying to and completing internship, the internship year is an exciting time during which many professional and personal milestones are met. In contrast to graduate school—where boundaries between personal and professional life are not always clearly defined or defended—internship

programs expect interns to complete a manageable set of responsibilities within fixed working hours. Internship also stimulates an attitudinal shift among trainees, who are called to assume greater autonomy and develop a professional identity independent of their graduate advisor(s).

Numerous resources address how to successfully apply and match to an internship (e.g., Prinstein, 2013; Williams-Nicholson, Prinstein, & Keilin, 2018), yet there is a relative dearth of published recommendations for making the most of the internship year itself. In addition to relocating (sometimes with partners or families), interns are asked to identify training goals, establish productive relationships with new supervisors and peers, demonstrate specific professional competencies, and secure a future postdoctoral/staff/faculty position—all in a short period of time! Accordingly, balancing and prioritizing various responsibilities and opportunities become key components of what ought to be a formative and pleasurable year. Reflecting on our experiences as outgoing interns (SMB and ESS) and Training Director of an APA-accredited internship program (SRM), we offer recommendations for maximizing enjoyment and mastery across multiple domains during the doctoral internship.

Cultural Humility as an Overarching Framework

The comments that follow in this article are overlaid with a respect for individual differences among multiple identity dimensions. Cultural humility has been conceptualized as the “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important” to that person (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 2). We respectfully expand on Hook and colleagues’ (2013) original definition in this article to acknowledge the additional relevance of complex social, historical, religious, political/systemic, and other factors on individual identities. Within the context of psychology internship training, we understand cultural humility to be a framework, not a training module; a direction, not a terminal credential. It demands an appreciation not only for individual differences, but for their infinite intersections and interactions. It is optimized through trainee vulnerability, nondefensiveness, and willingness to discuss difficult issues with supervisors, mentors, and peers.

Though full exploration of how to practice cultural humility within professional psychology is beyond the scope of this paper, we do recommend interns incorporate the following essential components of delivering multiculturally sensitive care: (a) fostering a willingness to experience one’s own and other people’s “differentness” and the resulting potential discomfort, (b) clarifying one’s own values and attitudes about ways in which people are “different,” (c) seeking patient referrals of people from diverse backgrounds, (d) actively learning about the contextual and systemic issues related to people’s “differentness”; (e) openly discussing these issues as they arise in supervision; and (f) willingly looking inward to identify one’s strengths and growth areas in this domain. We encourage interns to remain open and engage in ongoing self-reflection throughout the training year, leaning into potential discomfort rather than shying away from it. Respectful curiosity and honest introspection will help interns improve their knowledge, awareness, and skills as they work toward cultural humility. By striving to see through the perspective of others, interns will be better positioned to reflect upon, monitor, and adjust the impact of their implicit and explicit biases on patients and

¹ Although some programs offer extended part-time positions, most internships are year-long, full-time (40-hour) placements.

² Profession-wide competency areas identified by the American Psychological Association (APA) include: research; ethical and legal standards; individual and cultural diversity; professional attitudes, values, and behaviors; communication and interpersonal skills; assessment; intervention; supervision; and consultation and interprofessional/interdisciplinary skills (APA, 2018).

other professionals. Readers interested in learning more about this topic are referred to work by Hook and colleagues (2013), Fisher-Borne, Cain, and Martin (2015), and Yun (2017).

Clinical Skills Enhancement

Given its conception as a self-contained clinical immersion experience (Lamb et al., 1982), internship training is primarily grounded in supervised intervention and assessment, enhanced by exploration of the role of psychologists across various settings and/or patient populations. In accord with the APA (2018) Standards of Accreditation, internship is by definition a broad and general training experience. We therefore encourage interns to consider both long-term career trajectories (e.g., hospital versus university setting) as well as short-term professional goals (e.g., maximizing competitiveness for postdoctoral, clinical staff, or university faculty positions) in selecting clinical rotations and adjunctive experiences. Ideally, the internship training year should include elements of both (a) expanding breadth of training in novel

domains and (b) enhancing depth of training in select areas of interest in order to prepare for the next stage of one's career.

A central responsibility of internship programs is to help trainees extend their repertoire of clinical skills and apply these skills in novel professional contexts. To this end, interns are often given opportunities to complete rotations in specialized services distinct from prototypical outpatient mental health clinics (e.g., behavioral medicine or rehabilitation psychology settings) as well as deepen prior learning through more immersive, complex applications of existing skills. Interns might also be invited to attend elective clinical workshops and trainings to learn new therapeutic protocols or approaches—sometimes even earning formal credentials denoting specialized competence in that approach. For example, interns at VA internship programs can sometimes complete formal training sequences for specific empirically supported treatments, gaining marketable “certification” in those therapies. Alternatively, interns across diverse training settings and systems can receive more infor-

mal, experiential “on-the-job training” in therapeutic approaches through their work with experienced clinical supervisors. Interns’ immersion within multiple—and likely interprofessional—clinical teams also confers the advantage of developing a broader appreciation for perspectives of providers from diverse training backgrounds, in addition to greater familiarity with various team structures and dynamics.

Whereas some interns strive to maximize breadth experiences, it is important to balance exploration with deepening of clinical skills. We thus recommend trainees consider the unique value of developing and refining one's professional identity above and beyond their professional skill set. This can be achieved in several ways. Some interns might prioritize continued training in their area of clinical expertise early in the year in order to be more competitive for fellowships or jobs in those areas, with plans to pursue training in novel approaches, populations, or settings later in the year. Other interns may practice delivering familiar treatments with novel

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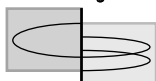
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restraints throughout the entire year—or example, exercising “flexibility within fidelity” to evidence-based principles through their work with patients during short-term inpatient stays or with complex comorbidities. Ultimately, there is no single or perfect way to strike this balance; interns should make the best decision for themselves after careful thought and discussion with trusted advisors.

Being closer to independent practitioners than graduate practicum students, interns are typically expected to take on commensurately more complex cases, including patients who are at higher risk of harm to themselves or others. Although there is regional variability in the type and representativeness of patients’ diversity characteristics, interns generally get to work with more demographically and clinically diverse populations than is typically possible during graduate training. Moreover, the internship training year is rich with intentional reflection on interpersonal, cultural, social, historical, institutional, and systemic factors related to the provision of health service psychology. Such reflection—while admittedly demanding on trainees’ emotional and cognitive resources—facilitates personal and professional growth, empathic capacity, and clarified professional identity through the catalytic integration of professional values, attitudes, and ethical principles. The prospect of encountering complex situations and working with people from different backgrounds can feel daunting at first, but it is necessary for developing independent ethical and clinical decision-making skills. We recommend that interns draw from available sources of supervision and consultation as they ultimately increase their competence in providing effective, multiculturally sensitive care.

Other new experiences on internship are equally vital for professional functioning, albeit sometimes less glamorous. One of the biggest initial hurdles for many interns is adjusting to new administrative procedures, including learning potentially challenging electronic medical health records systems, processes related to patient flow, and/or insurance and billing procedures. Once relatively mastered, it can be helpful (and can reduce frustration/annoyance) for trainees to consider the functionality of these specific procedures embedded in the broader system, considering “what purpose does this procedure serve?” and “how effectively is it fulfilling its intended purpose?” Consider the

example of an intern completing a supervised evaluation and report for individuals seeking organ transplants. At the surface, this exercise could be seen as the intern fulfilling programmatic assessment requirements, mastering the particular assessments consistent with the clinic’s procedures, and documenting findings in accord with supervisors’ stylistic preferences. Deeper and more significant questions inherent in these tasks include the intended and possible audiences who may access this report, the legal and ethical implications of documentation, and the potential consequences of the evaluation on other professionals’ decision making. Interns’ formation of an underlying conceptual or “bigger picture” framework, even regarding tedious administrative procedures, is necessary preparation for independent professional practice.

Another important (yet often overlooked) element of clinical training is the concept of interns as experts, despite having fewer years of practical experience than their supervisors. Interns are ideally treated as full members of interprofessional teams who bring their own unique interests as well as their knowledge of state-of-the-art research and practices. Accordingly, we encourage trainees to respectfully share their interests and expertise with colleagues and supervisors not only to familiarize team members with their areas of specialty, but also to facilitate relevant referrals and highlight interns’ value as contributing team members. This recommendation is more easily offered than followed; both the first and second authors of this article admittedly had to explicitly identify the ownership and advertising of their clinical skill sets as a formal training goal during their internship placements. It is therefore based on lived experience that we empathetically encourage interns to lean into potential discomfort when refining and embracing their professional identities during internship.

