

the Behavior Therapist

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PRESIDENT'S MESSAGE

The Only Thing to Fear

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



A FEW WEEKENDS AGO I accompanied my older daughter's 8th grade class on an action-packed trip to Washington, DC. We visited George Washington's home at Mount Vernon, observed the changing of the guard at the Tomb of the Unknown

Soldier at Arlington National Cemetery, took in five memorials on the National Mall at night, sat in the actual courtroom where cases are argued at the Supreme Court, and marveled at the rockets in the Air and Space Museum.

And after 2 days of nonstop learning it was time for some good clean fun, so we spent our final day at Kings Dominion—an amusement park outside of Richmond, VA. While 30 years ago I would have dashed from coaster to coaster, Father Time has not been kind to my vestibular system and I am no longer able to enjoy the loops, spins, twists, and turns. Even the merry-go-round makes me dizzy. The upside of all of this is that I am now the ideal chaperone! I'm happy to hold cameras and phones, stand guard over backpacks, and check kids in at lunch time. I'm really terrific at any task that involves keeping my feet on the ground.

I was doing just that—and savoring the aroma of turkey legs roasting on an open flame—when my daughter, one of her friends, and their teacher suggested I join them on the Drop Tower. No loops or turns here—this ride boasts a 4-second free-fall from north of 300+ feet (yep, that's about 27 stories high), hurtling

[continued on p. 115]

the Behavior Therapist

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ABCT

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Mary E. Larimer, Ph.D.
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Sandra S. Pimentel, Ph.D.
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The membership also passed three bylaws proposals:

1. Article III: Membership
2. Article III/2: Fellow status
3. Article XVI: Employee and Volunteer Protection Open Door and Whistleblower Protection Policy

INSTRUCTIONS *for* AUTHORS

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

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

Submissions must be accompanied by a Copyright Transfer Form (a form is printed on p. 35 of the February 2011 issue of *tBT*, or download a form from our website): *submissions will not be reviewed without a copyright transfer form.* Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Brett Deacon, Ph.D., at bdeacon@uow.edu.au. Please include the phrase ***tBT submission*** and the author's last name (e.g., ***tBT Submission-Smith et al.***) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

riders toward earth at a top speed of 72 miles per hour. Yeah, right!

But before offering my obligatory “no thank you,” I considered all that I’ve preached to so many patients, students, and trainees over the years about the importance of exposure therapy for anxiety disorders: “Face your fears, take a risk, lean in to your anxiety, practice living with uncertainty, bring it on.” And I found myself following them to the Drop Tower. I remember thinking, “Sure, I’ll humor them for now and then invent some creative excuse to bail as we get closer.” But before I knew it, positive peer pressure had paved the way for a bout of temporary insanity, and the next thing I knew, I was buckling myself in next to my daughter.

My sympathetic nervous system revved into gear as we waited (for what seemed like an hour) for the stragglers to strap themselves in. As I would help others to do, I reminded myself that it’s just my “fight-or-flight” response. But fight-or-flight soon gave way to pure unadulterated terror as our ascent began. At times like this, moments from the past that have paralyzed us with fear will often flash through the mind. My trip down memory lane took me

first back to Muhlenberg College, freshman year, as I sat in a calculus final exam and realized that I could solve exactly none of the problems; and then to Disney World where our younger daughter (age 3 at the time) wandered off, and we were convinced we’d never see her again.

Back to the present moment as we sat at the top of the Drop Tower, awaiting our free-fall plunge—the longest in the world, according to the ride’s PR campaign. I was overcome by fear. And as much as I’d love to report that my fear transformed into exhilaration as gravity took over, the truth is that it was raw fear all the way down. Four seconds seemed like . . . well, a lot longer!

Even for those of us who routinely use exposure therapy with anxious and fearful clients, it’s easy to wall ourselves off from facing our fears as we move through life. The world throws us enough curveballs as it is; why lean into the strike zone looking to get hit? Yet there’s nothing like a “Drop Tower moment” to force us to stop and consider the fear and discomfort that our clients and students struggle with—leaving one’s home, driving, using a public toilet, being called on randomly in class. If you’ve

raised children, you know that they experience other anxieties—perhaps the same ones we all knew as we came of age: asking someone on a date, changing clothes after P.E., figuring out voice and body changes. All of these loom large in the moment. Even as we encourage our clients, students, and significant others to conquer these fears and put life’s hurdles in proper perspective, the occasional reminder of what exposure therapy feels like isn’t so bad. I look forward to my next confrontation with the Drop Tower, which will come in a few years when I visit Kings Dominion on our younger daughter’s 8th grade class trip (yes, we found her after a few terrifying minutes that day at Disney World—she had followed Sleeping Beauty over to the Teacup ride).

...

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

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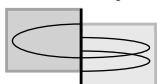
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Developmentally Sensitive Implementation of Core Elements of Evidence-Based Treatments: Practical Strategies for Youth With Internalizing Disorders

Julie Newman Kingery, *Hobart and William Smith Colleges*

Rachel L. Grover, *Loyola University Maryland*

David J. Hansen, *University of Nebraska-Lincoln*

Douglas W. Nangle, *University of Maine*

Cynthia Suveg, *University of Georgia*

Matthew P. Mychailyszyn, *Towson University*

MANY TREATMENT APPROACHES for psychological disorders among children and adolescents are downward extensions of adult treatment models. According to Barrett (2000), when treatments for childhood disorders are based on cognitive behavioral models of adult disorders, clinicians may make inaccurate assumptions, such as viewing children as “little adults,” thereby failing to adjust treatment terminology for children and ignoring contextual factors such as families and peers. Subscribing to adult models may also result in a lack of awareness of research findings in the field of developmental psychology (e.g., cognitive abilities, social skills, emotion regulation) and, consequently, implementation of treatment strategies in a similar manner across levels of development (e.g., assuming all children possess the same level of meta-cognitive skills). As Kingery and colleagues (2006) emphasize, simply utilizing a treatment that has been developed for youth is not sufficient. Particularly when implementing manual-based CBT for youth with internalizing disorders, clinicians must be knowledgeable, creative, and flexible, taking each child’s individual cognitive, social, and emotional skills into consideration to provide the most developmentally appropriate intervention.

According to Holmbeck, Devine, and Bruno (2010), “. . . although many authors suggest possible adaptations of treatment manuals to make them more developmentally sensitive, few provide methods for doing so” (p. 29). The present article aims to address this gap in the literature by out-

lining developmental modifications for several key components of CBT for anxious and depressed youth. As a starting point, we turn to general guidelines provided by Holmbeck et al. (2010) for therapists who want to practice in a developmentally sensitive manner. These authors suggest that clinicians stay up-to-date with research published in developmental psychology journals (e.g., *Child Development*, *Developmental Psychology*, *Development and Psychopathology*, *Journal of Research on Adolescence*), take each child’s cultural background as well as contextual factors (e.g., parents, peers school environment) into consideration, use developmentally appropriate therapy strategies (e.g., drawing, puppets, other hands-on activities for young children), incorporate developmental tasks relevant for each child into treatment (e.g., begin by focusing on symptoms that are most problematic from a developmental standpoint), educate parents about normative developmental expectations, and plan for children’s upcoming developmental milestones and transitions during treatment (see Holmbeck et al. for further information and a summary table of key developmental milestones across age groups).

For this article, we present developmental adaptations to core treatment elements that frequently occur in empirically based treatments for youth with internalizing disorders. Recent research focused on identifying common treatment elements across evidence-based treatments for youth has found that 50% or more of the protocols for

childhood depression share the following elements: psychoeducation, cognitive/coping, problem solving, activity scheduling, skills building/behavioral rehearsal, social skills training, communication skills, maintenance/relapse prevention, relaxation, and self-monitoring (e.g., Chorpita, Becker, & Daleiden, 2007; Chorpita & Daleiden, 2009). Many of these elements are also present in evidence-based treatments for childhood anxiety. Consistent with this approach, the present article focuses on a few of the core elements that are shared across treatments for internalizing disorders among youth (i.e., psychoeducation, relaxation techniques, praise and rewards, cognitive strategies, self-monitoring). For each element, we provide a brief definition, followed by adaptations appropriate for younger children and then suggested modifications for older children and adolescents. Our goal is to provide concrete and practical strategies for developmentally sensitive implementation that are useful to both graduate students and clinicians with varying levels of experience.

Psychoeducation

It seems appropriate to begin this discussion with psychoeducation as it is commonly the first component in treatments for youth with anxiety and/or depression. Psychoeducation refers to the sharing of useful information related to the disorder, such as prevalence, symptoms, course, etiology, and common treatment approaches. When working with youth, this treatment element usually involves caregivers (typically parents), as family psychoeducation may facilitate mood monitoring, treatment adherence, and family response to the illness (Brent, Poling, McKain, & Baugher, 1993). To deliver psychoeducation, the clinician first establishes rapport, next assesses children’s and parents’ current level of understanding regarding the disorder and available treatment, and then adds to the existing knowledge.

Fortunately, psychoeducation is easily adapted for use with different ages and cognitive abilities. With younger children, an interview game that involves taking turns asking questions while passing a microphone back and forth may be a fun and engaging way to assess current knowledge. When sharing new information about anxiety or depression, it is important to use age-appropriate language and clear examples or metaphors. For instance, in discussing prevalence rates, the clinician can use the child’s class and/or school to con-

cretize the example (e.g., “This means that about one student in each classroom in your school worries more than he or she needs to”). Discussions of the cause of the disorder should stress that nobody is “at fault” and neurobiological theories of etiology may be simplified by talking about a “brain hiccup” (March & Mulle, 1998). Sharing information about treatment can be done in simple language (e.g., “we are going to talk about how you feel,” “things you can think about,” “things that you can do that may help you feel better”) and/or by drawing cartoons about what children will be doing in therapy. Finally, for younger children, it may be helpful for the clinician to first share information with a parent and/or the family. In this way, a parent may act as a treatment “coach” and continue the psychoeducation process at home in between treatments sessions (Freeman & Garcia, 2008).

In contrast, older youth may benefit from engaging in psychoeducation with the clinician first, and then sharing the information with their family. This process allows for passing information throughout the family, but also supports the growing independence of older youth. In general, the content of psychoeducation for older youth is more sophisticated. When reviewing common symptoms, older youth may benefit from looking over a checklist of diagnostic criteria with the clinician, identifying symptoms experienced, and talking about how the same disorder can have different symptom presentations. Similarly, older youth are more likely to understand prevalence rates and different theories of etiology. During this process, it is important to be open to questions and to have handouts and/or brief videos to supplement the discussion. In presenting information regarding treatment, older youth may be curious about efficacy and about the rationale for different treatment ingredients. More advanced youth may also benefit from talking about medication interventions and other possible treatments in case the current one is not effective.

