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CLINICAL SCIENCE

Society for the Science of Clinical Psychology
Section III of the Division of Clinical Psychology of the American Psychological Association

Developing clinical psychology as an experimental-behavioral science

NEWSLETTER

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Presidential Column

Thinking About Our Future

Bethany Teachman Ph.D., University of Virginia

Perhaps it is because spring, the time of new growth, is finally arriving in Virginia after an especially long and cold winter that my mind has been turning to the future. No, I haven't taken to reading tarot cards or looking into crystal balls (this is SSCP after all!), but I have been wondering what the future of clinical science will look like…

I want to use this newsletter column to share with you some of the questions I've been pondering about the future of clinical science and my hopes for SSCP's role in shaping that future.

It is my fervent hope that the future of clinical science will see more collaboration between researchers and practitioners, and that SSCP will be a professional home for clinical scientists using their skills in many different ways. To this end, we are excited to have Jackie Persons leading our newly-formed Committee on Science in Practice. The goals for the committee include: a) making it easier for people to practice as clinical scientists; b) helping clinicians both consume and contribute to clinical science (e.g., doing research in private practice); c) helping clinicians get better at monitoring progress/collecting data in clinical practice; and d) talking to researchers about how to design interventions so that they're easier to put into practice.

As we look toward the future, I hope that SSCP will become part of a larger community of clinical scientists. There is no longer any need to be restricted by national borders. To this end, I expect that learning from and connecting with clinical scientists internationally will greatly advance our work. Moreover, sharing what we have learned about best practices in science-based clinical care in places that don't have the same access to clinical science tools can broaden this international community. Along these lines, we are thrilled that James (Jim) Maddux will be leading the newly-formed SSCP clinical science outreach committee. Jim has led workshops on evidence-based treatments throughout Eastern Europe (I was very fortunate to attend one of these trips to present in Romania, and it was an incredible learning experience and opportunity). He is going to bring his expertise to consider how SSCP can become more involved with dissemination of clinical science internationally (e.g., offering training and supervision in evidence-based approaches in regions where practitioners typically have little opportunity to gain exposure to these approaches). I believe we have an opening now to encourage a global community of clinical scientists, which will greatly enrich our field.

Along with expanding our international connections, I hope that in the future SSCP can become a more diverse clinical science community. To help make this happen, the SSCP Diversity committee has been established with the dual goals of increasing the diversity of our membership, and considering how SSCP can promote clinical science approaches to diversity issues in clinical psychology more broadly. We are very happy to have David Rosmarin chairing this committee, and working with a great group: Yesel Yoon, Sarah Tarbox, Joye Anestis, Adam Miller, Susan Lin, and Ben Hankin.

I have been writing thus far in this column about my hopes for ways SSCP can grow over the coming years and contribute to a clinical science community that is more inclusive. Beyond these hopes for SSCP specifically, there are many open questions about where our field is headed more broadly.

I recently posted to the SSCP student listserv and asked them to 'read the proverbial tea leaves'. Specifically, I inquired: How do you think the field of clinical science will be different 10 years from now?

There was considerable variety in the students' responses and variable levels of optimism and pessimism about where the field is headed. Some students expected positive trends, such as greater influence of empirically supported treatments and emphasis on actuarial decision making, as well as clinical psychologists having more impact in diverse disciplines, both within and outside psychology. Further, there was discussion of an expected shift from traditional categorical conceptualizations to a more dimensional approach in conceptualizing clinical phenomena. Multiple people expressed the expectation that we will rely on technology (e.g., cell phones) more to assess and treat psychopathology, indicating a shift in mental health care delivery models. A related expectation centered on the more frequent use of complex statistical approaches that can detect patterns within large amounts of data. Other students talked about more negative trends they feared would occur, including the idea that securing grant funding will get even more competitive, and that "things will remain more or less the same." Further, there was disagreement about the extent of progress that is likely to follow efforts to increase "our ability to understand and treat psychopathology based on an understanding of the underlying biology." There was also an interesting discussion about whether or not researchers and practitioners would work together more effectively in the future, but despite disagreement about the probability of this connection, there was consensus on the value of such collaboration, and even a call for a "decade of clinical practice" akin to the old "decade of the brain." Thank you to the students for this fascinating discussion. I look forward to seeing which of these predictions will be realized.

Finally, this is a time when SSCP has been considering how it can best have impact moving forward. We recently asked you to read a summary of the SSCP APA Affiliation Task Force's work and complete a survey to consider different options concerning how SSCP wants to preserve or change its affiliation with APA. Evaluating these options is important for us to determine how we can best advance clinical science. I want to thank the many people who took time to provide feedback on these issues (well over 150 people had responded as of the day I wrote this piece). Your comments were very thoughtful and I have greatly appreciated the respectful consideration the membership has given to this issue. I also want to thank the Task Force members who put in many hours to bring us to this stage. Thank you to Mitch Prinstein (Chair), Lee Anna Clark, Scott Lilienfeld, Doug Mennin, Ken Sher, and Victoria Smith for their insight and open minds. We assembled a group known to have some diverse opinions on the SSCP-APA relationship, and the group has done a wonderful job working together to think about our shared goals for SSCP over the next ten years. What do we want to achieve? The SSCP of the future will encourage science-based assessment and treatment approaches; support greater dialogue between practitioners and researchers; promote clinical science education and training; increase the international impact of clinical science; influence policy and funding of clinical science; and promote increased visibility of work in clinical science.

As we near the end of this evaluation to determine how we can best position ourselves to help shape the future of clinical science, I am excited about the shared vision that is emerging. Clearly, our work is cut out for us, but I am confident that SSCP members will work together to meet these challenges.

For Varda: Goodbye Forever…For Now

David A. Sbarra, Ph.D.
University of Arizona

The ridiculous (post-colon) title for this remembrance column comes from the title of a poem I wrote for my colleagues Varda Shoham and Michael Rohrabaugh, a husband and wife research team, when they departed Tucson and the University of Arizona permanently in May, 2013. At the time, of course, I had no idea I'd be sitting here 10 short months later writing a note of memorial for Varda, who died on March 18, 2014 after a four-year battle with lung cancer. Varda was 65 years old at the time of her death.