In sum, interns generally experience tremendous clinical skills enhancement, assume agency in determining their training goals, and have significant influence over how their self-identified training goals will be met. Constructing a comprehensive training plan that effectively addresses interns’ training goals within the structure of the internship program (and within only 1 year!) can seem like a Herculean task. Designing this plan requires attention to both short-term goals and forethought to advancement beyond internship. It also ideally occurs with the supportive input of

trusted and experienced mentors, such as interns’ clinical supervisors and/or internship program training director. We strongly encourage interns to embrace the chance to “try on” a (reasonable) variety of experiences, understanding that both positive and less enthusiastic reactions can calibrate one’s professional sense of self and inform future career choices. Interns might also benefit from envisioning their future selves to anticipate the type(s) of careers they might want, reflect upon current areas of strength and skills that need bolstering, and consider ways in which certain training experiences will enhance existing interests/skills and cultivate growth in new areas. Overall, a combination of depth and breadth experiences adds layers of nuance and complexity to clinical, academic, and personal perspectives alike, which is essential for understanding the complexities of human experiences and behavior.

Research Training

In addition to supervised clinical training, many programs offer trainees protected time to engage in research (e.g., 4 to 8 hours per week). Research-related activities, broadly defined, might also be infused through other internship training components such as clinical service delivery, consultation, and continuing education. Internship training therefore promotes the integration of clinical science and clinical service delivery, consistent with APA’s strategic plan and definition of evidence-based practice in psychology (APA, 2006, 2019). Because designing, obtaining relevant Institutional Review Board (IRB) approval, and implementing original research studies is typically not feasible within a single calendar year, interns often elect to join ongoing projects, run secondary analyses using existing data sets, and/or continue collaborating on projects initiated during graduate school instead.

While most graduate students equate “doing research” with authoring empirical manuscripts, internship allows trainees to engage in several novel forms of scientific inquiry. For example, quality improvement (QI) projects involve analysis of data provided from human participants but are not officially considered “research” by most IRB groups. QI projects are common in hospital settings and have the potential to rapidly inform and improve health service delivery—experiences not commonly available or encouraged, relative to conducting systematic investigations, during graduate school. Interns could also deepen

and/or expand existing research skills through working with new populations (e.g., refugees), applying new methodologies (e.g., case reports), or exploring new funding mechanisms (e.g., VA Office of Research & Development). Interns may also face unique constraints placed by certain settings and/or systems (e.g., when conducting research with protected populations).

For outgoing graduate students accustomed to unrestricted time for data analysis and manuscript preparation, the transition to minimal (or no) protected research time can be difficult at first. Designated research hours may also be distributed in smaller chunks over the course of the week rather than provided in a single block, requiring interns to practice task shifting (e.g., format tables between clinic intake appointments). Moreover, many interns find they have substantially less energy to work on research projects after a full day of clinical service delivery compared to a day of classes and lab meetings. We therefore recommend trainees set realistic research goals for the internship year. It is easier to commit to one to two projects and make

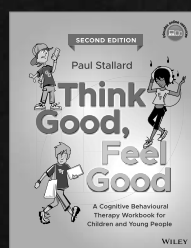
additional research commitments if time allows than to fall short of target output/deadlines for the four to five projects originally promised. At the same time, it is essential to practice self-compassion; even the most thoughtful, proactive, and research-focused trainees have difficulties maintaining research productivity among competing internship demands. Research productivity might also fluctuate throughout the year as interns rotate across clinical placements, apply and interview for jobs/fellowships, and navigate other life events outside of work.

Consistent with our belief that internship should build upon and extend graduate school experiences, we encourage interns to explore diverse applications of clinical science rather than maintain the status quo of writing as many empirical manuscripts as quickly as possible. Opportunities to explore varied scientific interests using new methodologies and/or clinical populations are fewer and farther between after the internship year, so we recommend trainees take advantage of the chance to diversify their research skills while they can. At the same time—and consistent with

our initial recommendation to set manageable research goals—it becomes important for interns to balance remaining open to new experiences with learning to say “no.” Research is only one of several professional competency areas emphasized during internship training and there are only so many hours in the work week.

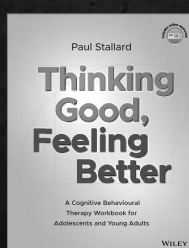
It is important to acknowledge the above recommendations are easier to implement if interns have completed their dissertation. In fact, some internship programs will not permit trainees to engage in new research until their dissertation has been successfully defended. We therefore encourage potential and incoming interns to prioritize dissertation completion above all other research goals. We similarly advise interns to carefully consider the advantages and drawbacks of continuing graduate school projects during internship. It can be difficult to balance old and new research activities across settings (not to mention time zones!) and investing time in graduate school projects can interfere with building new professional relationships and skills. For this reason, it can be helpful for incoming interns to speak with their graduate

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advisor to honestly discuss mutual expectations for the internship year.

Continuing Education and Didactics

Interns can take advantage of numerous formal and informal learning opportunities beyond supervised clinical and research activities. Most programs offer didactic seminars, case conferences, journal clubs, and/or research forums to complement the experiential nature of internship training. Program-sponsored seminars ideally review foundational skills, extend prior skills to new practice settings, and prepare interns for entry into the job market. Though interns may bemoan mandatory didactics after graduate school, continuing education during internship is qualitatively distinct from attending academic lectures or conference presentations. Tailored to meet interns' needs and interests, seminars address professional development, mental/medical health conditions and interventions, and important multicultural, legal, and ethical issues related to health service psychology. We encourage interns to approach continuing education as a vehicle through which to explore professional interests, identify growth areas, and gain "free advice" related to professional development and advancement.

Depending on the training site, interns might also gain access to didactics offered through the larger setting as well as nearby teaching hospitals, universities, and other institutions. Supervisors with varied expertise and training backgrounds can also recommend or lend resources (e.g., books, articles, protocols) as well as direct interns to additional training opportunities of interest. Certain systems might also offer continuing education online; for example, the VA Health Care System grants interns access to the Talent Management System, which hosts thousands of recorded courses and webinars related to specific populations, conditions, and patient care issues. Although impossible to attend or complete every didactic offering on internship, such valuable opportunities at least expose interns to topics they are likely to encounter in their early career and beyond. Moreover, pursuing educational offerings inside and outside of the training facility enhances interns' clinical training and fosters a commitment to life-long learning.

Professional Development

As described above, interns can expect to see rapid development of their baseline competencies within clinical, research, eth-

ical, and diversity domains. This growth is often both exhilarating and exhausting. Adding to this mix is the underlying growth of one's self as a maturing professional person and the corresponding shedding of one's identity as a "student." The daily experience of working with complex patients, of taking on primary responsibility for their care and outcomes, of navigating multiple duties in time-sensitive situations, of collaborating with providers of other disciplines—all these elements conspire in helping interns to act with greater agency, autonomy, and responsibility.

With these changes comes a corresponding recalibration of the intern's identity as a professional. In this sense, internship is truly a "finishing school," in the sense that "school" is in the rearview mirror and in the sense that interns will integrate their knowledge and skill at a higher level of organization than previously possible. As a result, professional behaviors become more fluid, more effective, more authentically integrated into one's "self," and less effortful or "foreign." Undoubtedly, interns can expect to finish their year with a rediscovered sense of their strengths and capabilities. Beginning the year as a "student" and ending the year as a "psychologist" is a heady experience of crossing a critical threshold. There is likely no other single year in a graduate student's tenure that will have such a profound effect on how one views oneself.

The immersive experience of internship additionally promotes another important aspect of professional development. Operating in a new professional setting outside of the home doctoral program—with its attendant expectations and pressures—allows interns to step out from the shadow of important mentors and to use their new freedom to explore additional career options or to revisit earlier-formed self-concepts. It is not uncommon for interns to discover a new excitement for clinical work or a rekindled passion for research. Whether someone forges a new career pathway or recommits to a longstanding career preference, internship provides an unparalleled platform for experimentation and exploration.

