

APA



Division 12

# 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

Winter 2016: Volume 19, Issue 1

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Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

## Presidential Column

### Generating Treatment Guidelines in the Public Interest

Steve Hollon, Ph.D., Vanderbilt University

As I write this column I am sitting in the anteroom of the Department of Psychology at Exeter University. I am over in the United Kingdom (UK) visiting colleagues (David Richards and David Ekers) who are about to break the blind on a study comparing cognitive therapy with behavioral activation in the treatment of patients with major depressive disorder. A study like that can get funded in the UK because the National Health Service (NHS) employs therapists who are competent to implement empirically supported psychosocial interventions and guidance is sought about what works for whom with a particular emphasis on psychosocial interventions. In fact, the UK has invested over 700 million pounds to be sure that therapists working for the NHS (or who want to work for the NHS) are trained to provide exactly those psychosocial interventions that have been shown to be efficacious in randomized clinical trials. David Clark, the chair of experimental psychology at Oxford, and Richard Layard, the world-renowned health care economist at the London School of Economics, devised a program called Improving Access to Psychological Therapies (IAPT) that oversees this process and made the case to the government that ensuring access to quality psychosocial interventions is not only good for the people who get treated but also makes economic sense (Layard & Clark, 2015). The National Institute for Health and Care Evaluation (NICE) provides the necessary guidance under the able leadership of Steve Pilling (a psychologist) and Tim Kendall (a psychiatrist). NICE commissions multidisciplinary panels of experts and consumer advocates to generate treatment guidelines based on carefully conducted systematic reviews to identify just what works and for whom and the NHS then follows those recommendations to guide the training it provides (under the auspices of IAPT) to the therapists it hires. Training is provided in whatever works (including interventions that are decidedly not cognitive or behavioral, like interpersonal psychotherapy and family focused interventions) and an ongoing system of outcome monitoring is rigorously maintained (Clark, 2011).

We have nothing like it in the United States (US), but we are moving in that direction. The Affordable Care Act (ACA) (aka Obama Care) promises to change the health care landscape with regard to reimbursement for the treatment of psychological disorders. Well in advance of that landmark piece of legislation, the

American Psychological Association (APA) embarked on a program to generate treatment guidelines for the various psychological disorders (Hollon et al., 2014). APA has long dragged its heels with respect to identifying the empirically supported treatments (most of its dues paying members are practicing clinicians who are concerned about restrictions on their practice) and it has been slow to embrace the call for using science to guide clinical practice. Early efforts to identify efficacious interventions on the basis of high quality science met with strong resistance, but there has been a change in leadership at the top (torture is out and science is in) and the climate has clearly changed within the organization. The federal government made an effort to generate treatment guidelines back in the early 90's and did a reasonable job with an early effort on the treatment of depression in primary care (Munoz et al., 1994), but ran afoul of Congress when a subsequent guideline found little value in surgery for back problems (never doubt the power of money in professional affairs). By and large, the process of generating treatment guidelines was left in the hands of the various professional organizations like the American Psychiatric Association (the other APA) and the products they produced tended to reflect the biases and economic interests of their profession. As George Bernard Shaw once said all professions are "conspiracies against the laity". (There is nothing unique about the other APA in that regard; witness the recent pronouncement by APA Council that all psychotherapies work and that they all work equally well and that all you have to do is ask a licensed clinical psychologist.) Managed care corporations also were busy generating treatment guidelines but often in two forms, a more reasonable public version that they used to sell their product to interested corporations and a more restrictive private versions that they used to deny even the most reasonable requests for service (Stricker et al., 1999). Capitalism is a marvelous engine of growth and innovation but all too often it is powered by avarice and greed.

The recently commissioned Agency for Health in Research Quality (AHRQ) is now allowed to commission systematic reviews but not to generate treatment guidelines. That is left to various professional organizations like the APA and others (although the AHRQ is clearly going to press for them to work together in the public interest). The Institute of Medicine (IOM) recently formulated standards

for exactly how to generate such guidelines (based on international standards like those instantiated by NICE) that represent a marvelous compilation of current best practices in the field (IOM, 2011a,b). The IOM recommends having an independent group of methodological experts conduct a systematic review based upon the best available scientific evidence (framed around the key questions of interest) that is then presented to a multidisciplinary panel of experts who are asked to integrate the identified benefits and harms through the lens of clinical judgment to arrive at specific actionable recommendations that can be used to guide clinical practice. The whole process is rather like conducting a jury trial with the systematic review used to generate the evidence and the guideline panel serving as the jury. A key feature is that the guideline panel be multidisciplinary in nature. Human nature being what it is, perhaps the best way to deal with conflicts (whether related to financial interests or intellectual passions) is to balance them off by appointing people with competing interests. This is the process that cognitive psychologists refer to as **adversarial collaboration** (Mellers, Hertwig, & Kahneman, 2001). That is the tact that we have advised the APA to take in generating their treatment guidelines and that is the course that they have followed. For example, the panel that we have constituted to generate the guideline on depression is composed of psychologists, psychiatrists, and family practitioners with respect to professional affiliation, with participants who represent dynamic, behavioral, humanistic, and family systems orientations. Some are scientists, some are practitioners, some are administrators, and some are two or three. I will have more confidence in the recommendations that such a diverse group generates than whatever I (or any other member of that group) could have arrived at on our own. We have members of other relevant professions serving on other guideline panels and patient advocates (including former patients) serving on them all. The latter serve to keep the professionals honest. It is helpful to be reminded that we are dealing with real people with real lives when we make our recommendations and it helps to have people who have had to live with those issues participate in those deliberations.

