

# *the* Behavior Therapist

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## PRESIDENT'S MESSAGE

### **Technology and Young People: The Perils and Potentials**

*Jonathan S. Abramowitz, University  
of North Carolina–Chapel Hill*



MANY IS THE DAY THAT I come home from work to see my two middle-school daughters splayed out on the couch clutching their respective electronic devices and entranced in their own cyber social worlds (even as the TV plays in the background; see

Figure 1). Sure, it's been a long day and this is one way to unwind with friends, but I remember playing touch football and trading baseball cards with my neighbors after school—the face-to-face interaction was what I craved. How could so much have changed in one generation?

For her eighth-grade term paper, my oldest daughter is exploring the use and negative effects of technology—primarily social media—on teens. So, as a psychologist, I've taken an interest in her project. And in providing (*just the right amount of*) guidance for Emily as she completes her background research and writes this paper, I've stumbled across some rather striking data that I thought I would reflect on in my column for this issue. Given the role of technology in our lives—much of it for the good, I believe—it is important that we understand what and how much media we are consuming, as well as the correlates of this consumption. Some of what I learned might surprise you.

In recent years, researchers have begun to more comprehensively document and quantify the extent to which various forms of media have come to monopolize our lives, especially for

[continued on p. 59]

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*Published by the Association for  
Behavioral and Cognitive Therapies*

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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 air-mail 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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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
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- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.
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“Generation M2” (a.k.a, the “Millennials”)—those people born in 2000 or later. For example, an oft-cited national study on media usage by young people (Henry J. Kaiser Family Foundation, 2010) found that, on average, 8- to 18-year-olds spend 7 hours and 38 minutes each day with electronic devices and consuming media.<sup>1</sup> Heavy media use was also correlated with poor grades, and frequent users reported being less content with their personal lives. What’s more, in a typical day, 46% of 8- to 18-year-olds reported sending text messages (I’m quite sure this number is even higher in 2015). But from this group, respondents sent an average of 118 messages per day, and they spent more than 90 minutes sending and receiving texts cumulatively. In a typical day, 8- to 18-year-olds spent an average of 1 hour and 13 minutes playing video games. Boys spent twice as much time as girls, on average. Seventy-one percent of 8- to 18-year-olds had a TV in their bedroom.

Two studies published in 2014 seem to replicate the 2010 findings. In the first, Pressman, Owens, Evans, and Nemon (2014) surveyed more than 50,000 families and found that significant screen time correlated with a drop in academic performance (especially in middle school), greater difficulty falling asleep, and greater social-emotional volatility. They also found an inverse correlation between *grit* (the ability to perform a strenuous or difficult task without giving up) and amount of screen time. By contrast, performing chores was correlated with greater self-worth and responsibility.

In the second study, Uhls et al. (2014) examined the link between screen time and interpersonal intelligence. In this investigation, 105 sixth graders were evaluated for their ability to recognize people’s emotions—happy, sad, angry, scared, confident, excited—in photos and videos. Then, the children were randomly assigned to one of two groups: half spent 5 days at a camp and did not glance at a screen. The other half followed their normal routines,

reporting an average of 4.5 hours per day texting, watching TV, and playing video games. When tested a second time, the “no screen” group showed significant improvement at reading human emotions. Uhls et al. concluded that screen time can cause “decreased sensitivity to emotional cues.”

It is interesting to consider how these realities might interact with other societal changes over the last generation quite apart from the rise of technology. For instance, the average family home is now larger than ever, meaning family members can retreat to their own corners of the house, so there’s less chance that parents and children will see each other. Because everyone is so busy with work, school, and extracurricular activities, there’s less time for families to spend together. Add technology to the mix and it seems to get worse. I have friends who say that they email and text with their children more often than they talk face to face—even when they’re at home together!

My first inclination was to draw causal conclusions and assume that increased screen time leads to the negative outcomes mentioned above. But when I discussed these findings with Mitch Prinstein, Ph.D. (my friend, colleague, and expert on this topic whose office happens to be down the hall from my own), I learned that there are other ways to look at these correlational findings. Mitch raises the reverse scenario—that perhaps those teens who spend more of their time in virtual worlds are in fact those who are prone to this type of behavior anyway (and vice versa). For example, kids who have less grit in the first place might be the ones who gravitate toward using electronic devices more regularly than those with more grit. And those who are less satisfied with their social lives might be more drawn toward computer gaming than those who have more fulfilling options. So, perhaps it is not that

increased screen time *leads to* negative outcomes.<sup>2</sup>

But still, with technology being intrinsically reinforcing, what are the behavioral and cognitive ramifications of all of this? Regardless of the direction of the causal arrow, does less connecting—the real kind—mean that younger generations are less able to develop and maintain strong relationships? Will they grow up deficient in important social skills? Will our teens’ experience of familiarity, comfort, trust, security, and, perhaps most important, love, differ from how we experience these cognitions and emotions? Mitch points out that there is also a bright side: Do kids who indulge in technology learn to become good multitaskers? Are they our future computer scientists? And do those who cannot resist virtual social networking become better at the real thing?

As cognitive and behavioral clinicians and researchers, what can (or should) we do about this? Is it something that we need to change, or does it require that older generations merely adjust to what will inevitably become the “new normal”? I believe we have crossed a great divide when it comes to the presence of media in our lives—there’s no going back. Yet even as technology brings remarkable tools to our fingertips and provides access to an increasingly connected world, I can’t help but be concerned about the cumulative effects of all those hours spent staring at a screen. Technological change is not merely additive—it is ecological. Research shows that our media alter the environment in which we live, and in the process we can surrender the relationships, activities, and values that are essential to a meaningful life.

From an interventionist perspective, I agree with Mitch’s suggestions—steeped in good old learning theory—that it is helpful

<sup>1</sup>These averages might seem high because simultaneous exposures to different forms of media are counted double in the literature; so, for example, watching TV while texting for 1 hour is counted as 2 media hours in these studies.

<sup>2</sup>Does this remind anyone else of the popular (and empirically baseless) assertion 20 years ago that watching TV shows such as *Beavis and Butthead* caused the kids of that time to act out? Perhaps each generation needs a scapegoat on which to blame their kids’ undesirable behavior.



Figure 1. Entranced in the world of social media

to leverage the reinforcement value of screen time to help families and kids make changes where they are needed. Perhaps parents can make the use of electronic devices contingent on completing homework. Maybe screen time can be earned and limited, and devices could be “parked” far away from the table at dinner; and somewhere outside the bedroom at bedtime. As for the Abramowitzes, we try to spend more time tossing the softball, riding bikes with neighbors, or just relaxing and discussing the day’s drama (remember, I have two daughters in middle school!) when we have family time. Among their many benefits, these activities all necessitate direct interaction with others and call upon us to share in the things that, I believe, make us most fully and most happily human.

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I would like to thank Mitch Prinstein for the wisdom he shared about this topic during one of our many end-of-the-day treks from Davie Hall to our campus parking garage.

**Correspondence to** Jonathan S. Abramowitz, Ph.D., University of North Carolina-Chapel Hill, Department of Psychology, Campus Box 3270, Chapel Hill, NC 27599; [jabramowitz@unc.edu](mailto:jabramowitz@unc.edu)

## CLINICAL FORUM

# Building Awareness, Openness, and Action: Values Work in Behavior Therapy

Emily K. Sandoz and Russell S. Anderson,  
*University of Louisiana at Lafayette*

PSYCHOTHERAPY IS SCARY. So scary, in fact, that nowhere near as many individuals who are suffering with psychological disorders are seeking therapy. Epidemiological studies suggest that DSM-IV Axis I disorders are highly prevalent among U.S. adults, with 12-month prevalence estimates ranging from 26% to 30% (Kessler et al., 1994; Kessler, Chiu, Demler, & Walters, 2005; Reiger et al., 1998). It seems less than one fourth of these seek mental health services, however. According to the American Psychological Association’s (APA) most recent annual survey on “stress in America,” an estimated 6% of Americans are receiving mental health services at any one time (APA, 2013).

Psychotherapy is also difficult. Clients often experience increased distress upon initiation of therapy, preventing some from ever attending. Data from a family psychotherapy clinic suggests that 56% of clients do not attend their first appointment (Lester & Harris, 2007). Once they consent to treatment, one in five psychotherapy clients drop out of therapy before completion (Swift & Greenberg, 2012).

And therapists are not immune to the challenges therapy brings. Therapist trainees experience significant anxiety and fear around the practice of psychotherapy (see Skovholt & Rønnestad, 2003). In fact, demoralization has been proposed to be inherent in therapist development (Watkins, 2012). Once practicing independently, many therapists experience emotional exhaustion, or “compassion fatigue” (Figley, 2002), due to the high levels of empathy required for effective therapy.

Despite being scary and difficult for both the client and the therapist, therapy is generally effective (Lambert & Ogles, 2004). In terms of efficacy research, a little over half of RCT participants reach recovery and about two thirds experience some meaningful change in symptoms (Hansen, Lambert, & Forman, 2002). Meta-analyses converge on the conclusion that part of what works in psychotherapy is the thera-

peutic relationship (Horvath, Del Re, Flückiger, & Symonds, 2011). It seems that part of what works in psychotherapy is the therapist and the client meeting the challenge of psychotherapy united by some shared purpose.

The psychological flexibility model, which describes purported mechanisms of change in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012), offers values work as a potential strategy for “directing and dignifying” the hard work of behavior therapy (Wilson, Sandoz, Kitchens, & Roberts, 2010). Values have been defined in several ways in the psychological flexibility literature with varying levels of technical precision (e.g., Plumb, Stewart, Dahl, & Lundgren, 2009; Wilson & DuFrene, 2009). Values work establishes the primary purpose of therapy to be increasing the client’s active contact with whatever is most important to him or her. This includes facilitating (a) values clarification, (b) values construction, and (c) valued living (Dahl, Plumb, Stewart, & Lundgren, 2009).

From the perspective of the psychological flexibility model, incorporating values into therapy is not about distraction or redirecting focus to the positive. Instead, values work is proposed to increase vulnerability and, perhaps more important, to increase willingness to experience vulnerability in service of valued living (Dahl et al., 2009; Wilson & Sandoz, 2008). In short, the psychological flexibility model suggests that a focus on building effective, values-consistent action allows for behavior therapy to be not merely scary and difficult, but scary, difficult, and meaningful. Research on values from the broader psychological discipline is largely in support of this proposal.