Relaxation Techniques

Relaxation techniques (e.g., guided imagery, progressive muscle relaxation, deep breathing, meditation, biofeedback) are used to help youth increase awareness of tension, reduce physiological symptoms of stress, gain control over achieving a state of relaxation, and potentially facilitate engagement in other components of treat-

ment (e.g., exposure tasks; Clarke & Debar, 2010). As deep breathing and progressive muscle relaxation (PMR) are the most commonly used relaxation techniques, this section will focus on those two approaches. Deep breathing involves slowly breathing through the diaphragm, which is in contrast to the rapid, upper chest breathing often associated with anxiety. PMR refers to the process of systematically tensing and releasing muscle groups.

Deep breathing and PMR, often used in conjunction with each other, are easily adapted and have been used with a broad range of ages and developmental differences. For example, it may be helpful to present the relaxation techniques in shorter pieces when working with children with shorter attention spans (Beidas, Benjamin, Puleo, Edmunds, & Kendall, 2010). Deep breathing may be simplified as “belly breathing” or instructing to “fill a balloon in your belly” to remind the younger child of the importance of making the diaphragm inflate and deflate. In addition, pinwheels or bubbles may help the younger child learn the technique and remain engaged with the process (Cautela & Groden, 1978). Prior to teaching PMR, it is important to conduct an assessment of muscle awareness and motor ability. Depending on ability, the clinician can focus on a few gross-motor muscle groups (e.g., shoulders and arms, legs and feet) as this approach may be easier than learning to control fine-motor areas (e.g., facial features, hands; Cautela & Groden). Whole body tension and relaxation may also work with younger children. For instance, having the child pretend to be a “robot” with stiff arms and legs, and then a “rag doll” who flops around with no tension in the body may be a playful and engaging way to increase awareness of muscle tension and relaxation (Kendall & Hedtke, 2006).

Relaxation techniques used with adolescents tend to be more sophisticated than the approaches described above; however, this age group may comprise a range of developmental levels, so it is still wise to assess cognitive and attention abilities. Adolescents may be interested in more details about the physiological stress response and how relaxation techniques work to combat that response. Some adolescents may respond to briefer methods like deep breathing, in contrast to the lengthier PMR (Curry et al., 2000). If engaging in PMR, the length and depth of the intervention can be adapted depending on the abilities and interest of the adoles-

cent. For example, Ollendick and Cerny (1981) suggest using short and to-the-point directions (e.g., pull your shoulders up and try to touch them to your ears), and clinicians can choose to focus on fewer, larger muscle groups for a shorter intervention. In contrast, it may be helpful to use a PMR script designed for use with adults, which includes directions to tense and relax more specific muscle groups.

Praise and Rewards

Broadly speaking, praise and rewards are behavioral strategies that apply positive reinforcement (e.g., verbal praise, small prizes, tokens/points, enjoyable activities), which can be used by clinicians, parents, or teachers to increase desired behaviors among children and adolescents (King & Ollendick, 1997). As a treatment component in CBT programs, youth learn the basic principles of praise and rewards, including developing a list of possible rewards for treatment progress, monitoring progress, and eventually learning to self-administer earned rewards. From a developmental perspective, clinicians should consider three key aspects related to the implementation of praise and rewards: types of rewards, frequency and timing of rewards, and extent of parent involvement. This section will discuss each of these issues as they apply to developmentally younger children and then to older children and adolescents.

To increase motivation and treatment compliance, Kingery and colleagues (2006) suggest that clinicians develop reward lists collaboratively with youth to ensure that the types of rewards closely match each child’s developmental level and his or her individual interests and preferences. Younger children tend to enjoy concrete rewards such as candy, school supplies (e.g., pencils, pens, erasers, notebooks), Matchbox cars, bubbles, stickers, and other small prizes. In terms of rewarding activities, individual time with a parent (e.g., playing a game, baking, reading, building with Legos), choosing a special outing (e.g., going to a frozen-yogurt shop, choosing a favorite book from the library), or arranging a play date are often used. In addition to making sure that the types of rewards are appropriate for younger children, clinicians need to pay careful attention to the frequency and timing of rewards. For example, Freeman and Garcia (2008) highlight that in contrast to older youth with OCD, younger children need to receive positive consequences more frequently

(e.g., rewards given for resisting hand washing before each meal rather than for an entire day). Due to their cognitive abilities, younger children usually respond best to concrete rewards given immediately after a positive behavior, rather than points that must be saved and exchanged for a prize later. Younger children may also need a desired behavior to be broken down into smaller steps (e.g., first tell salesperson you would like to purchase the item, then pay for it) with a reward provided after each step or even a reward provided for partial success if the task is too challenging at first. Finally, parents of younger children play a crucial role in helping to develop reward lists, keeping track of prizes earned, and administering rewards when target behaviors are accomplished outside of therapy sessions (Kingery et al.).

In contrast, older children and adolescents have different interests and preferences that impact the types of rewards used during treatment. For example, iTunes gift cards, teen-focused magazines, gift cards for a clothing store or manicure, or additional screen time tend to be popular with older youth. In terms of activity-oriented rewards, although they may still enjoy an occasional activity with parents, teens tend to gravitate toward activities with peers (e.g., going bowling, ice skating, or to a sporting event). It is important for clinicians to keep in mind that expensive rewards may be stressful or impossible for some families. Social rewards, such as earning the privilege of going to bed later, staying out later with friends, or simply extra time spent “hanging out” with a friend, are low- to no-cost alternatives that can be very motivating for older youth. Regarding the frequency and timing of rewards, with older or more developmentally advanced youth it is common to use points or tokens that can be “saved up” and exchanged for a larger prize later on. Clinicians can teach older youth to self-evaluate and reward fairly independently, using only occasional verbal assistance from parents (e.g., reminders about the reward system, praise for accomplishing target behaviors).

Cognitive Strategies

Cognitive strategies, such as Socratic questioning, testing the evidence, cognitive modeling, decatastrophizing, and the downward arrow technique, are a group of therapeutic tools used to teach youth with internalizing disorders to identify negatively distorted thoughts that may be maintaining their symptoms of anxiety or

depression. Cognitive strategies involve two main goals. First, clinicians help youth develop an awareness of maladaptive thoughts. Then, clinicians use cognitive restructuring to guide youth through the process of challenging the validity of their thoughts and generating more rational or adaptive coping thoughts (Kendall & Suveg, 2006).

To deliver cognitive strategies in a developmentally sensitive manner, clinicians must begin by evaluating (either formally or informally) each youth’s cognitive abilities in areas such as causal reasoning, memory, attention span, and metacognitive awareness. Although youth in early to middle childhood often have difficulty identifying and reflecting on their own thoughts (e.g., Kane & Kendall, 1989), this does not necessarily mean that their thoughts related to anxiety or depression cannot be accessed. When working with younger children, clinicians can use cartoon strips of favorite superheroes to provide children with a more concrete way to express their thoughts. Other strategies that may be effective with younger children include externalizing the source of upsetting thoughts to a fictional character (e.g., “Worry Monster,” “Nervous Bug,” “Sadness Cloud”), or comparing the child’s attitude toward a stimulus with that of a peer (e.g., excitement versus anxiety about riding a roller coaster at an amusement park) and discussing the thoughts that correspond with these contrasting feelings. When presenting questions to help youth access their thoughts, Friedberg and McClure (2002) suggest using open-ended questions that promote imagery (e.g., “What popped/flew into your mind?”; “What did you say to yourself?”), rather than “What are you thinking?” (p. 91). After identifying thoughts, cartoons or drawings can be used to help youth restructure their thoughts (e.g., picture of child in a feared situation with two thought bubbles above his/her head—one for the anxious thought, the other for the more adaptive or coping thought; Kendall & Hedtke, 2006). To simplify the cognitive restructuring process, clinicians can help young children write brief self-statements (e.g., “I can do it!”) on index cards that can be posted in key places at home (e.g., mirror, refrigerator) or carried in a pocket for a tangible reminder. Finally, younger children typically need direct instruction from clinicians with completing daily thought records, and also may need assistance from caregivers with recognizing and challenging maladaptive thoughts outside of ther-

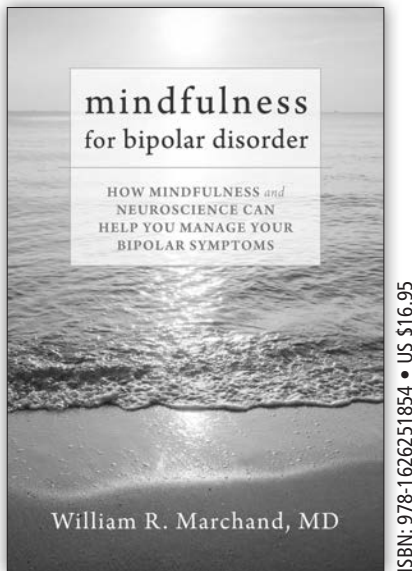
apy sessions. For example, parents can offer brief supportive statements (e.g., “It sounds like your OCD is giving you a hard time,” p. 1192) to remind youth to use their cognitive coping strategies (Piacentini & Langley, 2004).

Several of the strategies mentioned in the previous paragraph (e.g., cartoon strips, externalizing the source of upsetting thoughts) can be adapted to match the interests and developmental level of older children and adolescents. For example, an adolescent who enjoys ballet could brainstorm coping thoughts that her favorite dancer might use in an anxiety-provoking situation, or clinicians can ask youth to imagine assisting a friend in generating coping-focused thoughts for a particular situation. Metaphors can also be used to help youth become more aware of their thoughts. For teens interested in sports, the clinician could apply a “ticker” analogy (Mychailyszyn, 2015), explaining that our thoughts come and go like updates in the ticker that runs across the bottom of the screen on ESPN. Just as we might focus on a certain piece of negative news (e.g., favorite team lost a game) and disregard other information running across the ticker, we tend to focus on negatively biased and ignore contrary evidence in a similar manner. The metaphor of a detective who is working to gather evidence for negative thoughts (i.e., testing the evidence) can facilitate cognitive restructuring. Clinicians ask questions to help youth to gather facts that support their beliefs (e.g., “What makes you 100% sure that your prediction is true?”) and that do not support their beliefs (e.g., “What else might happen in this situation?”; Friedberg & McClure, 2002; Kendall & Hedtke, 2006). Teens who have difficulty answering these questions could be prompted further with the question, “What would your friend say about ____?” By reviewing the facts and reflecting on alternative ways to view a situation, youth are able to come to a new conclusion and generate coping thoughts.