On that night in May our entire clinical program gathered at my home to say farewell to our beloved colleagues. After three years of being on leave from the UA to NIH (as a special advisor to NIMH Director, Tom Insel), Varda decided to become a Fed and to officially move into the areas of policy and science leadership at NIMH. After 25 years at the UA (15 of which she served as DCT), she was leaving us for Bethesda and we had a terrific goodbye party planned in Michael and Varda's honor.

My poem contained several long and rambling verses, but I started like this:

Saying goodbye is hard, we know that much is true,
But your joint departure is leaving us so blue.

We've cried already and shed lots of tears,
and this poem hardly captures what we've shared through the years.

You've made our program great but now it's time for you to go,
Before you leave the desert there are several things you should know.

Please forgive the fact that, when read, the poem sounds a bit like the Night Before Christmas. (What can I say?! I am a crappy poet…). When I came around to talk about Varda, here's what I wrote:

Varda, I'll start with you first and make the case,
It's so damn hard for me to be DCT in your place.

When you told us about your "leave," I just started fretting,
It didn't take NIMH long to see what they were getting.

You know the politics of the game, you have vision and poise,
Everyone looks to you to make a lot of noise.

Indeed, the Israeli in you is always ready for a good, fair fight,
It won't be long before you set our field right.

You've given Arizona your all—your blood and guts,
Letting you go away just meant we were nuts.

At NIMH you'll thrive, through and through
I guess that makes it easier to bid you adieu.

Change is part of life, we'll learn in good time,
For now we'll sit back and watch you shine.

There's so much I can say about Varda and her list of professional accomplishments is very impressive-- she served as president of organizations such as the SSCP, the Academy of Psychological Clinical Science, and the North American Society for Psychotherapy Research. In addition, she helped lift the Delaware Project off the ground in important ways, and she made innumerable contributions to research in clinical science, mostly in her studies with Michael around couple and family interventions for health problems.

To me, Varda was far more than the sum of these impressive achievements, and in my poem I tried to capture the gist of my experiences with her. Now that she is gone, I feel my words on that May night were far too inadequate.

If I had just one more night with Varda, I would tell her some important things. I would want her to know that she changed my life in a profound way. When I first applied for jobs in our field, I could not get a single interview. Nothing. Varda saw something in me that most others did not and she trusted what she saw. I remember being on the phone with her for the first time. Although I had difficulty understanding her thick, Israeli accent (which, years later, I would end up explaining to other people-- "What she is saying is THIS…), she told me the following point blank: "I don't really know what it is you do, but you've somehow convinced me that it's worthwhile and I would love to see you come here to Tucson to do it with us."

I would tell her that this belief in my potential and her support for me realizing my potential meant everything to me. When I joined the clinical program here at Arizona, Varda and Michael became my champions, and their unfailing belief in my potential propelled me to do the best science possible.

I would also tell Varda that I loved working with her in the trenches—writing grants together, figuring out how to prepare accreditation documents, managing student issues and problems in our program. As my career progressed and I became increasingly involved in the Academy of Psychological Clinical Science, we spent many dinner parties together strategizing over the future of the field. Mostly, it was her updating me on what was happening at a national level and, more often than not, it involved her becoming deeply upset about the ways in which she perceived someone or some organization to be undermining clinical science. I often argued for a more balanced viewpoint and Varda was very easy to influence. Don't get me wrong: She was tough and opinionated. She was, however, always open to influence from people she respected. When she talked with you about important matters, she would take your opinion seriously and, if the idea had any merit, update her thinking accordingly.

Varda groomed me to be her successor as DCT in our program. After 15 years, she had done it all and seen it all, and it was clearly time for a change. I learned a tremendous amount from her—she was savvy, smooth, and very driven. If I had that last moment with her, I would tell her that I hope I've made her proud; she cared for our students and faculty enormously, and it's sometimes quite daunting for me to sit in her office-- literally, my office is her old office.

Personally, Varda, Michael and I had our share of great times together. Varda loved to tell the story of how she tried to lure me to Tucson (perhaps she forgot that I only had one job interview) by dropping the top on her Saab convertible in February while we were headed out to dinner. Unfortunately, it started raining on us while we were in the convertible. "This never happens!" she cried! I would give nearly anything for another ride in that rain-soaked convertible with her today.

Here's the thing about all these thoughts and remembrances: I was just one of Varda's many friends and close colleagues, and I am pretty sure that she shared these kinds of special memories with a lot of people. Perhaps this is why her loss is so profound for all of us.

Thinking about Varda's life reminds me of a lesson I learned from my father when I was in high school. There was an extremely successful high school athlete in our town that we all admired—he set so many records and was a feared opponent far and wide in his sports. We would follow his accolades in the paper on a near-daily basis. He also happened to be an exceptional student and a very kind person. One day, my dad met one of his teachers. The teacher remarked that he didn't know Adam even played sports, but he was sure that Adam was a very nice and hard-working young man.

My dad and I were astounded-- how could the teacher not even know about all the sport records? My dad remarked, "This is the kind of person we should all be—you should be known for the quality of your character, not just what happens on the field."

In the field of psychological science, Varda was a giant and she was doing very important work. As good a scientist and science administrator as she was, however, she was also a far better person—warm, loving, creative, and fun.

No more is our goodbye "Farewell… For Now," it's just come down to "Farewell." Varda, it is these qualities about you that I'll miss most. You've changed my life in a deep way, and I hope I can do half as much for someone else in my days.

SSCP Treasurer's Report

Stewart Shankman, Ph.D.
University of Illinois-Chicago

BALANCE as of April 19, 2014
$31,989.96

FINANCIAL HIGHLIGHTS:

EXPENSES: Div12 processing fees of our dues/paperwork (-$23.00).

INCOME: None.

PENDING: Delaware Project ($2,000).

Congratulations to Dr. Connie Hammen!

Connie Hammen, Ph.D., Professor of Psychology at the University of California, Los Angeles, received the **2014 SSCP Lawrence H. Cohen Outstanding Mentor Award**.