We hope in the future to join forces with other professional organizations to produce guidelines jointly. We are already in conversations with the Academy of Child and Adolescent Psychiatry regarding a guideline on oppositional defiant disorder in childhood and plan to start talks soon with the American Psychiatric Association with respect to a guideline on schizophrenia. No profession has a monopoly on the various approaches to treatment and we can do better by the public if we do not continue to produce guidelines that are tainted by guild interests. People have to make real choices regarding their various treatment options

that they face and they are entitled to information that informs them about the benefits and harms in a manner that allows them to make an educated decision in accordance with their preferences. All of this should rest squarely on the best scientific evidence currently available. If what the APA does (and other professional organizations do) is in the best interest of the public, then it will be in the best interest of the organization.

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## Welcome New SSCP Board Members

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## Financial Report

**Secretary/Treasurer**

**Kate McLaughlin, Ph.D.**

### RECENT FINANCIAL ACTIVITY

Income - \$6800 in dues

Expenses - \$2000 for Dissertation Awards (\$500 each, four awards); \$30 monthly PayPal fee

Pending reimbursement - \$1046.95 (purchasing error)

## Call for Applications Varda Shoham Clinical Science Training Initiative Grant Program

Applications are invited for small (up to \$1500), non-renewable grants for training programs at the pre-doctoral, internship, or postdoctoral levels to launch new projects or support ongoing initiatives designed to more effectively integrate science and practice into their training program.

The Initiative provides three tracks for applicants: 1) Conducting science in/on applied settings, 2) Innovation in clinical science training or resources, or 3) Value-added to the program. These tracks are aimed at maximizing the diversity of applications and awards given.

Applications are due by March 31, 2016, and funds will be distributed in summer 2016. Application instructions are list of past awardees can be found at: <http://www.sscpweb.org/page-18087>

The application is short and easy, so please consider applying!

For more information on the grant and coverage of prior winners, see the APS Observer: <http://www.psychologicalscience.org/index.php/publications/observer/2012/january-11-2012-observer-publications/training-grants-encourage-integration-of-clinical-science-and-practice.html>

# Diversity Corner

## Sex and Gender in Clinical Science Research

Sarah Tarbox-Berry, Ph.D. and Yesel Yoon, M.S.

Clinical science has a long history of confounding the terms “sex” and “gender”. Although many studies purport to include gender as a variable, what is actually being measured is sex. In fact, gender is rarely considered unless it is a specific focus of study. Unfortunately, improper use of these terms remains commonplace, even among eminent researchers, and continues to be passed down to future generations of clinical scientists. This article addresses key, research-pertinent distinctions between sex and gender and considers relevance of gender assessment to clinical science research. A list of references and resources are provided at the end of the article. We begin with (research friendly) definitions of sex and gender (APA, 2011; WHO, 2015).

### Definitions

**Sex:** Male or Female. This is a discrete, categorical variable. Category assignment is based on a set of biological attributes, including chromosomes, physical features, hormones, and reproductive anatomy.

**Gender:** Femininity and Masculinity. These are multi-dimensional, non-mutually exclusive constructs representing socially determined characteristics, behavior, and roles of males and females.

### Distinguishing Sex and Gender

As variables, sex and gender have distinct properties and connotations that affect assessment, analysis, and interpretation of results.

Sex is a well-behaved, low maintenance variable. It typically consists of two distinct categories, male or female (although “intersex” or “other” can be included as an additional category), it is easily assessed by self-report (DNA testing or physical exam are valid, but unnecessarily invasive), and results are generalizable across populations and studies. That said, when we assess sex, it is important to be clear on what is and is not being measured. This sounds silly. Obviously, we want to know if a subject is male or female. Yet, it can be easy to forget that these data are collected independent of social context and interpretation is specific to biological effects. On its own, sex does not reflect the influence of social roles or norms. Without information about social context and environmental factors, interpretation is limited to effects of male and female physiology.

Gender can provide this missing information, allowing for more nuanced interpretation of results.

Gender is highly relevant to human experience, impacting social and cultural roles and expectations, social cognition and behavior, self-perception and perception by others, decision making, socioeconomic status, help-seeking behavior, experience of illness, and social wellbeing. Accordingly, characterizing the role(s) of gender is relevant to many areas of clinical science and has implications for psychological treatment, public policy and law. Gender also can interact with a number of commonly assessed variables, including age, education, income, family structure, and interpersonal functioning, and may influence results. Assessment of gender can be uniquely informative and aid interpretation of other measured variables. However, gender norms can vary greatly between and within populations. As such, for main and interaction effects to be interpretable, gender must be carefully operationalized and appropriately assessed within a well-characterized sample.

There are several resources that can assist with selecting measures of gender and integrating gender assessment into a research protocol or program. Three sources are described here, but this list is certainly not exhaustive. References and links for these and other resources are provided below.

The Williams Institute, a collaborative research initiative on sexual orientation and gender identity law and public policy, provides examples of different approaches to gender assessment. Among those discussed are: 1) a two-item method of assessing socially assigned gender expression, with the first item assessing gendered appearance and the second assessing gendered mannerisms (e.g., very feminine to very masculine) and 2) a “single” item assessing both gender identity and sexual orientation, structured as a series of Yes/No questions (e.g., Are you straight? Are you gay or lesbian? Are you bisexual? Are you transgender, transsexual or gender-variant? Are you not listed above?).