Interns also gain the opportunity to refine their approach to effectively navigating a larger network of supervisors and colleagues. Whereas it is typical for graduate students to have only a few direct supervisors at any given time (e.g., one faculty advisor, one clinical practicum supervisor, and one instructor of record overseeing teaching assistant duties), interns can work

under or alongside more than a dozen research and clinical staff members during the training year. Accordingly, we encourage interns to thoughtfully consider the manner in which they interact with other professionals, who are likely to present with unique personalities, communication styles, and expectations of interns rotating through their clinic/laboratory. At the same time, working alongside colleagues at various career stages confers several advantages. Whereas more senior supervisors can offer guidance in cultivating team leadership skills, more junior supervisors can offer practical advice for applying to jobs/postdoctoral fellowships. Because trainees must begin applying to post-internship positions soon after initiating internship, obtaining vertical mentorship from a wide range of supervisors can prove invaluable as interns navigate the training year.

Life-Work Balance

Internship is a transitional phase between graduate school and the working world. For many trainees, this adjustment to full-time clinical work restricted to set business hours and a single or small set of predetermined locations can be simultaneously a relief and a challenge. It is therefore critical to cultivate a balance between work and personal life during this demanding year. Though expectations vary across sites, many internship programs advertise 40-hour weeks during operational hours, which can be in stark contrast to the flexible but often quantitatively greater number of working hours during graduate school. Trainee reactions to adopting a different working schedule vary; some relish the ability to compartmentalize personal and professional endeavors while others find it difficult to transition to a rigid, closely monitored, program-determined work schedule. Reduced control over one's schedule can be especially challenging for interns with parenting or other family responsibilities that sometimes arise during normal business hours. Even though many interns elect to continue working on graduate lab projects, the structure (or even symbolic concept) of a 40-hour workweek can be conducive to developing time-management skills that extend to multiple life domains.

The newfound ability to "leave work at work" can be seen as an opportunity to take greater advantage of nonworking hours. The internship year is ripe for engaging in valued activities, exploring new places and

cultures, developing interests and hobbies, attending community events, or adopting a new pet. It is also common for interns to consider and/or begin to have families, which could involve becoming legally partnered or even welcoming children into the home. Although APPIC does not require member programs to offer standardized parental leave, it does recommend the program and requesting trainee be creative and cooperative so as to obtain adequate leave while still meeting program requirements (Ponce, Aosved, & Cornish, 2015). At the very least, the structure, stability, and insurance benefits that accompany full-time employment can be helpful in supporting families, although it can still be challenging to juggle work and family responsibilities.

It is important to acknowledge that not all interns will be financially equipped to pursue every fee-based recreational activity. Intern stipends are generally low and there can be little (if any) “fun money” available after accounting for basic living expenses—especially on the heels of a potentially expensive geographic relocation. For its many advantages and oppor-

tunities, the internship year can also be a stressful time. Fortunately, most internship programs provide a built-in social support system: the intern cohort. Intern cohorts range from two (a required minimum class size for APPIC member programs) to over a dozen in size. Undergoing such a challenging and transformative experience together can forge bonds of friendship, professional collaborations, and general collegiality that last well beyond the internship year. In addition to seeking peer support and practicing compassionate self-care (e.g., Bettney, 2017), we encourage trainees to discuss with their supervisors how to mitigate work stress. For example, reducing the intern’s workload, decreasing perfectionism and/or self-expectations, or promoting greater task efficiency (e.g., creating note templates to facilitate swifter clinical documentation). In this way, interns can practice building a sustainable career, even in highly demanding or evaluative settings.

General Recommendations and Conclusion

The doctoral clinical internship is an immersive, integrative training experience in health service psychology. Building upon and extending graduate training, internship learning experiences converge to prepare newly minted health service psychology doctorates for activities in clinical practice, science, education, and public interest. Interns often have the benefit of working in a different setting/system alongside new mentors than they did during graduate school, which allows them to evaluate their professional values and passions away from perceived pressures of their graduate program faculty supervisors. Thus, while it is critical to meet internship program requirements and expectations, interns are generally encouraged to invest time and energy in proportion to what is personally meaningful. We also advise interns to remain open to new experiences and bring a curious attitude throughout their placement, as training goals might change during the year. At the same time, learning to say no and set appropriate



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boundaries is essential to maintaining a healthy life-work balance.

Although the internship placement itself is time-limited, the associated professional experiences and relationships are not encapsulated. In addition to forming a social support network with fellow interns who may serve as future collaborators or consultants, relationships with clinical supervisors and other training program faculty can be instrumental in one's professional development. We therefore advise interns to maximize personal and professional opportunities by approaching the internship year with the mindset of living one's personal life as if it were only a 1-year experience (*carpe diem*) but interacting with colleagues as if it were a career-long commitment (protect your professional reputation). Finally, we urge trainees to "pay it forward" during and after internship. Whether that entails sharing resources with fellow members of the internship program, helping recruit future interns, giving honest and encouraging advice to internship applicants, or engaging in some other act of professional service, remember that professionals in health service psychology are united in a shared mission to promote and apply psychological science and knowledge to benefit both the greater society and the individual members it comprises.

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No conflicts of interest to disclose for any authors.

Dr. Blakey was supported by the Department of Veterans Affairs Office of Academic Affiliations Advanced Fellowship Program in Mental Illness Research and Treatment. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States Government.

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DEC. 12 Written Exposure Therapy for PTSD: A Brief Treatment Approach

— Denise Sloan, Ph.D.

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

Written Exposure Therapy (WET) represents an alternative, evidence-based PTSD treatment approach that is efficient and associated with low treatment dropout rates (e.g., less than 10%). Moreover, WET has been found to be noninferior relative to the more time intensive CPT, with significantly lower dropout rates relative to CPT. This webinar describes the development of WET, efficacy findings support its use, and provides recommendations for the types of patients for whom WET might be most appropriate. For a full description, including learning objectives and recommended readings, go to:

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A Review of *Exposure Therapy for Treating Anxiety in Children and Adolescents* and an Interview With Dr. Veronica Raggi

Nichollette C. Lewis, *Adelphi University*

Clark R. Goldstein, *Growth Psychology*

IN THEIR BOOK *Exposure Therapy for Treating Anxiety in Children and Adolescents*, Raggi, Samson, Felton, Loffredo, and Berghorst (2018) provide a comprehensive treatment guide for clinicians. As the authors state, this book was written “by clinicians for clinicians to address the gap within the existing literature for books that provide practitioners with a comprehensive review of CBT and exposure principles tailored for children, adolescents, teens, and their family members.” Everything that a clinician would need to begin implementing exposure treatments when working with a younger population is detailed within this book. In the words of Mary Alvord, Ph.D. (who wrote the foreword), “this book provides a treasure chest of practical, implementable, realistic, and clinician-tested exposures” for clinicians who are looking for successful and creative ways to effectively treat anxiety disorders in children through exposure therapy.

The book opens with a review of the literature detailing how anxiety develops during childhood. In addition to describing the differences between developmentally normative and pathological anxiety, Raggi et al. (2018) also identify seven key risk factors for anxiety disorders in children and teens: negative affectivity, cognitive biases, anxiety sensitivity, intolerance of uncertainty, environmental factors, parenting factors, and perception of control.

Raggi et al. (2018) also provide a detailed review of the current most effective diagnostic assessment tools for clinicians working with children and adolescents. They present this information in two stages. Stage 1 describes in-depth assessment of the child’s difficulties. Assessment can take many forms, ranging from clinical interviews to rating scales. The authors provide details about the most useful assessment tools within these categories in addition to other methods of gathering information, such as school observations

and consultations with primary care doctors. The goal of this stage is to understand the diagnostically important factors, such as symptom duration and severity.

Raggi et al. (2018) suggest that for Stage 2, clinicians complete a functional behavior analysis to better comprehend the child or teen’s difficulties within the context of their life. Through this crucial second stage, the therapist will learn more about the ways in which the child’s anxiety disorder has impacted their life, how it is maintained, what avoidant or safety behaviors to avoid, and situational triggers. This information is crucial for tailoring exposure exercises that are effective and practical later in treatment. This book provides detailed dialogue prompts to guide the clinician, utilizing developmentally appropriate language, on how to explain “functional behavior analysis” to their young clients. For clinicians who have never completed a functional behavior analysis (FBA) with a child and their caregiver, this book is particularly important as it provides step-by-step instructions on how to complete this process. For clinicians who have experience in this domain, this book’s usage of potential dialogue samples and case illustrations provides effective models for developing an FBA.

As all clinicians who work with children and adolescents know, parental involvement is a key factor that impacts important aspects of treatment. Useful to both new and seasoned clinicians, Raggi et al. (2018) provide an in-depth review of the many ways in which parents influence their children’s anxiety disorders and the ways in which parents can help or harm their child’s treatment. There are also recommendations for working with parents to foster healthy emotion regulating capacities to be positive coping role models for their anxious children. Specifically, the authors present five separate tools that clinicians can share with parents to teach

them how to effectively use empathy to respond to their children’s anxieties without unintentionally accommodating and encouraging unhelpful responses in their children. With each tool discussed, supporting examples and sample dialogue (helpful for clinicians working with parents) are included.