This award is given to an individual who has provided exceptional guidance to clinical psychology graduate students, interns, and/or postdoctoral fellows in clinical psychological science through leadership, role modeling, advising, supervision, instruction, advocacy, and other activities aimed at providing opportunities for scientific growth, professional development, and networking.

SSCP Varda Shoham Clinical Scientist Training Grants
Congratuatlions to the Recent Awardees!

1. Improving Practice with Clinical Data

Anna Van Meter, Ph.D.
Ferkauf Graduate School of Psychology, Yeshiva University

In 2013, a new initiative was launched by the clinical program at Ferkauf Graduate School to formally integrate training in research and practice. Our goal is to move beyond static training in the content of empirically-supported treatments and toward training students to use evidence-based processes. We believe this will better equip students to actively draw from the evolving scientific literature to inform their practice.

Preparing for this new initiative led us to realize that we can take advantage of an invaluable education resource – our clinic. The Parnes Clinic is one of the largest training clinics in the country and has the potential to offer important data to improve the quality of training and the delivery of services. In order to provide valuable clinical data to students and faculty, we are developing a flexible, web-based system (CARE – clinical assessment, research, & evaluation) that will serve as both an electronic medical record and as a tool to collect and aggregate assessment data at intake, during treatment, and at termination for all patients. The CARE system will support a diverse range of uses, from follow-up on patients, to therapist feedback, and addressing research questions, including program evaluation. It will also be an important teaching tool, providing opportunities to demonstrate to students the role that data can play in improving clinical outcomes and determining factors that moderate the success of evidence-based treatments.

Funds, provided through SSCP, make it possible for us to host in-person training sessions on how to make the most of the CARE system, enabling students and faculty to utilize the system's resources in their research and practice more effectively.

2. Enhancing the Integration of Science and Practice in a Rural Community Clinic through a Routine Outcome Monitoring (ROM) System

Lee Cooper, Ph.D. and Haley Gordon
Virginia Polytechnic Institute & State University

Our clinical training clinic, set in a rural community, had begun a systematic initiative to enhance the integration of science and practice through the development and implementation of a standardized assessment and treatment evaluation protocol. A recent analysis of its utilization and barriers determined that a web-based, auto-scored, regularly administered outcome monitoring system would improve utilization. The goal of our submission was to select, implement, and integrate such a system within our current protocol. More specifically, we will be using the Varda Shodam Clinical Scientist Training Initiative grant to implement and integrate Owl Outcomes, http://owloutcomes.com/. The integration of our current protocol with this web-based system should provide our student clinicians the ability to more efficiently and effectively provide scientifically informed practice.

3. Improving the Dissemination of Evidence Based Assessment Strategies for Common Mental Health Diagnoses

Eric Youngstrom, Ph.D.
University of North Carolina at Chapel Hill

Description forthcoming.

SSCP Varda Shoham Clinical Scientist Training Grants
Updates From Recent Awardees

1. Integrating Modular Approaches to Evidence-Based Practice During Pre-Doctoral Internship Training

Andrew J. Freeman, Ph.D. and David Elkin, Ph.D.
University of Mississippi Medical Center

The Psychology Residency Training Program at the University of Mississippi Medical Center (UMMC) is a scientist-practitioner internship program with the goal of graduating academically oriented clinical psychologists who have a strong generalist background as well as one or more specialty areas. At the beginning of the internship year, many of our interns are extremely proficient clinicians and scientists in one or two areas but may have only cursory knowledge of many other treatment approaches due to lack of opportunity to treat these populations in their graduate training. For example, interns whose prior training focused on anxiety are often very good at treating anxiety using evidence–based practices (EBP; e.g., Coping CAT), but may have less experience treating disruptive behavior disorders due to lack of clinician resources and training. The SSCP Clinical-Scientist Training Initiative grant provided resources for our internship site, which seeks to purchase licenses for the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH) and to implement regular electronic monitoring of treatment outcomes through the purchase of two tablets.

The primary goal of the project was to provide a breadth of resources to our interns. Our child interns now use the MATCH protocol as the primary treatment resource for approximately 80% of child and adolescent cases seen in our general psychotherapy clinic. Interns note substantial decreases in preparation time for psychotherapy sessions (between 50%-75% decrease) due primarily to not needing to search multiple resources for therapy materials (e.g., handouts, homework). They appreciate the flexibility MATCH offers in creating individualized treatment plans while remaining consistent with EBP principles. Interns describe supervision as a time spent focusing on adjusting case conceptualizations and therapy practices to match individual client circumstances and needs (e.g., how to do time-out in a 1-bedroom apartment with 6 family members present). At the program level, the residency has changed from a presentation-based case-conference to a discussion-based case conference format that focuses on treatment decisions and case conceptualizations.

The secondary goal of the project was to provide an electronic outcomes monitoring system. Interns are only just starting to use this system as a standardized method for the monitoring therapy outcomes. The grant has helped us to encourage the medical center to think about how it collects patient-reported outcomes and provide easier methods for integrating psychology "lab values" into the electronic health record. In the very near future, interns will be able to use instantly scored symptom checklists to help guide the treatment process, monitor reliable change and aid in clinical decision-making.

The training grant has also provided us the opportunity to demonstrate the effective use of a modular approach to psychotherapy in a primarily low-income, rural, African-American population. Mississippi Medicaid recently awarded Dr. David Elkin a large grant to integrate pediatric primary and mental health care. The resources provided by the SSCP training grant served as a small-scale demonstration project for how a larger initiative could reach the youth of our state more broadly by providing

evidence-based practices in a modular format based on the model our residents used in their general clinical practice.

2. Disseminating Evidence-Based Transdiagnostic Anxiety-Focused Group Treatment

Emmanuel Espejo, Ph.D.
VA San Diego Healthcare System/University of California, San Diego

Growing demand for mental health services at Veterans Affairs (VA) hospitals presents significant challenges to offering Veterans prompt access to evidence-based mental health care. To help meet this growing demand, the VA has developed nationwide training initiatives in the delivery of evidence-based psychotherapy for Posttraumatic Stress Disorder (PTSD). However, over 25% of Veterans meet criteria for an anxiety disorder other than PTSD. While offering group psychotherapy can help to increase the availability of anxiety treatment, empirical support for psychological interventions for anxiety disorders has largely been developed with protocols specific for each anxiety disorder. Training providers in a variety of disorder-specific protocols can be time and cost prohibitive and offering disorder-specific treatment groups presents scheduling challenges which may lead to extended patient wait times for treatment initiation. A single transdiagnostic anxiety-focused group treatment offers an effective means for making evidence-based cognitive-behavior therapy (CBT) more readily available and can help to meet the growing demands for anxiety treatment services at VA healthcare settings.