The World Health Organization (WHO) provides research and literature on gender, particularly in the context of health risk and services. Resources include information on the roles of sex and gender on health outcomes. Assessment tools are also available, with a particular focus on gender analysis and use of these data in health-related contexts.

The Institute of Gender and Health (IGH), Canadian Institutes of Health Research, promotes integration of sex and gender into biomedical and health research. They offer a variety of resources for researchers, including publications, education, and strategies for using sex

and gender in research.

### Relevance of Gender to Clinical Science Research

Assessing gender and integrating this information into research can be a step towards improving clinical science. The following is a brief discussion of the potential benefits of assessing gender, as well as the challenges researchers may encounter when considering or trying to implement the assessment of gender in research.

**Benefits of assessing gender.** As opposed to attributing similarities or statistically significant differences between groups to biological sex, gender-informed data allow for the possible influence of an array of social factors that may be at play. Additionally, the assessment of gender provides a more precise and sensitive measurement of the socially and culturally relevant experiences of participants. Gender can reflect the differential impact that these social and clinical phenomena have on men and women. For example, gender-sensitive research considers how social hierarchies and roles differ by gender, and we may be able to find interactions of gender and other key variables of interest such as income, education, and age. The point here is not to debunk important clinical science that examines biological sex differences and utilizes “sex” as a variable of interest in studies. The Institute of Medicine (2001) released a report emphasizing the importance of understanding the biological contributors to health, and we uphold these points and recommendations to continue promoting this research. Instead, by assessing both sex *and* gender, researchers may find that some variables are differentially associated with sex and gender. Researchers are encouraged to think about how, from study conception to dissemination of results, gender and sex can be considered separate variables and data disaggregated to clarify differential effects of biological sex and gender as a social construction.

An example of how the fields of research and health care have become more gender-conscious and attuned to gender as a key determinant of health is the strategy of “gender mainstreaming” by the World Health Organization (WHO). This strategy assumes that gender norms and roles are experienced by both men and women, but they impact individuals differently due to socially accepted values about women, or other oppressed and marginalized groups (e.g. gender non-conforming, transgender individuals). The WHO response aims to integrate gender analysis and actions into the work by the WHO, and this strategy was adopted by the Sixtieth World Health Assembly in May 2007. The WHO Gender Strategy includes ensuring capacities for gender analysis and planning, mainstreaming gender in corporate functions (e.g. gender responsive results-based management planning, budgeting, monitoring

and evaluation), disaggregating data and conducting gender analysis, and establishing accountability for mainstreaming gender. Gender is an important determinant of health outcomes (WHO 2011), and by assessing for gender and including gender-specific research, clinical science can address the implications of gender values, norms, and behaviors on mental health and other clinical outcomes.

**Challenges of assessing gender.** There are also challenges with assessing for gender in psychological research. The misuse of the term “gender” versus “sex” in psychological research may often be attributed to misinformation or lack of knowledge about the difference between these two terms. However, there may be reasons researchers intentionally choose to use the term “gender” interchangeably with “sex”, or disregard the importance or relevance of examining gender in research studies. One such reason may be due to the dimensional nature of the gender construct. From a methodological standpoint, adopting constructs that are not well defined adds “messiness” at the level of statistical analyses. A nominal category of “male” and “female” appears to be a clear-cut way of assessing for “gender”. However, as noted above, it is important that selected measures accurately reflect the conceptual variable we are interested in studying. For example, in a hypothetical study examining differences in adolescents’ academic functioning and possible results indicate that “girls perform better than boys” on an achievement test, are findings reflecting something biologically different between males and females? Or, might these findings speak to the impact of gender socialization, stereotype threat, or biases in teachers’ treatment towards girls and boys, which in turn, impacts their academic performance?

Secondly, researchers may argue that gender, as a social construct, is not relevant to their studies. Conceptually, individuals may be interested in examining differences between males and females from a categorical level on the basis of biological sex. In this case, we propose that researchers accurately reflect this goal by using the term “sex” in the dissemination of their work, not “gender.” On the other hand, those who desire to find differences in peoples’ experiences based on their gender identity, and utilize the term “gender” in their research questions, are encouraged to recognize that this construct assumes important social roles, norms and values.

Thirdly, researchers may believe that the conclusions they draw from finding “gender” differences are synonymous to sex differences. One may ask, “does it really matter?” or claim that consumers of our research will know what the intended meaning is when someone states there are effects by gender or sex. We want to challenge these assumptions and propose that clinical science should accurately reflect what we intend to relay

to the community. Specificity in our language can help reduce bias and overgeneralization, making research increasingly accurate as well as culturally sound.

## Summary

The wide-spread acknowledgement in today's society of the variance in gender identity and the greater prevalence of gender non-conforming individuals require methodological assessments and terminology to reflect this variance (APA, 2011). Scientists generally agree that variable operationalization and measurement are a key aspect of a well-designed study and essential for clear communication of findings, and sex and gender are no different. The more nuanced our assessments, the more inclusive and accurate our conclusions and in turn, the information we bring back to the community.

We end with the following resources (not an exhaustive list) that include assessment measures for gender. We encourage the growing use of gender-specific assessments to add a more clearly differentiated and accurate representation of the constructs we as clinical scientists intend to study.

