the Behavior Therapist

Contents

President's Message

"So You Say You Are an Expert": False CBT Identity Harms Our Hard-Earned Gains

Dean McKay, *Fordham University*

Imagine for a moment that after a routine visit to your general practitioner (GP), it is revealed that you require minor surgery. Let's say, for the sake of this example, you need parathyroid surgery. The procedure can be done in a day-op center, recovery will take about a day, and the risks are minimal. Your GP does not personally know any of the named endocrine surgeons on your insurance plan, so you contact your carrier and they provide you the names of several doctors who indicate expertise in parathyroid surgery. You then call one of these professionals and discuss the findings from your GP. It is at this point the doctor says, "I am pretty sure I can do this. The parathyroid is in the neck region, right? It's been a while, but I watched this procedure once in the operating room, and enrolled in two continuing medical education workshops, and so I listed it as an area of expertise when I joined your insurance company as a provider."

If you are thinking that this hypothetical situation sounds ridiculous, you are absolutely correct, and it is intentionally so. The vetting process for surgeons by insurance companies is far more extensive, and it is unlikely our hypothetical doctor who has only a vague sense of the physical location of the parathyroid would even pass the state or provincial board exam, let alone

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be allowed on any insurance panel as an endocrine surgeon.

To be perfectly fair, requirements to join insurance panels vary by state and province. The medical professions are guided by numerous factors, including the listing of the specialty by the American Board of Medical Specialties (www.abms.org) and how each state or province regulates the practice of medicine. In this vein, there are recognized specialties, emerging specialties, and some idiosyncratic areas of expertise. Insurance companies rely on these and other sources in determining how a medical professional meets the standards for being on its panels.

Consider now our own profession. For readers who are on insurance panels, summon to memory for a moment how you were "vetted" for your expertise in cognitive-behavior therapy (CBT) as a listed specialty. If you recall that the primary vetting mechanism was completion of a checklist and providing evidence of general licensure or certification, well now you get the picture of the problem at hand. Our profession, at this stage of development, has a vast array of areas of expertise, with some recognized as specialties. Clinicians all over the land have come to the brilliant marketing realization that advertising that one conducts CBT is good for business because more and more consumers demand it. However, very often these professionals do not know what the approach entails.[1] It does not matter that many of these practitioners would be hard pressed to distinguish exposure from relaxation, or tell the difference between cognitive disputation and an argument they had with a deli counter clerk. The mere fact that they said they practice CBT is often sufficient for insurance companies to list one as a qualified provider. Remember how ridiculous my hypothetical surgeon situation seemed? Despite the fact that Cognitive and Behavioral Psychology is a recognized specialty by the Council of Specialties of Professional Psychology (www.cospp.org), our profession has my aforementioned hypothetical situation as its reality. This could be due to the relatively recent development of evidence-based approaches to practice,

and the lack of consensus on what constitutes established procedures. Indeed, it is only this year that substantive clinical practice guidelines were published for psychologists (Hollon et al., 2014). Until these rigorous practice guidelines—or other criteria for sound clinical practice—are adopted, the current situation leaves consumers in the lurch when it comes to finding genuinely expert providers.

As you might imagine, the fact that insurance companies have not developed a system for determining the bona fide credentials for providers in listing a specialization as rich and detailed as CBT represents a significant threat to our procedure in the marketplace. For the vast majority of truly expert practitioners, the fact of one's expertise is only earned through reputation in repeated demonstration of actually conducting the procedures. There are also some ways to distinguish oneself as an expert in our communities, such as through lectures, workshops, and publications. For a small segment of practitioners such as psychologists, one can also seek out board certification. However, board certification is generally optional. Indeed, in researching this column, I was surprised to learn that board certification is optional for many medical specialties (http://www.abms.org/About_Board_Certification/means.aspx).

The Threat

In many communities, consumers have come to recognize that, typically, CBT is the treatment of choice for psychiatric conditions. What will happen to this hard-earned reputation, established through decades of careful research, not to mention the challenge to the psychodynamic hegemony, if the profession is choked with self-declared experts who in fact know little about CBT, conduct treatment that has the patina of CBT to it (i.e., administer only relaxation training, or very crude cognitive disputation), or implement approaches that really are part of other disproven therapeutic traditions, but with the clinician calling it CBT? How long before the public grows skeptical of the efficacy of CBT?

Ethical and Legal Risks of Self-Identifying as an Expert

Declaring oneself an expert can carry with it specific hazards. Geraghty and Michmerhuizen (2013) note several potential legal pitfalls for lawyers who might declare expertise in an area, whether it is a recognized area or not. Among these are ethical prohibitions regarding legitimacy of scope of practice and the reasonable expectation of higher levels of care. While at the time of this writing I could not locate any cases where any practitioner was sued for misrepresenting himself or herself as possessing adequate CBT training when they did not, it is clearly a potential hazard for practitioners who do so.

Consumer Implications

Engaging in ineffectual treatment has some serious implications. It has been noted that the profession lacks clear consensus on what constitutes harmful psychotherapy (Dmidjian & Hollon, 2010). While clinicians of any stripe could potentially make inaccurate clinical decisions that lead to worsening of symptoms, there is another pernicious aspect to having a problem for which CBT is clearly indicated and failing to receive it from someone claiming it as a specialization. Notably, a practitioner improperly claiming CBT expertise could very easily deliver an inert treatment.[2] Dmidjian and Hollon (2010) identify inert therapies as harmful due to lost resources and other opportunity costs (e.g., lost motivation for treatment, a sense that intervention will not be helpful with other providers) that delay efficacious treatment delivery, demoralizes the client, and is associated with a loss of resources. In the specific instance of CBT, it has the added adverse effect of implying to the client that this approach is not effective, at least not in this individual instance. This can in turn lead to a further delay in the client seeking a bona fide CBT practitioner.

Surprise and Reform

Far greater attention has been paid to the delivery of mental health services for a wide range of psychiatric problems. As more high-profile crimes take place involving missed opportunities by the mental health profession, the need for better determination of who is an expert and who is not takes on far greater urgency. With the implementation of the Affordable Care Act (ACA), the need for effective mental health service delivery is also of great importance. It is therefore a surprise (at least to this writer) that insurance companies have not

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[1] Note that ABCT has excellent public education materials, including how to determine the expertise of a prospective provider, and this has been a great benefit to consumers. However, there are very large swaths of the population that remain unsure or unaware of how to "interview" prospective providers to establish their bona fides regarding CBT expertise.

[2] Whether there are in fact any inert psychosocial treatments can be called into question, given that a case has been made for the benefit of the therapeutic relationship (i.e., Norcross, 2011). While this basic ingredient of treatment is not being argued, an inert treatment could be construed as failing to provide any benefit above and beyond that expected from the minimal quality therapeutic interaction.

identified this as a serious risk that warrants reform. The challenge, and it is an enormous one, is that insurance companies openly have fiduciary responsibilities to their shareholders rather than an obligation to ensure quality care for patients. Requiring board certification or other demonstrable levels of expertise would crater a system that purports to attempt to contain costs by implying equivalence among providers.

A related matter for our consideration is whether CBT should in fact be the approach that falls in the category of expertise for which insurance companies verify. This would require the assistance of actuaries or other professionals qualified to demonstrate that this is, indeed, a strategic cost-containment strategy in addition to having the benefit of delivering better care to patients. Perhaps a more desirable goal would be that clinicians identify (with a suitable vetting process) that at least in general empirically based interventions are practiced. While a large number of empirically supported treatments are CBT in nature, we do not have the market cornered on this count. Perhaps it would be satisfactory to know that clients can be assured that treatment will at least be grounded in science. I think that any member of ABCT could support this while concurrently advancing our own methods of intervention.

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As this marks my last President's column, I would like to take this opportunity to thank the membership for entrusting me with leading our outstanding organization for the past year. It has truly been an honor, and also one of the most satisfactory and enjoyable professional services I've had in my career. I've met many people whose work I admire, worked with many professionals who are truly dedicated to the mission of ABCT, and throughout the year I frequently stopped myself to consider how fortunate I was to be in the company of such innovative and thoughtful scholars. Finally, I would like to thank our central office staff for making this an enriching professional experience and of course for their incredible commitment to the everyday operations of ABCT. To all the members of the organization, I hope that I have served ABCT in ways that met or exceeded your expectations, and look forward to seeing you all at our annual convention in the years to come.

Thanks to Jonathan Hoffman, Brett Deacon, and Jonathan Abramowitz for comments on a prior draft of this column.

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Beyond Psychologist Training: CBT Education for Psychiatry Residents

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VA Boston Healthcare System and Boston University School of Medicine

Cindy J. Aaronson, *Icahn School of Medicine at Mount Sinai*

Justin Hill, *VA Boston Healthcare System and Boston University School of Medicine*

Training psychiatry residents in cognitive-behavioral therapies (CBTs) is a valuable endeavor that offers exciting possibilities and complex challenges. Within mental health, psychiatry residents approach CBT theory and practice from a perspective distinct from that of psychology trainees. Despite the importance of CBT training within psychiatry, formal discussion of training approaches, assessment, challenges, and benchmarks is limited (cf. Accreditation Council for Graduate Medical Education [ACGME] & American Board of Psychiatry and Neurology [ABPN], 2013; Sudak, 2009; Sudak, Beck, & Gracely, 2002; Sudak, Beck & Wright, 2003; Sudak & Goldberg, 2012, for notable exceptions). For example, the ACGME (2007) guidelines offer little specific direction to residency programs for training to competence in CBT, and the more recent Psychiatry Milestone Project (ACGME & ABPN, 2013) provides important, but broad, benchmarks across the range of required psychotherapies. In addition, only a handful of publications explicitly discuss potential training guidelines and specific learning assessments for CBT training (e.g., Friedberg, Mahr, & Mahr, 2010; Karlin & Cross, 2014; Sudak et al., 2003; Weingardt, Cucciare, Bellotti, & Lai, 2009). Adding to these challenges, the influence of different educational backgrounds on the development of competence in CBTs is substantially understudied. Though data from many clinical trials support the abilities of psychiatrists to deliver CBTs (e.g., Elkin et al., 1989; Keller et al., 2000; Turkington & Kingdon, 2000), some suggest that the time parameters of typical psychiatrist appointments may challenge effective implementation of more intensive CBTs in conventional psychiatry practice (e.g., Franklin et al., 2011).

The authors are clinical educators (four psychologists and one social worker) with close to 30 years combined experience training psychiatry residents in CBT, across various educational formats including seminars, clinical didactics, and supervision. Here, we will address considerations for training psychiatry residents in CBT, including: (a) trainee educational context and future practice, (b) potential challenges in transdisciplinary CBT training, (c) the definition of competence and its assessment, and (d) the importance of (and questions regarding) transdisciplinary CBT training.

Psychiatry Residents' Educational Context and Future Practice: Factors That Influence CBT Training

Educational Background

Notably, psychiatry residents have very little psychotherapy experience (Wallerstein, 1991), receiving minimal experiences beyond observation during medical school, and not beginning psychotherapy practice in residency until their second or third postgraduate year (PGY 2 or PGY 3). Over the past few decades, there has been a move in the field of psychiatry to develop and emphasize training in psychopharmacology (Glick et al., 2001). As such, the first years of psychiatry training most often are focused on medicine and psychopharmacological interventions (Mohl et al., 1990; Sudak, 2009). To complicate matters further, psychiatry residents frequently are introduced to the three required psychotherapy competencies (i.e., psychodynamic, supportive, and CBT; ACGME, 2007; ACGME & ABPN, 2013; Gastelum et al., 2011) simultaneously. As such, they are in the very challenging position of learning distinct approaches and clinical "languages" at the same time, with a limited foundation in broad psychotherapy skills.