The main purpose of this project was to provide training in transdiagnostic anxiety-focused group CBT to mental health providers at the VA San Diego Healthcare System (VASDHS). San Diego has a high Veteran population and a large military presence with several Naval or Marine bases located in or near San Diego. The VASDHS consists of a main hospital in San Diego and five satellite outpatient clinics throughout the greater San Diego area. The training was conducted by Dr. Peter Norton, Associate Professor in Clinical Psychology at the University of Houston and an expert in transdiagnostic anxiety-focused group CBT. Dr. Norton has published extensively on a transdiagnostic anxiety-focused group CBT protocol that he developed, including several randomized control trials demonstrating the efficacy of this treatment approach. The training was based on his recently published book Group Cognitive-Behavioral Therapy of Anxiety: A Transdiagnostic Treatment Manual. Training attendees received copies of Dr. Norton's book. Over 20 participants took part in the training which took place in August 2013. Training attendees were from a variety of mental health disciplines including social workers, psychiatric nurses, psychologists, and psychology trainees across five different VHASDC treatment facilities.

Eight months following the training, over half of training attendees (59%) are providing weekly transdiagnostic anxiety-focused CBT groups at their respective VHASDC facility. The majority of these providers continue to participate in weekly consultation to discuss the administration of the group treatment. Thus far, patient data is available from three treatment groups that have been completed since the training at the main VHASDC hospital. Results are promising with nearly 80% of treatment initiators completing the treatment and treatment completers demonstrating significant reductions in anxiety and reporting high satisfaction with the treatment. The results of this training program, made possible with the SSCP training grant, may serve as basis for making transdiagnostic anxiety-focused group CBT treatment more widely available at VA healthcare settings.

Clinical Science Early Career Paths

Joanna Arch, Ph.D.

After five years of volunteering abroad and working as a community organizer on affordable housing issues in Boston, I needed to face the truth. My GRE scores would soon expire. It was now or never for graduate school.

The logical course was to apply for public policy graduate programs – Boston offered several good ones. But when my friend David Moscovitch (then a doctoral student at Boston University, now an Associate Professor at the University of Waterloo) told me about a study he was working on adapting Acceptance and Commitment Therapy (ACT) for GAD, I was immediately intrigued and purchased the Hayes et al (1999) ACT book. Reading quickly cover to cover, I was hooked by their profound understanding of human suffering and how to intervene. Their approach resonated with my many years of mindfulness meditation practice. Soon thereafter, I decided to go to graduate school in clinical psychology to study mindfulness and ACT. Thanks to the kindness of Drs. Liz Roemer and Sue Orsillo (study PIs), I volunteered on the ACT for GAD study, and I was fortunate enough to be coached by their students on how to apply to graduate schools (I was clueless).

Dr. Michelle Craske at UCLA generously accepted me as a graduate student despite my declaration that I wanted to study mindfulness and ACT, topics she had never pursued. I privately believed that I would become a full-time clinician because I had greatly enjoyed working one-on-one with people as a community organizer. However, I could not have asked for a better research mentor. Michelle's passion and talent for clinical science was matched by her exceptional openness to new ideas and compassion for others. Michelle is a clinical scientist for all of the right reasons, and continues to inspire me greatly.

Over the next six years, I realized how much I enjoyed research. This surprised me! Once again, I found myself in the position of thinking I would travel in one direction – towards full-time clinical work – yet traveling in another – towards research and teaching. In my final year of graduate school, the University of Colorado Boulder offered me a golden opportunity– a tenure-track position – and my instinct was to accept immediately. However, I was pregnant with my first child and my husband David, an oncologist/hematologist, had recently joined the medical faculty at UCLA and needed a job in Boulder. Fortunately, the University of Colorado agreed to have me defer for a year so that I could have my child and David could find a job. I cannot emphasize enough that having a flexible and (extremely) supportive partner has proven essential both then and now. Frankly, I would not have been willing or able to pursue an academic career, 1-year-old in tow (and another on the way shortly thereafter) without his very high level of support and the egalitarian nature of our parenting. We live a child-centered life as much as possible and both find parenting deeply rewarding. But a tenure-track position at a Research I university is highly demanding. I could not put forth the effort without the strong support I enjoy at home.

The best part of my job at the University of Colorado is that I have the creative and scientific freedom to pursue the research that is most meaningful and engaging to me. I also enjoy the autonomy to (largely) work when and where I choose – a degree of flexibility that is unusual for demanding jobs.

Although we each must forge our own path, I have been lucky to pick up some tidbits along the way that are worth sharing:

1. **Be completely honest** with yourself about what you enjoy in your work, even if it means taking a different path than you anticipated or than others want for you. At the end of our lives, when we look back, we want to live our life, not someone else's.

2. Allow yourself to be afraid. To lack confidence. To not know for certain how to move forward or what direction to pursue. **Accept your fear and move forward anyway.** If I had let fear stop me I would not have gone to graduate school. Instead I am pursuing a fulfilling and challenging career.

3. **Balance your roles.** If you are extraverted (as I am), balance the creative, rich, and highly fulfilling but sometimes isolating work of writing (grantwriting, analyses, writing articles) with the more interpersonally oriented work of seeing patients and teaching and mentoring students. When one role is going badly (a grant gets rejected), bolster yourself with another role (a thankful student).

4. **Consult your colleagues.** Being independent by nature, I have to push myself to run ideas by other people, even those I trust. I'm always glad when I do. Listening to others' input and advice has prevented me from falling into rabbit holes numerous times.