## Resources

### Definitions

American Psychological Association (APA, 2011) presents an excerpt with definition of terms (sex, gender, gender identity, sexual orientation) taken from the *Guidelines for psychological practice with lesbian, gay, and bisexual clients*. Retrieved from <https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>

A comical, simplified, but poignant illustration of the differences between gender, sex, sexual orientation, and related terms is available at <http://itspronouncedmetrosexual.com/2011/11/breaking-through-the-binary-gender-explained-using-continuums/>. The continuum approach is illustrated here.

Institute of Gender and Health, Canadian Institutes of Health Research. This webpage provides definitions, information, and publications on gender in pre-clinical and clinical research. <http://www.cihr-irsc.gc.ca/e/8681.html>

The World Health Organization (WHO) Gender fact sheet N°403; August 2015 provides key facts about gender, definitions and information about gender equality, as well as the WHO response. <http://www.who.int/mediacentre/factsheets/fs403/en/>

### Gender Assessments

World Health Organization (2011), Department of Gender, Women, and Health. Gender mainstreaming for health managers: a practical approach

Williams Institute, GenIUSS group (Gender Identity in U.S. Surveillance) (2013), Gender-Related Measures Overview This document discusses models of gender assessment and provides examples of questions that assess gender. Retrieved at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/GenIUSS-Gender-related-Question-Overview.pdf>

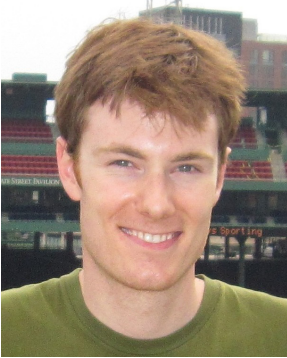
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# Awards & Recognition

## 2015 Outstanding Student Researcher Award Winners



### **Jonathan Stange, M.A.**

Jon completed his undergraduate degree with honors in Psychology at Bates College in 2008. He is a doctoral candidate in clinical psychology at Temple University and a clinical psychology intern in the Department of Psychiatry at the University of Illinois at Chicago (UIC). He studies interactions between cognitive and affective systems and vulnerability-stress models of mood disorders.

### **What are your research interests?**

I am particularly interested in flexibility, the ability to adapt to meet changing demands, a multifaceted set of characteristics that often are impaired in individuals with mood disorders and that may confer vulnerability to the onset and recurrence of problems such as depression, mania, and suicide. I evaluate individual differences in flexibility using behavioral, neural, autonomic, and self-report methods within the context of longitudinal studies with naturalistic and treatment-seeking samples.

longitudinal studies with naturalistic and treatment-seeking samples.

### **Why is this area of research exciting to you?**

Many types of psychopathology, including mood disorders, appear to be characterized by deficits in cognitive, affective, and behavioral flexibility. This research has the potential to illuminate characteristics that underlie difficulties with adjusting to stressors or to negative affective states, and that may be suitable targets for intervention to prevent or improve the course of mood disorders.

### **Who are/have been your mentor(s) or scientific influences?**

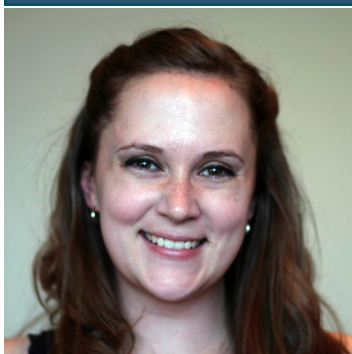
I have been fortunate to receive excellent mentorship across ten years of training in psychology. My undergraduate mentor, Michael Sargent, was influential in helping me to refine my critical thinking and writing skills while pursuing my passion for psychology. Thilo Deckersbach has influenced my thinking about grant writing, publishing empirical research papers, and thriving as a psychologist in an academic setting. John Abela inspired me to pursue questions of interest to me and to use multi-wave study designs. Lauren Alloy, my graduate mentor, has been incredibly supportive and generous with her time and energy in many domains. David Fresco has supported and facilitated my development of theoretical models of flexibility and the design of empirical studies to test these models. At UIC, Scott Langenecker has been influential in my investigation of the neural underpinnings of cognitive control using fMRI, and Luan Phan and Annmarie MacNamara have provided a wonderful environment for assessing attentional control and emotional salience using event-related potentials. Finally, I am grateful to the many other colleagues and collaborators I have had over the years, who have made my work so intellectually stimulating, enjoyable, and productive.

### **What advice would you give to other students pursuing their graduate degree?**

Time is your most precious commodity. Protect it and use it as best as you can. Pull your weight in the lab and support your classmates and the department, but don't volunteer for everything. Relatedly, it is hard to do (or be the best at) everything. Think about your long-term goals (e.g., obtaining a job as a professor at a university), use these to inform your shorter-term goals and priorities, and then budget your time accordingly. I also would recommend balancing obtaining training (e.g., learning new methods that you want to use) with being productive (e.g., publishing, if this is relevant to your career goals). For example, if you focus only on obtaining training, you may not have many (research) doors open at the end of your training because you did not publish enough. If you publish a lot but do not get training you need, you may have more doors open but feel unprepared to start your career. It also is worth investing in a balance of projects that have short- and long-term payoff. Check in with yourself periodically to see how you're doing in each of these areas, in case you need to readjust with your investment (or non-investment) in future projects.