Thus, a key consideration when training psychiatry residents in CBTs is the educational context in which they are learning. Against a backdrop of medical school and medically oriented residency training, psychiatry residents' focus may be more biologically oriented and less attuned to the full range of psychosocial factors that may influence psychopathology (and, by extension, CBT; Glick et al., 2001; Mohl et al., 1990). Consistent with this, psychiatry residents' case presentations tend to be more symptom-focused and succinct, and less focused on conceptual issues or contextual/life circumstances. This approach seems distinct from that of psychology trainees, who tend to be more focused on psychosocial factors and context, but can be less concise and (particularly early in training) may have trouble discerning key clinical points from more extraneous ones.

History of Supervision

Experiences in supervision also may have important effects on training psychiatry residents in CBT. The focus of clinical supervision in the earlier years of residency training is often characterized by a focus on psychobiology, psychopharmacology, and efficiency in case presentations (Mohl et al., 1990). With such a broad supervisory agenda, early clinical supervisors may not have the luxury of devoting substantial amounts of time to more nuanced clinician-patient interactions, including basic communication exchanges as well as more complex therapeutic interactions (CBT-oriented or otherwise). The culture of supervision for psychiatry residents also may diverge from that of psychology trainees in important ways. For example, psychiatry residents are likely accustomed to a rounding format, in which attending supervisor(s) and multiple trainees review clinical cases in a group setting that typically involves both the presence of the patient and a series of questions posed to the trainees by the supervisor(s). This format translates into greater formality, pressure to demonstrate competence and knowledge quickly, minimize vulnerabilities or gaps in understanding, and quickly present the best possible version of themselves as clinicians. Admission of knowledge gaps may be seen as a sign of weakness or professional incompetence (e.g., Mavis, Sousa, Lipscomb, & Rappley, 2014; White et al., 2011). These formative professional experiences and values may translate into less candid case presentations, and less awareness and admission of relevant personal reactions to

patients, as well as minimal communication outside of formal meetings with supervisors or other attendings.

Relevance of CBT to a Psychiatrist's Future Practice

The way(s) in which CBT will play a role in a psychiatrist's career is often different from those of a psychologist. Relatively little care provided by psychiatrists is done so in the context of a solo private practice (17% to 29%, where more time is available for psychotherapy), compared to the proportion of care delivered in publicly funded settings (44% to 50%, in which the differential between the salaries of psychiatrists and those of psychologists or social workers is often connected to the former group's ability to prescribe medications; Griffith, 2001; Guze, 1998; Ranz et al.). This pattern also appears to be becoming more pronounced (Ranz et al., 2006). In addition, in a hospital environment, psychiatrists typically have 15- to 30-minute follow-up appointments, approximately 2 to 4 times per year (once patients are stable), with a substantial proportion of that time devoted to evaluation of medication effects (Regestein, 2000). As such, job parameters limit the extent to which many psychiatrists in these settings can implement full CBT interventions (Mojtabai & Olfson, 2008; Wilk, West, Rae, & Regier, 2006). Thus, training in extremely brief CBT-consistent interventions that can be implemented within these abbreviated time parameters, such as motivational interviewing and problem solving (Arkowitz, Westra, Miller, & Rollnick, 2008), low-intensity CBTs (Bennett-Levy et al., 2010), and single-contact acceptance-based interventions (Robinson, Gould, & Strosahl, 2010), may be most relevant to psychiatry residents' future practice. In addition, attention to the ways in which more elaborated CBT protocols may be distilled down to key principles and applied in small doses is important.

Potential Influence on Dissemination and Interprofessional Collaboration

Also pertinent to this discussion is the relevance of CBT training for psychiatry residents as future collaborators and advocates. That is, even in an extreme scenario, in which a psychiatry resident's career is fully focused on psychopharmacology, successful interdisciplinary team collaboration will be facilitated by a basic understanding of CBT principles and interventions. A psychiatrist facile with the details of CBTs can advocate for such interventions for his/her patients, interact with patients in a conceptually consistent way, and provide support to patients working within this framework. Ultimately, this can facilitate continuity and coordination of care, dissemination of evidence-based psychotherapies, and patient-centered services.

Summary and Recommendations

Psychiatry residents come to CBT training with a learning history and clinical perspective distinct from psychology or social work trainees. In addition, the role that CBT may play in their future careers is likely to be different from nonphysician clinicians. Still, CBT training can play an important role in treatment dissemination and interdisciplinary collaboration. With these contextual factors and possible career paths in mind, we offer the following goals when training psychiatry residents in CBT:

- Integrate a foundation of basic therapy knowledge and skills as part of CBT training.

- Introduce to, and highlight for, residents the broad literature on CBT (mechanisms and outcomes), and the value of knowledge in clinical research to evaluate treatment outcomes more broadly.

- Explicitly highlight differences and similarities across therapeutic approaches.

- Provide multiple domains in which to learn and rehearse CBT case conceptualization and skills (e.g., clinical didactics, interactive seminars, skills labs, and supervision for individual and group CBTs).

- Include modeling of CBT, inviting residents to observe experienced clinicians conducting CBT (e.g., staff members, senior CBT trainees, or professional DVDs).

- Include direct observation of residents' CBT application through coleading groups and/or audio/visual recording and review.

- Encourage professional vulnerability. Reduce the value of impression management within supervision (while maintaining professionalism).

- Maximize integration across trainees of different disciplines to learn from each others' strengths and address relative weaknesses.

- Keep salient the most likely ways in which psychiatry residents will use CBT
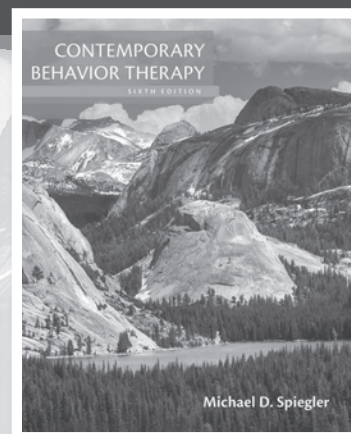
in their future career. To maximize applicability, emphasize case conceptualization and understanding of broad principles to enhance residents' ability to flexibly apply CBT interventions.

Potential Challenges in CBT Training for Psychiatry Residents

There may be practical, conceptual, and professional development challenges when training psychiatry residents in CBT.

Practical Considerations

Practically, educators have to contend with on-call schedules and associated limits on work hours, as well as vacation time (which tends to be more extensive than that of psychology trainees and can be difficult to absorb in rotations that are often part-time and last less than a full year). Not only do these logistical details mean that a given resident may be off rotation for stretches of time (e.g., periodically 2 to 3 weeks at a time), it also means that group discussions are often missing a subset of residents. Perhaps most important, these gaps in attendance can disrupt patient care. In addition, from a purely educational perspective, outside didactics speakers may be reluctant to devote time to a small (or "incomplete") group of residents, and there is increased need to be mindful of communication so that information is conveyed to residents repeatedly to ensure the full cohort has been exposed to it.

Conceptual Challenges

Conceptually, based in part on differences in learning history and context (noted above), psychiatry residents may hold specific perspectives regarding the kind of patient who is "good" or "appropriate" for CBT. Despite evidence to the contrary (e.g., Khoury, Lecomte, Gaudiano, & Paquin, 2013; Rathod & Turkington, 2005; Rector & Beck, 2001; Sensky et al., 2000; Thorn et al., 2011), psychiatry residents frequently believe that a patient must have certain minimal levels of intelligence, education, and/or functioning to engage in (let alone benefit from) CBT (Sudak, 2009). This, coupled with understandable anxiety about learning and applying a new psychotherapy approach, can combine to produce avoidance of CBT applications (Lovell, 2002). Residents also may view CBT as mechanical, impersonal, and dismissive of interpersonal process in the therapy, increasing their reluctance to adopt CBT interventions.

In addition, psychiatry residents typically face the challenging task of learning psychodynamic, CBT, and supportive psychotherapies simultaneously during their training. Even in an environment in which all trainees and supervisors are accepting and respectful of all three approaches, confusion and misunderstanding can flourish. Unfortunately, personal preferences and cohort effects in supervisors also can create situations in which a resident "gets in trouble" for implementing "the wrong" treatment approach, i.e., that which is different from his/her supervisor (Carmin & Albano, 2003; Sudak, 2009).

Professional Context

In addition to educational context, psychiatry residents generally function in a professional context that includes other educational experiences (e.g., journal reading, conference attendance) and a broader hospital structure.

Psychiatry residents read different journals and attend different conferences from psychology trainees. For example, of the 1,265 professional attendees at the 2013 meeting of the Association for Behavioral and Cognitive Therapies (ABCT), only 3% were M.D.s (personal communication, M. E. Brown, ABCT Director of Education and Meeting Services, April 21, 2014).

In addition, many hospital supervisory hierarchies are organized with physicians at the helm. Thus, the experience of supervision by a nonphysician may be unusual and/or uncomfortable for some psychiatry residents. Related to this, there may be variability in initial levels of comfort and familiarity with (and respect for) nonphysician supervisors. Third, compared to psychology trainees, psychiatry residents have an additional therapeutic tool at their disposal—psychopharmacology. This may serve as an important tool with which to complement CBT, or an alternate option that may be perceived by the resident as "easier" or more familiar, if CBT is found to be difficult and/or treatment effects are slower to emerge.

Summary and Recommendations

A number of challenges can influence CBT training for psychiatry residents. Residents experience demands on their time that are often different from nonphysician trainees, and operate in an environment that includes biological, as well as psychosocial, interventions. Based on this context, psychiatry residents may have strong beliefs about which patients are appropriate for CBT, and may experience discomfort outside a medical model (including supervision by a nonphysician). To address these challenges when training psychiatry residents in CBT, we offer the following suggestions:

- Use data to inform case conceptualization and treatment discussions.
- Encourage residents to be fully informed of various intervention options.
- Be a thesaurus—work to translate universal concepts and principles into the various terms associated with distinct theoretical orientations.
- Be respectful of other attendings/supervisors.
- Encourage additional learning by providing information about local and national meetings and trainings in CBTs.
- Be mindful of, and explicitly discuss, interpersonal dynamics within the therapeutic relationship (as well as other "process issues") in CBT.

Competence and Its Assessment

The question of clinical competence is extremely broad and complex (cf. Epstein & Hundert, 2002; Newman, 2013; Shaw & Dobson, 1988). ACGME guidelines require that psychiatry residents demonstrate "competence" in CBT, but don't define it (ACGME, 2007). The more recent Psychiatry Milestone Project (ACGME & ABPN, 2013) provides a broad framework for evaluating psychotherapy competence, as it addresses the range of psychiatry competencies including, but not limited to, CBT. However, this framework provides limited specific recommendations regarding evaluation of CBT-specific content (e.g., "…capacity to generate a case formulation, and to demonstrate techniques of the intervention, including behavior change, skills acquisition, and addressing cognitive distortions"; p. 17). It also does not offer concrete guidance regarding empirically based methods of evaluation in CBT competence.