5. If you want to pursue a tenure-track job and be a highly involved parent, accept that **for years at a time you may need to put most other interests on hold**. I say 'no' on a regular basis to all kinds of tantalizing opportunities. This is the hardest part of my chosen path to accept because I love life and have many interests. I can still pursue some of them – spending time outdoors, gardening, and some community involvement – but I have left most on hold. Some days I accept this and other days I find this painful…but on no days do I have time to do the range of activities – backpacking, kayaking, traveling, cooking, hosting big meals, reading widely, keeping up on foreign languages, broader community involvement, social justice work – that I used to do. On the other hand, I have a highly fulfilling job, a wonderful family, and (on most days) my physical health and sanity.

Note: If you need little sleep, have a less demanding job, or no kids, this last point may not apply to you, or not to the same degree.

I wish each of you the best in clarifying what you care about, accepting fear and uncertainty as normal parts of this process, and flexibly pursuing what you most want in your career. As the Buddha said and ACT teaches – don't just listen to me, go out and find out what works for you!

About the author: Dr. Joanna Arch is an assistant professor in the Department of Psychology and Neuroscience at the University of Colorado Boulder. Her research interests include basic and applied work on mindfulness, compassion, and acceptance for anxiety disorder and cancer populations.

Student Perspectives Series I

So you want to be a professor when you grow up? Six tips I wish I had when I was beginning graduate school

Evan M. Kleiman, M.A.

Many people begin graduate school wanting to go into academia when they "grow up". Despite this being a common goal of first year students in clinical psychology, there is relatively little direction available for people in this developmental period on the internet and in books. Searching Google for "how to get an academic job in psychology" yields a variety of results pointing to websites about the difficulty of getting an academic job and resources for people in the dissertation stage. While this information might benefit someone in the later years of their graduate education, it might not be as useful for someone who is just starting out. Thus, the goal of this article is to give the advice I wish I had as a beginning graduate student who wanted to go in to academia. Before going any further, I should say that this list of tips is far from an exhaustive list. Some may disagree with some of the tips I've listed, and nothing here will guarantee anyone a job. There are probably many other useful tips that I haven't included.

I've written the tips below for students who are in the early stages of their graduate career who have some sort of reasonable desire to go in to academia after they finish graduate school or a post-doc. It doesn't mean you must, at this point, sign your life away to become a professor, but these tips will help those most who have at least some strong desire to be an academic in a university or medical school setting. If you're still deciding what you want to do when you graduate or finish post-doc, there are many great resources to help with that, including the excellent postdoctoral Q&A on the SSCP students' website. If you're further along your graduate career some of this advice might be useful, but at this point, other advice is important too (see Chrobak & Winterrowd, 2013).

These tips are generally targeted at employment in research-heavy positions in psychology departments (i.e., faculty within a clinical psychology Ph.D. program). They will also help prepare individuals who wish to have a career in a departments that grant masters' or PsyD degrees as well as positions in teaching oriented liberal arts school that do not have a graduate program. Some tips will be more important than others depending upon the career that interests you. By following these guidelines throughout most of my career, I was prepared (and lucky!!) enough to have interviews at nearly every sort of program. In effort of full disclosure, for reasons not relating to the tips below, I ended up accepting an offer to join the Harvard College Fellows program, which is a position with a unique mix of teaching and research responsibilities (read more about it here).

Publish a lot of papers (but not really, because not all papers are equal)

Many people would say that publishing as many papers as possible is the route to an academic job. I disagree with this idea on some grounds. Of course, given two otherwise equal candidates, the one with 20 publications is going to be more appealing than the one with 10. More is always better, but not all publications are equal. Rather than quantity, I would suggest you focus on quality. Find out what the first and second tier journals are in your sub-discipline of clinical psychology. Journal of Abnormal Psychology and Clinical Psychological Science are likely two names you will hear, but ask

your advisor and others to find out which journals they value. Try to create publications that are worthy of these journals. This doesn't mean you will (or even need to) publish in these journals, but striving for publications that are top tier worthy will ensure you focus on quality and not quantity. Your body of work will be scrutinized when you apply for a faculty job and anything you publish can be read by a potential future collogue. Make sure anything you publish is of the quality that you'd want a potential future collogue reading.

I remember wanting someone to tell me that there's a "magic number" of publications one must have to be deemed worthy of employment. Unfortunately, such a number does not exist. You will be asked to submit three (or five) representative publications when you apply for an academic job. Using this as a guide, you'll want to have at least this many publications that, when viewed together, present a cohesive narrative of your program of research and demonstrate your strengths as a scientist. I say this is a minimum because in reality, people who are beginning faculty jobs have more than this number (see below).

Another important aspect to focus on is how many publications you have been a first author on. A first authored publication (in theory) takes far more initiative and effort to achieve than a paper in which you are fifth author. Surveys of individuals who were entering their first year as assistant professor in a school with a research heavy PhD program had on average 5.6 publications, 2.8 of which were first authored (Stenstrom, Curtis, & Iyer, 2013). I should note that although the publication was recent, the data are from 2007 and thus I warrant some caution in using these numbers as exact guidelines for a "magic number" of publications to have. The job market has become far more competitive in the years since these data were collected. The important thing to take from these data is that the people whom you hope to emulate had a 1:1 ratio of first authored to co-authored papers.

Get a grant, or at least write a grant

In recent years, grant funding has become one of the most crucial parts of a program of research and this trend will only continue in to the future. Most job postings explicitly mention grant funding as a requirement. Having grant funding as a graduate student or post doc is used as a predictor of having grant funding in the future as a faculty member. Despite the growing importance of grant funding, it is becoming more difficult to get grant funding. For example, the success rate of getting an NRSA F31 from NIMH (see below for more information on this) was 30.3% in 2004, and was 22.8% last year (NIH, 2014). Of course, not all funding agencies and mechanisms have such low success rates. Even if you don't get a grant, writing a grant, at the very least, provides behavioral evidence that you are a scholar who is interested in grant funding. The most common ways to get grants are NRSA and NSF awards and there are great resources on these grants in the Winter 2014 issue of the *Clinical Science* newsletter (Banducci, 2014; Feinstein, 2014).