## 2015 Outstanding Student Researcher Award Winners



### **Colleen Stiles-Shields, M.A.**

Colleen Stiles-Shields is a fourth year doctoral candidate at Northwestern University Feinberg School of Medicine. She earned her M.A. in clinical social work at the University of Chicago and her M.S. in clinical psychology at Northwestern University. Colleen's research focuses on better understanding behavioral health concerns in an effort to overcome barriers to treatment, improve treatments, and increase access via alternative delivery mechanisms (i.e., technology, telehealth). She is currently conducting a National Institute of Mental Health-funded research project on mobile apps for depression to improve design and usability of mental health apps, and to identify comparative outcomes of face-to-face treatments for depression instantiated within apps.

### **What are your research interests?**

My main research interests are around the development, evaluation, and dissemination of Behavioral Intervention Technologies (BITs) for behavioral health concerns in adolescents and adults.

### **Why is this area of research exciting to you?**

I began my career as a social worker. Time and time again, I witnessed clients with emotional, practical, and cultural barriers to initiating or maintaining treatment. While these barriers frustrated me, I came to the realization that a strong solution existed in the increasing use of technology; a trend that stretched across all demographics. Initiating research in the growing field of Behavioral Intervention Technologies (BITs) has been thrilling—from getting to investigate a variety of avenues to improve BIT efficacy and reach, to having the opportunity to work with a variety of talented, multi-disciplinary teams. It's difficult to describe the excitement I have had when receiving anecdotal feedback from participants who note how their life has transformed from exposure to an evidence-based intervention; something made feasible for them because the intervention was delivered through technology. In this way, having the opportunity to research the delivery of behavioral health interventions through technology ties directly to some of my earliest clinical experiences.

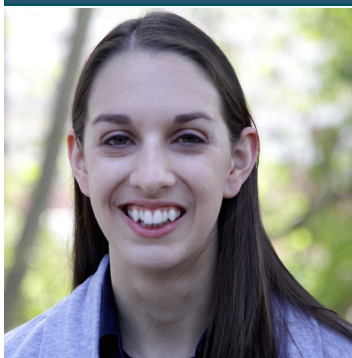
### **Who are/have been your mentor(s) or scientific influences?**

I was incredibly fortunate to start my research training under Dr. Daniel Le Grange at the University of Chicago. He taught me how to run an incredibly "tight ship" when it came to executing a research study and encouraged me to work on writing and dissemination by always asking, "When's the next one?," following the submission of every paper. Since starting graduate school, I have had the privilege of working with and being mentored by a multi-disciplinary group of individuals, including Drs. Jenna Duffecy, Stephen Schueller, Jackie Gollan, Mary Kwasny, Tina Drossos, Khalid Afzal, Enid Montague, and many others. However, my strongest influence has been my primary research mentor, Dr. David Mohr, who is a superstar in the field of BITs. David is a gifted writer and consistently shows incredible insight into research mechanisms by how he poses and answers research questions that arise in the burgeoning field of BITs. As a mentor, David has provided ample room for autonomy, yet has challenged me to learn and grow as a researcher, writer, clinician, and professional.

### **What advice would you give to other students pursuing their graduate degree?**

Learn from as many people, in as many places, as you can. Supervisors, professors, and other researchers are typically very kind and open to collaboration and contributing to your learning and development. The key thing is to keep your mind open, to ask lots of questions, and be excited when doors of opportunity open—and run through them! However, an important piece of remaining open and excited is through replenishing your resources. Also go spend time with friends and talk about non-research things, watch Netflix, try out a yoga class, etc. Graduate school is such a unique time to get to learn so many things, but also to take breaks to have the capacity to take it all in and grow.

## 2015 Outstanding Student Researcher Award Winners



### **Hannah Williamson, M.A.**

Hannah Williamson is a graduate student in Clinical Psychology at the University of California, Los Angeles where she works under the mentorship of Drs. Thomas Bradbury and Benjamin Karney. She received a BA in Psychology from the University of Rochester and was awarded the Department of Psychology's Zimmer Award for completing the best Honors Thesis of the graduating class. Over the course of her graduate work she has been awarded an NSF Graduate Research Fellowship, the Psi Chi/APA Edwin B. Newman Graduate Research Award, and the Administration for Children & Families, Family Strengthening Scholars Grant for her work in understanding basic relationship processes and evaluating interventions for low-income couples. She will graduate from UCLA in 2017 and plans to pursue an academic career in psychological science.

### **What are your research interests?**

My research focuses on understanding the challenges that low-income couples face in trying to make their relationships succeed, and on evaluating interventions intended to improve the quality of life for these couples and their children. In my basic studies I am particularly interested in understanding the mechanisms through which contextual factors such as stress and financial strain erode relationships. My applied work has used data from experimental studies to determine whether interventions designed to strengthen low-income couples and families achieve their intended aims.

### **Why is this area of research exciting to you?**

Intimate relationships are so interesting because the basic act of being in a romantic relationship with another person is an innate human drive, but when we begin to look at things like marriage, divorce, and childbearing the concept becomes much more socially constructed and dynamic. Add to that the rising income inequality in our country and the fact that more and more couples are finding themselves trying to keep their families together in the face of very stressful and difficult circumstances. Understanding how the ecological context impacts these families and developing effective methods of addressing their needs is a challenge that will not easily be solved and thus I am excited to dedicate my career to this issue. I definitely see this field changing over the course of my career as public opinion on marriage, divorce, and cohabitation shifts and government policies on employment and social safety nets change and this dynamism keeps me motivated and excited. I also find it exciting that addressing this problem requires the skills of a clinical psychologist who can conduct basic and applied research but also draws from other approaches such as community psychology, sociology, and economics.