Use of Learning Models to Help Us Define Competence and Guide Assessment

Though a full discussion of the topic is beyond the scope of this article, it is worth noting that many models exist in the educational literature that address phases and types of knowledge acquisition. These models can serve as guides, directing clinical educators to key aspects of learning that are important for assessment of psychiatry resi-

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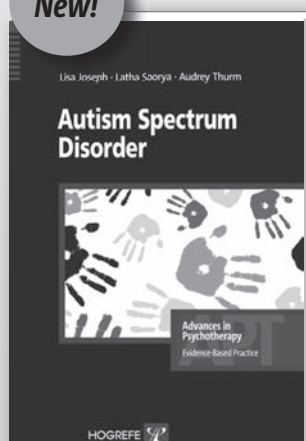
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Autism Spectrum Disorder

Volume 29
Sept. 2014, vi + 100 pp.
ISBN 978-0-88937-404-1

This book is a straightforward yet authoritative guide to effective diagnosis and empirically supported treatments for autism spectrum disorder (ASD).

The book starts by reviewing DSM-5 and ICD-10 diagnostic criteria, current theories and models, and prevalence rates for ASD and related neurodevelopmental disorders. It explains the differences between the disorders and changes in criteria and names (such as Asperger's syndrome, childhood and atypical autism, pervasive developmental disorder, Rett's syndrome) over time. It then provides clear guidance on evaluation of ASD and comorbidities, with practical outlines and examples to guide practice.

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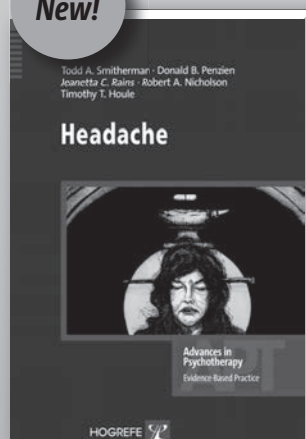
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Headache

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Headache

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Nov. 2014, xiv + 112 pp.
ISBN 978-0-88937-328-0

This book describes the conceptualization, assessment, and evidence-based behavioral treatment of migraine and tension-type headache – two of the world's most common medical conditions, and also frequent, highly disabling comorbidities among psychiatric patients.

Headache disorders at their core are neurobiological phenomena, but numerous behavioral factors play an integral role in their onset and maintenance – and many providers are unfamiliar with how to work effectively with these patients to ensure optimal outcomes.

This book, the first major work on behavioral treatment of headache in over 20 years, provides much-needed help: An overview of relevant psychological factors and the behavioral conceptualization of headache is followed by a step-by-step, manual-type guide to implementing behavioral interventions within clinical practice settings. Mental health practitioners and trainees and other healthcare professionals who want to improve their headache patients' outcomes by supplementing routine medical treatment with empirically supported behavioral strategies will find this book invaluable.

"For clinicians and others who seek a single authoritative, clearly presented, and fully referenced discussion of how to manage tension-type headache and migraine".
John F. Rothrock, MD, Director, Professor and Chair, Department of Clinical Neurosciences, University of Nevada School of Medicine, Reno, NV

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dents (and other trainees) during their training rotation(s).

A quick review of the literature yields a number of information perspectives. For example, according to Bloom's Taxonomy (Bloom, 1956), students transition through six cognitive stages or domains (knowledge, comprehension, application, analysis, synthesis, and evaluation) as they transition from more concrete to abstract knowledge. In contrast, Kirkpatrick's Four-Level Evaluation Model (Kirkpatrick, 1967) addresses evaluation of the learning process based on the following: how favorably trainees react to the content and instruction (reaction), how well the trainees learn the knowledge/skills (learning), the extent to which the training creates behavioral changes (behavior), and the extent to which training achieves the intended influence on outcomes (results). In the 1980s, Dreyfus's model outlined a perspective on skill acquisition and professional skill development, suggesting that students pass through five distinct stages: novice, competence, proficiency, expertise, and mastery (Dreyfus & Dreyfus, 1980). The Dreyfus model has been increasingly used as the basis for describing and assessing the learning and development of medical trainees. Finally, Miller's Model of Clinical Competence (cf. Miller, 1990; Wass, Van der Vleuten, Shatzer, & Jones, 2001) identified a pyramid of learning, with a base of cognitive competence ("knows" and "knows how") that should transition to behavioral competence ("shows how" and "does"). More recently, this model has been elaborated, with the additional dimensions of attitudes, skills, and knowledge (cf. Mehay & Burns, 2009).

Taken together, these models suggest that mere self-report of learning is insufficient for assessment of psychiatry residents' acquisition of learning, let alone clinical competence. They point to the need for a richer evaluation of residents' (and other trainees') behavioral demonstration of learning.

Assessment of Competence

Although there is no broad, standardized, empirically based evaluation of psychiatry resident (or other clinical) competence, learning models such as those mentioned above, and the literatures on both psychiatry and psychology training (cf. ACGME, 2007; ACGME & ABPN, 2013; Newman, 2013; Plakun, Sudak, & Goldberg, 2009; Sudak, 2009; Sudak et al., 2003; Swing, 2007), are consistent in their focus on cog-

nitive, behavioral, and efficacy-based assessment. Ideally then, assessment of CBT learning (and clinical competence) would include (a) tests of content knowledge (e.g., multiple choice, essay, and/or oral exams), (b) performance-based evaluations (e.g., role-playing, direct observation of clinical care), and (c) outcomes-based analysis (e.g., reduction of patient symptoms, improvements in functioning, over expected periods of time; ACGME, 2007; Wass et al., 2001). Unfortunately, budget, time, and staffing constraints can represent substantial obstacles to implementation of the full range of assessment. Educators need to consider formal versus informal evaluation of key learning, based on the parameters of their training experience and educational infrastructure.

Summary and Recommendations

Though learning models are useful to inform targets and modalities of assessment among psychiatry residents (and other clinical trainees), practical constraints such as budgets and staffing often limit such assessments. Still, even when resources are constrained, some limited assessment is likely possible. Based on these models of competence and assessment, we offer the following suggestions when training psychiatry residents in CBT:

- Incorporate direct observation of CBT (e.g., coleading a group with the resident, audio/video recording).
- Include multimethod assessment of multiple learning domains (e.g., knowledge acquisition, attitudes and confidence related to CBT, behavioral application of CBT, and efficacy of intervention), such as: broad self-report measures (e.g., Cognitive Therapy Awareness Scale, Wright et al., 2002; cf. Karlin, Brown, Trockel, Cunning, Zeiss, & Taylor, 2012), formal observation-based, rating scales (e.g., Cognitive Therapy Rating Scale, Young & Beck, 2009), and patient measures of symptoms and/or functioning.
- Consider level of training and time training in psychotherapy (both broadly and CBT specifically) when setting expectations and completing evaluations.

The Value (and Questions) Regarding Transdisciplinary CBT Training

A number of questions can be raised about the value of training psychiatry residents in CBTs. As outlined above, there are questions regarding how much residents will use (and/or be compensated for) these skills in their future clinical practice. In addition, questions may exist regarding psychiatrist adherence and competence to CBT principles and interventions, given a distinct perspective on mental health intervention that includes psychopharmacology. Psychologist and/or social work groups may even question whether training psychiatrists in CBTs somehow undermines the specialty training (or market value) of the former disciplines.

Most broadly, we would highlight that ABCT's mission statement indicates that, "The Association for Behavioral and Cognitive Therapies is a multidisciplinary organization committed to the advancement of scientific approaches to the understanding and improvement of human functioning…" This language is mirrored in the mission statement of the organization's Academic Training Committee (ATC), and includes with it an explicit assertion that ABCT is tasked with training and disseminating evidence-based therapies across disciplines. In addition to this philosophical perspective, there is a practical one. ACGME requires training in CBT as part of psychiatry residency training. Whether or not psychologists or social workers choose to participate in the process, psychiatrists will be trained in CBT. One goal of this paper is to highlight the important role that ABCT can have in this undertaking, and hopefully increase the likelihood that ABCT members (across all disciplines) will embrace this educational endeavor. We hope that raising this issue might also stimulate closer empirical study of a variety of essential questions, such as:

1. To what extent does educational background (e.g., psychiatry training, psychology training, social work training, etc.) influence adherence and competence to CBT principles and interventions?

2. To what extent might CBT knowledge change clinical referral patterns among psychiatrists (or other mental health professionals)?

3. To what extent might delivery of brief (or low-intensity; cf. Bennett-Levy et al., 2010) CBTs by psychiatrists influence patient perceptions of CBTs

(and/or their likelihood of pursuing more intensive CBT interventions)?

Given the many challenges and complexities associated with training psychiatry residents (or any trainees) in CBT, it can be easy to forget (or question) its importance, and the rewards associated with it. With that in mind, we offer our personal endorsement for this endeavor.

Psychiatry residents typically come to CBT training eager to gain skills in psychotherapy broadly, and CBT skills in particular (Lanouette et al., 2011). As mentioned above, medical school and the first two postgraduate training years are generally not focused in these areas, and residents are often aware of this need in their training (Mohl, 1990; Sudak, 2009). Thus, incremental gains in their knowledge and skills tend to be bigger than those of psychology interns or postdoctoral fellows, who have already spent many years learning psychotherapy. Along with this larger incremental learning, there is often greater potential for this type of training to produce qualitative shifts in perspective, approach to clinical cases, and understanding regarding what other mental health professionals are doing. For example, seeing a psychiatry resident who was previously focused only on symptom reduction broaden his/her perspective to understand and integrate exposure and/or acceptance-based approaches into his/her schema of psychotherapy is an immensely gratifying educational experience. As educators, when we work closely with residents, we also benefit by expanding our knowledge of psychopharmacology, seeing (and contributing to) the integration of psychotherapy and psychopharmacology, and gaining a richer appreciation for the perspectives of our psychiatrist colleagues. This cross-pollination between psychology and psychiatry seems crucial for interdisciplinary collaborative practice and (in at least a small way) dissemination of evidence-based psychotherapies.

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Science Forum

Recruitment and Retention of Low-Income, Urban Participants in a Longitudinal Study: Recognizing and Strengthening Participants' Motivations

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Longitudinal designs allow researchers to measure relationships between variables over time, draw strong causal inferences, and control for a variety of threats to internal validity. To optimize external validity, sampling needs to be representative, so successful recruitment is essential. Also, when study design requires ongoing participant involvement, the ability to generalize findings relies on participant retention (Kazdin, 2003; Taris & Kompier, 2003). Unfortunately, recruiting and retaining participants often poses significant practical challenges. The personal and environmental stressors experienced by urban, socioeconomically disadvantaged populations compounds the usual challenges of eliciting high recruitment and retention rates. Therefore, longitudinal research with this population calls for an especially thorough and thoughtful approach (Qualls, 2002).

Although it is critical for researchers to address the specific logistic barriers that their participants need to overcome in the initial design phase of a project, investigators may further increase retention by understanding and addressing the diverse participant motivations to both enroll and maintain involvement in a study. Studies have shown that extrinsic motivators serve an important role in initially gaining participation in a given activity (Leonard et al., 2003); however, intrinsic motivations may be the determining factor to ongoing participation (Collins, Ellickson, Hays, & McCaffrey, 2000). By recognizing and strengthening participants' motivations throughout the course of their participation, researchers can optimize participant retention.

This paper was written within the context of a larger study on which the first three authors worked as research assistants (RAs), supervised by a Project Director (fourth author) and Principal Investigator (last author). After several years of recruiting, tracking, and following up with more than 1,000 primarily low-income, urban and minority participants, we developed an increased understanding of factors that led to successful recruitment and retention for this trial. The aim of this paper is to describe participants' initial reasons for participating in this longitudinal study and motivations for returning for follow-up appointments. This is not an empirical paper; instead, it is intended to provide researchers across diverse domains and settings with a valuable, "in the trenches" perspective on participant research-related motivations. Although this paper focuses on sharing the insights, tools, and techniques that resulted in our successful recruitment and retention, we hasten to add that ethical research practices, particularly voluntary participation and noncoercive practices, should always be of utmost priority to researchers.