For clinicians who are unsure of how to begin incorporating exposures into their work with children, this book is a tremendous resource. Through a detailed outline for setting the stage to begin exposure work, Raggi et al. (2018) provide examples for many aspects of exposure work, including explaining this work in developmentally appropriate language, useful worksheets for practitioners, providing dialogue examples to present psychoeducation portions within enjoyable and engaging storytelling frameworks specifically useful for working with younger children. There is also a refresher on key cognitive distortions and how to identify and challenge them specifically when working with young clients. Additionally, there are detailed instructions for structuring and implementing exposure sessions that include parental involvement, as well as samples of logs, fear and avoidance hierarchies, agendas, homework assignments, rewards, and more to guide the clinician in a useful manner.

Common difficulties when treating anxiety disorders, in general, are complications that arise from comorbid diagnoses. Within this book, the reader is offered a breakdown of how to adapt this format to accommodate a variety of different disorders, including co-occurring anxiety disorders, depression, ADHD, ODD, and other common diagnoses.

The book features detailed guides for clinicians wishing to use exposure therapy to treat specific anxiety disorders, including panic disorder, separation anxiety, school phobia, specific phobia, selective mutism, generalized anxiety disorder, social phobia, OCD and emotion tolerance. For each of these difficulties, a full chapter is dedicated to elaborating on ways to use exposure therapy with young clients.

In order to better understand the authors’ reasons for writing this book, and to gain insight into the way they use its contents to conduct therapy, we interviewed Veronica Raggi, Ph.D., of Alvord, Baker & Associates (ABA) in Chevy Chase and Rockville, Maryland.

What would you say is the main difference between exposure work with children or teens vs. working with adults?

With children, it is critically important to engineer therapy that is engaging and creative; it often requires more to hold the interest of the child than with adults. CBT therapists work hard to incorporate games, make exposures creative, and use external reward systems to increase the motivation to participate. Also, if you think about the broader set of CBT skills, we're trying to incorporate the use of multiple modalities for learning. So, for example, using cartoons, videos, or bibliotherapy that might illustrate a particular CBT concept. There are superheroes that illustrate each thinking trap. These different activities help the child more easily assimilate the concepts and stay engaged.

Work with kids also typically includes collateral involvement. That is, parents, teachers, coaches, tutors, nannies, etc., who observe and interact with the child's anxiety in different settings are key players in the treatment of the anxiety. Collaborating with these individuals on therapeutic goals allows them to support the child in those goals.

What are some ways that you've found that allow for discussions of the cognitive piece of exposure work to be more digestible to younger children? (like when working on the three-component model worksheet or cognitive distortions)

Again, we want to incorporate activities that are visually stimulating, engaging, creative and fun, that help children more easily identify with and understand the concepts that we're trying to teach. For example, the Optimistic Child Program by Martin Seligman has an initial story about Sherlock Holmes and a silly counterpart named Hemlock Jones who believes the first thought that pops into his head; in a very fun, engaging way, this story teaches kids how to be a detective of their own thought process. As another example, Phil Kendall's Coping Cat Program utilizes cartoon pictures with thought bubbles that highlight thinking errors and help us identify the connection between the character's thoughts and feelings. Mary Alvord's Resilience Builder Program uses characters such as Captain Catastrophe, Negative Nelly, and Polly Personal to identify thinking traps, providing a salient, engaging method for understanding the concepts.

All of this being said, we also need to be cognizant that very young children may not be ready for in-depth cognitive work. This is not a large component of therapy for kids under the age of 7. An emphasis on behavioral therapy is often the focus for kids who do not yet have the insight and abstract reasoning skills to fully benefit from the cognitive piece.

Why do you think some children with anxiety disorders go untreated?

There are a number of reasons why this can occur. Sometimes, especially with young children, parents and teachers may assume they will outgrow the condition or interpret clinically significant anxiety as within the normal range. Also, when there is resistance on the part of the child to go in for treatment, especially with adolescents, parents may struggle to collaborate with their child and work through initial obstacles to get in and start treatment. Broader issues of access to care are also a common obstacle—in many places the options for mental health services may be limited, especially for folks who do need insurance to cover costs. In certain areas of the country, it can be incredibly difficult to find a CBT or exposure specialist in-network, so that really limits broader access to care, timely treatment of disorders, and specialty treatment for specific anxiety-based conditions.

What are some ways that a therapist can assuage parents' concerns about typically developing fears from more clinical ones?

This is a good question because parents do often worry and may hold off on seeking treatment initially because of the question, "Is this a normal fear or is it a problematic fear or anxiety?" I think it is important to share with parents that all children have fears over the course of development. Typical early fears include separation anxiety, fear of the dark, and specific phobias. As children get older, social anxiety, self-consciousness, and worrying often increase. The key to identifying clinical fear from normal fear is whether the symptoms exist at a greater intensity or frequency compared to other children their age and whether these symptoms result in clinically significant impairment in their lives. However, for many families, regardless of reaching a diagnostic threshold, parents and children often benefit from learning skills to help cope with and face the situation bothering them. Therefore, I often encourage families to seek short-term support in

that regard. For example, if they are afraid of the dark, you can work on helping them examine evidence against their worries about the dark, practice lying in bed with lights on low and progressing to more dim lighting, offering rewards for increasing amounts of time practiced lying in bed alone, etc. Families and children can benefit from CBT-focused guidance and practice whether the fear severity is low or high. Having a set of skills in their toolbox can then be useful as other fears arise over time.

You also mention that it is important for parents to know that they should be responsible both as a coach and a leader before, during, and after a session. How important is parent involvement for the success of exposure therapy?

Research suggests that exposure-based CBT with parent involvement, where parents learn strategies to help the child face his fears and intervention control moves from the provider to the parents (or other key players) over time, is associated with longer-term maintenance of treatment gains. This is not surprising as we know that how parents interact with the child around the anxiety can either reinforce or further establish the anxiety-based patterns (such as when a parent is providing extra attention or comfort during a tantrum or allowing the child to escape a situation when they complain) or their response may aim to reduce the secondary reinforcement the child gets and instead encourage coping and facing the fear (such as when they offer brief validation but also set firm limits for the child, express a belief in their child's ability to handle the situation, and have expectations for the child to face some or all of the situation depending on the nature of the fear). That being said, parent involvement in exposure-based therapy often reduces as the child matures. Adolescents who are motivated and take ownership of their problems will have a greater ability to map out a plan with therapist support, track their own exposures and self-reward as compared to a younger child with less insight and motivation.

What role do you find parents often playing in the maintenance of anxiety disorders in their children?

One common concern is the presence of overprotective behaviors, whereby the parent enables avoidance or allows avoidance in that they might speak for, do for, or allow the child to skip a situation or activity

that is age-appropriate and within the child's capability of doing or attending. This prevents the child from developing coping skills. Instead, we want to encourage parents to scaffold, that is, provide the minimal amount of support needed for the child to engage in the activity, but not so much support that it takes away the child's ownership or independence and trust in their own decision making and actions. For example, parents who take over and do part of their child's homework because they are personally worried about the child's grades or jump in the water with child during swim lessons because they observe their child is stressed or resisting. So in other words, we want to prevent anxiety from being put in the driver's seat and serving as the basis for making decisions (such as whether or not to stay or leave an anxiety-provoking situation).

Another way parents inadvertently reinforce anxiety in their children is when the parent himself is highly anxious and it's apparent through both his nonverbal mannerisms and verbal cues that he is not managing that anxiety effectively. Exposure-based CBT trains parents to function as coping models for their children. That is, it helps parents recognize their own responses to their child's anxiety and use skills of their own to demonstrate coping and problem solving in the face of uncertainty or adversity. This sends an entirely different message to their children.

What are some tips for working specifically with parents to handle their own anxieties about putting their children through anxiety-provoking exposures?

This is a common concern for parents and so critical to address for a positive therapy outcome. I like to explore the belief systems the parent has regarding their child's anxiety. Often parents hold beliefs that contribute to a low tolerance for their child's anxiety or distress and emotions such as guilt or shame when setting limits. I like to explore and better understand what beliefs might potentially serve as obstacles to CBT and exposure treatment and then work with the parents to systematically challenge those notions.