## Values

Humans benefit from contacting and expressing what they care about. There is, currently, a growing scientific interest in what matters to people and how that “mat-

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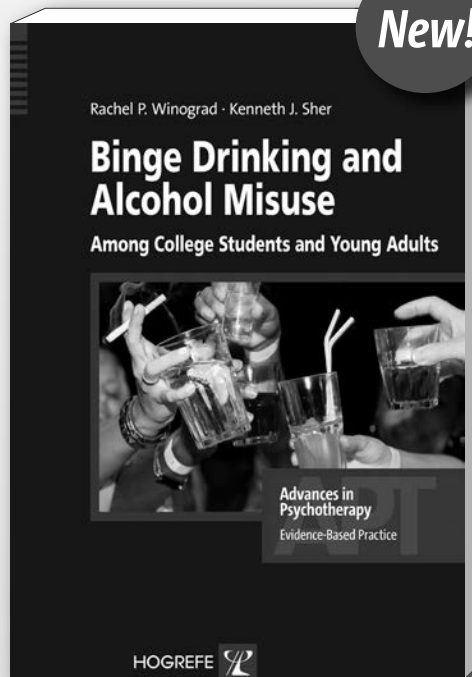
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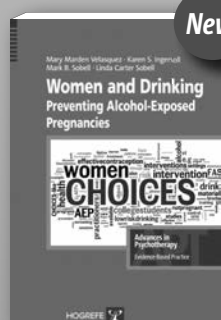
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tering" affects people's lives (e.g., Dahl et al., 2009). Particularly in the social psychology literature, researchers note that "values affirmation" interventions have a broad, sustained impact on individuals' responses to threatening situations. In values affirmation interventions, clients typically rate a list of commonly held values, and then they write about the value rated most important (McQueen & Klein, 2006). Most relevant to clinical applications are the convergent and robust findings that values interventions seem to foster increased awareness of threatening events, increased openness toward experiencing those threats, and increased behavioral effectiveness and commitment in the face of threat.

### ***Values Increase Awareness of Threat***

Contacting values is associated with improved awareness of threatening events. For example, moderate drinkers who engaged in values affirmation exhibit an attentional bias toward threatening words while reading an article linking alcohol consumption to breast cancer (Klein & Harris, 2009). This threat sensitivity is also reflected at the neurophysiological level, where values affirmation increases emotional and attentional responsivity to performance errors (i.e., increased error-related negativity; Legault, Al-Khindi, & Inzlicht, 2012).

### ***Values Increase Openness to Threat***

Making contact with values facilitates openness in the face of threatening situations (Sherman & Cohen, 2006). Individuals who engage in high-risk behaviors often deny or ignore information about the negative consequences of their behavior, but simple values interventions can facilitate an acceptance of such information, making behavior change more likely. For example, smokers given the chance to write about their values tend to more readily acknowledge the health risks of smoking (Crocker, Niiya, & Mischkowski, 2008). Values affirmations have also been shown to increase acceptance in female coffee drinkers exposed to information linking caffeine consumption and breast cancer, and in sexually active individuals exposed to information about the risks associated with their sexual behavior (Sherman, Nelson, & Steele, 2000). The effect of values affirmations on openness in the face of threat may be attributable to reduced physiological stress, as values affirmation is associated with reduced cortisol levels in threatening situations (Creswell et al., 2005).

### ***Values Increase Effective, Committed Action***

Making contact with values also facilitates more effective and committed action in threatening situations. For example, individuals who have engaged in values affirmation are more likely to help strangers and friends alike, even when others' success is personally threatening (Tesser, Martin, & Cornell, 1996). In another example, sexually active individuals who write about an important value are more likely to purchase condoms after an AIDS educational video than those who do not (Sherman et al., 2000). Effective action in the face of threat seems to be directly related to the awareness and acceptance of that threat. Individuals who write about an important value have a greater neurophysiological response to performance errors and subsequently show a reduction in errors (Legault et al., 2012).

Behavior of those in contact with values may not only be more effective, but also more persistent. For example, individuals who contact personal values in a volunteer activity show greater commitment to that activity in the face of adversity than those who do not (Lydon & Zanna, 1990). With socially anxious individuals, values affirmation results in improvements in social behavior that are not just maintained, but that continue to grow over 8 weeks (Stinson, Logel, Shepherd, & Zanna, 2011). Individuals show more self-control following social exclusion when they are given an opportunity to affirm an important value, particularly when that value is self-transcendent (Burson, Crocker, & Mischkowski, 2012).

### ***Potential Impact of Values in Therapy***

No research, to date, has focused on the unique or incremental impact of values work in behavior therapy. Several positive repercussions are implied, however, based on the body of research reviewed above. Extended to the therapy context, these findings suggest that values work could enhance the effectiveness of psychotherapy by facilitating key processes involved in client change.

First, values work might facilitate clients' awareness of aversive experiences that occur in the therapy session. Behavior therapies almost universally require the monitoring and reporting of aversive thoughts and feelings. Values work might help clients experience more immediate success with those foundational exercises as a result of increased experiential awareness.

Second, values work might facilitate clients' openness toward those experiences, thereby increasing engagement. Behavior therapy often aims not only to build awareness of aversive thoughts and feelings but also to teach new behaviors in their presence. Values work may support learning new skills like recognizing overgeneralization and disputing, noticing anxiety levels rising and practicing relaxation, or observing the ebb and flow of rigid, painful thoughts because it allows clients to remain in contact with the experience long enough to attempt the new skill.

Third, values work might increase the effectiveness and persistence of attempts to use the novel skills therapy is teaching. The skills that therapy teaches require practice and are often not met with immediate success. Values work may help clients build motivation to continue practicing until palpable benefits begin to accrue.

Finally, the benefits of values work may reach beyond the repertoire of the client. Behavior therapists are required to be aware of and open to aversive experiences occurring in session, both in terms of the client's suffering and in terms of their concern about the client's suffering (e.g., Am I not helping her? What else can I do for this person? I'm just not even sure what she's doing here). Behavior therapists must also be committed, even when changes are slow to emerge. Values work may foster client change while empowering therapist behavior.

### ***Values Work in Behavior Therapy***

Supported by the growing body of research on the benefits of values affirmation (see Cohen & Sherman, 2014, for a review), values work is a transtheoretical approach to improving engagement, openness, and effective, meaningful action in behavior therapy. Over the past decade, a number of cognitive behavior therapies have come to incorporate values work into standard protocols (e.g., Lejuez, Hopko, Acerno, Daughters, & Pagoto, 2011). Because values work is defined functionally, values work has taken different forms, depending on the therapeutic stance into which it is being incorporated. Dahl and colleagues (2009) propose that values work can be integrated into assessment, treatment planning, and treatment with the ultimate purpose of increasing contact with values.

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### **Values-Based Assessment: Values Clarification**

Values work begins upon initiation of therapy. As the therapist engages in assessment to build a diagnostic picture and conceptualization of the client's difficulties, he or she also has the opportunity to foster values clarification. In values clarification, the therapist creates a context in which clients can first notice, then name what it is they care about. Asking clients to report during assessment not only what they struggle with, but also what they value, serves several purposes. Just as symptoms and proposed mechanisms are repeatedly measured to track the progress of therapy, so values clarification is revisited throughout the course of therapy (Dahl et al., 2009).

#### **Purposes of Values Clarification**

First, values clarification provides useful information to the therapist that will help with conceptualization and treatment planning. Often the costs of a client's ineffective behavior are reflected in the areas he or she most values. For instance, a father might highly value his relationship with his daughter, but his guilt about his ineffectiveness as a father might result in excessive drinking, further damaging their relationship. Likewise, values identify potential motivations the client might have for change. Together, the consequences of the client's current behavior and the desired alternatives elucidate a purpose for therapy.

Values clarification is not simply information gathering, however. Values clarification during the assessment portion of therapy begins to establish therapy itself as valued. As clients speak about the things that they care about, the reinforcing and motivating functions of those valued aspects of their lives become associated with everything present. The therapy context, including the physical environment and even the therapist herself, comes to evoke the same thoughts, feelings, and overt behavior that emerge when values are present. Some of these functions are even transferred to the client himself, as he begins to experience himself in terms of that which he cares about.

Finally, values clarification communicates with the client, albeit implicitly, a central tenet of values-based treatment. Values clarification begins to establish client awareness of the intimate relationship between pain and values. Despite the aspiration associated with values, early conversations about values are often painful. By contacting that pain, clients begin to learn

experientially to approach pain in order to approach that which is purposeful or meaningful.

#### **Approaches to Values Clarification**

Several assessment instruments are available to facilitate values clarification, each with a slightly different emphasis, purpose, and format. Three approaches—the Values Bull's Eye, the Survey of Life Principles, and the Valued Living Questionnaire—have been investigated as psychometric instruments.

*Bull's Eye (BULLI; Lundgren, Luoma, Dahl, Strosahl, & Melin, 2012).* The BULLI employs brief values writing prompts focusing on three domains of the client's choice as well as perceived barriers. Each writing prompt is followed by a printed dartboard with a bull's eye representing behavior completely aligned with one's values. On each of the first three dartboards, the client makes a mark representing how close to the bull's eye he is living. On the last dartboard, the client makes a mark representing how persistently he has been acting in the face of perceived barriers. The average of distances from the bull's eyes to the client's marks on the first three dartboards provides an estimate of values-consistent action. The distance from the bull's eye to the client's mark on the fourth dartboard provides an estimate of persistence with barriers. The BULLI has demonstrated good test-retest reliability and criterion-related reliability (Lundgren et al., 2012).

*Survey of Life Principles (SLP; Ciarrochi & Bailey, 2008).* The SLP is a structured worksheet that was developed to aid therapists in facilitating comprehensive inquiry of a wide range of possibilities for valued living. The SLP involves self-ratings of 55 life principles on four dimensions: value importance, pressure, activity, and success. The 55 items represent 13 clusters of values dimensions that have been identified as universal (e.g., Schwartz & Bilsky, 1990) and that have been repeatedly observed in clinical and vocational settings (Ciarrochi & Bailey, 2008). Preliminary reliability and construct validity are sound (Ciarrochi & Bailey).