### **Who are/have been your mentor(s) or scientific influences?**

I have been lucky to be surrounded by a group of outstanding clinical scientists here at UCLA, including my mentor Tom Bradbury and the rest of the clinical area faculty. Tom has been such an exceptional mentor throughout my graduate career. He has supported my interests and has pushed me to pursue big ideas and important problems in the most rigorous way. I was also lucky to get a two-for-one deal when I came to UCLA in that our lab is co-advised by Ben Karney, who is a social psychologist. Working with Ben and having this mix of perspectives in our lab has been so important in helping meld the basic and applied sides of my research. Ben is such a rigorous theoretical thinker and he has really pushed me and made every bit of my work better. Finally, I have had the good fortune of being supervised in integrative behavioral couples therapy by Andy Christensen, which demonstrated to me how interventions derived from rigorous outcome research can be combined with assessment, clinical judgment, and genuine compassion to promote the well-being of couples in distress.

### **What advice would you give to other students pursuing their graduate degree?**

Grad school is long and hard and it is easy to get bogged down in the day-to-day and lose sight of the bigger picture and why you pursued this path in the first place. To combat that I think it's important to find a real problem that exists in society that you are passionate about and remind yourself that you are pursuing a solution to that problem. I also think it's important to be open to using any feasible approach to address the problem because the answers will not always come within disciplinary bounds. This is also a good reason to read papers, attend talks, take courses, and network outside of your narrow field because, in my experience, new ideas, statistical techniques, etc. often come from other fields.

# Awards & Recognition

## 2016 Distinguished Career Award Winner



**David M. Clark** will be the 2016 recipient of the Distinguished Career Award from SSCP. David is a Professor of Experimental Psychology at Oxford University and a former recipient of the Distinguished Scientist Award from the American Psychological Association. He has made a series of remarkable breakthroughs in the treatment of the anxiety disorders (panic and social anxiety in particular) and has taken the lead in promoting the dissemination of the empirically supported treatments in the United Kingdom and abroad. He is the driving force in Increasing Access to Psychological Therapies (IAPT) the largest and most ambitious program ever attempted to disseminate the empirically supported treatments (with 700 million pounds devoted to training NHS therapists in those treatments). His work is remarkable both in the quality of the treatments he has developed and the skill with which he has promoted the dissemination of treatments that work. Professor

Clark will receive the Distinguished Career Award this coming May at APS in Chicago and will be giving a major address in conjunction with the receipt of that award.

## Outstanding Student Teacher Award Winners

The award committee has completed its review of applications, and was very impressed by the large number of phenomenal, truly exceptional candidates and their exceptionally advanced teaching accomplishments and experiences. We are very pleased to announce the three winners of the SSCP Student Outstanding Teacher Award! Please look in the spring newsletter for interviews with each of our three award winners.

### **Alexander J. Williams, M.A.**

Advisor: Sarah B. Kirk, Ph.D., ABPP

University: University of Kansas

Expected graduation: July 2016

Internship: VA Eastern Kansas Health Care System

### **Kimberly Kamper-DeMarco, M.A.**

Advisor: Jamie M. Ostrov, Ph.D.

University: University at Buffalo, SUNY

Expected graduation: September 2016

Internship: University of Rochester Medical Center

### **Anne Winiarski, M.A.**

Advisor: Patricia Brennan, Ph.D.

University: Emory University

Expected graduation: August 2017

# Awards & Recognition

## Dissertation Award Winners

### **Anne Malaktaris, M.S.**

Advisor: Steven Jay Lynn, Ph.D., ABPP

University: Binghamton University

“Attentional capture and difficulty disengaging from threatening and pain-related stimuli in chronic pain and clinical anxiety populations”

### **Andrew Peckham, M.A.**

Advisor: Sheri Johnson, Ph.D.

University: University of California, Berkeley

“Transdiagnostic cognitive control training for emotion-relevant impulsivity”

### **Katharine Reynolds, M.A.**

Advisor: Candice Alfano, Ph.D.

University: University of Houston

“Impact of experimental sleep extension on adolescent social emotion regulation”

### **Marianne Rizk, M.A.**

Advisor: Teresa Treat, Ph.D.

University: University of Iowa

“The effects of caloric education, trial-by-trial feedback and their interaction on college-aged women’s abilities to estimate caloric content”

**Join us in Chicago...**

## **SSCP Events at APS (May 26-29)**

**Board meeting** - Friday 5/27 8:00 AM - 10:00 AM

**Poster presentations** - Friday 5/27 10:00 AM - 10:50 AM

**Distinguished Scientist Award Address** - Friday 5/27 4:00 PM - 4:50 PM

David M. Clark, Oxford University, *“Developing and Disseminating Effective Psychological Therapies for Anxiety Disorders: Science, Economics and Politics”*