The Parent Study

The goals of the parent study were to decrease sexual risk behavior among patients attending a publicly funded, walk-in Sexually Transmitted Infections (STI) clinic in a U.S. city (Carey et al., 2013, 2014), and to investigate assessment reactivity in the context of HIV prevention research (i.e., do detailed assessments, themselves, prompt risk reduction). To recruit participants, patients were called directly from the waiting room of the clinic to a private exam room and were screened for study eligibility. Informed, written consent was obtained

from interested patients. Participants then provided contact information, completed an Audio Computer Assisted Self-Interview (ACASI), and watched one of two behavioral health intervention videos. Total participation time for the research component of this baseline session averaged 1 hour. Participants then returned every 3 months over the course of the next year to complete another ACASI and to provide a urine sample that was screened for two common STIs. When it was time to return for follow-up assessment, a reminder letter was mailed and a hand-written, personalized note was included if the participant had been previously difficult to reach. Reminder phone calls for all participants were also made. Participants were compensated for the baseline assessment and each follow-up visit they attended, in order to offset lost wages, transportation, child care, or other expenses.

At the conclusion of the study, the recruitment rate (those who agreed among those eligible) was 77% and our retention rate at 1 year was 75%. These recruitment and retention rates compare favorably with the rates from other longitudinal studies conducted with urban, socioeconomically disadvantaged populations (Ahmed, Fowler & Toro, 2011; Dandona et al., 2013).

Barriers to Recruitment and Retention

To optimize participation, we needed to understand and address barriers that could impact patients' enthusiasm for initially joining or remaining in the study. Based on prior research in this setting (Carey et al., 2008, 2010), we knew that the most commonly reported barriers to recruitment included time constraints, inability to commit to follow-up assessments, and lack of interest in the study or research. The most common barriers to retention included a lack of reliable communication (e.g., no working phone), transient lifestyles, dependency on public transportation, inflexible work schedules, unexpected crises, and legal difficulties. Good rapport between participants and RAs encouraged communication of barriers and allowed the research team to help participants problem solve and overcome constraints.

Six Motivational Factors That Can Improve Participation

Observation and discussion among the team led us to identify six major factors that we believe contributed to participants' motivations to initially enroll in the study and return for follow-up visits: (1) structure of the study, (2) reimbursement for participation, (3) health-related benefits, (4) positive beliefs ("it's meant to be"), (5) altruistic motivation, and (6) interpersonal connection to the RAs. In the following, we discuss each factor and its impact on participant recruitment and retention.

1. Structure of the Study

Study format and design may play an important role in recruitment, retention, and overall participant satisfaction. The format of the current study was conducive to strong recruitment and retention rates.

Environment. Conducting studies with a respected community-based partner can help to increase participants' trust of the research (Leonard et al., 2003). The current study was conducted at a well-respected community clinic where all clinic staff members were well-informed about the project. We frequently updated the clinical staff regarding study progress, checked in with them about our impact on clinic flow, and recognized the priority of clinical care. As a result of these practices, the nursing, clinical, and administrative staff supported the study enthusiastically. The clinic facilities were originally designed to allow for research-related activities to occur in conjunction with clinic activities. As a result, the research team was able to develop a positive reputation in the community and improve participant recruitment and retention.

Privacy. For studies involving sensitive topics, it is important to recognize that patients may feel embarrassed about attending appointments and may have concerns about their privacy and the information that they share. In the current study, patients completed all study procedures in a private room. We also obtained a Federal Certificate of Confidentiality that assured participants that we would protect their data, even if a subpoena were issued. These factors likely contributed to the authenticity of participant responses, improved data quality, and increased comfort in participating. Additionally, the ACASI allowed participants the safety and freedom to report on thoughts, feelings, and behaviors via a computer interface—a neutral and confidential "third party" (Hallowell et al., 2010). These procedures likely increased participant retention in our study.

Informative, brief, and consistent contact with research staff. Patients' initial contact with research staff was informative, respectful, and interactive. Through the informed consent process, eligible patients learned what to expect during study visits and were encouraged to ask questions. Dixon-Woods and Tarrant (2009) have noted that the informed consent process plays an important role in shaping rapport and establishing trust. The trust that is built during the initial visit may encourage participants to feel invested in the project and to return for subsequent follow-ups.

Furthermore, follow-up visits were designed to be brief and convenient. Participants were allowed to "drop in" to the clinic (i.e., no appointment necessary) and complete their follow-up visit anytime within a 4-week window. Once they arrived, participants were called to a private room to begin their follow-up visit within minutes of entering the clinic, enabling participants to complete their visits quickly and conveying respect for their time. Additionally, each follow-up visit was structured identically. The consistency and predictability of follow-up visits was reassuring for participants and likely contributed to their return.

Informal information delivery. Informal methods of relaying health information may be an effective way to communicate with participants, particularly African American participants (Musa, Schulz, Harris, Silverman, & Thomas, 2009). Musa et al. (2009) found that informal sources of health information, such as church leaders and family members, are more trusted by African Americans, and may contribute to higher usage of preventive health services than when the information is delivered by formal sources. In our study, an "edutainment" video viewed by participants at their initial clinic visit (after their baseline assessment) was designed to informally communicate information and reflect the health-related experiences and challenges commonly reported by patients (Senn, Scott-Sheldon, Seward, Wright, & Carey, 2011). Participants found the video enjoyable, informative, and relevant (cf. Carey et al., 2013), which contributed to a positive initial experience and motivation to return.

2. Reimbursement for Participation

Studies have shown that reimbursement for participation can increase motivation for participating in research (Singer & Bossarte, 2006). Many participants in the current study reported that the monetary reimbursement motivated their initial decision to participate, as it served as an immediate reward and showed that their time was valued by the team. Providing compensation minimizes some of the barriers to retention,

such as child-care or transportation, faced by socioeconomically disadvantaged groups and can contribute to higher recruitment and retention rates in longitudinal studies. Monetary compensation can also help to overcome reservations about participation in research studies that involve sensitive topics, such as sexual risk behavior (Carey et al., 2005; Singer & Bossarte).

Intrinsic motivations with long-term benefits, however, may emerge over time and are often essential to retention. Thus, financial compensation may serve as a token of the researchers' genuine appreciation for a participant's time, effort, and contribution to a program, while increasing the participant's commitment to the goals of a project.

3. Health-Related Benefits

Health intervention studies often include health-related screening in order to aid in evaluating the program. Additionally, regular screening may increase participants' sense of control over their health risks due to renewed awareness, focus, knowledge, and continuous support surrounding the issue. For example, in a cancer risk study, Hallowell et al. (2010) found that some individuals participated because they believed they were proactively managing their risks of developing cancer. In the current study, some participants acknowledged their renewed confidence in independently managing their risks of acquiring an STI, or other risky health behaviors following participation. Some participants were motivated to participate for health-related reasons—to improve the health of themselves, their loved ones, or their community.

Benefiting the participant. Participants were screened for two prevalent STIs (gonorrhea, chlamydia) at each follow-up visit. Many participants appreciated that the study included STI testing every 3 months, as it served as a reminder to get tested. Such regular testing raised awareness of health risks and may have led participants to increase their awareness of their own health behaviors and the associated risks; consequently, this may have motivated participation and any subsequent behavior change.

Benefiting the health of loved ones. Numerous participants proudly stated that they chose to participate to benefit the health of those they love. Smith et al. (2007) found that research that addresses personal or family medical problems increases participation. Some participants in the current study saw the project as an opportunity to gain valuable knowledge and become a role model for their loved ones. Others reported that they wanted to be healthier in order to ensure that they are alive and able to care for loved ones.

Benefiting the community and future generations. Other participants thought their involvement contributed to a larger, community cause and contributed to the goal of regular STI testing to decrease rates of STIs and HIV for future generations. By engaging in the study project, these participants believed that they could help improve the health and wellbeing of their community.

4. Positive Beliefs

Another common motivational source was participants' religious beliefs or life philosophy. A number of participants referenced the view that fate or a higher power led them to be invited to participate in the study. Some said that their participation in the study, or even their decision to come into the clinic, was "meant to be" and attributed it to religious control, fate, or destiny. African Americans might be more likely to endorse higher beliefs in religious control than Caucasians (Schieman, 2010). Ultimately, it is important to recognize that such beliefs may serve as strong motivational factors and consequently influence participant recruitment and retention.

5. Altruism

Hallowell et al. (2010) found that some individuals participate in research to "repay" the organization or benefit their community, to contribute to advancements in the field (often in order to help affected loved ones), and to promote the cycle of altruistic behaviors. Such acts of altruism, or acting to promote the well-being of others (Mattis et al., 2008), encourages both initial agreement at baseline and serves as an important motivation for retention.

Societal benefits. Some individuals participate because they understand the benefits that research can have on society. Smith et al. (2007) found that when research is directly relevant to African Americans or their community, participation rates are higher. Some participants in the current study were active members of their communities and sought out opportunities to help. Many reported that they planned to share the knowledge gained with other organizations in order to improve related services in the community.

An opportunity to contribute. Some women, especially those who do not have power in their sexual relationships, viewed the study as an empowering opportunity to have their voices heard. Some men, recently released from prison, viewed their decision to participate as a way to repay society. Leonard et al. (2003) noted that people are generally happier to participate in research if it could help others. A few participants voiced that they did not need payment for participating in the project, as they had already been "paid" through the receipt of services (i.e., assessment, intervention, and extra attention) associated with the project. Therefore, they chose to donate their compensation to a local nonprofit organization.

6. Interpersonal Connection to the Research Assistants

Lastly, establishing a personal connection and rapport with participants is essential to encouraging initial participation and maintaining high retention for most longitudinal studies. Many participants in the current study noted that they planned to follow through with their commitment to the researchers and the project, whereas others also mentioned that they looked forward to returning and sharing their recent life events. As trust is built, participants become more comfortable discussing sensitive topics, an issue that is particularly relevant to underprivileged populations (Leonard et al., 2003).

Many patients initially expressed some reservations about participating in research, perhaps because of a lack of exposure to research, misunderstanding, or even negative associations with research. Both perceived and actual disparities in health care between African American and Caucasian Americans may fuel this distrust and contribute to negative associations, leading African Americans to feel that research is intended to benefit Caucasians (Musa et al., 2009; Smith et al., 2007) or, worse, that research participation is harmful (cf. Tuskegee Study; Katz et al., 2008). Additionally, African Americans' personal and historical experiences with racism may contribute to decreased interpersonal trust in researchers, in some cases leading to attrition (Kneipp, Lutz, & Means, 2009; Musa et al.). Recognizing and proactively addressing these real concerns about medical research is critical to maintaining participant motivation (Musa et al.; Smith et al.).

Building rapport with participants. Building rapport begins with the initial interaction with the participant during the screening and consent process. The RAs projected confidence and passion for the project and its purpose and throughout the screening and informed consent process,

they encouraged questions and remained warm, professional, and nonjudgmental—contributing to a safe and trusting environment. Leonard et al. (2003) found that showing warmth and expressing an interest in the lives of participants can generate interest in the project. Consequently, participants may be more motivated to return.