Don't be a clone of your advisor: develop your own independent program of research

You may end up being incredibly productive with your mentor as a graduate student or post doc. Despite the vividness of any nightmares you might have, however, your mentor will not be following you to your first job. Your future colleagues will want to know that you are a productive researcher whose research can stand independently of their mentor's research. You want to have a program of research that is related to, but qualitatively different from, your advisor's research. This doesn't mean that if your advisor studies anxiety, then you should study autism, but it should be clear that you study something somewhat different from your advisor and the others in your lab. Nearly every academic job interview involves giving a job talk—a 45 to 60 minute presentation of your entire research program. You want to go in to job applications with a program of research that will allow you to craft a (somewhat) cohesive narrative that shows you are a researcher who collaborates well with

others (including your mentor) but is still an independent scientist

Collaborate

If I were only allowed to give one piece of advice it would be to collaborate, a lot. Collaboration has been one of the most important and enjoyable parts of my academic career thus far. Collaboration has taught me a lot of valuable things including how another person goes about their scientific process and how to be a good collaborator. Every time I collaborate with someone, I learn something. Collaboration will also help with other goals: you will get more publications (two people write a paper faster than one does!) and you will further refine your independent program of research because collaborators will introduce you to new topics.

As a graduate student, I had several collaborators at other universities who were post-docs or beginning assistant professors. I learned a lot from my collaborators because I was able to benefit from their training and experience, which was different from my own (hopefully they benefitted as well!). I also collaborated with other faculty members in my program and learned a lot from them as well. Collaborating with others outside of your primary research lab can be a tricky subject because it involves managing your relationship with your advisor and whatever expectations they have for you. So, I recommend keeping this in mind when seeking out collaborators.

Teach a class (at least once)

How important teaching is has a lot to do with what your ideal job setting is. If you want to be at a smaller school without a PhD program, you will do quite a bit of teaching (think 3 or 4 classes per semester). If you want to be at a more research heavy institution, you might only teach a class or two per year. Even if you plan to have grant funding for your entire career and never teach, you'll still do all sorts of activities as faculty that will benefit from teaching experience. Giving symposium presentations, mentoring graduate students, and doing therapy all involve some element of teaching. The more practice you have here, the better.

Learn to be an exceptional presenter

Being an exceptional presenter (see Kogel, 2007 for what I mean by "exceptional presenter") is a crucial skill for anyone who wants to go in to academia. Your research ideas might make you the next [insert name of big celebrity researcher in your area], but that won't matter if you can't communicate these ideas effectively. Presenting at conferences is a regular part of most academic careers and is an important way to get your ideas (and name) out in the research community. Even more important than conference presentations are job talks. This is often your best (or only) time to make an impression on your future collogues (i.e., the people who will decide if you get a job or not). The quality of your presentation can make or break your chances. In fact, I'd even say that how you work can be even more important than the work itself (provided the work is of a certain level of quality, of course).

There are several ways you can become an exceptional presenter before the "big performance" (i.e., when you have to give a job talk). Giving conference talks and teaching classes (See above) are great ways to become a more effective presenter. If you're anxious about public speaking, think of this as exposure. If you want to start lower on your fear hierarchy, I'd recommend watching TED talks and trying to emulate the people whose presentation styles you like.

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About the Author: Evan Kleiman, M.A. is a clinical psychology intern at Temple University. His research focuses on the intra- and interpersonal factors associated with risk and resilience for suicide.

Student Perspectives Series II

What is this thing I'm studying, anyway? The network approach to mental disorders

Donald J. Robinaugh, M.A.

Over the past several years, I've been fortunate enough to contribute to a small but important and growing body of research on a mental disorder known as prolonged grief, complicated grief, or, most recently, persistent complex bereavement disorder (PCBD; APA, 2013). Much of my work in this area has been focused specifically on bias or impairment in the ability to recall the past and imagine the future in bereaved adults experiencing PCBD. As results from my early studies came in, I excitedly began making my way to seminars, colloquia, and conferences to present these findings. In an effort to introduce PCBD to audiences unfamiliar with the syndrome, I would typically include a slide early in the talk designed to answer a simple question: "What is PCBD?" The slide would begin, "PCBD is….", and proceeded to identify five or six of the most prominent symptoms thought to reflect the presence of the disorder. I was not unique in providing such a definition. Even now, most articles on PCBD begin with a brief expository sentence that is some variation of: "PCBD is a mental disorder chiefly characterized by [its core symptoms]."

As I proceeded with my research in this area, this definition of PCBD began to feel uncomfortably circular. What is PCBD? It's a mental disorder characterized by persistent yearning and preoccupation with thoughts related to the death or the deceased. How do you know if someone has it? Well, they experience persistent yearning and preoccupation with thoughts related to the death or the deceased.

This difficulty defining PCBD without reference to its symptoms illustrates an uncomfortable fact about PCBD and other mental disorders. It is difficult to disentangle the disorder from the symptoms thought to reflect its presence. Unlike many medical disorders, where, for example, a doctor can detect a tumor in someone not yet experiencing any symptoms of cancer, an asymptomatic bereaved adult cannot be said to have PCBD. Exacerbating this problem, researchers frequently conflate the causes of PCBD, the consequences of PCBD, and the symptoms that reflect the presence of PCBD. For example, rumination is both a risk factor for PCBD and a proposed symptom of PCBD. Similarly, suicidality is both a proposed symptom of PCBD and a consequence of the disorder.

As I struggled with these issues, I became increasingly stuck on a seemingly straightforward but ultimately very confounding question: What is this thing called PCBD that I've been studying, anyway?

Shortly after this mid-graduate school crisis began, there was a book published titled "What is Mental Illness" that grappled with many of the questions that I had been struggling with in my efforts to understand PCBD. Conveniently, the book was authored by my research adviser, Professor Richard McNally, whose office was just a few feet from my own. I found myself down the hall and, over a series of conversations about the nature of mental disorders, Dr. McNally introduced me to a new approach to mental disorders being pioneered by Dr. Denny Borsboom, Dr. Angelique Cramer, and others. According to this approach, known as the network (or causal system) approach, mental disorders are

causal systems of functionally interrelated symptoms (Borsboom & Cramer, 2013). The symptoms do not arise because of common underlying pathology. Rather, the symptoms themselves are constitutive of the disorder.