For example, some parents feel their role is to prevent the experience of negative emotions or anxiety in their child. In this case, we want to help parents realize that their job is not to extinguish discomfort—negative emotions are part of life—and to teach the child how to better navigate and cope with emotional situations so they can

show up and experience life to the fullest. Teaching parents relaxation skills and mindfulness so they can be more fully present in the moment when their child is exposed to anxiety or is working on an exposure task can be very beneficial. And if their anxiety is significant, I also refer for additional individual therapy to help them manage their own emotions.

How can clinicians help parents come to terms with the negative consequences of being a safety person and encouraging avoidant behavior?

I think that parents are 99% of the time well-intentioned in their attempts to help their child. There is a natural parental instinct to provide comfort, safety, and protection to the child. I think that we can validate that perspective and how very understandable it is, to reduce the blame or guilt a parent might feel, and at the same time, help them to recognize that what feels right in the moment is not always the best long-term strategy. We want to help them understand that their child needs to experience some anxiety in order to overcome it. If they do not understand the rationale, it will make it very hard for them to follow through or implement strategies moving forward. So, working with them to understand that as they push their child gently outside of their comfort zone, they're giving their child the opportunity to learn coping skills, build independence and resilience, and gain greater self-esteem as they master these tasks. I like the analogy that our job as parents is not to provide a smooth-sailing life with an ever-present calm sea, but rather, helping our children develop skills to effectively navigate the rough and choppy waters of life. In my opinion, resilience is one of the most important skills you can help a child develop. I also explore what needs of their own are being satisfied by avoiding, taking over, or overprotecting and work through those potential emotional obstacles as well.

What can be done if parents are not receptive to changing their parenting behaviors that are exacerbating their children's symptoms?

That's a good question, and it can be frustrating! I would say that collaborating with parents on the obstacles that they see arising and their concerns is critical. I incorporate the use of motivational interviewing questions if they are getting stuck or resistant to adjusting a specific behavior. These open-ended questions allow them to weigh

the pros and cons to change and can generate internal motivation and ownership for making the change. Also, we need to be direct with parents that their involvement is key to change. I remind them that they are investing a lot of time and resources, I want them to achieve the maximum benefit, and in order to do that, we need their full participation. Sometimes I use the following analogy: when you go to the medical doctor and get antibiotics for your child, you don't give them half the required dosage or shorten the duration of the treatment. That's a concrete example that can be mapped onto therapy; in the therapeutic setting, there are certain key factors that are critical for change. We want the child to get the "full dosage" of therapy so we can maximize benefit.

Once treatment has begun, what are some challenges in the assessment process when working specifically with younger kids and older kids?

Younger kids often have less awareness of their own internal feeling states. They may be able to use a verbal label, such as "I am sad" or "I am angry" but struggle to connect the emotional label to specific physical sensations they are experiencing in their body and the thoughts that are occurring that created it. We need to use simple visual diagrams to map out thought and body states. With younger children, I also might rely more heavily on parent-report to fill in the gaps in the child's self-report and gain a more complete picture of what's occurring. In addition, many children, especially young children with lower capability for self-expression and self-awareness, demonstrate anxiety through secondary emotions (e.g., tantrums, meltdowns, and oppositional behavior), which can be misinterpreted as simply disruptive behavior. It is important to adequately explore the underlying reasons or triggers behind any observable behavior.

With older youth, building trust, rapport, and being genuine is key. It helps adolescents when therapists are clear and upfront about confidentiality and the desire to keep the therapeutic relationship a safe setting where the adolescent has ownership of the decision-making process, goal setting and what is shared with parents and other individuals (excluding, of course, limits to confidentiality). Some adolescents may be more reticent to share information and you need to put extra effort in initially to ensure you have established a strong therapeutic bond before attempting expo-

tures. At times, the parent is telling them they need to come to therapy and it is not necessarily their own decision. This ambivalence can impact their openness in session and the subsequent exposure work. Buy-in is critical. Using motivational interviewing techniques can come in handy in these cases. I also try to identify what is most important to the adolescent and make this a priority in therapy.

Also related to the assessment phase of treatment, what are some common mistakes that clinicians make when doing a functional behavior assessment?

One common pitfall when conducting an FBA is not adequately assessing the safety behaviors involved; that is, what other ways is the client trying to avoid the fear? I think sometimes less experienced therapists may not recognize that avoidance is not just escaping or fleeing the situation, but includes other protective behaviors that allow the child to avoid the perceived threat or not give full attention to the feared stimuli in the moment. For example, an adolescent with emetophobia may keep a garbage pail near their bed, a child with separation anxiety a cell phone with them at all times, or a child with panic disorder a water bottle handy for fear of choking. We want to understand and work to reduce and eventually eliminate any safety behaviors that are occurring during exposure work. During exposures, I also periodically assess for mental rituals occurring during the exposure by asking the client what they are thinking and/or if they are engaging in any safety behaviors. For example, a child may not be fully attending to the exposure exercise because they are counting in their head, holding their breath, squinting their eyes, or repeating a lucky phrase. This may prevent the client from fully habituating and/or experiencing the stimuli enough to build confidence.

Another critical piece is trying to uncover the core underlying fear. We want to ask questions like, "What does that mean to you? And then what?" or "What's the worst thing about that?" These questions allow us to understand not just the surface-level fear—"I'm going to be laughed at"—but the core fear, which often has to do with deeper level concerns like bodily injury, death, loneliness, rejection, etc. By understanding all levels of the fear, we can more effectively engage in cognitive work with the client and increase their confidence to face the situations that trigger the core fear. Last, it is important to include an

assessment of parental accommodation in your FBA. How are the parents interacting with their child around their anxiety? This helps us coach them to use more effective strategies.

What are some common difficulties that clinicians may face when a child or teen is resistant to beginning exposures because they might be afraid?

These difficulties become much less common when a therapist effectively plans and collaborates with the client around developing the fear hierarchy and determining the starting place for exposure. Additionally, engaging with the child in a fun, humorous way can significantly lighten the mood and reduce the likelihood of resistance. Still, in some cases, there may be a strong reaction in the moment or an attempt to avoid or flee the situation. I also have had kids who say, "You know I'm fine, it doesn't bother me anymore. We don't need to do this." I think one way to address this would be by taking a step back, considering an adjustment of the difficulty level of the exposure, finding an easier starting place or breaking the task down so that you can build momentum from there. I always try to end with a successful exposure even if we do not engage in the exact task we hoped for. I try to find some small part of the fear that the client is willing to face, even if it is a baby step. I would also consider giving the client some space and time to, with our support, use some of their coping skills to regulate their emotional response before we reengage in the exposure.

What are some tips for helping children and adolescents who feel hesitant to engage in imaginal/role-play exposures?

Making the imaginal exposure less goal-directed and more informal can be beneficial, such as, "Hey, let's chat about this situation," or "Tell me more about this part of the event." If we can get little snippets of engagement with or attention to a discussion about that fear, then we are starting the process of imaginal work. With permission, we can then work on developing a script regarding the details of the sensory experience and/or action sequence of the event. If we're engaging in a role-play exposure, I often model the role-play first for understanding. I also use different hands-on activities to make attention to the fear more palatable, such as story-telling, cartoons, puppets, and drawings. All of those

things tend to be interesting and salient to kids and help them feel like the task is less onerous. It is important to recognize, however, that imaginal work may be harder for young children. Some kids may prefer and more easily engage in concrete activities such as visual or auditory exposures.

Do you have any tips for helping children who have difficulty understanding their own emotions to rate their fears on the fear hierarchy?

This is a challenging problem that sometimes comes up! With the child's help, I write each fearful situation on an index card and have them rearrange the cards in order from most difficult to least difficult. So indirectly we get a sense of the degree to which each task provokes anxiety, through the child's sequencing of difficulty. Another tactic I use is to reduce the number of anchor points on a feeling thermometer or other scale. It may be something as simple as three descriptors—"a little, more, or a lot"—on the scale. Alternatively, a gradation of facial expressions can be a fun visual way for them to understand subtle changes in emotion. When a number scale is used, I try to carefully explore with the child what each number on the scale means in terms of their body sensations and thoughts. That is, making sure that descriptions are clear at each anchor point (e.g., a 3 might mean "I'm feeling shaky" or "I'm thinking I can't do it"). With young children who have less insight into their feelings, I like to spend additional time on developing a feeling vocabulary, understanding facial expressions, and awareness of body sensations associated with each emotion.

You list many different types of relaxation, from diaphragmatic breathing to visualization and progressive muscle relaxation. Are there any reasons why a clinician might use one over the other?