A consistent research team over the course of the project helped to build rapport between participants and the RAs. RAs were genuinely interested in participants' lives, and they recognized participants, recalled their names, and remembered details of prior conversations. Active listening, a nonjudgmental approach, and an attitude of respect helped to further build participant trust. Following each visit, participants were provided with a counseling and resource list, as well as specific referrals (e.g., for mental health or substance use treatment) when indicated, demonstrating our willingness to assist participants with areas of their lives beyond sexual health. Motivated, goal-oriented staff has been found to be integral to successful data collection and the overall success of a project (Leonard et al., 2003). Finally, the mutual trust between participants and research staff helps participants to view the research as a collaboration of efforts in which they have a critical role.

Recommendations

The six motivational themes discussed in this paper were influential in overcoming barriers (e.g., transportation, distrust of the medical community, other obligations), thereby facilitating recruitment and maximizing retention in the research (Gorelick et al., 1998; Qualls, 2002). Based on our experiences, we offer the following suggestions to aid other research teams:

- *Structure of the study*—Consider carefully the location (e.g., a comfortable and private setting), mode of data collection, and nature and format of information provided because all will influence recruitment and retention. Try to keep study visits informative, brief, and consistent to aid retention.

- *Participant reimbursement*—Provide compensation for time and effort; compensation can be a key motivator, especially for initial participation with low-income populations.

- *Health-related benefits*—Identify health-related benefits of participation. Research that positively impacts participants' health (e.g., through regular

health screening) can aid recruitment and retention.

- *Fate and higher power* ("it's meant to be")—Understand that some participants will be motivated to participate in research due to a "higher power" or "fate." Allowing participants to discuss these thoughts with the research team can help build rapport and a connection to the study. (However, we do not advise investigators to formally identify this as a motive when recruiting participants.)

- *Altruistic motivations*—Recognize participants' personal connections to a project and their potential desire to help their friends, family, and the community. These motivations to participate can be validated and praised.

- *Interpersonal connection to the RAs*—Build trust with participants. Rapport between study staff and participants can allay uncertainty, distrust, and misconceptions about research, and open the door to discussing barriers to retention.

As a research team, we were involved in all aspects of recruitment, participant tracking, and follow-up. The retention rates observed in this large trial reflect all six of the motivations discussed above. Ultimately, it was the heartwarming stories of the impact that study participation had on participants' lives that strengthened our initial passion and provided the inspiration to prepare this summary.

Elsewhere we provide extensive details regarding the research design, measurement approach, and outcomes for this trial (Carey et al., 2013, 2014). Here, our goal has been to share our front-line experiences so that other research teams will be able to strengthen their research and improve recruitment and retention rates critical to longitudinal work with urban, low-income populations.

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Clinical Forum

What Does Bad Supervision Look Like?

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Less than 20% of clinical psychology supervisors have received formal training in clinical supervision (Peak, Nussbaum, & Tindell, 2002), and estimates indicate that only 34% of training programs offer coursework or practicum in supervision (Scott, Ingram, Vitanza, & Smith, 2000). This is a serious deficit, given that clinical supervision is the most frequent means by which we teach the core competencies required to become a clinical psychologist and that feedback on supervision can improve its effectiveness (Milne & James, 2002). Previous approaches to clinical supervision assumed that if one was trained in the applied skills of clinical psychology (i.e., assessment and psychotherapy), one could easily teach those skills to trainees. However, most supervisors, without training, base their provision of supervision upon their own experiences as a trainee, thus perpetuating these experiences (sometimes without question) onto trainees. This may or may not translate into competent supervision. Contrary to what some might expect, the act of providing supervision does not, in and of itself, increase supervisory proficiency (Watkins, 1992). Furthermore, as Ladany (2004) notes, supervisors who do not receive training reach their potential more slowly than those who do receive training.

Our purpose is to briefly outline global characteristics of "bad" supervision. We consider bad supervision to be that which leads to one or more of the following outcomes: limited learning for the trainee, potential harm to the trainee, providing subpar care for clients, and restricted professional growth of the supervisor. For more specific and detailed models of inadequate and harmful supervision, we recommend readers consult Ellis et al. (2014). Our points are based, in part, upon Ladany's (2004) article, specifically the subsection "What Are Some of the Worst Things a Supervisor Can Do?" (p. 6). However, here we provide an updated and expanded review of a bad supervision, and conclude with recommendations to address these potential challenges as a clinical supervisor.

One criticism of this approach might be that it is overly negative. Why not focus on the positive provision of clinical supervision, rather than discussing the characteristics of bad supervision? First, bad supervision occurs at concerning rates. In a survey of 363 trainees, Ellis and colleagues (2014) found that 93% of supervisees were experiencing inadequate supervision (e.g., "Supervisor does not listen") at the time of study; 35.3% reported experiencing harmful supervision (e.g., "Supervisor has threat-

ened supervisee physically"). Second, all supervisors are capable of providing bad supervision at times. For example, many clinical supervisors work in contexts that provide inadequate time for supervision. In one survey of practicum sites, 24% of sites reported insufficient trainee meeting time (Hatcher, Wise, Grus, Mangione, & Emmons, 2012). This problem points to systemic issues such as staffing concerns. The same survey reported that most practicum sites employ four or fewer clinical psychologists, with most sites having only one or two. In addition, as Norcross and Guy (2007) note, many psychologists work at or above our total capacity and experience large caseloads and insufficient work time, all of which can lead to stress and burnout. Almost a third of therapists, for example, experience burnout and depression serious enough to interfere with their work (Wood, Klein, Cross, Lammers, & Elliot, 1985). Unfortunately, such stress and burnout can lead to impairment and improper behavior (Renjilian & Stites, 2002), even among the best clinical psychologists. Thus, knowing the indicators of bad supervision is important for all psychologists, and we agree with Stucky, Bush, and Donders (2011) that ongoing reflection and being open-minded to continued development are important defining characteristics of good supervisors.

Bad Supervision Has No Theoretical Model

One problem with the lack of pervasive formal training in clinical supervision is that it is "likely that supervisors' behaviors are based on implicit models of supervision, pulled from their experiences as a supervisee . . ." (Falendar & Shafrankse, 2004, p. 7). Without models, supervisors perpetuate their own experiences, which can become problematic when one's own supervision was inadequate, disorganized, or even abusive. As Bernard and Goodyear (2004) note, the provision of supervision involves multiple sources of information (e.g., experiences of the client, the supervisee, the supervisor, assessment data, and the plethora of interactions between these sources), which can quickly become complicated. Supervisors are then called upon to make decisions and negotiate this complexity. Just as a theoretical orientation allows us to organize, make sense of, and predict client behavior, a model of supervision can provide us with a theoretical framework from which to approach this complicated clinical skill. That is, a supervision orientation pro-

vides a model of how trainees best learn and thus informs supervision "intervention" strategies. For example, both cognitive behavioral supervision and therapy emphasize learned behavior. Supervisors utilizing this model focus on teaching appropriate, behaviorally identifiable skills and extinguishing inappropriate skills, employing principles of learning (Boyd, 1978). They utilize agenda setting, Socratic questioning, and challenging supervisee cognitions (Bernard & Goodyear, 2009). The alternative (working from no planned theoretical model, by the "seat-of-the-pants"; Blocher, 1983) is reactive rather than proactive, and can be ambiguous for both the supervisor and trainee. In fact, a "learn[ing] by doing" approach is often associated with a negative supervision experience for the trainee (Stucky et al., 2011, p. 745).

Bad Supervision Is Interpersonally Uncomfortable

The working alliance is one of the most crucial components of supervision and it is related to both the quality and satisfaction of supervision (Livni, Crowe, & Gonsalvez, 2012). In one study, bad relationships between supervisors and trainees, in addition to issues related to supervision tasks and responsibilities, accounted for the greatest number of negative supervisory events (Ramos-Sanchez et al., 2002). These events included personality conflicts, differences of opinion, communication difficulties, and the supervisor being perceived as overly critical, judgmental, unsupportive, and disrespectful. A poor working alliance is associated with a host of negative outcomes, such as shame, loss of confidence, and leaving the profession, in extreme cases (O'Donovan, Halford, & Walters, 2011; Ramos-Sanchez et al., 2002). Most concerning is the fact that in an uncomfortable supervisory relationship, trainees might avoid disclosure of important information, such as clinical errors and difficulties. In fact, 39.9% of sampled supervisees, in one study, reported failing to inform supervisors of perceived clinical errors at a moderate to high frequency (Yourman & Farber, 1996). Not only does this cost the supervisor an important opportunity to provide critical feedback, it places client care (an important purpose of supervision) at risk.

Uncomfortable supervisory alliances might be the result of several factors. First, the inherent power differential within the supervisory relationship may prevent students from expressing their dissatisfaction, particularly because students are in the vul-

nerable position of being evaluated (Stucky et al., 2011). Second, difficult supervisory relationships often use a more authoritarian style (Allen, Szollos, & Williams, 1986), or at the other extreme, use an unstructured, laissez-faire supervisory attitude, sometimes to the point of neglect (Allen et al., 1986). Third, while challenging a supervisee is an important aspect of supervision (e.g., inviting self-reflection, providing alternate perspectives or opinions), a heavy reliance on this approach may be experienced as oppressive and threatening. In contrast, if a supervisee is not sufficiently challenged, then difficult ethical dilemmas or other complex situations may be downplayed or ignored (Pickvance, 1997).

Bad Supervision Does Not Include Difficult Feedback

Evaluating and providing feedback to supervisees is one of the most important components of clinical supervision. In a study of supervisor ethical violations (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999), 33% of ethical violations that participants reported were related to evaluation of performance. Providing critical feedback may be "antithetical to supervisor interpersonal preferences" and run "counter to being nonjudgmental and supportive" (Ladany, 2004, p. 8), which are often requisite skills for provision of other clinical services (i.e., assessment and intervention). Supervisors might convince themselves to be lenient, avoid, or inflate evaluations for a variety of reasons (see Falendar & Shafranske, 2004, for further discussion), including interpersonal discomfort, inexperience, and potential institutional repercussions. Unfortunately, this difficulty on behalf of the supervisor might only serve to generate fear of evaluation in the trainee (Gray, Ladany, Walker, & Ancis, 2001).

Bad Supervision Does Not Include Timely Feedback

In addition, bad supervision does not utilize timely feedback. For example, supervisors might avoid providing feedback until forced to do so in a summative manner (i.e., providing feedback on formal evaluations at the end of a practicum placement). This may occur for a number of reasons. Supervisors might see ongoing evaluation as hindering a supportive working alliance with trainees, or they might see evaluation as punitive, rather than as an opportunity for learning. Most important, supervisors have likely never been trained in

how to provide formative (i.e., ongoing) critical feedback. Supervisors are thus likely to feel anxious at providing feedback. Unfortunately, not providing timely constructive feedback might only serve to compound a trainee's difficulties with certain areas of skill and might exacerbate a difficult interpersonal situation at summative evaluation time. In addition, as Ladany, Mori, and Mehr (2013) note, not providing formative feedback might contribute to trainee anxiety, as many supervisees are suspicious of entirely positive feedback. In a survey of trainees' complaints about inadequate supervision, some trainees reported receiving no feedback whatsoever (Ladany, Ellis, & Friedlander, 1999)!

Bad Supervision Ignores Diversity

Problems related to ethics, legal, and multicultural issues are one of the most common domains of negative supervisory events (Ramos-Sanchez et al., 2002). In one study, approximately half (56%) of the student sample reported their supervisors lacked multicultural competence in general, but also in addressing international students' language barriers and understanding cultural issues that influenced the supervisory relationship (Wong, Wong, & Ishiyama, 2013). Exploring diversity as it relates to the supervisor-supervisee relationship is regarded as an important factor to consider (Fernando, 2013). For example, age or level of training differences between the supervisor and the trainee may affect work attitudes, commitment, the rate at which supervisees learn, performance ratings, satisfaction, sense of self-efficacy, and supervisee motivation. There is also some indication that supervisees are negatively affected by their supervisors' unwillingness or discomfort in discussing racial issues. In some cases, supervisors provided poor advice for handling racial dynamics in the workplace, which had a negative effect on supervisees, such as increased psychological distress (Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010). Furthermore, there is some suggestion that bad supervision may adhere to cultural stereotypes, using broad and overinclusive categories to guide their clinical practice (Seo, 2010; Wong et al., 2013).