From a network perspective, PCBD is a causal system of mutually reinforcing thoughts, emotions, and behaviors that arise following the death of a loved one and settle into a pathological equilibrium. As I began viewing PCBD from this perspective, I found myself on firmer ground when trying to explain many of the issues with which I had struggled when considering the nature of PCBD. The reason that PCBD could not be so easily distinguished from its symptoms was because the symptoms themselves are constitutive of the disorder. The reason that the causes, consequences, and symptoms of PCBD were so often conflated is because the symptoms of PCBD have plausible causal relationships with one another (e.g., frequent painful emotions when reminded about the death [PCBD symptom B2] are likely to provoke efforts to avoid reminders of the loss [PCBD symptom C6]). The more I explored the implications of this approach, the more I became confident that I had found a much clearer answer to the question, "What is PCBD?"

It is possible that the network approach is exclusively well-suited to understanding PCBD. I suspect this is not the case. As Borsboom (Borsboom & Cramer, 2013) and others (e.g., Kendler et al., 2011) have convincingly argued, mental disorders are replete with plausible causal connections between symptoms, both within and between disorders. These causal connections between symptoms are proscribed by latent construct approaches that dominate much of our current work on mental disorders but comport well with the network approach, suggesting that the network approach can be an appropriate conceptual framework for understanding metal disorders more broadly.

As a relatively new syndrome, PCBD frequently elicits questions about its nature, but these are questions we should be asking about all mental disorders. The researchers who have pioneered the network approach offer a provocative new view of mental disorders, one that resolves many troubling issues about the nature of mental disorders and their relation to one another, and one with enormous implications for our understanding of psychopathology. In taking this new approach, researchers have already drawn compelling conclusions about the structure of mental disorders (Borsboom et al., 2011), the nature of comorbidity (Cramer et al., 2010), and the paths by which risk factors affect disorders (Cramer et al., 2012). These early findings suggest that the network approach is not only a useful conceptual framework, but a promising basis for future research on the etiology and treatment of mental disorders.

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About the Author: Donald J. Robinaugh, M.A., is a graduate student in the Clinical Science program in the Department of Psychology at Harvard University. He studies the etiology and treatment of mental disorders that develop in the wake of loss or trauma, including persistent complex bereavement disorder and post-traumatic stress disorder.

Clinician Perspectives

Collecting Data on Ourselves

Kimberly Wilson, Ph.D.

When I left academia to pursue private practice alone, I was determined to maintain my data collecting habits. Many of my clinician colleagues also remain committed to this approach. We consistently use progress monitoring to assess patient symptoms, mechanisms, and goals throughout each stage of treatment, and encourage patients to systematically collect information to evaluate or challenge their ideas.

I want to put in a plug for something less common, at least among the clinician folks I know: systematic evaluation of our effectiveness as clinicians, and the quality of our sessions. As part of that endeavor, I ask each patient after each session to privately complete in the waiting room a questionnaire, the Session Assignment and Feedback Form (Hong, Beckner, Persons, Ling, & Owen, 2011). My patient gets a copy and I get a copy. Items are rated on a 5 point scale and include "How well did you feel heard and understood in session?" "How well did we agree on what is causing your problems?" "How well did today's session help address your problems?" "How confident are you that you are progressing toward your therapy goals?" and "How helpful were the homework assignments?" Patients are also asked to write down 1 or 2 things they want to remember from the session.

This is the measure I use, and find helpful. There are others that are similar, some of which have been used in process research or to assess important variables in RCTs. When these measures have been discussed in the literature for private practitioners, the main function has been to improve clinical care, and to demonstrate clinic effectiveness to potential clients. Both of these motivations, and especially the former, are of course very important. I want to add another reason I choose to do this.

When I started to use this measure, it dramatically improved my job satisfaction. Dramatically.

Let me take you back to the time before I used this measure. I was seeing up to 8 patients each day, delivering cognitive-behavioral therapy to adults with anxiety disorders. I work hard to be helpful and effective, and I care a lot about my patients' suffering. I don't think I'm alone on this. Delivering quality therapy is important and challenging. Imperfection is inevitable. And it can feel lousy. If there was a session that day that included moments I could have done better, my mind would swim on those moments, well after I left my office. If there was a client not progressing, my heart would be heavy, and my attention would disproportionately drift to that person, amplify my perception of the lack of progress, how I had let that person down, which would not surprisingly leave me less satisfied with my professional life than I might otherwise feel.

I began using this measure after it was given to me by Jackie Persons who leads my (cherished) consultation group.

Of course I want to devote attention to cases that are not progressing well, or to sessions with flaws that might be corrected, but adding this more objective, data collecting tool changed HOW I devote attention to these areas.

First, I noticed that I mostly get very high scores. The quantitative feedback helped bring my attention to the overall picture of very successful work that happened that day. This matters a lot.

We all need positive feedback. And it turns out that positive quantitative feedback increases my job satisfaction.

Second, those high numbers also make it far easier to look at the low numbers, when they happen, straight in the face. And rather than being left susceptible to overgeneralization bias by thinking of the session as globally bad, the specificity of what was deemed imperfect has been identified. And it is a fabulous starting point for an upfront discussion next session. Also, even when there is a low rating, it almost always happens alongside other items that are rated more highly. It's not a globally bad session; some aspects went well, other aspects did not. Acknowledging the parts that are going well puts me in a better position to wholeheartedly attend to fixing the parts that are not, and to really like my job.

Third, sometimes I am wrong. If you don't know something, collect data on it. In addition, if you think you know something, collect data on it as objectively as you can and see what happens. When a client rates the session in surprising ways, it yields a productive conversation. And also strengthens my own capacity to not take my assumptions so seriously. Again, I'm left enjoying my work that much more.

Fourth, the measure asks my patients to record one or two things they want to remember from the session. The main function of course is to allow patients to consolidate new learning and to have a record of important ideas to refer to in the future. However, I also use this as an evaluation tool of how effectively I have communicated or highlighted clinically important points. And back to enjoying my professional life, it adds to my job satisfaction that every single patient, every single day has had something to say here. It helps reinforce the message to me: people learn things from this work. That feels good.