Children with ADHD or high energy levels may have difficulties settling their bodies and coming to a place where they can engage in a relaxation task. In addition, young children and those with inattentive symptoms may struggle to turn their attention inward to focus on their breathing and body sensations. For these kids, I often think about and implement more active forms of relaxation such as yoga poses and short muscle tension and release exercises using fun analogies like squeezing a lemon or scrunching a bug off your nose. Also consider using props, so when you teach

belly breathing, you can model putting a block on your belly or chest to watch the rise and fall. When teaching mindfulness with young children and youth who have ADHD, consider active tasks such as drinking a cup of tea or hot chocolate to focus on each aspect of the sensory experience, as opposed to a sitting meditation that may feel more tedious and less engaging for kids with high energy.

For more concrete and rigid thinkers or youth on the autism spectrum, having concrete indicators to guide their practice can be beneficial, such as using terms like belly full versus belly empty for diaphragmatic breathing. Fun analogies like asking children to assess whether they feel like a robot (rigid and tense) or a ragdoll (limp and relaxed) from the Coping Cat program provide a fun, visual method for assessing body state. With older youths who have more insight and abstract reasoning skills, longer periods and more still forms of relaxation and mindfulness can be utilized.

Regarding the different forms of exposure (in vivo, visualization, audio/video, modeling/observation), are there instances where you would recommend one over the others?

Often a progression is used, where you might start with less direct forms of exposure, such as imaginal or audio or video, and move towards live, in vivo participation and more direct sensory experiences. However, when you don't have direct access to the feared stimuli, audio, visual and imaginal exercises may be more heavily relied on (for example, a fear of the ocean or somewhere the clinician cannot easily join the patient). Although in many cases we can now conduct telehealth sessions to talk the client through an exposure of that nature.

There are also instances where we might consider moving more quickly to an in vivo or higher-level exposure. For example, if there is high client motivation—they come in, really want to work through this, and are open to a more difficult initial challenge. Sometimes, there is also a time-sensitive nature to the problem. For example, with school refusal, the longer the child stays out of school, the more schoolwork they miss and the larger the problem becomes. In this scenario, returning to school as quickly as possible becomes incredibly important, and thus, less time may be devoted to imaginal and audio/video exposures. That being said, gradual steps will likely still be built in; for

example, the child may go back to school but attend only part of the day, or attend only the easier classes at first.

To your knowledge, are there any data to suggest when flooding might be preferred over gradual exposures?

Quickly moving up the fear hierarchy or starting with a higher-level challenge can be effective under certain conditions. There are numerous studies that demonstrate the effectiveness of one-session, intensive treatment of a specific phobia. This plan can be preferred when there is high client motivation, a desire to move quickly, and an openness to starting higher up on the fear hierarchy, and also when there is a time-sensitive need to complete treatment quickly. In these cases, it is critical that trust and rapport be built quickly because it can be impacted at times when we move too fast. Client dropout is higher when we start with high-challenge exposures, so we want to consider those aspects in our decision making. It may be less favorable with clients who are slow to develop trust and rapport. Many exposure protocols for youth emphasize a gradual and systematic approach to conquering fears. Personally, I find that many clients prefer this approach and it can be helpful in giving them the confidence and momentum to face the larger challenges. I think it can increase the willingness of many youth to engage in and even enjoy the therapy process as they work through the problem in manageable steps.

What goes into your decision-making process when deciding if a psychiatric referral is necessary before starting treatment or simultaneously with treatment?

If the problem has been longstanding with minimal change over time, they continue to experience a significant degree of impairment, and especially when they have had a previous history of working with other evidence-based CBT providers without success, I would likely recommend a medication consult at the onset of my work with them. I would also collaborate with any previous providers to better understand if there was an aspect of the CBT or a piece that either wasn't incorporated or can be emphasized more to increase the effectiveness of the exposure-based CBT. Similarly, once they have started therapy, I would likely consider suggesting a medication consult when an initial trial of CBT with exposure has not resulted in clinically

meaningful change in the key settings where the anxiety manifests.

The age of the child has an impact as well. Many families of young children prefer to start with therapy and assess improvement from a trial of CBT before considering the addition of medication. That being said, if there is a high initial severity of the problem, I might suggest they consider a combined approach to start. Alternatively, impairment may be mild to moderate, but they may have a strong preference for including medication in the treatment approach. I am careful to consider both parent and child/teen preference for starting medication immediately versus waiting. We know that combined treatment can have more robust effects, so I'm typically very open to helping the family consider this, knowing it is likely going to improve the course of the exposure therapy.

I would suggest a medication consult prior to initiating treatment when the problem severity is great enough that they are unlikely to benefit from exposure therapy or CBT because they cannot adequately engage—for example, when their physiological arousal is so high that they are not able to discuss or attend to activities without extreme distress. Additionally, if there are comorbid issues that will impact therapy progress, such as significant depression, suicidal ideation, ADHD, or other factors that may prevent full participation, it is important to concurrently address the comorbid concern, whether that be through medication or focused therapy goals that target or manage the interfering condition.

Overall, what do you think your book might contribute to the literature or to clinicians that other books have not yet contributed? What is different about your book?

My history of training within the scientist-practitioner model has led to a high value on the implementation of evidence-based therapeutic approaches. After graduate training, as I became a full-time clinician, I found myself wanting more nuance from many CBT or exposure manuals and textbooks in terms of what detailed steps I might take to lead the client up the fear hierarchy. I often sifted through a variety of ABCT list-serve posts, author blogs, and used peer consult groups to generate ideas for creative exposure exercises that would suit my individual clients' needs and diagnoses. All of this led to my desire to create

a book that could serve as a comprehensive resource for clinicians seeking exposure task and activity ideas for their session—for anything from a fear of loud noises, weather, needles, vomiting, etc., to exposures that address excessive worrying, specific ritualistic behavior, speech inhibition, you name it; in essence, a one-stop shopping manual of exposure ideas. I was fortunate to work with a talented and creative group of expert clinicians, well versed in the use of exposure-based CBT. While there are always new ideas and we can't be completely exhaustive in our compilation, our team strived to create an array of flexible, creative, and diverse ideas for each condition. We also endeavored to provide a strong foundation on the basics of how to conduct exposure-based CBT with children and adolescents. We wanted to provide step-by-step guidance that would appeal to both beginning and expert clinicians. We hoped to fully flesh out what exposure therapy work is like with kids and adolescents and, in doing so, speak to the developmental needs of this group.

Concluding Remarks

Raggi et al.'s (2018) *Exposure Therapy for Treating Anxiety in Children and Adolescents* certainly achieves what its authors set out to accomplish. For both beginning and seasoned therapist, this book serves as a resource for treating children and adolescents with anxiety disorders through the use of CBT and exposure therapy. As one of the most comprehensive guides within the child anxiety field, there is something to learn from and apply to one's own practice for all clinicians who seek to begin or continue working with this population.

Reference

- Raggi, V. R., Samson, T. G., Felton, J. W., Loffredo, H. R., & Berghorst, L. H. (2018). *Exposure therapy for treating anxiety in children and adolescents*. Oakland, CA: New Harbinger Publications.

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The authors declare there are no conflicts of interest.

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LIGHTER SIDE

The da Vinci Manual Affair

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

WE'D VOWED to ignore the many treatment manuals that keep sending us follow requests—especially the really persistent ones, like for OCD. Once upon a time we had fallen hard for that cute little manual for self-regulation, *The Emotional Emu*.¹ It broke our hearts.

But the comment posted to our latest data selfie by a manual that was new to us was hard to resist. It simply said, “wanna paint a portrait like da Vinci?” What a come on! We rationalized that we would just politely see what it was all about, but that's it.

So, deluding ourselves that we would only take a quick view, which worst case would provide some joke-fodder for office downtime, we responded with a simple, “K.” Apparently, that was all *The da Vinci Manual* needed to ask us to take it private. “What the heck,” we said as we swiped right. In retrospect, *The da Vinci Manual* had us from “hello, emu!” Ugh! Nothing worse to us CBTers than a Freudian slip!

According to the manual, da Vinci questioned why portrait painting training programs had to take years and years to complete. “Sure, some true masters came out of this process, but not enough of them to meet demand,” the manual messaged, which was followed by another one that said, “Da Vinci had also become critical of how many Bitcoins, I mean Florins, it cost to get one of those masters to paint your portrait.”