*Valued Living Questionnaire (VLQ; Wilson, Sandoz, Kitchens, & Roberts, 2010).* An early version of the VLQ was developed as part of the first ACT manual (Hayes, Strosahl, & Wilson, 1999). The purpose was to guide a semistructured interview on the importance and consistency of action with valued domains (Wilson, Sandoz, Flynn, Slater, & DuFrene, 2010). The VLQ

was then adapted as a psychometric instrument with clients rating 10 domains on importance and the consistency of action. Scores on importance and consistency subscales are scored by adding ratings and are multiplied to produce a valued living composite. The VLQ has demonstrated good reliability and validity (Wilson, Sandoz, Flynn, et al., 2010). Currently, the VLQ-2 (Wilson & DuFrene, 2009), which expands on valued domains and rating scales, remains under investigation.

*Other approaches.* Several other approaches to values clarification are currently emerging. For example, the recently published Valuing Questionnaire (VQ; Smout, Davies, Burns, & Christie, 2014) moves away from identifying valued domains and domain-specific behaviors, and instead relies on self-report of perceived valued living. In addition, the Meta-Valuing Measure (Taravella, 2010) focuses on valuing, freedom from values conflict, and flexibility in valuing.

Finally, many have responded to the complexity of values clarification by developing more nuanced or extended approaches to make the process of assessing values more experiential and meaningful for the client. For example, Hayes and colleagues (2012, p. 304) describe an eyes-closed exercise in which a client imagines loved ones providing a eulogy as if he had lived exactly as he valued and shares with the therapist the values he would want his life to stand for. Ciarrochi and Bailey (2008) adapt the same 55 principles from the SLP to a card-sorting task followed by a careful debriefing. Dahl and colleagues (2009) offer the Values Compass, a seven-step self-assessment that includes valued directions, values-based behavior, related obstacles, current strategies for dealing with obstacles, and willingness to change behavior in service of values. In another example, Wilson and DuFrene (2009) offer the Hexaflex Functional Diagnostic Experiential Interview (HFDEI), which builds off the VLQ-2, adding (a) a values writing component; (b) an extended values-based interview focusing on the importance of valued domains, consistency of action, and avoidant behavior that interferes with action; and (c) a series of behavioral rating scales for therapist ratings of psychological flexibility in the context of particular values.

#### **Values-Based Treatment Planning: Values Construction**

Values are defined in the ACT literature as “verbally constructed” (Wilson &

DuFrene, 2009), emphasizing that the valued behavioral pattern is constructed by the client. Once the client has had the opportunity to clarify a broad purpose she wishes her life to serve, the next step is to choose the form that value might take in her life. In values construction, the therapist creates the context for collaborative determination of values-based goals, or “specific achievements sought in the service of a particular value” (Hayes et al., 2012; p. 333).

### *Purposes of Values Construction*

Values construction provides a foundation for specific treatment goals that are meaningful to both the client and the therapist. Many clients enter into therapy motivated by behaviors, feelings, and thoughts they want to stop (Harris, 2009). Therapists can become similarly compelled to bring their clients relief. However, if treatment goals are based on these avoidant, short-term desires, the targeted behavior is not likely to be fulfilling (Dahl et al., 2009) and is less likely to turn into long-term behavior change. In contrast, the achievement of values-based goals (i.e., the products of values-consistent behavior) automatically maintains long-term behavior change by facilitating a sense of connection with and progress toward values.

Values construction can change the function of existing goals through their association with values. At times, incorporating values construction into treatment planning results in different goals than would be established otherwise. Often, however, the goals are not dissimilar from those that clients would describe otherwise. For example, a mother may come into therapy saying she “knows [she has] to quit drinking so she doesn’t lose [her] kids.” Abstinence is a reasonable goal, but is functioning as avoidance. This is problematic because a focus on avoidance is likely to strengthen the whole avoidant repertoire, which is likely to include alcohol consumption to escape painful experiences. In contrast, establishing abstinence from alcohol as part of what it means to her to be the best mother she can be creates the context for expanding an entirely different functional repertoire, motivating countless behaviors consistent with “being a mother.”

Like values clarification, values construction is not limited to the beginning of therapy. Values construction also provides some direction when goals are not being met or not facilitating the desired behavior

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change. Often in therapy, despite compelling, meaningful sessions, progress is not evident in terms of explicit treatment goals. This might be attributable to having goals that are not values-consistent or having goals that are too far removed from the client's current repertoire. Revisiting values during these periods can help the therapist to determine goals that are part of the valued behavioral pattern and that are accessible from the client's current level of functioning.

Finally, values construction allows for the client to continually adapt behavior to be guided by values, but in a way that is sensitive to changing contingencies. As therapy progresses, so do clients' lives, often presenting challenges that either were not present at the start of therapy or that only became apparent through the therapy work. This dynamic provides clients with an opportunity to reconstruct values by establishing new goals that are appropriate for new situations.

### **Approaches to Values Construction**

The Matrix (Polk & Schoendorff, 2014) and the Life Areas, Values, and Activities Inventory (Lejuez, Hopko, LePage, Hopko, & McNeil, 2001) are structured exercises that facilitate values construction.

*The Matrix.* The Matrix exercise was designed as part of an intensive outpatient program for PTSD to train clients to engage in functional assessment of their own behavior in different contexts through a series of discriminations. First, clients learn to discriminate their behaviors from the contexts in which those behaviors occur, and then they learn to discriminate functional relationships between contexts and behaviors.

The client identifies different aspects of context in terms of "experiences." The therapist guides clients in attending to multiple aspects of his or her ongoing behavior and in discriminating "five sense experiences" from "mental experiences." The therapist also guides the client in further discriminating aversive contexts (experiences they "move away" from) and appetitive contexts (experiences they "move toward"). In doing this, clients identify not only immediately reinforcing context (e.g., feeling happy or getting a paycheck), but also values (e.g., being a mentor or experiencing personal growth).

Next, clients shift from discriminating contexts to discriminating behaviors by function. The therapist guides the client in identifying behaviors they engage in to "move away" from aversive experiences

(i.e., unwanted "five sense experiences" and "mental experiences"). Then the therapist guides the client in identifying behaviors they engage in (or would want to engage in) to "move toward" their values. Finally, the therapist guides the client to notice the relationship between "moving toward" behavior and aversive experiences (i.e., often, distress or discomfort increases when taking valued actions), and the relationship between "moving away" behavior and valued living (i.e., avoidance results in behavior inconsistent with values). A number of exercises have been developed for use of the matrix, all of which elaborate on this common theme of increasing awareness of context, behavior, and functional relationships between context and behaviors (Polk & Schoendorff, 2014).

*Life Areas, Values, and Activities Inventory (LAVAI; Lejuez et al., 2001).* The LAVAI is a tool specifically developed for values construction in the context of Behavioral Activation for Treatment of Depression (BATD). The LAVAI lists five broad life domains and asks the client to describe what is meaningful to him about each of these areas. Once values are clarified by the client in each life domain, the client constructs specific activities that relate to each value. In this way, the LAVAI encourages clients to distribute their goals across different life areas as they often fixate on one domain as the source of their suffering. The therapist guides the client to choose activities that are small, achievable, observable, and measurable, while comprising the intermediary steps to reaching the larger goal. BATD's most recently revised manual (Lejuez et al., 2011) provides not only the LAVAI form, but also specific instructions for its use.

### **Values-Based Treatment: Valued Living**

The ultimate purpose in values clarification and construction is to create a context for valued living to emerge. Thus, values work involves not just identifying values and setting values-based goals, but engaging in activities that facilitate contact with those values.

### **Approaches to Building Valued Living**

Some clients, despite their ability to describe values and values-based goals, struggle greatly with translating those values and goals into action. They plan and plan again to make particular changes, then repeatedly fail to do so. This failure is likely because of the vulnerability that comes with pursuing values. Thus, building

valued living as a repertoire includes both creating opportunities in session for clients to contact values (and vulnerabilities) and helping clients to create contingencies that support contacting values out of session.

*The Sweet Spot exercise.* The "Sweet Spot" (described in Wilson & Sandoz, 2008) is designed to help the client practice contacting values with intention. In this exercise, the therapist asks the client to recall a moment in his life that was "sweet." The therapist defines a "sweet moment" to the client as one in which she was simply appreciating instead of struggling with or running from her experience. While recalling something sweet, clients are also invited to notice not only sweetness, but also any bit of longing, regret, fear, or disappointment that might arise. It is assumed that what is experienced as "sweet" to the client in this way will be related to that which she values. In this simple eyes-closed exercise, clients practice approaching values and the vulnerable experiences that come with values, so that they will be more likely to engage in valued actions in their lives with increased commitment when difficult experiences arise.

*Activity planning and daily monitoring.* Often, building values-consistent repertoires involves some sort of self-monitoring. Ciarrochi and Bailey (in press) offer a daily diary worksheet to be completed by clients at the beginning and end of each day. In the morning, the client lists the following: (a) a value he chooses to serve that day, (b) specific actions that can be taken to serve the value, (c) thoughts and feelings that may arise as barriers to the designated actions, and he assesses his (d) willingness to accept these thoughts and feelings in order to facilitate value-based action. If the client answers that he is not willing, then he is directed to work through the questions with another value. At the end of each day, the client assesses the degree to which he acted consistently with his chosen valued direction with a 5-point scale ranging from 1 (*not at all*) to 5 (*very much so*).

Similarly, clients in BATD conduct daily activity monitoring throughout the course of treatment that includes not only a description of the activity, but also how enjoyable and meaningful each activity was. After completing the LAVAI, the therapist guides the client in selecting 15 of the most important and enjoyable behaviors on her list, then ranking them from easiest to most difficult. The next week, the therapist assists the client in scheduling one to three of her easiest values-based activities for the following week by recording them

on the next week's daily monitoring forms. This continues weekly throughout the course of therapy, with the therapist providing support in dealing with obstacles like time management, specifying activities in sufficient detail, and seeking social support.

### **Challenges in Values Work**

Values work comes with a number of challenges. Clients present for therapy with some degree of discomfort or dissatisfaction, and framing their struggles in reference to their values often intensifies discomfort and dissatisfaction. Clients sometimes respond to this increased vulnerability with rigidity and avoidance in any number of forms.

#### ***Don't Know, Don't Care***

At times, clients report not knowing what they care about or deny that anything matters to them. In both cases, the therapist can assume that not knowing or caring might serve to protect the client from the vulnerability inherent in values work. In both cases, instead of challenging the client's protest, the therapist might offer

the client the opportunity to work towards choosing something to value (e.g., "What if our work could be about helping you to choose a direction or purpose for your life? Would that be something you would want?"). Even if the client refuses, the rejection of the offer to choose a value is a more genuine expression than the initial "don't know" or "don't care" response.