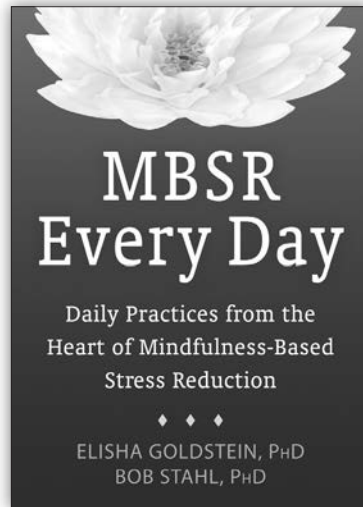
Self-Monitoring

Self-monitoring, a treatment component involving self-observation in the form of tracking thoughts, behaviors, or feelings, is included in most empirically supported treatments for youth with internalizing disorders. Implementation of self-monitoring requires selecting the variable to be monitored (e.g., sadness), deciding on the self-monitoring method (i.e., format, frequency), creating the method with the

New Resources for Your Practice

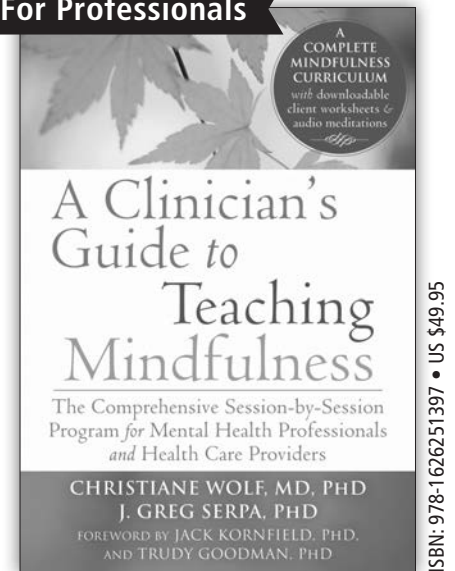


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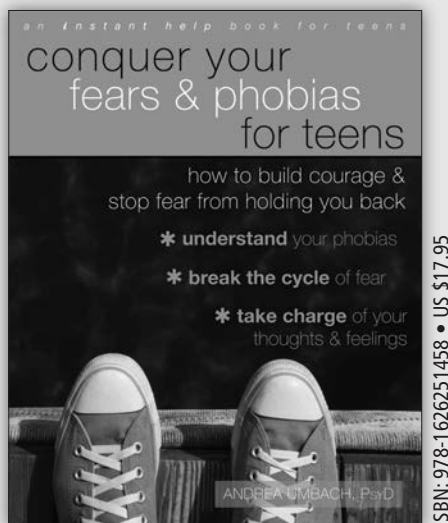
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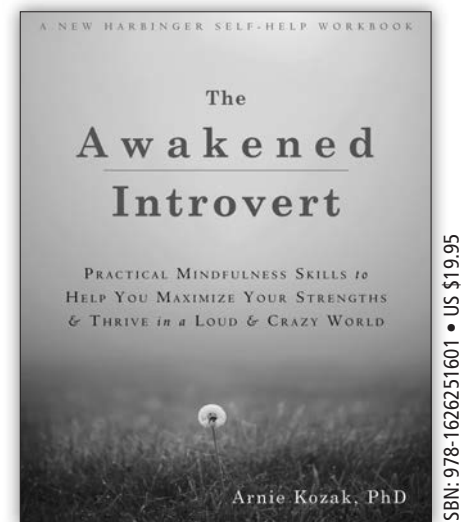
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youth, identifying reinforcers for compliance, and practicing the process. In addition, the self-monitoring log is typically reviewed in future sessions to assess change of emotions over time, identify antecedents of mood changes, challenge automatic thoughts, or problem solve more adaptive behaviors.

Although self-monitoring is more frequently included in treatments for older youth and adolescents, there are several adaptations for youth at earlier developmental levels. Younger youth may benefit from using pictures to aid in the self-monitoring of thoughts, behaviors, and feelings. For example, a photo of the youth with a friend could be placed on a self-monitoring chart that tracks number of playdates for a socially anxious child. Similarly, young children may have an easier time keeping a log of feelings faces (e.g., happy, neutral, sad) instead of mood ratings. Parental involvement and modeling may provide needed scaffolding for youth at earlier developmental levels. Indeed, an anxiety intervention designed for youth ages 4 to 7 (i.e., Kiddie Cat; Hughes, Hedtke, Flannery-Schroeder, & Kendall, 2005) encourages parents to help the child monitor feelings of anxiety and avoidant behaviors. In addition, the forms commonly used for self-monitoring may be simplified for younger youth. Feelings rating scales can be four or five points and anchored by concrete descriptions or feelings faces. Language can also be adapted on the self-monitoring log. For example, the term "thinking traps" may be more easily understood than the term "cognitive distortions" on a thought monitoring log (Kendall & Hedtke, 2006).

The ability to accurately recognize, label, and report thoughts, feelings, and behaviors tends to increase with age (King, Ollendick, & Murphy, 1997); thus, self-monitoring is typically easier for older or more cognitively advanced youth. Therefore, older youth may prefer to complete self-monitoring tasks without parental involvement (e.g., Clarke, Lewinsohn, & Hops, 1990). Older youth often feel comfortable with written self-monitoring logs and more detailed rating scales. For example, a number-based 10- or 100-point scale (e.g., Subjective Units of Distress Scale; SUDS) may be used with adolescents (Heard, Dadds, & Conrad, 1992). Similarly, while a young child may be able to keep a log of only their feelings, more advanced youth can record the preceding situation, resulting feelings, thoughts, the accuracy of those thoughts, and the consequences

(Clarke et al., 1990). Some studies have examined the use of technology (e.g., palm pilots, iPod Touch) in facilitating self-monitoring of anxious symptoms (Suveg, Payne, Thomassin, & Jacob, 2010); however, additional research is needed to determine the effectiveness of computer-assisted self-monitoring. Nevertheless, the use of technology to help with self-monitoring may be an attractive option for older youth.

Conclusion

Throughout this article, we present a variety of specific ways to tailor several core elements of CBT to each youth's developmental level. Before implementing these adaptations, we strongly recommend that clinicians evaluate each child's level of functioning in the cognitive, social, and emotional domains of development, either formally as part of the pretreatment assessment or informally during the first several treatment sessions. As Kingery et al. (2006) emphasize, these developmental skills can impact a child's ability to engage in and ultimately benefit from treatment. In addition to being creative and flexible, the developmentally attuned therapist is knowledgeable about developmental principles and integrates them in an ongoing manner into his or her clinical practice. According to Holmbeck et al. (2010), clinicians treating youth may need to focus not only on presenting symptoms, but also age-appropriate skills (e.g., emotion regulation, social skills) that may be lagging as a result of the child's psychopathology. To accomplish this, clinicians must acquire the necessary knowledge and skills through graduate-level clinical training that incorporates developmental principles, by following published developmental psychology research, or via continuing education workshops. In addition, clinicians need to apply this developmental knowledge in the therapy session. Finally, Barrett (2000) recommends taking the role of a child's cultural background into careful consideration, as the extent to which a particular behavior is considered developmentally appropriate is often defined by a given family's cultural background.

It is also our hope that this article helps to bring developmental issues to the forefront for researchers who evaluate the effectiveness of manual-based treatments for youth. Although it has been suggested that tailoring treatment according to a child's developmental level should lead to more favorable outcomes, much more

research is needed to inform effective implementation of developmental modifications. Holmbeck et al. (2010) recommend that researchers not only examine the role of chronological age in treatment outcome studies, but also include specific developmental variables (e.g., cognitive ability, emotion regulation, social skills, friendship quality) to evaluate mediators and moderators of treatment effects. As most research focuses on the effectiveness of treatment manuals as a whole, more component research is also needed to evaluate the effectiveness of individual treatment elements such as those discussed in this article. Overall, systematic research examining the role of developmental factors in treatment outcome will help to provide empirically informed recommendations for adapting treatments such as manualized CBT to fit each child's unique developmental needs and skills.

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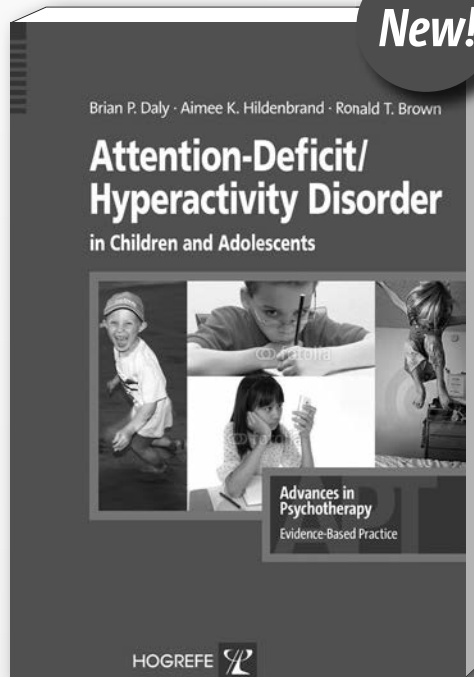
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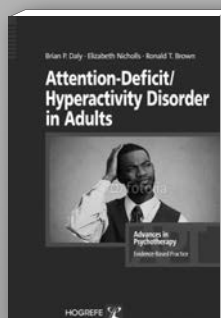
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- ...
- Correspondence to** Julie Newman Kingery, Ph.D., Department of Psychology, Hobart and William Smith Colleges, 300 Pulteney St., Geneva, NY 14456; kingery@hws.edu

Erratum

Due to editorial error, Jessica Armstrong and Victoria Ameral were not listed as authors of "First Generation Students in Professional Psychology: Challenges and Training Recommendations" in the March 2015 issue of *the Behavior Therapist*. The editor regrets this omission. The correct citation is: Palm Reed, K. M., Armstrong, J. L., & Ameral, V. (2015). First generation students in professional psychology: Challenges and training recommendations. *the Behavior Therapist*, 38, 74-77.

Guided Internet-Delivered CBT: Can It Really Be as Good as Seeing a Therapist?

Gerhard Andersson, *Linköping University and Karolinska Institutet*

Alexander Rozental, *Stockholm University*

Christian Rück, *Karolinska Institutet*

Per Carlbring, *Stockholm University*

USING THE INTERNET TO PROVIDE COGNITIVE behavior therapy (ICBT) has had a fairly short history but a very rapid development in terms of both controlled trials and subsequent clinical implementations (Andersson, 2014). ICBT was preceded by two treatment formats used in CBT, namely bibliotherapy and computerized CBT. While there is an overlap between these formats, we believe that it is better to separate computerized treatments in general as they are not as easily transferred to the

clients' own home as ICBT and moreover are less commonly used now that the Internet is with us. For example, in some studies the client had to visit the clinic to receive a training session in computerized CBT (Proudfoot et al., 2004). In a sense bias modification training is a form of computerized treatment (Amir et al., 2009), but so distinctly different from CBT in general that we refrain from including it in this brief paper (we have, however, tested bias modification training over the Internet

with somewhat disappointing outcomes; Carlbring et al., 2012). We also suggest that bibliotherapy should be regarded as a separate treatment even if text material is widely used in ICBT (for a background, see Andersson, 2014). There are several advantages to providing CBT over the Internet. For example, treatment can be accessed at any time, interactive features can be included, and therapist support can be delivered either in real time or asynchronous. While there are exceptions, most evidence to date speaks in favor of providing clinical support during ICBT. Thus, guidance from a therapist has been found to yield good outcomes whereas totally automated and unguided treatments usually lead to higher dropout rates and potentially smaller effects. Thus, the present paper will focus on clinician-guided ICBT. We will briefly mention different formats of delivery as Internet access is not restricted to computers but includes other platforms such as smartphones. The aim of this paper is to (a) briefly describe how guided ICBT is conducted, (b) provide evidence suggesting that ICBT can be as effective as face-to-face CBT, and (c) comment on the poten-



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tial negative effects. We will end by discussing possible future developments.