I enjoy my work. It's meaningful. And challenging every single day. Using a post-session measure to evaluate the session is one small piece of providing good clinical care, and self-care as well.

About the Author: Dr. Kimberly Wilson is in private practice in Oakland, California. She specializes in cognitive-behavioral therapy for adults with anxiety disorders.

Update from the Student Representatives

Victoria C. Smith, University of Maryland College Park

Rosanna Breuax, University of Massachusetts Amherst

As your student representatives, we would like to take this opportunity to make you aware of our new award for SSCP Student Members, the ***Outstanding SSCP Student Award***. This award is intended to recognize outstanding graduate students who are providing exceptional contributions to the science of clinical psychology. There are three different Outstanding SSCP Student Awards:

- ***Outstanding SSCP Student Researcher Award***: Call for nominations will be placed in September 2014. One student will be selected based upon his/her research contributions to the field (e.g., publications, grants, presentations, awards). Winner will be announced in the Fall Newsletter.

- ***Outstanding SSCP Student Teacher Award:*** Call for nominations will be placed in December 2014. One student will be selected based upon his/her excellence in teaching (this can include experience as a teaching assistant). Winner will be announced in the Winter Newsletter.

- ***Outstanding SSCP Student Clinician Award:*** Call for nominations will be placed in March 2014. One student will be selected based upon his/her interest in and dedication to clinical work and service contributions to the field. Winner will be announced in the Spring Newsletter.

We would also like to formally introduce our new SSCP Student Listserv Facilitator, Andrea Niles.

Andrea Niles is an advanced graduate student in the UCLA Clinical Psychology program. Her research focuses on treatment of anxiety disorders and links between physical and psychological health. Andrea has already begun to promote discussion on the SSCP Student Listserv and provide our members with informative content!

Join the SSCP Student Listserv Journal Club!

The SSCP Student Listserv Journal Club will be starting up again this May and will take place over the summer. Students will choose a topic of interest for the Journal Club and pairs of students will present an article every other week, providing both a summary and discussion questions to the Journal Club members. Look for an email on the SSCP Student Listserv in early May to join in this great learning and networking opportunity! Please email Rosanna with any questions or suggestions!

Follow us on Social Media!

Twitter: https://twitter.com/_SSCP

Facebook: https://www.facebook.com/pages/Society-for-a-Science-of-ClinicalPsychology/333436279606?ref=hl

Blog: http://sscpstudent.blogspot.com/

Contact Us!

We would love to hear from you with any suggestions, comments, questions, or concerns regarding SSCP student membership or resources for students.

Victoria Smith: vsmith@umd.edu
Rosanna Breaux: rbreaux@psych.umass.edu

Two-Way Bridge Initiative Between Research And Practice

The first round of findings of the Two-Way Bridge Initiative are now available.

The Two-Way Bridge initiative is a collaboration between the Society of Clinical Psychology (Division 12 of the APA) and the Psychotherapy Division of the APA—Division 29. It is part of an overall effort to bridge the long-standing gap between psychotherapy research and practice.

This initiative provides a way for practicing therapists to be a part of the research process by disseminating their clinical experiences in using various empirically supported treatments, which can hopefully inform future research.

For the survey findings on the use of empirically supported treatments for panic disorder, social anxiety, and OCD, visit: www.stonybrook.edu/twowaybridge.

Events at the 26th APS Annual Convention

San Francisco, CA, USA May 22-25, 2014

Society for a Science of Clinical Psychology
and
Academy of Psychological Clinical Science

SSCP Presidential Address

Bethany A. Teachman, *University of Virginia*

It's Not a Heart Attack, You're Just Out of Breath: Changing Threat Interpretations to Reduce Anxiety

Friday, May 23 | 4:00 PM - 4:50 PM

SSCP Distinguished Scientist Address

Friday, May 23 | 3:00 PM - 3:50 PM

Philip C. Kendall, *Temple University*

Psychosocial and Computer-Assisted Treatments for Anxiety in Youth

Invited Presenters

John R. Weisz
Harvard University
Mod Squad for Youth Psychotherapy: Transdiagnostic Treatment for Anxiety, Depression, and Misconduct
Friday, May 23
9:00 AM - 9:50 AM

Jennifer L. Tackett
University of Houston
Are Hormones Associated With Youth Externalizing Psychopathology?
Saturday, May 24
9:00 AM - 9:25 AM

Mark A. Gluck
Rutgers University
Global Collaborative Research on the Cognitive Neuroscience of Mood and Anxiety Disorders
Friday, May 23
10:30 AM - 10:55 AM

Clinical Science Forum

Programs of Excellence and the Delaware Project on Clinical Science Training

Lisa S. Onken (Chair), **Michael W. Otto, David A. Sbarra, Julie A. Schumacher, Steve Martino, Joanne Davila, Varda Shoham, Michael Rohrbaugh** (Discussant)

Thursday, May 22
1:30 PM - 3:00 PM

APS notes with great sadness the passing of Varda Shoham, on March 18, 2014.
A scholarship fund has been established in her name. www.psychologicalscience.org/vsfund/contribute.cfm

The Future of Clinical Science: Innovative Early Career Researchers Across the Translational Spectrum

Marc S. Atkins (Chair), **Jennifer Pfeifer, Renee J. Thompson, David A. Langer, Kate Zinsser, Timothy J. Strauman** (Discussant)

Thursday, May 22
3:30 PM - 4:50 PM

Symposia

Genes, Brain, and Environment: Biological Pathways to Psychopathology

Ryan Bogdan (Chair), **Francesca Filbey, Nim Tottenham, Luke W. Hyde, Ian H. Gotlib** (Discussant)

Saturday, May 24
9:30 AM - 10:50 AM

The Essence of Addiction: Implications for Re-conceptualizing Diagnosis and Developing Targeted Treatments

Kenneth J. Sher (Chair/Discussant), **Christopher S. Martin, John C. Crabbe, Terry E. Robinson, Reinout W. Wiers**

Saturday, May 24
11:00 AM - 12:20 PM

For more on these and other featured events at the 2014 APS Convention, visit
www.psychologicalscience.org/convention