#### ***Values-Related Conflict***

Most clients, at some point, describe conflicts, particularly around values construction. Clients often describe feeling torn between two incompatible courses of valued action, between valued actions and a sense of obligations, or between valued actions and the demands or desires of others. This can be experienced by the client as a conflict between the values themselves. Values, however, are not tied to particular courses of action, even in specific situations. In any one situation, any number of actions could be consistent with valued living. When faced with the issue of values-related conflict, the therapist's goal might be to facilitate a sense of potential connection between these seemingly divergent patterns of behavior (e.g., What if you

could choose a way of being a mother that could serve who you are as a teacher? What if you could choose a way of being a teacher that could serve who you are as a mother?). Ultimately, the therapist might aim to support the client with the creation of an overarching sense of who they would value being broadly, with each individual value as part of the greater whole.

#### ***The Have-Tos***

When discussing values, clients often feel a strong sense of obligation surrounding the things they care about. When the therapist notices the client using words such as "should," "need to," "have to," or "can't," it is a sign that the client may be constructing his values on the basis of self-imposed or societal rules. This is problematic in that rule-following does not offer the same benefits as valued living. When a value becomes just another rule, the client loses an opportunity for awareness, openness, and meaningful progress in his or her life. When a client's valuing becomes dominated by rules, the therapist's goal is to help the client to give himself permission to choose a course of action that serves his values. This involves first building aware-



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ness around thoughts of what he “should” or “shouldn’t” do without evaluating those thoughts, and then choosing a course of action independent of those thoughts.

### Values Mismatch

Client rigidity is not the sole challenge faced in values work. Sometimes the conflict is between the therapist’s values and that of the client. This occurs in different ways during different phases of values work. In early values work, therapists sometimes find themselves struggling to relate to the client’s values at all. They might notice themselves pushing for more values even after the client seems to feel that clarification is complete. During values construction, therapists may have difficulty seeing certain behaviors as values-consistent. They might notice their own rigid ideas about what pursuit of particular values should look like. In later stages, therapists might prioritize a client’s particular values differently than the client does, limiting progress by encouraging action in an area that’s not as fulfilling or rewarding for the client. In each of these cases, the therapist is challenged to recognize their inflexibility and return to clarification and construction of their own values relevant to being a therapist. Just as a client’s therapeutic engagement might be increased by values work, so might therapists enjoy the same benefit.

### Conclusion

Behavior therapy is a scary and difficult process, but one that can afford individuals with the chance to live their lives more effectively and with greater meaning and fulfillment. Integrating values into assessment, treatment planning, and treatment may help clients to meet the challenges of behavior therapy by facilitating awareness and acceptance of difficult experiences, while fostering engagement in effective and meaningful patterns of behavior. Although not without its challenges, a number of tools and strategies are available to support therapists’ integration of values work into their current approach.

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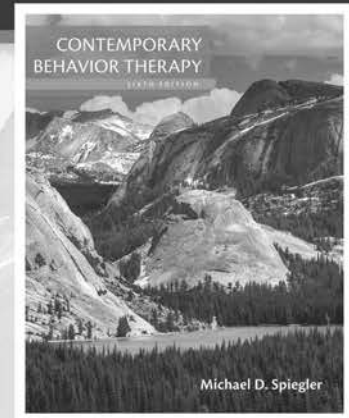
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**Correspondence to** Emily K. Sandoz, Ph.D., University of Louisiana at Lafayette Department of Psychology, PO Box 43131, Lafayette LA 70504-3131; [emilysandoz@louisiana.edu](mailto:emilysandoz@louisiana.edu)

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# The What, Why, and How of Tracking Your Training: A Primer for Clinical Psychology Students

Laura J. Dixon, *University of Mississippi Medical Center*

Brittain Mahaffey, *Stony Brook University*

THROUGHOUT PREDOCTORAL AND POST-doctoral training in clinical psychology, it is necessary to track the details of one's training experiences. Unfortunately, the importance of tracking is often minimized until students begin preparing material for internship, job, or licensure applications. Nevertheless, tracking can be relatively effortless when (a) the information to track is evident; (b) there is clear reason for tracking; (c) it is done on an ongoing basis; and (d) there is an organizational system for tracking. Though not exhaustive, this guide provides an in-depth review of the most pertinent data to be prospectively or retrospectively tracked for predoctoral and postdoctoral applications, with an emphasis on the Association of Psychology Postdoctoral and Internship Centers (APPIC)'s Application for Psychology Internships (AAPI). For ease of use as a reference guide, this article is divided into four key areas that are most likely to be relevant to a student in clinical psychology: clinical work, research, education, and teaching experiences.

## Clinical Work

For an individual in a clinical psychology program, the details associated with clinical training experiences are necessary for the AAPI and state licensure applications and may also be a requisite for applying for postdoctoral programs or clinical positions. Although seemingly irrelevant in the initial years of graduate school, it is worth the time to become familiar with the information provided by APPIC, AAPI, and Association of State and Provincial Psychology Boards (ASPPB) websites. These websites, in conjunction with the suggestions here, are useful for identifying information that needs to be recorded and reported.

## AAPI Overview

Altogether, the AAPI is comprised of applicant and educational information, the clinical practicum summary, and additional materials. See Table 1 for a summary of details pertaining to each section. The first information section is straightforward; however, the practicum summary section requires a much greater level of detail and is extensively reviewed in the next section of this guide. The additional materials section consists of four required essays (i.e., personal, research, diversity, theoretical orientation), a cover letter for each program, CV, and letters of reference. Although AAPI generally encourages programs not to require any supplemental materials, it is not unusual for programs to require a de-identified integrative report or case summary.

## AAPI Practicum Summary Section

The clinical practicum summary accounts for clinical hours attained through doctoral and terminal master's programs with the following subsections: intervention experience, assessment experience, adult assessment instruments, child assessment instruments, integrated reports, supervision received, support activities, and additional practicum information.

The intervention experience section requires a detailed summary of the specific type of face-to-face hours (e.g., individual/group therapy, career counseling, or intake interview) for every relevant age group (e.g., older adults [65+], school age [6–12]). Applicants must also document the number of individuals seen for each type of encounter. For instance, you may have 250 face-to-face hours providing individual therapy for 21 different adults (ages 18–64). One added benefit of tracking the type of experience early in your training is that you have the opportunity to round out your application. For example, if you have

gained many individual therapy hours with adults, then you might seek out different experiences, such as working with adolescents or leading groups.

The psychological assessment section of the AAPI requires applicants to document the number of integrated psychological testing reports and the assessment instruments completed for adults and children/adolescents. An integrated report is defined as a report that incorporates client history, clinical interview results, and results from at least two psychological tests, including objective or projective personality measures (e.g., MMPI, PAI, Rorschach), intellectual tests (e.g., WAIS-IV), cognitive tests (e.g., WMS-IV), and/or neuropsychological tests (e.g., Trails). Notably, the requirements of an integrated report can be easily met by adding in one or two tests to a standard intake or assessment battery, which is an important consideration as you are developing your clinical portfolio. It is also important to be aware that certain internship sites, particularly in the northeast, may require at least one integrated battery with the Rorschach or other projective measures. Next, the summary of assessment instruments section catalogues every self-report and clinician-administered psychological instrument (e.g., instruments such as the BDI, PHQ, and SCID are listed here). Applicants identify the number of times each instrument was clinically administered, integrated into a report, and/or administered as part of research. Given that 10–15 tests may be administered to one patient during a neuropsychology battery, and that you may be using clinical instruments in research, it is particularly important to engage in ongoing documentation.

The next section of the AAPI collects descriptive information about the practicum settings, supervision, and support hours. The practicum description section collects information regarding the types of practicum settings (e.g., outpatient clinic, VA Medical Center), theoretical orientation utilized (e.g., cognitive-behavioral), and a description of the diversity of clients including race/ethnicity, sexual orientation, disabilities, and gender. In the last piece of the practicum section, supervision and support hours are reported. Supervision hours are the total amount of group and individual supervision hours provided by a licensed psychologist or other mental health professional. The methods of supervision (e.g., audio tape, live/direct) are also recorded in this subsection. Support hours have less stringent reporting requirements

and broadly encompass indirect client hours, such as session planning, chart review, the writing of progress notes, scoring of tests and measures, and didactics. The number of total support hours and a description of the indirect hours are reported in this section.

Many questions arise during the completion of this application as there are a number of “gray areas.” Notably, experiences should only be counted once, yet may fit within multiple categories. For instance, a feedback session from a diagnostic assessment may be categorized as an “assessment” hour or an “individual intervention” hour, particularly if you transitioned from assessment into treatment. In these situations, it is beneficial to attempt to determine the primary purpose of the session (i.e., to provide feedback or to initiate treatment). If it becomes difficult to distinguish between the purposes of sessions, then it may be beneficial to clarify ambiguity with your supervisor or clinical training director. These resources may be able to provide guidance with respect to how encounters are typically coded in your program. Furthermore, it is often difficult to account for every detail of clinical hours, especially in complex settings. Accordingly, one’s ethical decision-making skills are applied to the situation and best estimates are relied upon. Such practice may not be ideal; however, it is inherent to the process of documentation. Prospective applicants should recognize that it is next to impossible to accurately account for every detail of clinical experience. Strive for accuracy, but not to the point of personal distress!

### ***Time Tracking Systems***

Once the information to track has been identified, there are a number of resources that exist to assist in the process of tracking clinical hours. At a most basic level, a Word document or Excel spreadsheet can provide a simple, cheap means of flexibly tracking clinical hours and additional relevant information, such as research, in one place. For instance, a simple table may include the following practicum information: dates, supervisor, number of supervision and clinical hours, number of clients, client diversity information, clinical hour details (e.g., assessment, type of therapy, instruments), and support hours. Students may access the AAPI to confirm that they are tracking the right data, even if they are not currently applying for internship. It is free to use the portal but it refreshes each year—thus any data you enter will be lost unless you print it out. Alternatively, if you

prefer a bit more organizational help or structure than Excel or Word can provide, new online programs have eased the tracking and upload process. For instance, MyPsychTrack is an APPIC-sponsored tool that recently became available for free to registered APPIC Doctoral Program Associates. Check with your training director to see if you and your program are eligible for this service. MyPsychTrack is the only program presently available that uploads tracked hours directly to the AAPI. This provides significant time savings as it prevents you from having to manually reenter digitally or manually tracked hours into the AAPI. Another online program, Time2Track, has a mobile app function and casts a broader net for tracking across mental health disciplines and at different levels (e.g., master’s, doctoral, professionals). However, one disadvantage is that Time2Track is a paid service that must be subscribed to by the individual or their doctoral program. These different methods of tracking vary in terms of their user-friendliness, cost, and accessibility; therefore, pick the format that is most suited for your needs and preferences.