**Presidential Address** - Friday 5/27 5:00 PM - 5:50 PM

Steven D. Hollon, Vanderbilt University, *“Treatment Guidelines and ESTs”*

**Student Event** - Details TBD (watch for an email from the student representatives)

# Clinical Science Early Career Path

**Blair E. Wisco, Ph.D., University of North Carolina at Greensboro**

My path to becoming a clinical scientist is likely similar to the routes that led many SSCP members to this career. I first became intrigued by an introductory psychology course at the University of Pennsylvania. I decided to major in psychology and then volunteered in a lab to get research experience. I quickly became fascinated by the process of research and knew that I wanted to pursue an academic career as a clinical psychologist. Between college and graduate school, I worked as a research assistant for Aaron Beck, where I became interested in the role of cognition in psychopathology. I then attended Yale University for my graduate training, where I was mentored by the late Susan Nolen-Hoeksema. I couldn't have asked for a better advisor. Susan was not only a brilliant scientist and a truly gifted writer, she was also a kind and decent person. I feel very lucky to have worked with her for as long as I did. After graduate school, I headed off to the Boston Consortium for my internship, where my clinical work treating combat veterans with posttraumatic stress disorder (PTSD) got me interested in studying trauma. I stayed on for a postdoctoral fellowship at the National Center for PTSD. A highlight was the opportunity to work with Brian Marx, whose mentorship cemented my budding research interest in traumatic stress. On post-doc, I was also fortunate to work in an environment that highly valued collaboration - I got to work with many different psychologists, each with different areas of expertise. After post-doc, I got my "dream job" - a tenure-track position in a psychology department. Currently, I'm in my third year on the faculty at the University of North Carolina at Greensboro. Although life on the tenure-track can be challenging, I must say that I absolutely love my job. I get to have my own lab, pursue research questions that I am passionate about, and help train the next generation of clinical scientists.

In reading through the other early career columns for this newsletter, I noticed that many ended with some advice for others in the early career stage. I decided to switch things up a little bit and use the cognitive theory that was so influential to me in my early days in Dr. Beck's lab. Below, I list four "cognitive distortions" that are common during the early career phase, along

with some musings about them.

## ***Distortion 1: "Now that I'm a professor, I shouldn't need my mentors anymore."***

I never questioned the fact that I would need a mentor during graduate school - that's just a given. But I didn't realize how much I would continue to consult my mentors as a professor myself. A recent conversation with a colloquium speaker drove this point home for me. He was discussing his plans for retirement, and mentioned that he would need to help more junior colleagues take over some of his research projects. I asked who these junior colleagues were - were they assistant professors or perhaps postdocs? He laughed and explained that he was talking about other full professors. Mentoring is important throughout your *entire* academic career. After graduate school, though, mentors can be harder to find. I am fortunate that my department automatically assigns all assistant professors a senior faculty mentor. Personally, I've found this program really helpful - I feel more comfortable going to my mentor with questions knowing that he has officially agreed to this role. But, whether or not your department has this kind of a program, you're unlikely to get all of your mentoring needs met by one individual. I also rely on a more informal network including former mentors and other faculty in my current department. And as important as good mentors are, sponsors are equally important to your success. A mentor is someone who provides advice and guidance, whereas a sponsor is someone who advocates for you when you're not around (e.g., during your tenure review).<sup>1</sup> As a junior faculty member, you need both!

## ***Distortion 2: "I have no idea what I'm doing."***

This distortion is the flip side of the last one - you think that you should have everything figured out on your own, and you secretly fear that you have *nothing* figured out. Also known as the "imposter syndrome," this distortion is likely to hit you at some point. You can take comfort in the fact that many of your peers are experiencing the same thoughts, and that the imposter syndrome is by no means unique to clinical psychology. Although this distortion feels true, the best way to

challenge it is to remind yourself that your department hired you for a reason. You were selected from a very large pool of competitive applications - you must be doing something right.

***Distortion 3: “I have to be perfect at all aspects of my job.”***

People who go into academia tend to be over-achievers. Not only do we want to be the best researchers, but we also want to be the best teachers, mentors, and departmental citizens. Oh, and we want to do this all effortlessly and still maintain a perfect “work-life balance.” The truth is, as an academic clinical psychologist, you wear a lot of different hats. You’re a researcher, teacher, mentor, clinical supervisor – each of these roles could easily be a full-time job on its own. There simply aren’t enough hours in a day to do it all, so you have to prioritize. The natural tendency is to prioritize tasks based on their deadline. This strategy doesn’t work well when some of your most important tasks (writing papers, coming up with grant ideas) have no defined due date. Rather than prioritizing things based on when they are due, prioritize them based on their importance.

***Distortion 4: “I shouldn’t spend time on service.”***

Like many cognitive distortions, this one has a grain of truth, but has been taken to an extreme. Service includes activities like volunteering for an SSCP committee, reviewing an article for a journal, or serving on a student’s dissertation committee. It’s definitely true that service counts the least towards tenure, and service takes valuable time away from the activities that will get you tenure: writing grants and manuscripts. But, I will say that service assignments can provide some benefits that don’t get discussed as much. By serving on a committee with faculty from other institutions or accepting a review request, you’re increasing your network and helping to get your name out there. So, my advice is to be selective about the service assignments that you take on. The best service assignments offer lots of networking opportunities without too large of a time commitment.

I have highlighted a few of what are probably many cognitive distortions that will rear their ugly heads during your early career as a clinical scientist. Although the transition from trainee to independent scientist brings its challenges, it’s also an exciting time in your career. At this point, you’ve received enough training to be able to work independently, and you still have many years left to pursue your work. Try to enjoy it!

1. For more information on the difference between mentors and sponsors, check out this article:

<https://www.insidehighered.com/advice/2015/06/03/essay-difference-between-mentors-and-sponsors-academe>

**About the Author:** Dr. Blair Wisco is an assistant professor in the psychology department at the University of North Carolina at Greensboro and a licensed clinical psychologist. Her research program focuses on cognitive and emotional processes in emotional disorders, with an emphasis on posttraumatic stress disorder and depression.