“That's what inspired da Vinci to design my trademarked, evidence-supported protocol for portrait painting,” the manual further explicated. “And we don't have to do years of apprenticeship like da Vinci did

with Andrea del Verrochio to learn it?” we asked skeptically. To which the manual replied, “Listen, you can master this methodology in practically no time at all,” quickly adding, “... and there's minimal thinking required.”

“But what if we want to achieve *moti mentali* in our portraits, was that not da Vinci's highest aspiration?” we inquired.² “First of all,” the manual said, “even the great da Vinci struggled to translate a portrait subject's inner life onto canvas. Take my word for it,” the manual opined, “your subjects wouldn't know *moti mentali* from *moti-vational* interviewing. How do you think he finished the *Mona Lisa*, anyway?”

That was a good question. As longtime *tBT* contributors, we were acutely aware that in an early biography Giorgio Vasari wrote that da Vinci had started the *Mona Lisa* in 1503 but never felt satisfied enough with how he was depicting the subtleties of La Gioconda's complicated personality to complete it. Nonetheless, a finished version of a “certain Florentine lady” was found among his possessions in 1507, shortly before his demise.³

“So, what are you saying?” we asked.

“You know how da Vinci foresaw the helicopter?” queried the manual rhetorically. “Well, my portrait painting protocol proves that he anticipated the invention of paint-by-numbers kits centuries ahead of their time, too.”

“What's your point?” we said, to which the manual responded, “please let me go on.”

“My Brief Portrait Protocol, BPP” for short, can be completed in—ta da!—four one-hour sessions.⁴ And instead of requir-

¹Don't even ask us about Copping Cat! We may never recover from that one!!

²*Moti Mentali* translates to “movements of the mind.”

³See “Life of Leonardo Da Vinci” by Giorgio Vasari in his historiographical masterwork, *Lives of the Most Eminent Painters, Sculptors, and Architects*, first edition, 1550.

⁴The da Vinci Manual's four-session protocol claim is dubious. According to our unimpeachable sources on the dark web, da Vinci had a strong aversion to the number “quattro” since childhood and avoided anything that even vaguely reminded him of it.

ing the subject to sit still in all sorts of awkward and uncomfortable poses for extended periods of time, the BPPTM doesn't require the subject to sit still for a second!"

The manual then posted the BPPTM for us to peruse:

Session 1: Process the subject's credit card. Artoeducate the subject about what a portrait is. Also get informed consent, and a signature on the no money back "Policy Form" (additional charge). Then use the rest of the session to "observe" the subject's face.

Session 2: Smush the face of the subject on the beta version one-size-fits-all portrait imager (additional charge).

Session 3: Apply the color designated by number for each section of the portrait (e.g. color #1 = nose) from your "Great Master Portrait Artist Palette." (additional charge).

Session 4: Present the portrait and ask the subject to complete a "Portrait Satisfaction Form" (additional charge).

"Ecco," The Da Vinci Manual said, "a finished portrait just like THAT (accompanied by a "smacking lips" sound effect)!" "But will it be great?" we asked. "Great, schmrait," it answered. "Confidentially," the manual wrote in a tiny, whispering font, "Da Vinci asked Michelangelo to give up on the Sistine Chapel and partner with him in a start-up company to disseminate me."

We did not respond to this preposterous statement because by this point it was as if we had gone into dissociative states, discarding any of our prior misgivings about treatment manuals as if they had never existed.⁵ We told each other: "This

one is different. Finally, a manual we can believe in!"

The da Vinci Manual was only too happy to inform us how we could order it as well as its various supplemental materials. "For a slight fee," the manual said, we could also enroll for ongoing "portrait artist support" from it via a group text. And for another nominal charge, we could fill out some paperwork and receive a diploma from "ABPP" (Association of Big-Time Portrait Painters) that we could frame and proudly display in our office. It even threw in a kicker; we would receive a free Vitruvian Man poster if we placed our order within the next 15 minutes.

Our minds started spinning with ideas about how we could use the BPPTM to augment evidence-based CBT (as well as our revenue). For instance, we could utilize it for awareness training in CBIT. Or, we could paint "before and after" treatment portraits that we could use as outcome data in DBT skills training.⁶ We could not help but envision ourselves as the celebrated founders of integrated Portrait-CBT, or P-CBT.

As if reading our thoughts, The da Vinci Manual informed us that we could optimize our valuable time by conducting portrait-enhanced group therapy. The manual said, "You get six to ten subjects to show up in a group, the Bitcoins, check that, Florins, really add up." Out of habit, we asked if portraits might be insurance reimbursable. "Why not?" said the manual, "EMDR is."

That insensitive comment from the manual suddenly shocked us back to our senses. We messaged The da Vinci Manual, "before we take this any further, we need you to send us some efficacy data."

There was a long pause in what had become a rapid flurry of back-and-forth messages and responses between The da Vinci Manual and us.

But after about an hour, The da Vinci Manual snapped us some unconvincing stats from its "Portrait Subject Satisfaction Form."⁷

The manual also sent us a research slide summarizing an article finding it to be more effective for depression than behavioral activation with or without Prozac. Well, we hadn't seen that study, but we really couldn't make a big deal about it given some of the other stuff that gets published.

Then we got this beauty: A selfie of its name, "The da Vinci Manual," literally written on a mirror. And "mirror written" underneath was @LeonardoDaVinci4real.⁸ When we asked the manual to explain the apparent anachronism, it responded "Easy, baby. Da Vinci also invented the @."

We replied, "Da Vinci Manual, you're trying to seduce us. Aren't you?"⁹

Further red-flagging itself, the manual proceeded to forward a slew of putative testimonials. "I was painting portraits like a pro in no time at all," read one. Another one said, "It's as easy as 1-2-3, just like CBT."

That was about all we could take. Civility being one of our core values, we informed the manual that although it seemed very nice, we wanted to think it over before "taking it to the next level," emphasizing that "it's not you, it's us" to soften the blow. But despite our best efforts to let it down gently, the manual seemed enraged, raining down upon us a hail of high-pressure sales GIFs of it saying, "Buy The da Vinci Manual Right Now!!!" It didn't stop until we were able to block it on all of our social media and smart speaker devices.

We did conduct some discrete investigation after a bit of time had passed. Turns out not one search engine we consulted had ever heard of The da Vinci Manual for portrait painting, let alone the BPPTM. The possibility that we were being catfished by an artificial intelligence (AI) app for manualized interventions couldn't help but cross our minds.

However, with the benefit of time and 20/20 hindsight, we suppose the best way to process our thankfully brief infatuation with The da Vinci Manual is to just count our blessings that we stopped it short of consummation!

Look, you're all free to do what you want if a manual sends you an unsolicited follow request. We understand, they seem to know just what you want to hear and promise the world. And maybe, just

⁵Unofficially, but on good authority, we've now learned that da Vinci indeed wanted to disseminate his art methods widely, but this ambition disintegrated when he insisted on writing the business plan "my way." The Medici bankers he was counting on for financial backing evidently took a dim view of his backwards written, cryptocoded Aramaic loan application, especially as it was written in a special ink that could only be seen under a black light. Not surprisingly, we have been unable to authenticate any da Vinci start-up partnership offers to Michelangelo.

⁶Egad, these treatment manuals are insidious!

⁷Does one hundred percent subject satisfaction seem a tad high to you, too?

⁸Mirror writing, formed by writing in the reverse of the direction of whatever language is being used, was common during da Vinci's era. Literally writing on mirrors, not so much.

⁹OK, these particular lines are derived from the 1967 film *The Graduate*.

maybe, there's a manual out there that truly will be worth getting serious with.

But as far as we're concerned, we don't want to settle for a manual. Call us starry-eyed or old-fashioned, if you must. Or plain old commitment-phobic about manuals. But when you've been burned by a manual not once, but twice (or, frankly, more), it's hard to forget.

So, the next time some random manual sends us a follow request, we will do our best to simply ignore it. But, still, sometimes in the wee hours when we're discussing the intricacies of clinical methodologies, we find ourselves reminiscing about The da Vinci Manual . . . and wondering what might have been.

POSTSCRIPT: We're not going to lie. It's been even more difficult to move on than we expected. Just the other day we actually almost talked ourselves into writing a manual to help our colleagues resist the temptation of manualized treatments.

But at least we didn't contact The Emotional Emu on a rebound.

. . .

The authors have no conflicts of interest or funding to disclose.

The authors wish to thank Elizabeth Machado, M.S., for her helpful suggestions in preparing this manuscript.