### ***Post-AAPI Tracking***

The need to record clinical and supervision hours does not end with completion of the AAPI. Internship programs may not require official hours tracking, but the applications for some postdoctoral programs and jobs may require you to describe your internship training experiences. Although less descriptive than the information required for the AAPI, it is important to remember that the clinical workload on internship will be closer to 40 hours a week. Additionally, interns typically rotate through a number of different clinics, supervisors, and/or sites across the training year. Thus, it is important to keep a careful record of these hours as well as a description of your experience on each training rotation.

For licensure, predoctoral, and often postdoctoral applications, clinical hours are reported to state licensing boards. For example, New York requires 3,500 hours of clinical or “professional” experience in psychology to be documented—1,750 of which must occur after the doctorate has been awarded. California, on the other hand, requires 3,000 hours, 1,500 of which must have been documented before you can sit for the national licensing exam, the Examination for Professional Practice in Psychology (EPPP). Some states will only require the training director or postdoc-

## ***The Modifiers***

Authored by John Marr, this novel blends science, psychology, human behavior, and personal healing into one. **No psychology major should miss this one.**

Dr. Mark Malone, a new Psychological Services Consultant, is eager to find out if operant conditioning also applies to humans—and not only to rats in a maze. He gets his chance to use this approach as therapy for thirteen-year-old Joan Hachmeyer, a patient with schizophrenia. Mark begins his rewarding journey to modifying Joanie’s behavior and bringing her back to sanity—while trying to untangle himself from the complexities of his own.

Based on real events, *The Modifiers* will interest students of psychology. Behavior modification procedures are well-discussed throughout the pages and enmeshed into the characters’ lives for the readers’ entertainment.

**Amazon.com**

toral supervisor to approve the requisite number of supervised hours and the training curriculum; however, this varies from state to state. Additionally, some states have additional requirements, such as your supervisor must be licensed in the state where your training occurred. This stipulation may be problematic at Veterans Affairs Medical Centers (VAMC) where a psychologist may be licensed in any U.S. jurisdiction. Conversely, this VAMC statute is beneficial if you are considering a VAMC career—you can be licensed through a U.S. jurisdiction, which increases the ease of mobility.

Overall, it is best to research the laws for the state(s) where you may seek licensure, but also plan for portability. There are also resources to assist with mobility, such as the ASPPB Credentials Bank and the National Register of Health Service Psychologists. These programs conveniently allow you to “bank” all your credentials (i.e., syllabi, clinical hours, EPPP scores, etc.) in one place, in the case where you have to attain licensure in another state. Although documenting may seem like a never-ending process, the precise details (e.g., the race, ethnicity, age and gender of your clients) are typically less imperative at

**Table 1.** Description of AAPI Sections and Tracking Information

Section	Description	Tracking Information
<b>I. General Information</b>		
Applicant	Contact, personal, verification of professional conduct.	N/A
Educational	Colleges attended, graduate program info, graduate transcript(s), summary of doctoral training (e.g., program information, anticipated practicum experience), doctoral status (e.g., courses remaining, dissertation status).	Official transcripts must be submitted to AAPI.
<b>II. Summary of Practicum Experiences</b>		
Intervention experience	Services provided in the presence of a client. May be direct face-to-face or telehealth. Categories are mutually exclusive and hours should only be counted in one category. Hours of supervision that you provided to a less advanced student are included in this section.	For individual therapy sessions: 45-50 minutes = 1 hour. For group sessions: a 1-hour 8-member group = 1 intervention hour.
Psychological assessment experience	Summary of psychodiagnostic and neuropsychological assessments.	Scoring and report writing hours do not count in this section.
Assessment instruments	Each specific instrument used as part of practicum or research. Divided into two sections – Adult Assessment Instruments and Child and Adolescent Assessment Instruments.	Scoring and report writing hours do not count in this section. Refers to the administration of full tests, not individual items. Includes: a) number of times an instrument was clinically administered and scored; b) number of interpretive reports written; and c) number of times each instrument was administered for research.
Integrated reports	An “integrated” report includes patient history, interview results, and at least two psychological tests from one or more of the following categories: personality measures, intellectual tests, cognitive tests, and neuropsychological tests.	Total number of integrated testing reports written.
Supervision received	Individual supervision, group supervision, level of supervisor training, and supervision format.	Includes number of received supervision hours. Does not include didactics.
Additional information	Treatment settings, population, type of intervention. Classify populations by: race, ethnicity, gender, sexual orientation, disability, “other.”	For each treatment setting: track the population (e.g., adult/child) and the number of hours for each type of intervention. Classify known racial/ethnic identification for all clients.

[ table continued on p. 73]

Support activities	Number of hours and description of client-related activities such as didactic training, progress notes, report writing, scoring, consultation, case presentations. Excludes supervision hours.	Total number of support hours and description of activities.
<b>III. Additional Materials</b>		
Cover letters	1-2 page document that typically includes an overview of your credentials, experiences, internship goals, and how each program fits these goals.	N/A
Essays	4 essays that are 500 words or less. Topics required: autobiographical statement, theoretical orientation, diversity, and research.	Anecdotes from clinical cases and specific examples from your training may be helpful to retain for reference.
Curriculum vitae	Content may vary by individual site requirements.	Regularly update during graduate training.
References	2-4 letters are requested by each program. Different references may be used for different programs.	Keep up-to-date contact information for these individuals.
Supplemental materials	Deidentified case summary; psychological evaluation report. Only required by select programs.	Retain from practicum experience and de-identify.

the licensure stage. Nevertheless, a record of internship and postdoctoral training should include: the type of clinic or setting (e.g., outpatient anxiety clinic, primary care clinic, etc.), the number of clinical hours (e.g., for each rotation, overall face-to-face hours), the types of interventions or assessments provided (e.g., cognitive-behavioral therapy, group/individual), the general demographics of the patients (e.g., children, Veterans), and supervision information (e.g., number of hours, specific supervisors).

### Research

The primary measure of success in academic psychology is research productivity. For an individual planning to pursue a research career, it is imperative to develop a strong CV as early as possible. Document any and all research activities, including poster and symposium presentations at local and national conferences, journal articles, book chapters, grants, awards,

invited talks, mentored journal review experience (discuss this with mentors, they are likely inundated with requests), and membership in professional organizations. Although the availability of some opportunities may be limited or beyond your control, it is prudent to take into account what you can do, such as applying for local-level awards or participating in local or smaller conferences in your research area. Be sure to document these experiences, because it is easy to forget them. Moreover, updating your CV on a regular basis can help focus your efforts and measure your progress in terms of both existing strengths and areas requiring further development.

### Education

Graduate courses are relatively standardized through APA accreditation of graduate training programs in clinical psychology. However, in some circumstances, some states or specific licenses may require additional courses. Licensing requirements

for states and provinces can be reviewed on the ASPPB website ([www.asppb.org](http://www.asppb.org)). In addition to the course information documented by graduate transcripts, course syllabi may also be required by licensing boards. Retaining course syllabi may provide additional benefits as reference for preparing future courses. Storing electronic copies of course syllabi while you are enrolled in courses is an easy and time-saving strategy, which may pay dividends later in the licensure process.

Some of your course work may also be important to highlight on your CV. For example, if you took any advanced statistics courses or a course on teaching, then it may be beneficial to record these supplemental experiences on your CV and reference in future job applications. These courses are not required for licensure, but can increase your marketability when applying for postdoctoral positions or jobs. Beyond course work, it may also be beneficial to keep a running log of other educa-

tional experiences, such as attendance at specialized workshops and seminars, continuing education credits, and certifications. Documenting these experiences on a master copy of your CV now will save you the time and effort of tracking down this information at a later time as it is difficult to retrospectively describe training experiences. The CV is a dynamic document that will evolve over the course of your career, and it can be modified or condensed for specific applications.

### Teaching

Finally, the lectures, courses, or workshops can further augment your CV and improve marketability in the event that you apply for a position that integrates education or supervision duties. It is beneficial to record the topic of guest lectures, lab sections, courses independently taught and/or developed (e.g., instructor of record status), public psychoeducation or information sessions delivered, and work-

shops conducted. Additionally, the size and demographics of the audience (e.g., college students, practitioners, and community members) can provide useful information, especially if you have had unique teaching opportunities beyond the traditional college courses. Although opportunities may be limited or restricted in this domain, think beyond traditional undergraduate courses (e.g., courses in the community, guest speaker) and highlight what you have been able to do.

### Conclusions

Although tracking may seem like an unnecessary burden in the midst of clinical work, research, course work, teaching responsibilities, and any attempts to see daylight, a few minutes of inconvenience now will save time and reduce distress during application crunch time. Be mindful of complacency and avoid convincing yourself some experience was not important enough to document. Avoid stretch-

ing the truth, but take the opportunity to take credit where credit is due. As you are tracking and considering your training experiences in the context of your career goals, seek guidance and feedback from trusted mentors and peers. That said, also remember that others' graduate school training experiences may be vastly different from yours; therefore, try not to get caught up in nonequivalent comparisons. As a final note, developing a system to track productivity is a great habit in and of itself. After all, as behaviorists we know self-monitoring is a great way to increase awareness and promote change.