What It Is

ICBT can be conducted in different ways and there are even examples of guided Internet-delivered psychodynamic treatments (Johansson, Frederick, & Andersson, 2013). However, our typical presentations of guided ICBT can be divided into several steps. First, we use online administration of validated self-report measures. This is a procedure that has been found to be valid and reliable (Andersson, 2014). Second, we complement the self-reports with clinical semistructured interviews either via telephone or in-vivo. The latter option makes ICBT less accessible but has been a way to disseminate ICBT into regular clinics (Andersson & Hedman, 2013). Third, following inclusion we provide access to a secure system that resembles the systems used when paying bills online, that is, they are encrypted and use a double authentication procedure at log-in. All communication with the client is done within the closed system and not the client's personal email. If e-mail and SMS messages are used, it is important that they are designed so as not to cause harm should someone else read the message without the patient's approval. Fourth, evidence-based treatment materials are provided gradually to the client with a pacing similar to face-to-face CBT and, also similar to face-to-face CBT, with a duration of about 8 to 15 weeks. Treatment material can involve text (read online or for printing), streamed videos and illustrations, and audio files. In one approach to ICBT we tailored the treatment according to patient characteristics and preferences (Carlbring et al., 2010), but otherwise it is more or less manualized treatments derived from face-to-face CBT. Fifth, clients receive guidance from an identified clinician who provides support and advice on treatment progression and answers questions regarding the treatment (Andersson, 2014). This is minimal guidance that often takes about 10 to 15 minutes per client and week. Other possibilities that have been tested include video chat and real-time telephone support. Our experience, however, is that e-mail contact (within the secure system) is sufficient to generate good outcomes. The treatment period usually ends with an interview and follow-up assessments using online administered self-report measures. More recent versions of guided ICBT have involved smartphone administration (Ly et al.,

2014). In general, contemporary Internet treatments should be responsive to different presentation formats (basically, different appearances depending on where it is displayed).

As Effective as Face-to-Face CBT?

Although a large number of controlled trials exist in which guided ICBT has been compared to control conditions like waiting-list or supportive counseling, the only way to establish how well ICBT fares against face-to-face CBT is to compare directly within controlled trials. In this section we will provide three arguments proposing that the evidence now points in the direction of guided ICBT being as effective as face-to-face CBT. We will also provide some counter arguments.

The first argument comes from a large number of controlled studies for a range of different conditions for which guided ICBT has been tested against no treatment or minor support, where effect sizes are comparable to those in face-to-face CBT. This includes mood disorders (mainly mild to moderate depression), anxiety disorders, somatic disorders for which psychological treatments have been developed and tested, and finally a few other examples of other problems such as procrastination (Rozenal, Forsell, Svensson, Andersson, & Carlbring, in press). It is interesting to note that the pattern of effects is fairly similar to what can be seen for standard face-to-face CBT, with large effects for conditions like panic disorder (Carlbring et al., 2006) and smaller effects for conditions like chronic pain (Buhrman, Fålténhag, Ström, & Andersson, 2004). This means that it is not uncommon to see effects in the larger range ($d = 0.80$ or higher) for conditions like social anxiety disorder, obsessive-compulsive disorder, generalized anxiety disorder, major depression, and, as mentioned, smaller effects for conditions like chronic pain, diabetes, and possibly tinnitus (Andersson, 2014). Studies on long-term outcomes up to 5 years after treatment completion also suggest sustained treatment effects just as in face-to-face CBT (Hedman, Furmark, et al., 2011).

The second argument comes from the direct comparisons between guided ICBT and face-to-face CBT. In a recent meta-analysis we located 13 controlled studies (total $N = 1,053$) in which ICBT had been directly compared with face-to-face CBT (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014). There were 3 studies on social anxiety disorder, 3 on panic disorder,

2 on depressive symptoms, 2 on body dissatisfaction, 1 on tinnitus, 1 on male sexual dysfunction, and 1 on spider phobia. Face-to-face CBT was either in the individual format ($n = 6$) or in the group format ($n = 7$). Results showed a pooled effect size (Hedges's g) at posttreatment of $g = 0.01$ (95% CI: $= -0.13$ to 0.12), indicating that guided ICBT and face-to-face treatment produce equivalent overall effects. Moreover, at least 4 more studies have been published since the review period, with 1 on depression (Andersson, Hesser, et al., 2013), 1 on depressive symptoms (Lapalainen et al., 2014), 1 on snake phobia (Andersson, Waara, et al., 2013), and 1 on tinnitus (Jasper et al., 2014). Thus, there are now at least 16 controlled trials suggesting equivalence when guided ICBT is compared with face-to-face CBT. However, it should be noted that many studies have not included any therapist competence ratings and most have had students as therapists.

The third argument is somewhat indirect. As most studies on guided ICBT have been conducted with participants recruited via advertisements, an important additional question is if guided ICBT works under more clinically representative conditions. In other words, are there any effectiveness studies? There is an increasing number of controlled and open effectiveness studies suggesting that ICBT works when delivered as regular care (Andersson & Hedman, 2013). For example, recent data from the Internet Psychiatry Unit in Stockholm, Sweden, show that effects are about the same as in the efficacy trials for depression (Hedman et al., 2014), panic disorder (Hedman et al., 2013) and social anxiety disorder (El Alaoui et al., in press), and there are more examples from other countries, such as a very large study from Australia (Titov et al., in press). However, more data are needed and it should be noted that most patients have been self-referred.

Obviously, more studies may be needed and there are some arguments against the notion that ICBT is as effective as face-to-face treatments (Andersson & Titov, 2014). First, it may be that ICBT is less suitable for less well-educated clients and persons with more complex conditions like personality disorders. Second, it may be that ICBT has smaller effects on measures of quality of life (Hofmann, Wu, & Boettcher, 2014), even if this is uncertain and not based on direct comparisons. Third, it is also possible and even likely that some clients are better suited for face-to-face treatments. But this may also be the other way around, with

some being better suited for ICBT—for example, because of less stigma or increased accessibility. But until we know more about moderators and mediators of outcome, it may be safer to recommend face-to-face treatments, even given the advantages of ICBT in other domains, such as cost-effectiveness (Hedman, Andersson, et al., 2011).

Negative Effects

The possibility of negative effects has largely been neglected in the literature on guided self-help and also in the earlier literature on ICBT. A recent consensus statement (Rozental et al., 2014) encouraged researchers to report negative effects of ICBT (for example, worsening of symptoms, stress because of the treatment; Rozental, Boettcher, Andersson, Schmidt, & Carlbring, 2015), as side effects are probably not uncommon (Boettcher, Rozental, Andersson, & Carlbring, 2014). Furthermore, qualitative methods have also been used to explore the characteristics of negative effects (Rozental et al., 2015), and a self-report measure to assess the occurrence of negative effects is currently being developed.

Conclusions

Emerging evidence suggests that guided ICBT can be as effective as face-to-face CBT, and we are now entering an era in which we are likely to have Internet interventions with a stronger evidence base than the corresponding face-to-face treatments for some conditions. The fact that ICBT studies tend to be larger and better controlled (because they are newer and easier to conduct) than previous CBT studies will be a challenge for policymakers. Indeed, ICBT is just beginning to be recognized in treatment guidelines, but many clinicians and researchers are largely unaware of the rapid development of ICBT and the surprisingly large evidence base of more than 100 controlled trials. Future challenges include integrating face-to-face and Internet services as blended treatments are likely to be more well received than standalone Internet treatments (at least by clinicians). However, the literature on blended treatments is still small and it is also clear that there will be a need for pure ICBT in that there will never be enough well-trained CBT clinicians to cover the need for CBT in society and the costs associated with evidence-based face-to-face CBT.

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Correspondence to Gerhard Andersson, Ph.D, Department of Behavioural Sciences and Learning, Linköping University, SE-581 83 Linköping, Sweden; Gerhard.Andersson@liu.se

NEWS & NOTES

Behavioral Interventions Are First-Line Treatments for Managing Changes Associated With Cognitive Decline

Claudia Drossel, *Eastern Michigan University*

Maranda A. Trahan, *Trahan Behavioral Services*

A FEW MONTHS AGO, on March 5, 2015, National Public Radio featured an article by Kales, Gitlin, and Lyketsos (2015) that summarized the current state-of-the-art of interventions for emotional and behavioral changes associated with degenerative neurocognitive disorders. The headline read "Behavioral Therapy Helps More Than Drugs For Dementia Patients." Indeed, individually tailored behavioral interventions have been the mandated first-line treatment for behavioral and emotional changes related to cognitive decline since 1987, when the Nursing Home Reform Act first attempted to curb the widespread use of chemical and physical restraint (see Lichtenberg et al., 1998). Behavioral functional analysis conducted by professionals with specific skills in collaboration with caregivers continues to be recommended (e.g., National Institute for Health and Care Excellence, 2010). In this brief paper, we want to support and supplement the review by Kales et al. (see also Gitlin, Kales, & Lyketsos, 2012) with more background information from a behavioral perspective; clarify why individualized behavioral interventions are indicated as first-line treatments; and illustrate why the often seemingly inescapable practice of prescribing psychotropic medications for individuals who are experiencing progressive cognitive losses should be a last resort.