Recommendations

Obtain Formal Training in Supervision

Loganbill and Hardy (1983) recommend that training in clinical supervision consist of (a) theoretical content, (b) simulated experiences, and (c) in vivo practice.

However, we recognize that these opportunities might be difficult to obtain for busy, practicing clinicians. We encourage clinicians to seek workshop opportunities when available. For example, many preconference workshops, including those by ABCT, often include didactic work on clinical supervision. Clinicians can also conduct independent reading on the process of competent clinical supervision (e.g., Bernard & Goodyear, 2009; Falendar & Shakfrankse, 2004), form peer supervision groups focused on professional development as a clinical supervisor, or subscribe to supervision-focused journals such as *The Clinical Supervisor*, *Training and Education in Professional Psychology*, and *Counselor Education and Supervision*.

Develop a Model of Supervision

As previously discussed, developing a model of supervision allows the clinical supervisor to (a) direct the course of supervision, (b) provide a framework that will inform what type of feedback to give to a supervisee, (c) set supervisee goals, (d) create a shared language with the supervisee, and (e) allow the supervisor to be proactive rather than reactive. It provides a framework for how trainees are expected to learn. However, supervisors should also be flexible with their application of their model of supervision. Subscribing to a model provides a base from which we can adapt to meet individual trainee needs, similar to individual case formulation in psychotherapy that allows us to "flexibly meet the unique needs of the patient at hand . . . [and] guide the therapist's decision making" (Persons, 2008, p. 1). Multiple supervision orientations exist, many based upon theoretical orientations to clinical work that psychologists will already be familiar with. Bernard and Goodyear (2009) provide an excellent overview of commonly used models of supervision.

Set Goals and Expectations

Beginning the supervisory relationship with an explanation of what supervision will entail (e.g., style, frequency) may quell fears on the part of the trainee and may serve to prevent miscommunication later on. A novice trainee might not understand what to expect in supervision. Supervision contracts might be useful in this regard as they provide the trainee with explicit information regarding the supervisor's model of supervision; delineate roles and responsibilities; grievance policy and due process; how to contact the supervisor; legal and

ethical issues (i.e., trainees informing clients they are being supervised, issues pertaining to confidentiality); and the training plan for the student, which contains specific and operationalized goals (i.e., how many intakes they will observe, what types of cases they will see; see Thomas, 2007, for a review). Creating a list of mutually agreed upon goals for the duration of the training period provides structure, clarifies expectations, provides direction for supervision, and informs the supervisors regarding the content of feedback.

Be Willing to Provide Difficult Feedback

Providing constructive feedback about difficult topics (e.g., interpersonal dynamics, professional comportment, unethical or inappropriate behavior) is one of the most challenging tasks for many clinical supervisors. However, we have a responsibility to both our trainees and our profession to provide the feedback necessary for our supervisees to develop into competent clinical psychologists; we must not shirk this responsibility, despite the discomfort that is often involved. Learning to receive constructive feedback is also a core skill for trainees (for a guide to receiving feedback, see Stone & Heen, 2014). A supervisory environment where the supervisee feels comfortable receiving feedback allows trainees to move beyond worrying about criticism to focus on making the most of supervision time and receiving valuable feedback on performance (Ekstein & Wallerstein, 1972).

Chur-Hansen and McLean (2006) detail principles of providing formative feedback to supervisees, which include providing frequent, specific, and balanced feedback (to both correct mistakes and build a student's confidence by positively reinforcing their strengths) that is based on observed behavior. Ideally, formative feedback should occur soon after the behavior has been observed and should be tied to the performance, not the individual. We add that feedback should contain specific information for how the student can improve problem areas. Competency benchmarks may facilitate the provision of specific feedback, inform supervisors of how to move a student from one developmental level to another, and overcome resistance to providing negative feedback by making the supervision process more objective while providing a common language among supervisors and students with which to communicate. As laid out by Fouad et al. (2009), benchmarks establish core competencies for various levels of trainee development (i.e., practicum, in-

ternship, and entry to practice) with each level containing trainee outcomes that provide operational definitions and behavioral anchors of expected skills. This model, in combination with goal setting at the outset of supervision, will form the basis of feedback. We encourage supervisors to seek assistance and consultation from peers when needed to practice and develop these skills. For example, supervisors can role-play providing the feedback with a trusted colleague, or consult with a colleague or peer supervision regarding the content and tone of the intended feedback.

Provide Regular and Ongoing Feedback

Another important component of clinical supervision is providing regular and ongoing feedback (i.e., formative feedback) instead of waiting until the final summative evaluation period (i.e., at the end of the practicum placement). This provides supervisees with sufficient time to respond and change as a result of ongoing feedback, and reduces overall trainee anxiety regarding receiving such commentary. We echo the opinion of Bernard and Goodyear (2004): "If all has gone well within supervision, a final summative review should contain no surprises for the supervised. In other words, the summative review should be the culmination of evaluation, not the beginning of it" (p. 35).

Create a Positive Interpersonal Environment

A positive working alliance is associated with supervisee satisfaction and positive client outcomes (Callahan, Almstrom, Swift, Borja, & Heath, 2009). Supervisor-related factors associated with a good alliance include staying focused within the supervision session, appropriate use of self-disclosure, challenging the supervisee effectively, providing a balance of negative and positive feedback (Bucky, Marques, Daly, Alley, & Karp, 2010), facilitating the supervisee's autonomy and self-direction (Ladany et al., 2013), being tolerant of mistakes, respectful, and creating an atmosphere of safety when discussing supervisees' weaknesses (Allen, et al., 1986). Other therapy-related skills such as active listening, reflection of feelings, and expressing empathy may also facilitate a strong relationship (Ladany et al., 2013). We encourage supervisors to remain focused on engaging in these behaviors, to seek their own supervision when difficult interpersonal dynamics arise with a trainee, and routinely discuss the interpersonal dynamics of the supervisory relationship with your supervisees.

Be Aware of the Potential Influence of Diversity Issues

Much of the literature speaks of diversity issues within supervision as pertaining to helping the supervisee develop appropriate culturally sensitive conceptualizations of clients and managing possible countertransference within the psychotherapeutic setting (Falender & Shafranske, 2004). Supervisors must also be aware of their own biases and identify cultural, ethnic, and other diversity-related issues that may affect psychological services as a foundational competence in supervision. While doing so, they must also help trainees become more aware and work through their potential biases, which might influence client care (Stucky et al., 2011). We also encourage supervisors to engage in self-reflection to determine whether they hold any biases regarding age, gender identity, racial identity, sexual orientation, or education (i.e., the school or type of degree the trainee is pursuing) related to the supervisee. If so, peer consultation or supervision is advised, as is ongoing self-monitoring to minimize interference with professional functioning. Recognition and discussion of cultural and racial issues as they pertain to the supervisory relationship is related to a positive alliance (Gatmon et al., 2001; Ladany, Brittan-Powell, & Pannu, 1997).

Be Developmentally Appropriate

Similar to being flexible within one's model, good supervisors are able to adjust their approach based on the unique needs and characteristics of their trainee. Students come to supervision with varying levels of experiences and skills, and rigidly adhering to a predetermined series of experiences or procedures may negatively impact the alliance and limit the growth of the trainee. Ways of avoiding this pitfall are to include a self-assessment of skills at the outset of supervision to determine the student's skill level, work collaboratively with the supervisee, and receive ongoing feedback about the style of supervision. Along those lines, given that students at earlier stages of their training tend to have weaker relationships with their supervisors, more attention should be paid to establishing and fostering an alliance to ensure negative supervisory events do not occur (Ramos-Sanchez et al., 2002). Checking in with the supervisee to determine if he or she feels supported, working to establish trust, and actively advocating for trainees will be useful in this regard. That is, regular open conversations between the supervisee and supervisor regarding their work and learning styles can help avoid difficulties. For further information, Bernard and Goodyear (2009) include an overview of developmental models of supervision.

Be Open to Feedback and Growth as a Supervisor

According to surveys of doctoral students, good supervisors are flexible, open to feedback from their students, and receptive to alternative suggestions (Allen et al., 1986; Wong et al., 2013). If supervisors do not explicitly request feedback from their students, they might miss an opportunity to receive constructive criticism and make adjustments accordingly. It is also essential to use this feedback in a way that allows the supervisee to feel heard and respected. Good supervision also involves systematic monitoring and adjusting one's own supervision as the situation requires and uses the supervisees' feedback to enhance reflective practice. As such, supervision might be truly bidirectional and ripe with opportunity for both parties to mutually learn from one another. However, supervisees may be hesitant to provide constructive feedback to their supervisor due to the inherent power differential within the relationship (O'Donovan, Dyck, & Bain, 2001). Research regarding medical residents' evaluations of faculty indicate that anonymous feedback might be more accurate, and that privacy is reported a barrier to nonanonymous feedback (Afonso, Cardozo, Mascarenhas, Aranha, & Shah, 2005). Providing supervisees an opportunity to provide anonymous feedback or feedback after the completion of their placement (i.e., the evaluative period) may offset such reservations. This option may be particularly useful within the context of bad or even harmful supervision. Although there are numerous questionnaires available online, unfortunately many of them have not yet been published or validated. Nevertheless, a comprehensive list of supervisor assessment tools is available online (http://supervision.yale.edu/resources/117365_Tools_Assess_Supervisors.pdf), which provides examples of mechanisms for feedback administered during and after the evaluative period has ended. Anonymous feedback could also be collected online, using a system similar to the Research Student Feedback Survey, for evaluation of research supervision, developed by Lee and McKenzie (2011).

Make Time for Supervision

High-quality supervision requires a commitment of time that can be difficult for busy clinicians to manage. In at least one study, time spent in supervision was correlated with overall greater satisfaction with supervision, a stronger interpersonal alliance, more perceived supervision effectiveness, and better supervision evaluations (Livni et al., 2012). This also includes time to prepare for supervision, complete paperwork, completion of trainee observation, conducting role-plays, modeling skills and techniques, and taking time to explain concepts and rationales for assessment and treatment, all of which are associated with positive supervisee outcomes (Wong et al., 2013). If supervision is a voluntary professional activity, we advise psychologists to decline to provide it if they do not have sufficient time to dedicate to the process. If supervision is an assigned job requirement, we advise psychologists to make supervision decisions that allow them to maximize the quality and efficiency of their supervision (e.g., considering group and/or peer supervision, if warranted). Furthermore, as both individual professionals and as a field we should advocate for adequate time for clinical supervision to our employers and institutions we work for. This might require persistent education to administrators and institutions regarding the time and effort involved in providing competent supervision. We hope that as clinical supervision becomes a more standardized component of graduate training, expectations regarding adequate supervision time will become a more normative part of the culture of clinical psychology.