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**Correspondence to** Laura J. Dixon, Ph.D., University of Mississippi Medical Center, Department of Psychiatry and Human Behavior, 2500 North State Street, Jackson, MS 39216  
laura.j.dixon8@gmail.com

## CLINICAL TRAINING UPDATE

# First-Generation Students in Professional Psychology: Challenges and Training Recommendations

Kathleen Palm Reed, *Clark University*

FIRST-GENERATION STUDENTS COMPRISE 30% to 50% of the college population across the United States (U.S. Department of Education, 2008; 2012). Significantly higher dropout rates among these students (Ishitani, 2003, 2006) have led to increased attention to factors that might increase success and degree completion for first-generation students (Engle, Bermeo, & O'Brien, 2006; Martinez et al., 2009). Unfortunately, the majority of these efforts have been focused exclusively on the undergraduate level and little attention has been directed to the growing number of first-generation students pursuing graduate degrees. First-generation students are as likely as their advantaged peers to have graduate school aspirations, yet they are significantly less likely to actually earn a graduate degree (Engle & Tinto, 2008). It is worth considering how to address the potential unique training needs of first-

generation students to increase their likelihood of success in graduate studies. While there has been accumulating research on the experiences of first-generation students pursuing education at the doctoral level (e.g., see Holly & Gardner, 2012), greater dialogue is needed to increase the rates of graduate degree completion for these students.

The purpose of this article is to review and extend the literature examining how first-generation status can impact the quality of training for students pursuing doctoral degrees in clinical psychology specifically. Further, we provide recommendations for mentors, programs, and students to address these issues. For this discussion, we will draw from both the limited empirical literature regarding first-generation doctoral students, as well as the author's personal experience as a first-generation student and as a mentor to

first-generation students. As a caveat, many of the difficulties discussed could also be salient for students who are not first generation, and likewise, there are some first-generation students for whom none of the issues would resonate. The goal is not to provide a cookie-cutter description of first-generation students who decide to pursue doctoral studies in clinical psychology. Rather, we hope to highlight potential challenges and reflect on how these challenges may affect performance in core clinical psychology training competencies. To this end, we focus on three factors that can influence success in a doctoral training program: stress and social support, access to professional mentors, and financial constraints.

### Stress and Social Support

Like many graduate students, first-generation students may experience significant stress in completing graduate program requirements. Strong, positive social support networks comprised of family members, friends, and/or partners may help graduate students cope with the pressure of juggling multiple roles and responsibilities. However, first-generation students may find that their loved ones struggle to understand the particular challenges and demands of a doctoral program in clinical psychology. Friends and family members with greater familiarity with

higher education may be better equipped to normalize their experiences and direct students to resources that could help them cope more effectively with academic and social stressors. Families of first-generation students may not be able to offer such instrumental and moral support. Even when support is offered, pursuit of graduate education may be devalued or undermined in subtle ways. For example, it is possible that members of students' support networks will be unable to relate to the academic-related stressors experienced by the student. This could be experienced as painful or alienating for the student as well as for the support member. As another example, support members may not understand or accept the student's decision to pursue graduate studies given the costs (e.g., financial, time, geographical).

While many first-generation students are able to identify or develop valuable support networks, there may be barriers to seeking additional help and support. First, the independent spirit and motivational drive that equipped the first-generation college student to be successful academically could simultaneously interfere with help-seeking. That is, this self-reliance may make it more difficult to ask for help. Indeed, in some instances, asking for help may feel like failure, thereby increasing feelings of stress. Another potential barrier to help-seeking could be related to fears that such requests would be interpreted as confirmation that he or she does not belong in graduate school. Indeed, some research has suggested that this "imposter syndrome" is particularly salient among first-generation students who pursue doctoral degrees compared to other students (Gardner & Holly, 2011). Finally, in general, graduate students often focus exclusively on classes and programming in their own departments. As a result, they often are unaware of services and offices in the larger university that may be helpful to them (e.g., student affairs, career services, financial aid, etc.). This combination of self-reliance, fear, and lack of information may compound first-generation students' sense of isolation and stress during their graduate school career.

It is worth considering how stress and social support may impact performance in clinical psychology programs specifically. Clinical psychology students are evaluated in a number of capacities and must learn how to receive, respond to, and incorporate feedback across several domains (i.e., clinical work, research, writing, professional identity development). Stress and

limited social support may impact the development of students' clinical and research competencies in subtle ways. For example, limited support may negatively impact students' comfort level with asking for supervision and mentorship. Further, students in clinical psychology will work with clients with a number of presenting problems, some of which could be quite distressing. Students whose own resources are not accessible or effectively utilized may be vulnerable to becoming overwhelmed when clinical demands increase. At a basic level, it can be difficult to provide support to others when not feeling supported oneself. Similarly, it may be difficult to engage fully in the process of developing academic and research competencies while feeling unsupported by significant others.

### **Professional Mentorship**

Professional mentorship both within the academic context and in students' personal lives is an important part of graduate training. Mentors serve multiple training and support roles for graduate students. For example, mentors provide opportunity for observational learning. That is, trainees can observe how mentors navigate professional relationships, conduct clinical and research work, and define their professional identities. Mentorship also provides an opportunity for feedback and dialogue regarding a trainee's work so that students can improve areas of weakness and bolster their strengths. An effective mentor can have a nonthreatening conversation about future plans and pathways to pursue and achieve goals. Finally, mentors can serve the role of a cheerleader, which is especially important if there is limited moral support from family and friends. Many first-generation students lack access to professional role models to help them navigate successfully through graduate training and beyond. Moreover, the independent and industrious spirit that likely aided their undergraduate success may interfere with their ability to seek additional mentorship. While many undergraduate institutions have identified this need for mentors and have instituted mentorship programs for first-generation students, this additional professional mentorship may be even more helpful in graduate training, as performance at the graduate level is less structured and the ability to network becomes more central. Academic and research advisors are often positioned to serve this function well; however, sev-

eral factors may limit first-generation students' ability to take full advantage of them. Namely, the anxiety surrounding performance evaluation and lack of knowledge about how to relate to and best take advantage of professional mentors may interfere with students' seeking out advisors for mentorship.

Limited access to professional role models may impact students' performance in unexpected ways across a number of clinical competencies. First-generation graduate students may have limited experience interacting professionally with clients, other members of treatment teams, or future trainees. Mentors can model how to communicate effectively and navigate these different relationships. Additionally, a lack of professional role models may lead to difficulty in observing boundaries of competence. That is, some may need more counsel on where the line is drawn between asking for professional advice versus advice about more personal concerns. This could lead to disclosure of too much personal information, but could also hinder the granting of needed support if students are afraid to share relevant private information, such as a medical illness or family-related problems that are interfering with performance.

Research competencies may be similarly influenced by a lack of professional role models. For example, they may have had limited exposure to observing others critically evaluate research and engage in intellectual debate. Additionally, first-generation students transitioning to graduate school may have attended larger public universities where opportunities to strengthen their verbal and written skills may have been limited by large class sizes. While most graduate students develop these skills throughout their training, first-generation students may encounter a steeper learning curve if they have not had as much exposure to these skills. Similarly, a lack of professional role models may affect students' comfort and skill in soliciting and processing specific feedback. Indeed, mentors of first-generation students should note that feedback related to research, clinical, or professional work may be experienced as reinforcing negative messages these students are getting from family or elsewhere, as well as personal concerns related to their experience of the previously described "imposter syndrome."

## Financial Constraints

Although financial stress is a burden for most graduate students (El-Ghorroury et al., 2012), first-generation students may experience this struggle more acutely (Hoffer et al., 2003) due to factors including more significant undergraduate debt because of lower family income and lack of knowledge about alternative funding sources and resources (e.g., financial counselors). In addition, these students may be less likely than their peers to have a financial safety net in their family members. Such circumstances will likely mean that some first-generation graduate students have had less opportunity to build and maintain their own savings account, making unexpected expenses particularly difficult to absorb. It is unsurprising that first-generation students may arrive at graduate school with a comparably less secure financial situation than their peers. However, the potential impact of such financial stressors could be broader than one might expect.

The practical implications of relative financial insecurity in graduate school are fairly straightforward. Many first-generation students who have completed their undergraduate degree and financed the graduate school application process can be expected to have some level of financial sagacity. However, there are expenses related to graduate school that students may not anticipate, such as malpractice insurance costs, software fees, organization membership fees, and costs related to conference attendance. Many graduate programs have the requisite software available on school computers, and it is not uncommon for programs to provide some support to students presenting at conferences as first authors. However, having consistent access to software (e.g., statistics programs) can greatly improve the academic experience. In addition, these students may not be able to attend conferences if they are not first author presenters given some common limitations of travel fund stipends. First-generation graduate students may even struggle to pay for costs beyond the amounts covered by their doctoral program (e.g., tuition remission, fees, potential travel/research assistance funds). For example, during the internship application process, students are responsible to bear the financial burden of application fees to internship sites, as well as potential travel costs, including room and board, to attend interviews at geographically diverse sites. Though it is likely that first-generation graduate students who are financially

limited have some experience managing a tight budget, the unexpected costs of graduate school may be particularly difficult for them to absorb.

There are more subtle potential consequences of financial struggles for first-generation graduate students. Having excelled as an undergraduate and successfully applied to graduate school, students are not without effective time-management skills. However, the relatively unstructured nature of doctoral programs, combined with a lack of financial stability, has the potential to manifest in challenges with time management. Many graduate students struggle to accurately estimate the amount of time they will need to devote to unstructured but important activities, such as writing and reading the current literature. This may lead first-generation students who are struggling financially to overcommit themselves to part-time employment opportunities, which in turn may negatively impact their ability to write as often as necessary. It may also be difficult for students who grew up in a household where finances are managed on a month-to-month basis to account for the long-term value of some expenses. For example, attending networking events such as conferences has the potential to provide major long-term advantages in the form of collaboration or job opportunities. However, for a student with limited resources or who is not used to considering long-term gains, it may be difficult to justify the cost of a conference in their current budget. In addition to the stress of making such decisions, these students may experience stigma resulting from the appearance to faculty members and peers of having their priorities wrong.

The above-mentioned difficulties may impact the development of some of the core competencies expected of graduate students in clinical psychology. For example, fewer society memberships, or an inability to attend as many conferences, may negatively influence students' awareness of the most up-to-date research in their area as well as their ability to disseminate their own findings effectively. In addition, though fellowship applications can lead to funding that may stabilize students' financial situations, the time required to successfully apply may impede students' ability to focus on publishing. Alternatively, a lack of knowledge about such options may keep students from pursuing them, spending valuable time working in an unrelated part-time job instead.