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CBT Medical Educator Directory

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

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.
2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.
3. Training should take place or be affiliated with an academic training

facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

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

To Submit Your Name for Inclusion in the Medical Educator Directory

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

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

ABCT's
Medical
Educator
Directory }

<http://www.abct.org>

[Resources for Professionals](#) ↗

[Teaching Resources](#) ↗

[CBT Medical Educator Directory](#) ↗



OBITUARY

Kieron O'Connor

IT IS WITH GREAT SADNESS that we have learned of the passing of our esteemed friend and colleague, Kieron O'Connor. Kieron passed away on August 27 at 3:45 A.M. With his passing, the research community has lost an exceptionally valuable individual with a great passion for scientific research. He was one of the founders of the Centre de Recherche de l'Institut Universitaire en Santé Mentale de Montréal (CRIUSMM) and an exemplary clinical researcher with a great commitment to his colleagues, friends, students, and patients. In the course of 30 years, Kieron has shaped numerous careers in both clinical practice and research. He was a source of inspiration for anyone fortunate enough to spend time with him. His presence and sense of humor always brought people closer together.

An Accomplished Science Career

Kieron first acquired a Bachelor of Social Sciences at North London Polytechnic (1972), and then went on to a master's in experimental psychology from Sussex University (1979), followed by doctoral research in psychophysiology at the University of London (1984). This subsequently led to a Diploma in Clinical Psychology from the British Psychological Society (1986). During his years in London, he worked closely with the eminent psychologist Hans Eysenck. In 1987, he crossed the Atlantic and accepted a position as a clinical researcher with the Centre de Recherche de l'Hôpital Louis-H. Lafontaine, the University of Montréal, while also maintaining affiliations with many other universities. Originally, Kieron O'Connor was trained as a neuroscientist with a focus on cognitive psychophysiology, but later he developed a strong interest in clinical psychology. The majority of his research was dedicated to the study and treatment of obsessive-compulsive spectrum disorders, tic disorders, and Tourette's syndrome. Throughout his career, Kieron aimed to improve treatment outcomes for patients, which led him to develop new therapeutic approaches that are now being applied internationally, including inference-based therapy for

obsessive-compulsive and related disorders and a cognitive psychophysiological treatment approach to the treatment of tic disorders.

The originality and promise of Kieron's research are recognized and underscored by the many grants he received over the years, consisting of over \$12 million in funding by organizations at the provincial, federal, and international levels. In the course of his career, Kieron authored or co-authored nearly 550 oral presentations and publications. Among those, close to 500 were peer-reviewed papers. In addition, he has contributed to over 60 research reports and book chapters. He wrote 20 books in the fields of psychology and clinical psychiatry that both appeal to researchers, as well as mental health professionals and key stakeholders in the field.

With the aim to improve the prevention of psychological disorders, while simultaneously fostering a better community understanding and social inclusion for often stigmatized populations, Kieron looked deeply into the causes of mental health disorders and their impact on quality of life and the daily functioning of sufferers. To counteract stigmatization, Kieron published a collection of five books and multiple videos to foster awareness aimed at the general public to improve awareness and understanding. He was highly involved in community organizations for people suffering from obsessive-compulsive spectrum disorders, Kieron presented conferences, intervention activities and led training sessions. He was a founding member of the Quebec Obsessive-Compulsive Foundation.

A Man of Many Talents

Kieron was a man of many talents with passions that went beyond science. Beyond his prolific science authorship, he also wrote and published novels under the pseudonym of Ken Konor (*The Twitch*; *The Super Way*). His artistic passions led him to outlets such as the piano, theatre, method acting, and mime. As a lover of nature, he was drawn to hiking, sailing, cycling and cross-country skiing. Kieron never denied his Irish roots either, and

never missed an opportunity to organize an original Saint Patrick's Day at the office with darts, Celtic music, and Guinness at the ready!

Kieron had a keen and natural awareness of the spirit behind our research center, including its culture, its foundation, and the people that breathe life into its projects. Kieron's many contributions were always filled with joy, humanity, social conscience, and a boundless passion for research, but also a deep appreciation and respect for colleagues who devote themselves to such endeavors. Each Christmas, Kieron's colleagues, students, research assistants, and staff received a gift in the form of a bottle of wine, chocolate, or some other thoughtfully chosen item in recognition of their personal contribution. As a firm believer in annual team dinners, he would always take the time to deliver a heart-warming speech to underline and individually thank each person who attended.

Kieron continued to work and write papers until the very end. His work and legacy will continue and be carried forward by the many colleagues who have been inspired by him. Kieron was a humble, big-hearted man with a generous spirit that has touched us all. Please express your sympathies by a donation in memoriam to the Foundation de l'Institut Universitaire en Santé Mentale de Montréal—Kieron O'Connor Fund. In accordance with Kieron's wishes, these donations will contribute to financing research in clinical psychology.

Donation link:

<https://interland3.donorperfect.net/weblink/WebLink.aspx?name=E910058QF&id=29>

...

*Contributed by Marc Lavoie,
Fred Aardema, and Julie Leclerc,
Kieron O'Connor's research team.*



call

54th Annual Convention

November 19–22, 2020 | Philadelphia

for Ticketed Sessions

Workshops & Mini Workshops

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

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

Institutes

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

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

Master Clinician Seminars

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

For more information or to answer any questions before you submit your abstract, contact the MCS Committee Chair, masterclinicianseminars@abct.org

Research and Professional Development

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

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

Conference Theme:

*“Better Access,
Better Outcomes:
Enhancing the
Impact of
Behavioral and
Cognitive
Therapies”*

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

Submission deadline: February 13, 2020

ABCT 2020

Enhancing the Impact
of Behavioral and Cognitive Therapies

BETTER ACCESS, BETTER OUTCOMES

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

Call for Papers

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

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

Examples of topics related to the theme include:

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

Submissions may be in the form of symposia, clinical round tables, panel discussions, and posters. **Information about the convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2020.**

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

**general
sessions**

Portal opens
February 13, 2020

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



Call for Award Nominations

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

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

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

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

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

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

Outstanding Contribution by an Individual for Education/Training Awarded to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Past recipients of this award include Gerald Davison, Leo Reyna, Harold Leitenberg, Marvin Goldfried, Philip Kendall, Patricia Resick, and Christine Maguth Nezu. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Then e-mail the completed form and associated materials as one pdf document to 2020ABCTAwards@abct.org. Include "Outstanding Educator/Trainer" in your subject heading. **Nomination deadline:** March 2, 2020

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

Nomination deadline: March 2, 2020

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

Student Dissertation Awards

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

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

Nomination deadline: March 2, 2020

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

Nomination deadline: March 2, 2020

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

Outstanding Service to ABCT Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to 2020ABCTAwards@abct.org. Include "Outstanding Service" in the subject line. **Nomination deadline:** March 2, 2020

ABCT's 2020 **Champions of Evidence-Based Interventions**

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

► **Potential Candidates**

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

► **Recognition**

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

► **How to Nominate**

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

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

abct.org > For Members > Champions

Meet Our Featured Therapists

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



Alan Berkowitz
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Ilyse Dobrow DiMarco
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Angela Klein
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Nehjla Mashal
Patrick McGrath
Paul R. Munford
Charles Melville
Christine Maguth Nezu
Shannon Couture O'Flinn
Terrence Patterson
Phillip Pierce
Erroll Philip
Rebecca Sachs
Gerald M. Stein
Stephen R. Swallow
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Jennifer L. Taitz
Jonathan Kaplan
Katherine Martinez
Melinda White
Reid Wilson
George Wing
Robin Yeganeh

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

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

Get to know the community. —Cheri A. Levinson

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

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

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

the Behavior Therapist

Association for Behavioral
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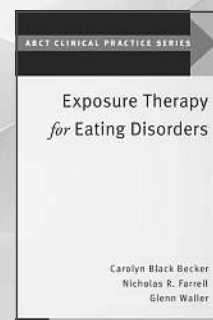
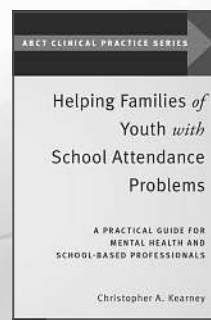
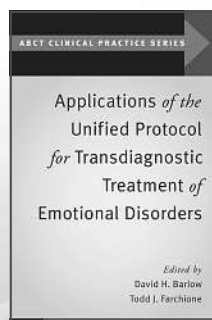
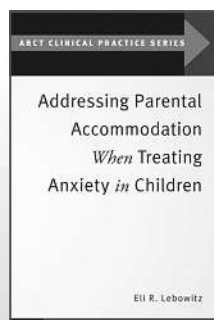
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