Conclusion

Given that supervision plays a pivotal role in clinician development (Steven, Goodyear, & Robertson, 1998), it is important to provide the field with standards and training. If we would not allow our graduates to practice other core competencies (e.g., using an IQ test) without training, why are we permitting them to practice clinical supervision without teaching them how to do it? Fortunately, clinical supervision is increasingly being recognized as a clinical skill in its own right. Furthermore, supervisor training has been shown to be effective (Milne, Sheikh, Pattison, & Wilkinson, 2011). In conclusion, we encourage clinical supervisors to reflect upon their skills, to obtain training whenever possible, and to continue developing as a clinical supervisor.

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Lighter Side

CBTers Assemble!
Episode Last?[1]
"The CBT/AT Strikes Back!"

Jonathan Hoffman, *Neurobehavioral Institute*

Dean McKay, *Fordham University*

Natch, we knew it all the time. Could anyone of even marginally normative mentation think a little ruse from another psychological association could fool your absurdly sagacious Cognitive-Behavior Therapy/Action Team (CBT/AT), any more than Carlo Rizzi could bamboozle Michael Corleone? No, not this crew! Our extensive training in mindful awareness of functional motives and intrusive ideation has rendered us uniquely skilled in evaluating the expected consequences of behaviors emitted by the superpowered beings that enter our clinic, albeit under the guise of seeking "treatment" (One of them, a rather misguided shapeshifter, was quite literally a wolf in sheep's clothing . . . like we weren't going to see through that one!). As our devoted readers well know, in Episode First we recounted how the CBT/AT received an "urgent" tweet from S. avering that he was seeking help for "a friend" and that The Watcher, a superbeing with impeccable observational credibility (though we would be remiss to note that, lacking opportunities for honing his interpersonal aptitudes, his social adjustment is at best rudimentary), had referred him. This began a marked uptick in our caseload of superheroes (e.g., one charmingly befuddled Dr. Banner, who turned out to be a MacGuffin if ever there was one) and the like—as described in parsimonious detail in Episodes Next and More—a statistical anomaly that, of course, might easily and erroneously be relegated to "noise" within the context of our previously described Big Bang–like expansion of theoretical influence and catchment area. But certainly not by practitioners such as yours truly, for whom the "dark art" of signal detection theory is de rigueur.

We decided to "play dumb," a time-honored stratagem within our profession that, like our prescience in understanding the implanted motives of the poor, victimized superbeings, comes all too naturally for clinicians of our ilk. Unfortunately our then-intern had to shoulder the brunt of our grandmasterish ploy when she found herself physically and metaphysically overmatched

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[1]Pardon the redundancy, by now our steadfast followers should be well aware that offerings in this series are most suitable for cognoscenti familiar with straddling the profound dialectic of higher-order philosophical hermeneutics and Comic-Con tropes. Nonetheless, the editorial policies of *tBT* require this declaimer, and we at the CBT/AT are nothing if not scrupulously mindful of the myriad sensitivities of the ABCT membership-at-large.

by the hyperpowered participants in her therapy group. Yes, she wound up unprofessionally fleeing the most highly coveted internship "match" of all, but we must trust that contributing to the preservation of our noble monopsony, however unwittingly, was well worth the sacrifice she will never know she made. (This, by the way, was not the first time interns have been justifiably and quite ethically sacrificed on the alter of psychological science, but that tale is for another day . . . really, they should take at least a modicum of responsibility for reading the [very] small print in their contracts, especially the part about exemptions from informed consent when the welfare of their professional homelands are at stake. Sorta explains some of those one-sided insurance panel contracts many of them will no doubt sign further down their professional roads, dunnit?)

Our new trainee, Intern Tasha, was another plot twist. No, it wasn't her advanced martial arts skills or haute Lululemon-like work attire that was the tip-off; it was more that she never rolled her eyes when we told her fascinating anecdotes about when we were in training or kvetched about the amount of her stipend—awfully fishy behavior for a clinical intern, wouldn't you say? Besides, despite her highly unorthodox methods, boy was she effective with her caseload![2]

So, what mischief might be afoot?

Well, this is hardly your CBT/AT's first rodeo. We've seen our share of "friendly fire" referrals before. Usually, they start something like this:

"Hi, I know we haven't spoken for a while, but I have a great case that is right up your alley . . . really special and deserving person. I said that you could assist them much better than I possibly could."

This transparent gambit is invariably followed by a hasty, "oops, running late for a session, catch up more about this soon, let's have lunch, gotta go." Next, the to-be-referred calls, awkwardly stating that they were sent by one of our colleagues who instructed them that signing a consent form to get background information from the former therapist would be "contratherapeutic." In the future said referrer will diligently avoid eye contact with us when sighted at professional conferences. Really not cool, but we have come to expect this and can't blame them. I mean, who but the CBT/AT has the redecorating budget to treat these superbeings? They require only the slightest anxiety trigger to detonate preposterous rage reactions, which are even worse when they bring their supervillain nemeses to sessions unannounced to work through their "communications issues." (Yes, superheroes and supervillains are as prone to self-defeating relationships as the rest of us.) Moreover, it is extremely difficult to retain a caseload of mortals who might be in the waiting room and be suddenly subjected to having to tolerate the ensuing wanton destruction of their erstwhile "safe place." The only reason there are not more complaints to the licensing authorities regarding these tantrums is the propensity for the superbeings to "undo" their childish mischief by taking selfies with the innocent bystander nonsuperpowered patients.

Hmmm. Might someone be trying to overrun the CBT/AT with URCs,[3] namely protocol-busting superheroes and even more Axis 2 compromised supervillains? And if so, toward what nefarious end?

Another question: S. says The Watcher referred him but where is the evidence? After all, who's watching this Watchman? Does he even own a smartphone with texting capabilities?

We sense our dear readers scratching their heads. Luckily, this is mere child's play for your CBT/AT! We haven't binge watched all of those *CSI* episodes for naught! Thus, it took but a nonce for us to discern—pardon the expression—the "latent content" hiding in plain sight behind all of these shenanigans. Underestimate the CBT/AT at your peril! As you will learn shortly, our networking is impeccable, leaving us with an incredible ace up our sleeve in discerning hidden agendas.

First, what audacity in assuming that anyone who rises to leadership positions in our field would not have compendious knowledge of the M-verse! Naturally, we recognized from the get-go that our Intern Tasha was in actuality—wait for it—Natasha Romanoff, or should we say Romanova![4] Seriously, how could we not? Lest thee be needlessly concerned for our continued ability to maintain our licensure, please rest assured that she truly had completed an accredited clinical graduate program while dually enrolled for her advanced kumite certification. Talk about the real dealio! (In an interesting postscript to this tale, after various psychology-related positions didn't pan out, Natasha ultimately went on to open a vegan bakery in Santa Fe, NM, with her mentor from her SHIELD training days, Clint Barton, codename: Hawkeye . . . this is not even remotely regarded as a boundary-crossing relationship in the Ethical Principles for Superheroes and Colleagues, a must-have reference book for any specialty clinic.) Moreover, while it's not exactly rocket science to contact The Watcher—all you have to do is just start talking . . . he gets the message—the real challenge is receiving a call back, since this violates his credo—pretty cushy job, no? Well, we adroitly figured out this little dilemma lickety-split. Among the numerous fringe benefits of hobnobbing with superbeings at various professional congresses is that their very particular set of skills comes in quite handy at times. Several years ago we treated a young couple of genetically enhanced heroes, Scott S. and Jean G., who had big-time relationship problems, generally revolving around Jean's just barely sublimated attraction to one adamantium-clawed ageless and superhealing mutant named Logan. So, shortly after beginning treatment, all the members of the CBT/AT received a LinkedIn request from a mysterious man simply named X. We didn't really know why a school headmaster wanted to connect with us, but we felt . . . well, compelled to accept his request. Turns out he proved most helpful in connecting us with the Watcher, although his methods were quite unorthodox. Let's just say X's surveillance methods would be the envy of anyone in the National Security Agency, and leave it at that. It wasn't long before the CBT/AT "received"[5] a message informing us that S. had indeed been prevaricating insofar any engagement with The Watcher was concerned. Just another name-dropping celebrahero in the final analysis.

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[2] Tasha did later publish findings from her unorthodox group work in a single-case controlled trial. For a brief period following her internship she was providing trainings in therapy for hyper-patriotic steroidal strongmen and memory impaired, artificially pumped-up super-soldiers with bionic prosthetic appendages (Romanoff, 2013).

[3] Unusually Refractory Cases

[4] She goes by the name Romanoff publicly as an inside joke, as this is the male form of her true surname, Romanova, translated from her native Cyrillic. The reason she finds this amusing is a closely guarded secret known only to the "elite of the elite," which by definition includes your always self-effacing CBT/AT.

Now the only matter left to discern was motive. We asked ourselves, who would have the most to gain from discrediting the CBT/AT and thereby the larger professional society from whence it came? Hold on, it gets worse. It was self-evident they were after The President. (No, not of the country, silly goose, it's much worse—their target was the duly elected leader of our august empirically based organization.)

There was only one possible culprit with the resources plus the twisted motivation to fulminate this dastardly conspiracy, as well as, a great deal of unstructured time on their hands, usually spent reminiscing about "the greatest generation of clinicians," which roughly translates into former "dues payers."

Yes, dear readers, thine eyes shall no longer remain wide shut as your worst fears materialize like a Tupla. No, it wasn't Hyman Roth all the time . . . it was the AP . . . eh? [*fifteen-minute tape gap*] Oh sorry, we were briefly interrupted by important clinic business. We're back now . . . the fiends! Evidently, our group's insistence on data, maintaining boundaries between science and politics, expanding membership roll, and extremely fun conventions had finally pushed a once noble fellowship of scientist-practitioners off the deep end.

Plot foiled. The CBT/AT not only proved that we would not, could not be overwhelmed by caseload saboteurs but adaptively pivoted by sparking the creation of a new subspecialty in clinical interventions for superpowered folk, a hitherto underserved population, out of whole cloth no less! Interestingly, our President, sensing something was amiss, had sent in Agent Tasha to be there just in case we needed assistance. As if! But appreciated nonetheless.

S., meanwhile, is nowhere to be found. No matter, his gargantuan Planet Eating employer is none too pleased with his minion's machinations. Surf's up, dude!

Well, that about wraps up this epic clinical saga. Keep those complex referrals coming, even the passive-aggressive ones. The CBT/AT is THAT GOOD!! And, as always, humble as the day is long.[6]

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in-press article

Specific Phobias in Youth: A Randomized Controlled Trial Comparing One-Session Treatment to a Parent-Augmented One-Session Treatment

"We are puzzled as to why this might have occurred but speculate as follows. It may be the case that parents in the augmented condition who had seen their children do well in treatment and felt empowered to help them following treatment developed inordinately high expectations for their children and perhaps became less tolerant of their children's avoidant behaviors following treatment."

Ollendick et al.
Behavior Therapy
doi: 10.1016/j.beth.2014.09.004

archive

"So I want you to *deliberately* practice blushing."

Salter, 1949
Conditioned Reflex Therapy
New York, Creative Age Press

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[5] If any of our dear readers are planning on pursuing specialized training in treating superheroes, we strongly recommend a LinkedIn connection with X. You needn't ask further how to contact him. He will surely find you. You may even feel connected to him, and receive some messages from him directly (and we mean REALLY direct, at the cortex level). Unfortunately, the CBT/AT routinely breaks confidentiality as it relates to X, but we are unable to help it unless we wear that ridiculous fashion-crime helmet that another mutant, a master of magnetism, always sports. No thanks, we'll instead opt for including our standard line about confidentiality limitations in our informed consent where we alert would-be clients that all sessions are strictly hush-hush between the therapist, client, and X.