Financial hardship and difficulty prioritizing time may also lead to less opportunity for optional clinical training opportunities. For example, it is often necessary for students to attend supplemental workshops to gain knowledge of interventions that are not supported by the student's training program. Missing such opportunities may hinder students' ability to collaborate and network to secure future placements. In addition to the time and cost of such trainings, simple lack of transportation may limit students' access to training sites. Students may geographically restrict their clinical internship applications so as to avoid travel costs, potentially lowering their chances to secure internship placement, or placement at a site that might be a better fit. Finally, though they may experience higher levels of stress relative to their peers, a student's ability to seek therapeutic support—key in the development of general competency as a researcher and clinician—may be challenged as a result of financial difficulty.

## Recommendations

### *Mentors and Faculty Advisors*

A starting place for any graduate mentor is to have a conversation with first-generation trainees about concerns regarding support, training, and mentorship. In order to help students effectively, it is important to approach such conversations with empathy and understanding. To this point, mentors should be aware of their own assumptions regarding students' supports, available mentors, and financial stressors when evaluating their students' performance. They should consider the potential effects of limited social support and be ready and willing to provide additional support or suggestions for developing support where necessary. It might be useful for mentors to become aware of potential programs on their campuses that offer support or assistance for first-generation graduate students. Further, students might be explicitly encouraged to cultivate a network of supportive peers and professionals, particularly when they are removed geographically or interpersonally from family or other support members.

Faculty may need to provide more explicit instruction to first-generation students related to professional mentorship and the development of competencies. As a graduate mentor, understand that it may feel unsafe for students to use faculty for mentorship and offer other sources for seeking out role models. For example, net-

working opportunities often exist as part of professional societies. Additionally, it may be helpful to normalize and validate feelings of uncertainty about how to behave in this new environment and to discuss the benefits of seeking professional mentors. Faculty mentors must also be aware of their assumptions regarding students' decisions to take advantage of certain opportunities that may require investment of time, money, or both. There should be a balanced perspective of weighing real financial costs with the value of a given opportunity. By doing so, they allow students to make informed decisions that are important for the development of their career and future financial success. When students are unable to attend national conferences, faculty should provide guidance for placing more emphasis on publications, outside collaborations, and conferences for regional associations. For these students, mentors may need to be more explicit about the importance of networking with key researchers in students' area of interest. In sum, a willingness to evaluate and reconsider one's own assumptions, to obtain and relay information about potential programs on campus that offer support for graduate students, and to have an open and honest dialogue with students regarding topics that may be considered difficult to approach, are the most important ways in which faculty members can help to support first-generation doctoral students.

### Graduate Programs

There are a number of strategies for helping first-generation students that can be addressed at a programmatic level. Some graduate programs automatically pair incoming graduate students with advanced students outside of their research lab to assist with questions about the culture and other more subtle types of information. Since university counseling services are often a clinical training site for students, this free or low-cost option is not always available to students. Thus, it would be helpful for programs to maintain a list of low-cost therapy referrals for students in need of emotional support. Additionally, graduate programs should remain informed about resources for first-generation students, both on campus and nationally. For example, the federally funded Ronald E. McNair Postbaccalaureate Achievement Program was created to address the lack of representation of first-generation, low-income, and cultural, ethnic and racial minority college students in higher education. McNair Program par-

ticipants have been shown to enroll in graduate programs at a higher rate than other first-generation, low-income students across the country (McCoy, Wilkinson, & Jackson, 2008). Further, departments or graduate school offices might consider coordination with undergraduate first-generation student services to bolster supports from the university level. Contact information for a graduate student ombudsperson, who can provide guidance free of any personal connection to the student's academic trajectory, may be particularly useful. Such a measure would serve to both provide necessary information and to normalize the struggles often associated with graduate school.

### First-Generation Students

First-generation doctoral students offer a breadth of background experiences, talent, and resourcefulness that can strengthen the diversity and intellectual climate of academic programs. It will serve these students well to remember the strengths and skills they have developed as the first individuals in their family to attend college. We emphasize that students must be ready to advocate for themselves, which may include accepting their own experiences, being willing to use any difficulties for growth, and seeking additional support. Perhaps even more important, students must strive to develop an effective balance between independence and collaboration in clinical psychology doctoral programs. By actively gathering information from mentors and more advanced peers, particularly those with similar backgrounds, students will be well positioned to anticipate new costs associated with graduate school, and to take advantage of relevant training and networking opportunities which they may otherwise miss. For example, some conferences will waive fees for students willing to volunteer their time to help with workshops. By volunteering, students may even gain exposure to workshop content for which attendees typically pay extra. If a student's lab is affiliated with a number of societies, the student might consider choosing the one most in line with his or her interests and become more deeply involved in the society, thereby increasing opportunities for networking within their research area. Students should also seek out opportunities for mentorship through professional organizations, as some professionals will sponsor students for conference attendance through their own lab or personal funds. Finally, students are encouraged to be open to having the con-

versations described above with their mentors, in which they make careful cost-benefit analyses regarding professional opportunities in order to ensure they are making informed choices for their development and career goals.

### Concluding Remarks

It is important to note that many of the struggles described in this paper may also be experienced by any graduate student (i.e., not only first-generation students). Additionally, many of the strategies mentioned could prove helpful for doctoral students who are not first generation. The purpose of this paper was to highlight those issues that might be most salient to first-generation students, particularly those that may be less obvious to observers, and to initiate a dialogue about the importance of supporting these students in their pursuit of doctoral degrees in clinical psychology. There is no doubt that first-generation students offer a unique perspective and set of experiences that will prove invaluable to both research and clinical work in the field of clinical psychology. In order to reap these benefits, we as a field must continue the important dialogue of how to address the potentially unique challenges of this group of students.

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**Correspondence to** Kathleen Palm Reed, Ph.D., Associate Director of Clinical Training / Research Associate Professor, Co-Director, Clark Anti-Violence Education Program (CAVE), Department of Psychology, Clark University, 950 Main Street, Worcester, MA 01610  
KPalm@clarku.edu



## OBITUARY

### Essential Arnie

Simon A. Rego, *Montefiore Medical Center*

I SHOULD NOTE THAT, if not for deadlines—and a deep-seeded sense of guilt that I tend to feel when I imagine breaking a commitment—I still would not yet be emotionally ready to write this introduction. This is because on October 1, 2013, the field of clinical psychology lost one of its true luminaries. The world lost a beautiful soul. And I lost a mentor and a friend.

In just a moment, you'll find the wonderfully written Davison and Wilson (2014) obituary on Dr. Arnold A. Lazarus (or "Arnie," as he was known to his friends, colleagues, and family), reprinted from a recent issue of the *American Psychologist*. In reading it, you'll be informed about all of the essentials from Arnie's background, including his education, impressive scholarly work, and the numerous well-deserved professional honors and awards that he received throughout his career. In addition, you'll hear about the "uncommon intelligence" and "restless intellect and appreciation of the complexities of clinical work" that made Arnie a "master clinician" who, "throughout his career, enjoyed the rare distinction of being one of the most influential, creative, and highly regarded clinical practitioners in the field of clinical psychology." Drs. Davison and Wilson also highlight Arnie's "influential clinical teaching of graduate students as well as fellow professionals who flocked to his formal and informal seminars and group supervision sessions."

I was one of those graduate students.

Although coming out of college I initially considered myself more of a scientist-practitioner than a practitioner-scholar, simply knowing that I might have the opportunity to take a course taught by the legendary Dr. Lazarus was one of the essential reasons that I applied to the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University in New Jersey. Almost immediately after starting at GSAPP, I began to hear stories about the popularity of Arnie, as both a professor and supervisor, from

friends who were ahead of me in the clinical program. Alarming, however, I also heard rumors about the fact that he was considering retirement and recall—although I admit that I may be making this up—that there was actually a waiting list to get into his class. Thus, I made it my mission to find a way to sneak into his class as soon as possible, and I consider myself very fortunate to have been able to take his class on Multimodal Behavior Therapy in the fall of 1997, shortly before he retired.

The course featured Arnie at his best—a wonderful and prolific writer, a remarkable clinician, and a charismatic storyteller. I was hooked! Needless to say, I then felt like I had hit the professional development jackpot when, after I finished his course, Arnie invited me to join the advanced supervision group that he had just started out of his home in Princeton, NJ. While I was honored (and intimidated) to join the supervision group, I must add that being a member of this group was not all "tea and crumpets," so to speak (although his darling wife Daphne always had plenty of wonderful teas and treats ready for us before—and often during—the meetings): group members were expected to bring to the group their most challenging cases—occasionally literally, if we were really struggling, so that Arnie could interview the patient directly—as well as stay on top of interesting developments in the field and be ready to actively contribute to the case presentations and discussions.

From time to time, immediately after the group ended, Arnie would have a private patient or two scheduled (he saw patients from a home office) and would need to excuse himself right away. Perhaps one of my biggest thrills as a graduate student was when, for the first time, instead of saying good-bye at the end of one of our supervision group meetings, Arnie casually asked if I'd like to join him for a session to do some co-therapy. I jumped at the offer but am not sure who was more nervous that day, his patient or

me! I am sure of this, though: being able to observe Arnie work with the patient that day, and then with different patients on several other occasions, taught me much more than any treatment manual could on how to select and ingeniously use the techniques I'd read about (and struggled to implement on my own) for so long. I was also able to witness firsthand his humor and wit, creativity and flexibility, and the warmth, kindness, and charm that he showed to all of his patients. In essence, he was role-modeling the importance he placed on attending to the non-specific factors before—and while—diving in with treatment interventions, a balance that he frequently referred to in his writings (e.g., “Whatever the measures decided upon, it is of the first importance to display empathy and establish a trustful relationship”; see Wolpe & Lazarus, 1966).

Although I eventually moved out of state—first to complete my internship and then postdoctoral training and finally to start my first job—I never lost touch with Arnie. He was my sounding board. He was my reality tester. He was my adviser. He was my friend. I believed I could come to him with any problem, dilemma, or crisis and that he would help me get through it, no matter what the “it” was. And so I did. Frequently. And he was always there when I needed him—at times to give me advice, at times to tell me a good joke, and at times to lend a quiet, nonjudgmental ear. I can only imagine that this is how his numerous other supervisees and mentees, friends and family members, and of course patients must have felt, as he always managed to calmly convey a sense of confidence that things would be all right.