Kales et al. (2015) estimate that at this time nearly 44 million people worldwide have progressive and irreversible neurodegenerative conditions, such as Alzheimer's or Lewy body disease, expecting this number to triple by 2050; and that here in the United States, 75% of the individuals with major neurocognitive disorders live in their homes and receive assistance from family members. Providing individuals with help poses great challenges for families: Most laypeople are unfamiliar with the consequences of subtle and gradual sensory, perceptual, and cognitive decline. Prominent among the changes that slowly,

and imperceptibly at first, affect daily functioning are the loss of olfaction (Kovács, 2004) and deficits in visual perception that affect color, contrast, depth, and motion discrimination (Geldmacher, 2003; Hamilton et al., 2012; Mandal, Joshi, & Saharan, 2012; Wood et al., 2013). The ability to perceive auditory stimuli, including binaural versus monaural verbal stimuli (Brønck, Nordby, Larsen, & Aarsland, 2010; Idrizbegovic et al., 2011), also diminishes. As perception is altered, the impact of the current context on the person's verbal and other behavior wanes. While the person continues his or her efforts to carry on usual activities and to stay connected within his or her psychosocial environment, episodes of disorientation and disruptions of the habitual sequential flow of routine activities become more frequent. Anecdotally, individuals with neurodegenerative diseases describe "blanks," during which they intensely try to summon the context in which their most recent actions occurred in order to figure out what they should do next. Concurrently, individuals' communicative repertoires decline: topics of conversation narrow, self-descriptions become unreliable, speech content loses its richness, the ability to flexibly problem-solve diminishes, and eventually expressive and comprehensive difficulties abound (Killick & Allan, 2001; Lubinski, 1995). Throughout this process, life-as-usual becomes increasingly effortful, and apprehension and withdrawal from activities are common and frequently culminate in social isolation (Charlesworth, Sadek, Schepers, & Spector, 2014).

In light of these difficulties, individuals with progressive neurocognitive disorders experience inadvertent extinction and also punishment contingencies at an increased frequency (Drossel & Fisher, 2006). First, their behavior often fails to produce the intended outcome. Second, social embarrassment and shame regularly accompany mischaracterizations or misinterpretations

of situations, faux pas, or failures to complete assigned chores or work tasks. Studies suggest that level of education correlates with longer periods of self-initiated compensatory strategies to maintain involvement in everyday activities (“cognitive reserve”) but also more rapid decline (Scarmeas, Albert, Manly, & Stern, 2006; Stern, Tang, Denaro, & Mayeux, 1995; Unverzagt, Hui, Farlow, Hall, & Hendrie, 1998). Once these strategies are no longer effective and deficits have moved into plain sight, behavior is more likely to be extinguished or punished, albeit inadvertently. Third, effects of neurodegeneration can be exacerbated by family members’ or friends’ reactions (e.g., Vitaliano, Young, Russo, Romano, & Magana-Amato, 1993), who struggle with their own profound sense of loss and helplessness. As the neurodegeneration progresses, most family caregivers acknowledge that they intermittently use coercive behavior change techniques such as threatening, yelling, insulting, or applying more physical force than necessary for the caregiving task (Cooper et al., 2009; Thoma, Zank, & Schacke, 2004). Any of these factors, or a combination thereof, can lead to more disability than would be predicted by the neurodegenerative disease alone (“excess disability”; Brody, Kleban, Lawton, & Silverman, 1971).

Accordingly, a pivotal target of behavioral interventions for individuals with major neurocognitive disorders is the creation of psychosocial scaffolding that serves to reinforce remaining repertoires, support the maintenance of close relationships, facilitate continued engagement in meaningful activities (versus activities for activities’ sake), and prevent conditions that could exacerbate functional difficulties (e.g., inappropriate or overwhelming physical or psychosocial environments, undetected medical conditions, uncorrected sensory loss, and adverse medication effects; Bernat et al., 1996). Clinical behavioral interventions involving individuals and their families are in essence constructional (Goldiamond, 1974). They provide individuals and their families with continuity of identities and roles across the continuum of the neurodegenerative process.

This constructional stance is also maintained when behavioral problems occur, typically once the person has become increasingly disoriented, has begun to misinterpret contextual cues, and fails to render accurate self-descriptions (see also Bem, 1972). To illustrate, topographical assessments developed within the medical model, such as the Neuropsychiatric

Inventory (Cummings et al., 1994) or the Cohen-Mansfield Agitation Inventory (Cohen-Mansfield, Marx, & Rosenthal, 1989) can identify “wandering” as a behavioral target, with descriptions of form, frequency, and perceived severity. However, these assessments do not inform about the function of wandering, i.e., what the behavior accomplishes. Consequences may be very idiosyncratic: Joe may have a long history of golfing, and for him so-called “wandering” away from home represents the mere continuance and maintenance of his daily walking regimen. Miko’s progressive degenerative condition decreased her English skills, and her “wandering” from home reliably takes her to a restaurant where people speak her first language. Andra has a chronic pain condition, and “wandering” is a reliable sign of increased pain that she is unable to verbalize. Behavioral interventions prescribed for these three scenarios will differ based on the function: Joe’s intervention involves access to supervised exercise or a walking companion, Miko’s support plan gives her access to meaningful social interactions, and Andra receives pain management. In none of these cases are psychotropic medication trials indicated. Indeed, in the latter case they would be especially contraindicated, as psychotropic medication would further reduce Andra’s ability to communicate her exacerbated pain condition.

In addition, family members tend to be unaware of the subtleties of perceptual and cognitive changes and often cannot gauge the person’s strengths and limitations (Ala, Berck, & Popovich, 2005a, 2005b). Studies of dyadic interactions (e.g., Small & Perry, 2005) have shown that “W” questions dominate everyday discourse (e.g., *What have you done*, *Where did you go*, etc.). When a person with a progressive neurodegenerative disease engages in these types of interactions, inaccurate verbal descriptions—or confabulations—typically result (Trahan, Donaldson, McNabney, & Kahng, 2014). The person fills in memory gaps, gives plausible reasons, or simply escapes from a social demand by providing an explanation that strikes the conversational partner as contrived. These confabulations alarm family members, who label them from a pathological perspective (“psychoses,” “delusions”)—possibly cued by their interactions with providers trained in the biomedical model—rather than viewing the individual’s efforts to maintain social interactions as a continued functional strength. Depending on prior functional assessments, behavioral interven-

tions may consist of differentially reinforcing accurate descriptions (e.g., through the use of compensatory strategies such as note-taking or journaling); differentially reinforcing social engagement regardless of veracity of the speech content; or changing psychosocial conditions that may give rise to inaccurate descriptions (e.g., when changes in the spouse’s affective responding set the occasion for accusations of infidelity). These interventions are again constructional in nature—they involve the maintenance of skills, and increase in social interactions are the targeted outcomes.

Finally, when severe cognitive decline has diminished the appreciation of one’s own situation or need for assistance, many individuals with major neurocognitive disorders tend to engage in self-protective behaviors. They misinterpret or do not appreciate caregivers’ attempts to help with personal care. Persons with neurocognitive disorders may feel intense violations of privacy (e.g., undressing in the presence of perceived strangers), of dignity (e.g., “If you take a shower, I’ll give you a cookie”), and of autonomy (e.g., “You need help!”). Knowledge of the person’s history, and skillful and artful caregiving to preserve dignity and respect are of the utmost importance to generate an atmosphere of collaborative care that promotes wellbeing.

Perceived problem behaviors associated with neurodegenerative conditions are typically intensely personal and situational (i.e., directly linked to the person’s history, current circumstances—such as family dynamics—and skill sets in relation to the caregivers’ expectations), and solvable with gentle and highly individualized yet systematic constructional strategies. Adverse events, such as the increased agitation noted by Kales et al. (2015) as a side effect of nonpharmacological interventions, would be expected if these were implemented in a one-size-fits-all fashion, regardless of individual history, preferences, or current behavioral function.

Empirically based principles of behavior change to guide effective, individually tailored practice with individuals with neurocognitive disorders have been described, evaluated, and implemented for the past 40 years, first as operant conditioning (Baltes & Barton, 1979; Hussian, 1981), and later disseminated as the functional approach (Bourgeois & Hickey, 2011) or the contextual model (Fisher, Drossel, Yury, & Cherup, 2007; McCurry & Drossel, 2011). Grounded in the philosophy and science of behavior analysis (Chiesa, 1994), these approaches also draw from models estab-

lished with sequential analytic methods (e.g., Patterson, 1982) to predict and influence how a person's history intersects with his or her current biopsychosocial context (i.e., characterized in terms of motivating operations, antecedent conditions and psychosocial or other consequences) to generate the presenting problem. Behavioral and emotional sequelae of neurodegenerative disorders are not only understood in the context in which they occur, but they can also be altogether prevented (Buchanan, Christenson, Houlihan, & Ostrom, 2011)—or addressed, as illustrated above—with appropriate caregiver training that teaches caregivers to explore the function of behavior in its context (for a self-help book, see McCurry, 2006). In comparison, the D[escribe]–I[nvestigate]–C[reate]–E[valuate] (DICE) model, proposed by Kales et al., is incomplete as it fails to include systematic procedures for evidence-based functional assessments and/or procedures to determine function-based interventions. Without this emphasis, DICE is at risk of focusing exclusively on antecedents of behavior and overlooking the role of history as well as psychosocial or other consequences that might maintain behavior. Moreover, the DICE model continues to highlight a role for psychotropic drugs—thus representing the current status quo rather than the direly needed paradigm shift in the care of individuals with neurocognitive disorders.

As Kales et al. (2015) point out, no medications have been approved by the FDA for the emotional or behavioral sequelae of cognitive and perceptual losses and of altered psychosocial interactions. Kales and colleagues advise that “psychotropic drugs are not likely to improve memory problems, not paying attention or caring about what is going on, repetitive verbalizations or questioning, rejections or refusal of care, shadowing, wandering, and behaviors that are dangerous to self [...] or inappropriate [...]” (p. 12). Yet, despite these caveats, Kales et al. recommend consideration of the use of psychotropic drugs, albeit “only after serious efforts have been made to mitigate target symptoms using behavioral and environmental modifications and medical interventions if needed, with three exceptions [...] because of concerns about serious and imminent risk” (p. 12): major depression, to be treated with antidepressants; and psychosis and aggression, both to be treated with antipsychotics on a time-limited basis. Here, the emphasis on “serious efforts” and “serious and imminent risk” represents the authors’ concerns

about medications that continue to be prescribed on a routine basis despite their adverse effects and limited evidence base.

Individuals with neurocognitive disorders are a vulnerable population, with an already compromised central nervous system, frequently multiple comorbidities (such as diabetes, hypertension, or other illnesses), associated use of many prescription drugs, and age-related changes. Together these factors alter pharmacodynamics as well as pharmacokinetic processes (Salzman, 2005). Indeed, the high use of prescription medications and the sensitivity of adults 65 and older to adverse drug effects has prompted the following heuristic: “Any new symptom in an older patient should be considered a possible drug side effect until proven otherwise” (Avorn & Wang, 2005, p. 36). Avorn and Wang further point out that a wide range of commonplace prescription medications can induce depression-like symptoms (e.g., beta-blockers), hallucinations and psychosis (e.g., levodopa, procainamide, corticosteroids), confusion (e.g., oxybutynin, digoxin, antihistamines), and agitation (e.g., bronchodilators, thyroid hormones). Emphasized by Kales et al., part of the effort to properly address behavioral and affective changes is to rule out adverse drug effects. We recommend consulting with geriatric pharmacists, as many factors (e.g., acute illness, dehydration) can alter the effects of existing drug regimens even if there has not been a recent medication change.