[6] <Credits roll, extra scene materializes: a CBT/AT senior staffer retrieves a message via Kik. It reads, "Have colleague going in misguided theoretical direction in need of your expertise." Burrhus F. <Slow fade out>

Introducing . . .

Barbara Mazzella, Administrative Secretary,
to the ABCT Central Office

What brought you to ABCT?

I love working in the nonprofit sector. I find it to be so rewarding to help people. There is nothing better than waking up everyday and going to work knowing that you are part of a team that is making a difference in people's lives. I heard that ABCT was hiring and wanted to be a part of the team. This is a great group of people. They were so welcoming. I love coming to work. I'm happy here.

Where did you grow up?

I was born and raised in Bronx, NY

What are some highlights of your past working experiences prior to ABCT?

I have a diverse background. I started out working in the banking industry. I then worked for Grocery Brokers in the NY Metro area as a Financial Analyst. I left the industry to become a Real Estate salesperson. While in that field, I felt that I wanted to work for an organization that helped people by providing services to them and so I found a job in the nonprofit world and took a job as the Executive Assistant to the CEO of the YWCA of Bergen County, NJ.

What inspires and/or motivates you?

Lots! I'm very observant.

Who or what has inspired/influenced/empowered you?

My grandmother. She was a strong woman. She was left to raise 5 boys on her own without any assistance. She was a homemaker and didn't have the skills to go out and find a job to support her family. So she took matters into her own hands and did what she knew best and started making a living by cooking for people. She worked hard for her family. Her life wasn't easy but she always seemed happy. When you asked her why she always smiled, her answer was always: "Look at what a beautiful family I have." She was a proud woman. When I'm struggling with my own hardships, I think of her and her strength and I pull through.

What other interests do you have?

First, I am a huge fan of Lucille Ball and I have a collection of Lucy items that I adore to look at (stop by my desk and see some of my collection). I love listening to music (I'm an 80's music fan, although I love all types of music). I also enjoy watching old black-and-white movies and 1970's television shows (I collect box sets of old television shows. *The Sonny & Cher Show*, *Tony Orlando & Dawn,* and of course, *I Love Lucy,* to name a few).

Do you have a secret skill?

I'm crafty . . . I make candy topiary trees and I sometimes sell them at craft shows. I also went to school to be a hairdresser and I have a small catering business that I run out of my home.

Tell us more about your thoughts on cooking ...

I love to cook. Cooking is therapy for my soul. It brings my family around the table for wonderful memories. If you cook it, they will come. Give me a wooden spoon, a pot and some classical music, put me in the kitchen and I will guarantee you that I will have your taste buds jumping and mouth smiling. When someone is under the weather, I cook for them. Food is love. It can warm the hearts of those you love . . . and don't forget the wine.

How would you like to be remembered?

For me, it's not about being remembered. My focus in life is to help people as best I can. Sometimes I do it with humor to lighten a difficult situation and sometimes it's just about being there for them in whatever way will get them through. It's about what I do while I'm here that counts. I never really think about being remembered.

If you were on a deserted island and could only bring three things, what would you bring?

My family, some good 'ol rock & roll music, and a pot to cook in.

"If you cook it, they will come ..."

Tammy Schuler, Ph.D, Director of Outreach and Partnerships, *to the ABCT Central Office*

What brought you to ABCT?

I first learned about ABCT during my graduate training. My graduate program was strongly CBT-focused and I was doing practicum training in DBT. We were encouraged to attend the annual ABCT Convention to learn about the upcoming DSM-5 changes and receive instruction in DBT from Dr. Marsha Linehan. Later, during my clinical internship year at VA Palo Alto, I was asked to participate in ABCT's "Applying to Internship" panel, and I presented my initial dissertation data at that Annual Convention.

So, you could say that ABCT has been part of my career path for a long time. I'm fortunate to be here now as Director of Outreach and Partnerships, as I am a firm believer in ABCT's mission. I don't think everyone gets to say that about their job and I'm grateful that I do.

Where did you grow up?

I grew up in a small town, a mile high in the mountains of central Arizona, called Prescott Valley (so New York City is quite the contrast!). My hometown area is known for being the home of the first rodeo. We had a carnival when K-Mart opened, it was that kind of place. I did a lot of horseback riding (bareback!) and marching band. My family still lives there, and some of the people I still consider best friends grew up with me there.

Tell us a little bit about your graduate work/research focus ...

My doctoral training was in the clinical psychology Ph.D. program at The Ohio State University, in Dr. Barbara Andersen's research lab, with clinical internship at VA Palo Alto. Prior to that, I received my master's degree in Health Psychology from Northern Arizona University, with Dr. Larry Stevens as my thesis advisor. My research focus is in psycho-oncology—particularly in biobehavioral intervention development, implementation, and dissemination for patients and families affected by cancer diagnosis. My postdoctoral training was at Memorial Sloan Kettering Cancer Center, where I received mentorship from Drs. David Kissane, Kate DuHamel, Talia Zaider, Jamie Ostroff, and Chris Nelson. Continuing this line of research is very important to me.

What inspires and/or motivates you?

My parents and sister do. My mentors do—I've been incredibly lucky to have extraordinary mentorship during my training years. They are all still involved in my professional life. And, I've worked with countless medical and psychiatric patients and families across a number of settings, and the fortitude of the human spirit under duress is very powerful.

What other interests do you have?

Athletics! I just ran the NYC Marathon. I also do a lot of obstacle course racing—Spartan Races, Civilian Military Combine, and that kind of thing. I also do yoga, I'll travel to just about any place, and I'm a fan of anything that can be done in the dirt and mud—like camping.

Do you have a secret skill?

I'm very nimble with kettle bells, and I can make a mean pot of chili—my family's recipe.

How do you avoid burnout in working with clients?

It's a bit difficult to articulate exactly how to avoid burnout. Unsurprisingly, it's more likely to happen with certain types of cases. I found inpatient hospice work to be some of the hardest (but also the most rewarding).

One key is to have supportive people in your personal life—but I think that having a nurturing, supportive professional environment is even more important. Those are the people who understand the nature of your experience—and you can consult with, process with, and monitor one another for signs of burnout.

Finally, I cannot stress the importance of self-care enough. We can't be optimally effective clinicians if we aren't caring for ourselves the best we can. That means sleep. That means good nutrition. That means exercise. That means doing things for ourselves that nurture us.

How would you like to be remembered?

I want to be remembered as someone who gave it her all to make a difference.

If you were on a deserted island and could only bring 3 things, what would you bring?

Is some sort of location device or something to throw out signals an option? No? In that case, a large flat of SPF-85 sunscreen, water purification kit . . . and jars of chunky peanut butter.

> # "I'm a fan of anything that can be done in the dirt and mud ..."

call
for

Continuing Education Sessions

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at www.abct.org.

Workshops and Mini Workshops

Workshops cover concerns of the practitioner/educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than FOUR presenters.

Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention.
Please limit to no more than FOUR presenters.

When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

Barbara Kamholz, *Workshop Committee Chair*
workshops@abct.org

Institutes

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

Lauren Weinstock, *Institute Committee Chair*
institutes@abct.org

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday.

Sarah Kertz, *Master Clinician Seminar Committee Chair*
masterclinicianseminars@abct.org

DEADLINE *for Submission : February 1, 2015*

Meet *ABCT's* Featured Therapist

Anitra Fay, Ph.D.

What one book do you recommend as a "must read" to improve your practice?

Full Catastrophe Living, by Jon Kabat-Zinn. It may seem like an odd choice, but the book has had a strong impact on my perspective professionally and personally. The mind and body can no longer be separated as entities. People really can learn skills that will allow us to set and achieve great goals despite obstacles and hardships . . . and yet the skills we need sometimes are the antithesis of the driven, intentional hard work, blood, sweat, and tears that are so prominent in our Western heritage.

CHECK OUT MORE IN-DEPTH INTERVIEWS AT:

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

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Psy 307 — Intervention
Psychotherapy Research E-2455
Psychology 3351 — Clinical Psychology
Psychology 3355 — Behavioral Medicine
Seminar in Psychotherapy (Graduate Level)
Psychology 718 — Research Methods and Ethics
Advanced Clinical Assessment II —(Graduate Level)
Psychology 770 — Psychometrics and Clinical Inference
PY 728 BC — Empirically Validated (Supported) Therapies
Psychology 785 — Seminar in Cognitive-Behavioral Therapy
Psychology 622 — Theory & Methods of Psychotherapy (Child Psychotherapy)
Psychology 655 — Seminar in Psychotherapy - Treatment of Children & Adolescents
 Psych 709-301 — Special Topics in Clinical Psychology: Empirically Supported Tx
  PSCL 529a — Cognitive-Behavioral Psychotherapy mindfulness-based Interventions
     Psychology 779A — Integrating Acceptance & Mindfulness into Psychotherapy
             PSCL 530a — Applications of Cognitive-Behavioral Therapy
                  Psychology 371 — Intervention Process and Outcome
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syllabi

Please take advantage of ABCT's catalogue of psychology course syllabi. This list is constantly growing as ABCT member and allied professional educators generously share syllabi for public posting. If you are interesting in submitting your own syllabi for public posting, please email each file as an attached Word document to jlerner@kean.edu, and include "syllabus submission" in the subject line. Thank you for your contribution to this valuable resource!

www.abct.org/Professionals/?m=mPro&fa=Syllabi

Call *for* Award Nominations

The ABCT Awards and Recognition Committee, chaired by Katherine Baucom, Ph.D., University of Utah, is pleased to announce the 2015 awards program, to be presented at the 49th Annual Convention in Chicago. Nominations are requested in all categories listed below. Please see the specific nomination instructions in each category. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Recent past recipients of this award include Antonette M. Zeiss, Alan E. Kazdin, Thomas H. Ollendick, Lauren B. Alloy, and Lyn Abramson. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

Outstanding Contribution by an Individual for Clinical Activities

Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Past recipients of this award include Marsha Linehan, Marvin Goldfried, Jacqueline Persons, and Judith Beck. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Clinical Activities" in your subject heading. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

Outstanding Training Program

This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Past recipients of this award include the Doctoral Program in Clinical Psychology at SUNY Albany, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, and Clinical Psychology Training Program at the University of Nebraska-Lincoln. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Training Program" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Training Program, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, and Vikram Patel. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Distinguished Friend to

BT" in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

Student Dissertation Awards

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

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2014. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/ or adolescents. Self-nominations are accepted or a student's dissertation mentor may complete the nomination. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include candidate's last name and "Student Dissertation Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

Student Travel Award

This award is designed to recognize excellence among our student presenters and to aid in allaying some of the significant travel costs associated with presenting at the convention. Accompanying this honor will be a monetary award ($500) to be used to facilitate travel to the ABCT convention. Eligibility requirements for this award specify that nominees must be 1) speaking at the 2015 convention as a symposium presenter (i.e., first author on a symposium talk), panel participant, or moderator; 2) student members of ABCT in good standing; 3) enrolled as a student at the time of the convention, including individuals on predoctoral internships in the 2015-2016 year but excluding postbaccalaureates. Information about the nomination form and application will be available following announcement of conference acceptances.

■ **Nomination deadline: August 3, 2015**

. . .

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

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

■ **Nomination deadline: March 3, 2015**

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**

NOMINATE ONLINE:
www.abct.org

NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals:

PRESIDENT-ELECT (2015–2016)

_____

_____

REPRESENTATIVE-AT-LARGE (2015–2018)

_____

_____

SECRETARY-TREASURER (2016–2019)

_____

_____

NAME (printed) _____

SIGNATURE (required) _____

2015 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2015, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send this nomination form to Christopher Martell, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001.