Arnie taught me many, many essential lessons over the years through his scholarly work, supervision, and through the countless telephone conversations and email exchanges that we had—one of the last of which we wrote up together shortly before he passed (see Lazarus & Rego, 2013). To this day, I can still hear Arnie's distinct radio-ready voice in my head, gently guiding me, both in my work with patients as well as trainees (e.g., “Never exploit, disparage, abuse or harass a client, and steer clear of sexual contact. Appreciate the significance of confidentiality, integrity, respect, and informed consent. All the rest of the rules, codes, and regulations are negotiable.”). While it is sad that he is gone, fortunately his lessons live on through his many publications. If you

haven't already done so, you need to read them. Trust me: you're going to enjoy them. And you'll be better off (personally and professionally!) for having read them. You can start with the list of “essential Arnie” reading I've included at the end of this introduction. Please consider that list just an appetizer.

Arnie taught me the value of taking risks, to not take criticism (or praise!) too seriously, the importance of being “personalistic” rather than “procrustean” in my clinical approach and in being an “authentic chameleon” with my patients. As he once said to me, “Clinical scientists are like astrophysicists: they create theories on things such as escape velocity, in order to calculate the speed needed to break free from the earth's gravitational attraction. But I know how to fly the rocket!”

Fly Arnie, fly.

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**Correspondence to** Simon A. Rego, Psy.D., Department of Psychiatry, Montefiore Medical Center, 111 E. 210th St., Bronx, NY 10467; dr.rego@gmail.com

## “Essential Arnie” Reading

### Books

- Lazarus, A. A. (1989). *The practice of multimodal therapy: Systematic, comprehensive, and effective psychotherapy*. Baltimore: Johns Hopkins University Press.
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### EDITOR'S NOTE

Dr. Arnold Lazarus was a founding member of AABT and served as AABT's 3rd President in 1968. In 1999, he received AABT's Career/Lifetime Achievement Award.

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## Arnold A. Lazarus (1932–2013)

Arnold A. Lazarus, distinguished professor emeritus at the Graduate School of Applied and Professional Psychology, Rutgers University, passed away on October 1, 2013. He is regarded as one of the founders of behavior therapy and one of its leading practitioners and teachers. His doctoral dissertation on systematic desensitization in groups, published in 1961 in the *Journal of Abnormal and Social Psychology*, was one of the earliest experimental efforts to examine Joseph Wolpe's anxiety-reduction procedure.

Lazarus was born January 27, 1932, in Johannesburg, South Africa. His parents, Benjamin and Rachel (Mosselson) Lazarus, had emigrated from Lithuania in the early 1900s, part of the mass migration of Eastern European Jews escaping from the pogroms of czarist Russia. At the University of Witwatersrand in Johannesburg, he received his bachelor's degree in psychology and sociology with honors in 1956, his master's degree in experimental psychology in 1957, and his doctoral degree in clinical psychology in 1960.

As a graduate student Lazarus began publishing in the emerging field of "behavior therapy," a phrase he is credited with coining. At the time, behavior therapy was defined as the application of "modern learning theory" to the modification of abnormal psychological functioning. His writing aroused the interest of Stanford University, and he was invited to become a visiting assistant professor in the Department of Psychology there during the 1963–1964 academic year. His charisma and clinical acumen readily attracted the attention of several of the clinical students, among whom was the first author of this obituary. It was an exciting time to be at Stanford. During his visit, Lazarus brought to bear in his clinical work the theoretical and empirical work of many different experts in the field, including two Stanford colleagues, Albert Bandura and Walter Mischel. He was a master clinician, someone who blended uncommon intelligence with the qualities of a *Menschenkenner*.

After his year at Stanford, Lazarus returned to Johannesburg as a lecturer at the University of Witwatersrand Medical School and as a private practitioner. Three years later he returned to the United States with his wife Daphne and their two small children, Clifford and Linda, to serve as director of the Behavior Therapy Institute in Sausalito, California, a privately funded outpatient and training clinic where he built a practice in collaboration with some of his former graduate students at Stanford. A few years later he joined the faculty of Temple University Medical School, after which he served as director of clinical training at Yale. Then he moved to Rutgers University to assume a leadership role in one of the earliest professional schools of psychology, the Graduate School of Applied and Professional Psychology, remaining there until his retirement in 1999.

As both an undergraduate and graduate student, Lazarus was educated within the dominant approaches of the time, namely, psychodynamic, person-centered, and Sullivanian therapies. However, under Wolpe's mentorship, Lazarus moved away from psychoanalytic and humanistic-existential frameworks to explore and develop the emerging field of behavior therapy. In 1966, Wolpe and Lazarus collaborated on a landmark book titled *Behavior Therapy Techniques*, which presented the methods characteristic of the behavior therapy of that time (e.g., systematic desensitization, assertiveness training). It was a productive partnership, but while they were co-authoring this book, theoretical and applied differences began to emerge between these two innovative and strong-minded scientist-practitioners. Lazarus came to believe that orientations other than behavior therapy offered valuable methods and strategies. Wolpe, on the other hand, continued to advocate for adherence to more narrowly defined behavioral theories and techniques. Their productive disagreements continue to be in evidence today in clinical psychology and psychiatry. Lazarus's restless intellect and appreciation of the complexities of clinical work led to his exploring the use of techniques that had been anathema to early behavior therapy, such as Fritz Perls's Gestalt therapy and Albert Ellis's rational-emotive therapy. Eschewing growing appeals in the 1970s for theoretical integration, Lazarus argued that attempts at such integration would create an unproductive hodgepodge of incompatible notions, whereas "technical eclecticism," as he termed his new approach, would allow a clinician to utilize a broad range of useful strategies. Clinical utility was all-important to Lazarus, and he demonstrated this throughout his career in his many publications and especially in his influential clinical teaching of graduate students as well as fellow professionals, who flocked to his formal and informal seminars and group supervision sessions. Throughout his teaching and mentoring, Lazarus combined supportiveness and kindness with frank and constructive feedback so that his students and clinical supervisees could grow as clear-minded and empathic clinicians.

Lazarus presented his broadened perspective in 1971 when he published his influential book *Behavior Therapy and Beyond*. In it, he argued cogently for the utility and necessity of adding cognitive constructs and change techniques to the prevailing behavioral methods for the treatment of anxiety and depressive disorders. He continued to develop his clinical approach in his 1976 book *Multimodal Behavior Therapy*, and he went even further in developing this theme in his 1981 book *The Practice of Multimodal Therapy*. In this system he emphasized the defining role of seven modalities in conceptualizing assessment and treatment. He used the acronym BASIC ID to summarize the seven modalities of behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs and biological factors. He was the author or editor of 18 books and more than 250 professional publications.

Often overlooked in considerations of Lazarus's writing and teaching are his challenges to prevailing perspectives on therapy boundaries. In particular, he argued that therapists need to be more tolerant of dual nonsexual, nonexploitative relationships for the benefit of the patient. Lazarus was open to interactions with his active patients outside of therapy sessions and wrote openly that he had meals and went to important events such as weddings with them and, on rare occasions, even invited patients to his home. He cautioned that therapists had to remain careful

not to misuse their power but that the impermeability of boundaries should be explored and discussed among colleagues in the helping professions.

Throughout his career Lazarus enjoyed the rare distinction of being one of the most influential, creative, and highly regarded clinical practitioners in the field of clinical psychology. As a reflection of his influential work, Lazarus received numerous professional honors and awards. He was a fellow of three divisions of the American Psychological Association (APA), Divisions 12 (Clinical Psychology), 29 (Psychotherapy), and 42 (Psychologists in Independent Practice). He received two lifetime achievement awards (from the Association for Behavioral and Cognitive Therapies and from the California Psychological Association), the Award for Distinguished Contributions to the Profession of Clinical Psychology from APA Division 12, the Distinguished Service Award from the American Board of Professional Psychology, and the Distinguished Psychologist Award from APA Division 29. In 1996, he was the recipient of the prestigious Psyche Award from the Nicholas and Dorothy Cummings Foundation in honor of his leadership and contributions to integrated health care delivery systems.

Arnold Lazarus influenced countless students, colleagues, and patients through his innovative and broad-minded approach to the complexities of psychological intervention. Clinical practice for Lazarus was a vehicle not just to help people but also to educate the next generation of therapists and to generate new ideas

for both improved applications and significant research. His effectiveness as a teacher was enhanced by his uncommon eloquence and personal magnetism. After retiring from Rutgers, Lazarus continued to host and lead a monthly supervision group for new and established psychotherapists. During his absence from the group for extended treatment of a serious illness, the group met on a limited basis. Trying in vain to fill the void, one member distributed a bumper sticker, "WWAD (What Would Arnie Do?)." When Lazarus returned after a course of treatment, his affection for and commitment to this group was demonstrated by his continuing attendance and active participation until the very day before his final hospitalization.

Lazarus is survived by his wife of 57 years, Daphne; his daughter Linda; his son Clifford, a psychologist; and his grandson Taylor. To those fortunate to have been his students, colleagues, or friends, Lazarus's intelligence, creativity, kindness, and mischievous and often irreverent wit made him very special indeed.

Gerald C. Davison  
*University of Southern California*

G. Terence Wilson  
*Rutgers University*

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ABCT's 2014–2015 President, Jonathan Abramowitz, Ph.D., invites submissions for the 37th 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. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established psychological principles. Submissions must include the nominee's current curriculum vita and one exemplary paper. Eligible papers must (a) be authored by an individual (an ABCT

member) with five years or less posttraining experience (e.g., post-Ph.D. or post-residency); and (b) have been published in the last two years or currently be in press. Submissions will be judged by a review committee consisting of Jonathan D. Abramowitz, Ph.D., Dean McKay, Ph.D., and Michelle G. Craske, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). Submissions must be received by Monday, August 3, 2015, and must include one hard copy of the submission (mailed to the ABCT central office) and one email copy (to [PNRAward@abct.org](mailto:PNRAward@abct.org)) of both the paper and the author's vita and supporting letters, if the latter are included. Mail the hard/paper copy of your submission to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001. In addition, email your submission to [PNRAward@abct.org](mailto:PNRAward@abct.org).

**Submission deadline: August 3, 2015**

# 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 Barbara Kamholz at [barbara.kamholz2@va.gov](mailto:barbara.kamholz2@va.gov) and include "Medical Educator Directory" in the subject line.

## 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.

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"He arrived early for his appointment one morning while I was still having breakfast. An intuitive whim led me to invite him to pull up a chair and have some toast and tea. This was a turning point."

—Arnold Lazarus, "How Certain Boundaries and Ethics Diminish Therapeutic Effectiveness" (1994) *Ethics & Behavior* 4(3), p. 257

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