Consequently, adding psychotropic medications in the context of already compromised physical functioning and/or complex medication regimens can have detrimental effects (Avorn & Wang, 2005), including but not limited to sedation, confusion, orthostatic hypotension, falls and fractures, sleep disruptions, cardiovascular problems with increased mortality, and extrapyramidal symptoms (i.e., tremor, rigidity, and akinesia or bradykinesia often mischaracterized as depression, lethargy, or apathy). The most common extrapyramidal symptom is akathisia (Jeste, Sable, & Salzman, 2005; i.e., motor restlessness and muscular tension accompanied by an inability to sit still). Of note, families as well as providers tend to interpret these adverse events as affective or behavioral symptoms of the neurodegenerative process and accept them as part of an inevitably accelerated decline. Stigma associated with major neurocognitive disorders may lead to failure to detect changeable problems and provide proper care.

Consider the example of antipsychotics, for which the FDA has issued two black box warnings prompted by serious adverse cardiovascular outcomes, including increased mortality (2005, 2008). Given these risks, Ballard and Cream (2005) argued a decade ago that ongoing administration of antipsychotics was attributable to prescribers’ therapeutic impotence, ignorance, placebo effects (i.e., regression to the mean), giving in to caregiver pressures, or a lack of skills to implement nonpharmacological alternatives. A recent survey of skilled nursing facilities by Bonner and colleagues (2015) found that overuse of antipsychotics continues, with both providers and families demonstrating poor understanding of when medication use might be indicated. Targets for drug use were vague and poorly described, and neither providers nor families were aware of the criteria constituting “serious efforts” to manage behavior nonpharmacologically or the presence of “serious and imminent risk” recommended by Kales et al.

From a principled behavior change perspective, “serious efforts” of using behavioral interventions must include the following:

1. Systematic rule-outs of drug effects, undetected illnesses, or pain as the precipitators of acute and abrupt behavior change (Eritz & Hadjistavropoulos, 2011; Hodgson, Gitlin, Winter, & Czekanski, 2011; Scherder et al., 2009) and, if indicated, treatment of delirium with first-line nonpharmacological interventions (Inouye, Westendorp, & Saczynski, 2014). To underline, precipitous decline involving episodes of increased confusion accompanied by unusual affect and behavior signals a need for a medication review and medical care. It is not an inevitable symptom of a neurodegenerative disease.
2. Careful definition of the target behavior in the context of perceptual loss and cognitive decline (e.g., confabulation or responses to visual disturbances versus delusions, psychosis, or hallucinations; self-protection versus aggression; confusion during personal care provisions—such as misinterpreting help while undressing as an advance by care staff—versus sexually deviant behavior). As indicated earlier, the stigma associated with neurocognitive disorders leads caregivers to regard behaviors as pathological when they are completely understandable in the context within which they occur

and easily modifiable. Of note, attribution of behavior to a disease rather than contextual variables may also prompt providers and caregivers to perceive a need for harsher treatment (Mehta & Farina, 1997).

3. Structured documentation of functional behavioral assessments to identify modifiable aspects of the context in which the behavioral or affective changes are occurring.

a. Indirect assessments (i.e., interviews and self-report instruments) to pinpoint psychosocial or other antecedent and/or consequent events. These assessments are most frequently used, are quick and easy, but rely on caregiver recollection.

b. Descriptive assessments (i.e., real-time observation of the behavioral or affective changes in their context, tracking antecedents, behavior, and consequences). These assessments are useful when caregivers perceive behaviors as “coming out of the blue” and are unable to identify contextual factors. They are more labor- and time-intensive and require training by behavioral specialists (McCurry et al., 2015; Teri, Huda, Gibbons, Young, & Leynseele, 2005).

c. Experimental assessments (i.e., systematic manipulations of antecedents and consequences to identify factors that modify the presenting problem; for an example, see Buchanan & Fisher, 2002). Because of the clinical expertise and the cost involved, these assessments are recommended if a person has lost his or her communicative skills, caregiver information is insufficient, and behavioral targets seem intractable.

4. In collaboration with caregivers, “serious efforts” should be evidenced by systematic documentation of the implementation and the effects of an intervention on the targeted behavioral and affective changes. Once the contextual events that influence behavior are known, antecedent variables can be altered (e.g., a person refuses to shower when asked during breakfast, but will agree to take a shower when sitting idle in her room), psychosocial consequences can be changed (e.g., family caregivers learn to refrain from correction or reality orientation if it is counterproductive), or appropriate alternatives can be instituted (e.g., structured exercise in the case of “wandering”; toiletting schedules to prevent restlessness due to urgency and inability to locate bathrooms).

5. The degree to which caregivers need education and skills to understand and appropriately respond to their loved one’s experience of neurocognitive loss cannot be overstated. Many caregivers require structured behavioral interventions to remove barriers to implementation of constructional, behavioral treatment plans (Drossel & McCausland, in press; Drossel, Mercer, & Fisher, 2011). When family caregivers’ own physical or mental health problems prevent engagement in or supervision of meaningful activities or exercise, community agencies (e.g., adult day centers) may be able to meet care recipients’ needs.

Only if these steps have proven futile is the use of psychotropic medications justifiable, as the last resort and temporary solution endorsed by Kales et al. (2015), using the guidelines detailed by Kalachnik et al. (1998) to obtain proper informed consent and to monitor the safety of individuals who cannot self-report drug effects. Through our training, which emphasizes functional assessment and attribution of behavior and affect within their biopsychosocial contexts, behavior therapists are equipped to provide a unique and irreplaceable service in the care of individuals with neurocognitive disorders. However, at this time, only a small number of trainees and professionals are interested in developing skills related to older adults (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) or provide such evidence-based treatments (Hoge, Karel, Zeiss, Alegria, & Moye, 2015). As long as this number is small, the implementation of nonpharmacological interventions for behavioral and affective changes recommended by Kales et al. will remain haphazard, and millions of people will remain at risk of receiving inappropriate or detrimental care. We can do better.

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Correspondence to Claudia Drossel, Ph.D., Eastern Michigan University, Department of Psychology, 341 Science Complex, Ypsilanti, MI 48197; ClaudiaDrossel@ba4all.org

SCIENCE FORUM

Developing International Collaborations for Early Career Researchers in Psychology

Julianne C. Flanagan, *Medical University of South Carolina*

Emma L. Barrett, *University of New South Wales*

Erica Crome and Miriam Forbes, *Macquarie University*

INTERNATIONAL COLLABORATION IS CRITICAL in the progress of mental health treatment, which represents a global issue of growing importance. Seminal reports by the World Health Organization (World Health Organization, 2001, 2010), among others (Collins et al., 2011; Demyttenaere et al., 2004; Murray et al., 2013), have outlined the staggering societal and financial burden associated with mental health problems worldwide. Startling projections describe the extent to which this disease burden is likely to multiply in coming

years (Cohen, 2000). This increasing burden is primarily due to the scarcity of resources for the development and dissemination of efficacious mental health treatments, particularly in low- and middle-income countries (Collins et al., 2011; Minas, 2012; Patel, Flisher, Hetrick, & McGorry, 2007).

Some attempts to minimize the gap between mental health disease burden and successful implementation of treatments include international efforts to collect, share, and analyze data. For example, the

National Institutes of Health (NIH) have developed hubs to facilitate international collaboration in mental health research. The Fulbright Program, which is sponsored by the U.S. Department of State's Bureau of Education and Cultural Affairs, also has a long history of facilitating cross-cultural research for public health improvement; the National Science Foundation includes an office of International and Integrative Activities; and the World Health Organization (WHO) recently developed the Mental Health Gap Action Programme, which aims to increase awareness of the disease burden of mental health and increase access to treatment services (WHO, 2008). Researchers have also emphasized the need to develop new models of treatment appropriate for larger-scale implementation, with an organized research agenda as a centerpiece of addressing the tremendous global mental health burden (Becker & Kleinman, 2013).

Each of these efforts is based on the notion that international collaborations are essential to identify cross-cultural similarities and differences in the etiology, course, and treatment of mental health

problems; to identify gaps in mental health treatment delivery; and ultimately to improve mental health care accessibility and efficacy worldwide. For these efforts to succeed, collaborative aptitude is necessary at a variety of levels. Extant research emphasizes the need for collaborative skills as a cornerstone of psychology training (Castonguay & Muran, 2015; Porcerelli, Fowler, Murdoch, Markova, & Kimbrough, 2013).

The authors are a group of early-career researchers (ECRs) in the U.S. and Australia who, with guidance from our mentorship teams, have built a productive ongoing collaborative relationship. It is our experience that international collaborations are related to a specific set of challenges and rewards, and provide opportunities for ECRs in psychology to develop a unique set of skills. In this article we draw on our experiences to encourage awareness among our early career colleagues regarding opportunities for international collaboration. Thus, the aims of this paper are to (a) discuss the importance of international collaboration in professional development for ECRs in psychology; (b) provide basic information regarding international research funding opportunities for ECRs; and (c) offer guidance on considerations for building and maintaining international collaborations.

The Role of International Collaboration in Professional Development

Early career psychologists face a number of responsibilities spanning clinical, empirical, educational, and advocacy forums, among others. We will focus on those engaged, in part or whole, in research-focused training and employment. For those of us pursuing careers in an academic setting, the necessity of articulating the impact of our budding programs of research is heavily emphasized. Through applications for internships, fellowships, career development awards, and in the preparation of promotion packets, we learn that our professional advancement hinges on our ability to describe our research trajectory and the impact of our program of research. One fundamental component of our professional development is being able to demonstrate the ways in which we are becoming nationally recognized experts. Expertise is typically shown through scholarly productivity in the form of internal and extramural funding, publication in peer-review outlets, and presentation at national conferences. International recog-

nition has also become part of the evaluation process for many of us, particularly with regard to attaining extramural funding and preparing for promotion; successful international collaboration suggests, perhaps more than any other endeavor, that you are working independently and productively.

For many ECRs, the concept of expanding one's program of research internationally might seem out of reach: to be considered at some vague future time when we have become "more senior." Over the past 2 years, we have each gathered our courage to make this leap a little sooner. Of course, international collaboration is challenging at times. However, our experiences suggest that an international collaboration between early career investigators is not only feasible, but is also scientifically, interpersonally, and professionally rewarding. We believe these collaborations not only facilitate individual growth early on, but also exponentiate the scientific rigor of our respective and collective research efforts.

Funding Opportunities to Support International Collaborations for ECRs

As mentioned below, there are many avenues to build an international collaboration. It may not seem natural for ECRs to pursue these opportunities when starting out in new positions. However, the opportunities exist, they are attainable, and many are exceptionally well suited to ECRs. Our group has found success through a variety of these opportunities: Dr. Crome recently hosted Dr. Flanagan on an International Visiting Research Fellowship at Macquarie University and the National Health and Medical Research Centre of Excellence in Mental Health and Substance Use at the University of New South Wales (Sydney, Australia). This visiting research fellowship aimed, in part, to enhance the existing collaboration between Drs. Flanagan and Barrett, and had the added benefit of Drs. Flanagan and Forbes forming an additional collaborative interest; the authors of this narrative are currently co-authoring a manuscript led by Dr. Forbes. Finally, Dr. Barrett was recently awarded a Fulbright Postdoctoral Scholarship and will spend 2016 abroad working with Dr. Flanagan and her group at the Medical University of South Carolina.

Perhaps the most concrete way to demonstrate an investment and interest in developing a collaborative relationship is to travel to work together in person. To out-

line some examples of longer-term travel opportunities: the Fulbright Scholar Program, funded by the U.S. Department of State, offers scholarships up to 1 year's duration for individuals to pursue collaborative research opportunities abroad. Fellowships to fund travel opportunities are particularly relevant to ECRs in the field of psychology, given psychology and mental health research are often impacted by current events, politics, language, and culture. The American Australian Association offers the Sir Keith Murdoch Fellowship, open to U.S. researchers at the graduate level or above to enroll in study at an Australian learning institution. The National Institute on Drug Abuse (NIDA) International Program also offers postdoctoral fellowships and fellowships for investigators to study global health topics in drug abuse.

Some examples of short-term opportunities include the Fulbright Specialist program, which requires a minimum 3-week stay abroad. The National Science Foundation offers a variety of research traineeship opportunities and publishes a website dedicated to international research endeavors. The value of visiting researcher fellowships available from individual universities and departments cannot be overstated. These programs often focus on consolidating the development of international collaborations to enhance the productivity and international visibility of the academics at the host institution. While these endeavors require more groundwork in terms of building collaborative relationships in advance of one's application, the competition is typically less stringent compared to federally funded opportunities. We also recommend discussing the use of existing research funds with one's mentorship team to support brief international travel where possible.

Tips on Building International Collaboration

Choose Collaborators Wisely

As with any partnership, it is important to choose collaborators carefully. Among those investigators working in your area of interest, consider who has written recent publications that captured your attention as being particularly novel, interesting, or in line with your research goals. It is ideal if your potential collaborator has an established track record of implementing their own projects and can write effectively and efficiently. If you are building your collaboration from scratch, a history of first author publications and/or successful

grant applications can be a good indicator of these characteristics. Existing international relationships of your mentors or research team can also offer a good starting point for considering potential collaborators.

Connect

In the absence of a letter of introduction from a senior colleague who has connections with the individual or group of interest, compose one for yourself. The letter should explain briefly the focus of your program of research, the fact that you have been following their body of work, and that you are interested in discussing opportunities for future collaboration. The process is similar to connecting with potential graduate school mentors, internship or fellowship faculty, or potential employers.

Start Small

Not every collaboration will grow to be long lasting, and some are more fruitful than others. The extent to which your international collaborative efforts are rewarding is dependent on a variety of individual, group, and environmental factors. Like any partnership, beginning with small steps and gradually increasing investment is an effective strategy. Utilize technology such as video conferencing to demonstrate commitment to the partnership and increase the sense of “realness” of your work together before your scholarly products are completed. Excellent starting points include determining whether you will be attending any of the same professional meetings where you could co-author a poster or assemble a symposium. Collaborative manuscripts are also a strong choice for research productivity, particularly if you have readily available data and a clear, concise research question established.

Awareness of Cultural Differences

Inherent to any discussion of international collaboration is the influence of cross-cultural differences in (a) professional norms and their influence on the collaborative experience and (b) developing research questions and implementing joint research projects. Regarding the former, it is important to remember that academic activities are implemented differently in different countries. Collaborating investigators may have different expectations about time spent in and away from the office, willingness to engage in work-related activities outside office hours, importance placed on professional/organizational

hierarchy, and who is responsible for which tasks (e.g., regulatory approval, data sharing and analysis, and designating writing responsibilities for scholarly products). While some of these lessons are best, or only, learned through practice, it is worth learning about cultural norms before the level of investment in the partnership increases. This is particularly true for individuals considering partnering with individuals or groups who work in countries with more substantial cultural differences from the U.S. It is our experience that discussing these differences openly provides the most opportunity for adaptation.

Regarding the latter, issues such as sociopolitical context, involvement in civil and/or international conflict, government regulation of research, gender and cultural norms, and even geography will greatly influence some important aspects of collaboration. While that may initially seem obvious, we will contextualize based on our mutual interests in co-occurring posttraumatic stress, substance use disorders, and interpersonal violence. Despite many similarities in culture, language, and politics between the U.S. and Australia, some important differences have influenced our research activities. For example, the prevalence of different potentially traumatic exposures differ substantially between our countries, and the emphasis and resources devoted to PTSD research among specific populations is substantially different. Prevalence of different types of substance use also differ, possibly due in part to substances available and distributed at different rates in different parts of the world, the justice system responses to drug use and distribution, and to cultural views on use of different substances. Perhaps the most poignant example in our experience is the requirement in Australia for violence between adults to be reported and intervened upon in similar fashion to how child or elder abuse is dealt with in the U.S. Another important difference is that firearm possession/ownership is heavily restricted in Australia. This changes the implications of asking questions that are not only typical, but also essential, in the context of research and safety planning with PTSD and violence samples in the U.S. (e.g., the frequency, type, and severity of violence experiences). Essentially, the U.S. and Australian governments have different conceptualizations of adult interpersonal violence that trickled down to inform nearly every aspect of our research design and implementation.

Communicate Clearly

Simply put, international collaborations can be challenging. We have found that effective communication not only facilitates our productivity together, but also increases our professional autonomy at our respective institutions. Within our collaboration, we have been challenged to refocus on the topics that genuinely excite us and are related to national funding priorities, rather than on the most convenient topic. Our investment in the success of our partnership has also challenged us to be more assertive when an aspect of the project planning or collaboration is not meeting our needs well. In difficult situations, clear communication has been key to help us adapt and strengthen our collaborative relationships, which have acted as an additional source of productivity and facilitated our growth in becoming increasingly self-reliant at our respective institutions. Clear communication has also been valuable in expressing our appreciation for one another's work on shared projects as well as our partnership generally, which has reinforced the positive aspects of the collaborative relationship.

Anticipate Challenges

Our most substantial difficulties have arisen from (a) differences in institution closures and holiday schedules, (b) time zone differences, (c) differences in funding application deadlines that often influence our priorities, and (d) navigating regulatory approval processes across institutions. Without careful planning, patience, and compassion, it could be easy to lose momentum or grow resentful of perceived differences in commitment or work output. We schedule Skype meetings at least quarterly, and we account for time differences between our locations and agree to stay late or arrive early to facilitate those meetings.

Authorship

Authorship and leadership on professional products can be a sensitive issue, and is critical to navigate in any collaborative relationship. It is important to avoid agreeing to any arrangement that you feel uncomfortable with, and to allow yourself adequate time to think arrangements over before agreeing or proposing alternatives. Be assertive and clear during the initial planning stages. If it is important to you to lead a particular paper or project, make it known. We have found success through sharing a belief and trust that each of us not only wants the others to be as successful

individually as they can be, but that prosocial behaviors bolster the best interest of the collaboration.

Conclusions

In preparation of this narrative and our other scholarly products, we have taken time to reflect on the quality of our professional partnership. We have gained autonomy, confidence, and self-efficacy through this process, and we have become friends as well as professional colleagues. In summary, we encourage our early career colleagues to pursue international collaboration opportunities. In our experience, the investment is entirely worthwhile. We hope that the lessons we have drawn from our experiences will boost our ECR colleagues' confidence in building collaborations, and that together our international efforts will maximize improvements in mental health treatments and accessibility.

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- Correspondence to** Julianne C. Flanagan, Ph.D., 5 Charleston Center Drive, Suite 151, Charleston, South Carolina 29401; hellmuth@muscc.edu

----- President's New Researcher Award -----

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) 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.

SUBMISSION DEADLINE: August 3, 2015

Clinical Psychology at Liberal Arts Colleges SIG

Catherine B. Stroud, *Williams College*

Erin S. Sheets, *Colby College*

Josephine H. Shih, *Saint Joseph's University*

Casey A. Schofield, *Skidmore College*

Dara G. Friedman-Wheeler, *Goucher College*

THE MISSION OF THE CLINICAL PSYCHOLOGY at Liberal Arts Colleges SIG is to develop a community for clinical psychologists and trainees who share a commitment to the liberal arts model of undergraduate education. Our SIG aims to (a) increase awareness of the liberal arts career path; (b) facilitate communication and sharing of resources related to teaching, research and clinical practice within a liberal arts setting; and (c) provide support and professional networking opportunities for members at all levels of training. Currently, there are 40 members, including 29 faculty members, 3 postdocs, 4 graduate students, and 4 post-baccalaureate or undergraduate members.

Background

Our SIG began after 22 clinical psychology faculty from liberal arts colleges met at a Mellon 23 Collaborative Workshop designed to support and strengthen teaching, research and mentoring at liberal arts colleges.¹ Energized by the conference and our new connections, we discussed how to formalize the workshop group. Although most of us had attended ABCT conventions for years, we did not realize that there were so many “others like us” (i.e., liberal arts faculty) involved in ABCT. Thus, we formed the Clinical Psychology at Liberal Arts Colleges (CPLAC) SIG to build a home for current and future liberal arts college faculty within ABCT.

Goals of the CPLAC SIG

Awareness

Clinical scientist graduate programs often provide students with opportunities to gain understanding of academic career paths within research universities and medical schools, but liberal arts colleges are

rarely discussed. As such, we seek to raise awareness of the opportunities and challenges of building an academic career at a liberal arts institution, as well as the preparation needed for obtaining such a position. To do so, we have sponsored ABCT panels addressing these issues, such as “Doors Closing or Windows Opening? Forging an Academic Career at a Liberal Arts College,” presented in 2013 by four panelists at different stages of their academic careers (DiBartolo, Sheets, Schofield, & Becker, 2013). Moreover, we hope to gain a “spot at the table” on ABCT career panels that often do not include the liberal arts professor as one of the career opportunities for clinical psychologists. Finally, liberal arts faculty play a key role in preparing students for graduate school and developing future clinical scientists, particularly by mentoring undergraduate research projects. To draw attention to research conducted by liberal arts college undergraduates and faculty, we have created a CPLAC SIG seal (see Figure 1), to be used when our members present posters, symposia and panels at ABCT. We hope our ABCT colleagues at graduate training institutions take note of the excellent work our undergraduates are producing!

Teaching

Liberal arts colleges emphasize undergraduate education. In comparison to (most) research universities, these settings offer undergraduates small class sizes and close mentorship relationships with faculty, and there is an emphasis on effective undergraduate teaching for promotion decisions. Our SIG aims to facilitate communication and sharing of resources related to teaching, mentoring, and advising at the undergraduate level. Thus far, we have developed two ways to share

resources among members. First, SIG members can access syllabi, in-class activities, media and assignments on our website, as well as a list of the courses taught by all current members. Second, through our listserv, members can pose questions to the group (e.g., seeking fresh ideas for a short research paper assignment in Abnormal Psychology) and quickly receive resources from their colleagues. In addition to intra-SIG communication, we strive to share our pedagogical experiences with the broader ABCT community. For example, at ABCT's 2014 convention, five SIG members presented a panel on novel strategies for teaching CBT at the undergraduate level, providing classroom activities that could be employed across varied clinically oriented courses (MacDonald, Blomquist, Bodenlos, Lootens, & Markowitz, 2014). Many of the teaching resources provided by ABCT focus on graduate teaching; it is our hope that we can fill a niche by sharing resources for undergraduate teaching.

Research

Our SIG also aims to dispel the myth that a career at a liberal arts college brings an end to one's program of research. We are clinical scientists who remain committed to conducting research on psychopathology and its treatment. Similar to other institutions, liberal arts colleges provide internal resources for research and expect that faculty maintain productive labs. This work, however, comes with challenges in a liberal arts setting. For example, we rely on undergraduate research assistants to fill the shoes of graduate students. Undergraduates participate in all aspects of our work, taking on roles typical of graduate students, such as conducting interviews, recruiting and running research participants, project management and preparing manuscripts. There are also advantages to the liberal arts setting, including funding options specifically designed for teaching-focused institutions and/or focus on training undergraduates (e.g., NIH Academic Research Enhancement Award [AREA] Program [R15]). Given these challenges and opportunities, this SIG seeks to (a) provide a forum for members to communicate about issues

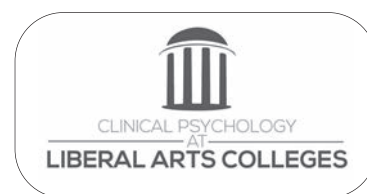


Figure 1. CPLAC SIG seal

¹Two Williams College faculty, Laurie Heatherington and Marlene Sandstrom, organized the conference, entitled “Clinical Psychology in the Liberal Arts Institution: Surviving and Thriving in the 21st Century.”

related to conducting research in liberal arts settings; (b) provide mentoring to junior faculty; and (c) foster collaborations among researchers at liberal arts colleges. In the short time we have been a SIG, several members have realized shared research interests, resulting in collaborations on research projects, grants, manuscripts and ABCT symposia.

Clinical Work

Unlike many other settings, clinical supervision and practice are not built into liberal arts college faculty positions. However, most of our faculty-level SIG members are licensed and maintain private practices and/or engage in clinical consulting work. Our group seeks to provide support for members engaged in clinical work of any form, with particular emphasis on the obstacles to launching and balancing a practice when this work is not built into your faculty position. To facilitate support and consultation, our website provides information about which members maintain practices and clinical resources.

Community

Although many of our activities and goals facilitate making connections within ABCT, we also explicitly strive to create a community for those with a commitment to the liberal arts model of education. In particular, we aim to provide support and professional networking opportunities for members, including clinical psychology graduate students and postdocs interested in faculty jobs at liberal arts colleges. In the future, our website will list job announcements for liberal arts colleges and will provide guidance on successfully applying to teaching-focused institutions.

Importantly, current undergraduates and recent alumni of liberal arts colleges have the opportunity to become more involved in our SIG by becoming the CPLAC SIG Undergraduate Representative. Undergraduates at liberal art colleges are also encouraged to submit their work to the SIG poster exposition. Each year one current undergraduate student is chosen for the CPLAC SIG Undergraduate Poster Award.² The winner receives a \$100 prize and has the opportunity to present his/her work during our annual SIG meeting. We also actively support our undergraduate alumni as they prepare for and apply to

graduate school. On our website, we have a database of available research coordinator positions as well as resources addressing common undergraduate questions about career options (e.g., What can you do with an M.S.W. versus a Clinical Ph.D.?) and graduate school applications (e.g., example cover letters, CVs, and interview questions).

Become a Member

As a group, we are thrilled with the community we have built in the 2 short years since establishing our SIG. Most important, we are proud there is now a home for clinical scientists who share a commitment to the liberal arts model of education. If you share our commitment or want to learn more, please join us. We welcome new members.

Membership is open to current undergraduates and liberal arts college alumni; graduate students and postdocs interested in pursuing a career at a liberal arts college; liberal arts college faculty; and liberal arts college enthusiasts. Membership is \$10 per year for faculty and \$5 for everyone else. Members gain access to the teaching, research, and clinical resources available on our website as well as the listserv. To become a member, please: (a) email us at cplacsig@gmail.com; or (b) sign up on our website (<http://cplac.org/>).

References

- DiBartolo, P., Sheets, E., Schofield, C.A. & Becker, C. (2013). *Doors closing or windows opening? Forging an academic career at a liberal arts college*. Panel presented at the Annual Meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.
- MacDonald, H., Blomquist, K., Bodenlos, J., Lootens, C. & Markowitz, S. (2014). *Enhancing the teaching of CBT: A multi-disciplinary perspective*. Panel presented at the Annual Meeting of the Association for Behavioral and Cognitive Therapies, Philadelphia, PA.

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Correspondence to Catherine B. Stroud, Ph.D., Williams College, Bronfman Science Center, 18 Hoxsey St, Williamstown, MA 01267.
Catherine.B.Stroud@williams.edu

²Past winners include: Jessica Fitts (Williams College), "Understanding the Development of Rumination: The Role of Mothers' Coping Suggestions;" and Yifat Levenstein (Lawrence University), "Eating Attitudes and Behaviors: A Cross Cultural Comparison."

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Babson, K.A., & Feldner, M. T. (2015). *Sleep and affect: Assessment, theory, and clinical implications*. New York: Academic Press

Jeffrey M. Lohr, *University of Arkansas, Fayetteville*

IN THE FOREWORD TO THIS EDITED BOOK, Edward Pace-Schott says, “*Sleep and Affect: Assessment, Theory, and Clinical Implications* provides the first comprehensive review of the emerging synthesis between the affective neurosciences and sleep psychology and medicine” (p. xiii). The quotation perfectly captures the substance of the book. It is comprehensive in that it contains a total of 21 chapters, wherein accomplished scholars from around the world cover separate but related topics. The chapters are organized into four different parts, some of which are divided further into sections. The first two parts provide for definitions of the central concepts and for research methods in addressing those concepts. Each of the chapters in these parts serve as primers and lay the groundwork for the subsequent chapters that elucidate the research that addresses the relationships between the concepts. The third part of the book is divided into sections on sleep and negative affect, sleep and positive affect, and sleep and affect among specific populations such as children, adolescents, and the elderly. Each of these chapters provides an overview of research in the area, including implications for treating problems related to sleep and affect. The section on negative affect provides the most extensive coverage of topics, where each chapter addresses the relationship of a particular kind of affect (e.g., anxiety, sleep paralysis, rumination) and reviews the research literature involving correlational, causal, and mediational mechanisms. The emphasis on negative affect accurately reflects the history of sleep research, where problems with sleep were often examined and treated as consequences of psychopathology characterized by negative affect, including disordered anxiety and mood. The section on positive affect is less extensive due to the relative paucity of research in this domain, but goes on to address the restorative and functional features that sleep plays in affect regulation. As this body of research is more recent in nature, some of the chapters in this section are relatively short, but in most cases, the authors make specific attempts to

address the direction of future research and clinical applications. The third section on special populations also includes a chapter relating sleep to the experience of pain. Though this chapter could have been included in the section on negative affect, it is one of the most conceptually complex chapters and serves as the entrée to chapters on special demographic populations. Readers can make their own decision about the order in which to access these topics. The fourth part of the book is an integrative synthesis by the book editors and serves as an excellent heuristic for research and application.

The reader will note that there is great diversity in the organization of the constituent chapters. The chapters in the section on negative affect seem to share a bit more coherence among them, but that is as it should be. The longer-term research literature has had time to address conceptual and research issues regarding negative affect and sleep dysregulation. The chapters on positive affect and special populations are based on a shorter history (with the exception of the pain chapter) and reveal those shorter histories in chapter content and organization.

As might be expected from the quotation in the foreword, this book is a reference volume and will surely see a second edition within a few years. As such, it should be on the bookshelf of any scholar who has had an interest in these two topics, and any student who is developing such interests. That said, the book (or at least specific chapters) could serve as required reading for (M.D. and Ph.D.) doctoral and postdoctoral courses that focus on the relationship of sleep and affect. In that regard, I found especially useful the primer chapters in Parts 1 and 2; Chapter 9 on sleep paralysis; Chapter 11 on sleep, sadness, and depression; Chapter 13 on sleep and resilience; Chapter 17 on pain and sleep; and Chapter 20 on sleep and the elderly. But that’s just me. This book provides a veritable menu of topics from which to choose in piquing one’s scholarly curiosity.

In addition to the value of individual chapters for targeted reading, the book as a whole provides a useful synthesis of concepts integral to understanding and studying sleep and affect. For example, Chapter 2 on Human Emotions discusses concepts related to the regulation of emotional experience, which is followed in Chapters 5 and 6 with detailed discussions of methods that can be employed in the laboratory to model and study emotion and sleep, including factors thought to influence emotional experience, such as emotion regulation. When the reader is subsequently provided an in-depth review of specific areas of inquiry, such as in Chapter 7 on links between fear and sleep problems, the convergence yields both the knowledge to understand the strengths and limitations of the work underlying current thinking about fear and sleep problems as well as the tools to conduct research that would uniquely advance understanding of links between fear and sleep problems. As such, the book is a resource for teachers that can be used at various levels to take students from being relatively unfamiliar with research on sleep and affect to a point where they could design and conduct sophisticated studies of a complex interplay between sleep and affect. It is, indeed, an area of inquiry ripe for investigation.

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Correspondence to Jeffrey M. Lohr, Ph.D., Emeritus Professor, Department of Psychological Science, University of Arkansas, Fayetteville, AR 72701; jlohr@uark.edu

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Candidates should send a letter of intent and a copy of their CV to Anne Marie Albano, Ph.D., Publications Coordinator, ABCT, 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008 or via email to teisler@abct.org

Candidates will be asked to prepare a vision letter in support of their candidacy. David Teisler, ABCT's Director of Communications, will provide you with more details on the selection process as well duties and responsibilities of the Editor. Letters of support or recommendation are discouraged. However, candidates should have secured the support of their institution.

Questions about the responsibilities and duties of the Editor or about the selection process can be directed to David Teisler at the above email address or, by phone, at (212) 647.1890.

Letters of intent MUST BE RECEIVED BY September 1, 2015.
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