Don't miss the winter issue of Division 12's

## Clinical Psychology: Science and Practice

Reviews in this issue include:

*Empirically Supported Treatment: Recommendations for a New Model* by David F. Tolin, Dean McKay, Evan M. Forman, E. David Klonsky, and Brett D. Thombs

*The Hopelessness Theory of Depression: A Quarter-Century in Review* by Richard T. Liu, Evan M. Kleiman, Bridget A. Nestor, and Shayna M. Cheek

*OCD Subtypes: Which, If Any, Are Valid?* by Marsha Rowsell and Sarah E. Francis

Find the full Table of Contents and articles at:

<http://onlinelibrary.wiley.com/doi/10.1111/csp.2015.22.issue-4/issuetoc>

# Student Perspective

**Jonah Cohen, M.A., Temple University**

*"The mind is like a parachute. It only works when it is open."* - Fortune cookie

One of my professional heroes is Dr. Paul Meehl, a famous psychometrician, brilliant methodologist, and influential theoretician. Less well known, however, is Meehl's interest in psychoanalytic thought and practice, as indicated by his own psychoanalytic therapy, the fact that he kept a chaise lounge in his University of Minnesota office, and some of his lesser known writings in which he works to put analytic thought on a firm scientific footing (e.g., Meehl, 1983).

I share this perspective on Meehl not to convince the readership of his particular ideas but to promote an approach to scientific inquiry more generally. Meehl was a follower of Karl Popper, one of the best-known philosophers of science of the 20th century. Popper argued that "imagination and criticism are the fundamental components of scientific inquiry" (Calver, 2013, p. 306) and that the scientific community needed a pedagogy of science in which students were taught to question the accepted dogma of the day. Popper believed that students should be encouraged to make bold conjectures and should then be encouraged to be highly critical of such ideas (Popper, 1970; 1985/1974). The writings of Meehl and Popper have been extremely influential in my graduate training.

Like many students in the SSCP community, I applied to graduate school because I was intrigued by the prospect of scientifically studying human experience. Subsequently, I sought a program in which intellectual curiosity and creativity, constrained by scientific rigor, would be a cornerstone of my training. Throughout graduate school, I have sought to push the boundaries of established knowledge through my coursework, clinical activities, and research. I believe that the quality of my work has benefited from this approach and that it rendered graduate school far more enjoyable than it might otherwise have been. It is this message—the virtues of questioning the scientific status quo—that I wish to impart to other graduate students.

Divergent thinking is often coupled with a fear of negative consequences. For example, a student may not want to offer a diverging viewpoint in class for fear of intellectual reprisal by peers or professors. Alternatively, a student may not want to face the stigma of adopting a clinical orientation different from his or her supervisor or department. Or a student may wish to follow his or her advisor's research closely because independent thinking could be, in the student's eyes, considered disrespectful or a mark of hubris. However, as Samantha Bernecker wrote in her Winter 2015 Newsletter commentary, I believe this deprives individuals, including oneself, of many potential benefits.

Although in clinical science more emphasis is given to research than to class work, the importance of expressing your divergent thinking in the classroom is difficult to overstate. Many individuals equate avoiding disagreements to a kind of respect. I believe this is the opposite of the truth; it often signals indifference rather than respect. The classroom, now more than ever before in your academic career, has to be a place where people can argue, debate, and disagree. Empirical facts are, after all, just temporary facts. Their "health" depends on responsible but vigorous challenges. You are extremely smart; share the wealth! You may also find that your experience in class is enlivened as a consequence.

Clinically, I urge adopting an open and potentially integrative point of view, even after you think you have found an orientation that suits your style and natural propensities. Freud studied hypnosis with Charcot until he created psychoanalysis, Beck studied psychoanalysis until he created cognitive therapy, and more recent "third-wave" behaviorists studied cognitive therapy until they discovered Eastern contemplative traditions. Evidence-based approaches extend far beyond cognitive behavioral therapy. By thinking critically about how you want to practice you do yourself and, in turn, your patients a favor. Putting aside a subscription to the latest clinical fads enables a willingness and ability to adopt a productive stance of "not-knowing" with

your patient. This exciting context of mutual discovery can profitably humble the therapist, empower the client and make the therapeutic endeavor richer and more vitalized.

Finally, although supporting your advisor's line of research is important, extending it (or perhaps even refuting some components!) is also crucial. This is the reflex against dogma that Popper hoped to promulgate. Moreover, this research approach holds considerable utility. Theoretical refinements and novel findings are often found in higher-impact journals and such an approach can serve as the foundation for establishing your own future research program. Conducting research that is personally interesting and/or contributes to the expansion of extant knowledge can also be an exhilarating experience.

So, in the spirit of Meehl and Popper, think creatively, conjecture boldly, and analyze critically. Your classmates, your clients, your research, your future career, and the scientific community all stand to benefit; and you might just enjoy in the process.

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**About the Author:** Jonah Cohen is a fifth-year doctoral student who works with past SSCP President Dr. Richard Heimberg at Temple University. His research focuses on personalizing therapeutic interventions for social anxiety disorder, identifying etiological factors for non-suicidal self-injury, and understanding the role of core beliefs and cognitive schemata associated with these conditions. Clinically, Jonah practices cognitive behavioral therapy at Temple's Adult Anxiety Clinic and practices psychodynamic and existential psychotherapy at Pennsylvania Hospital, an affiliate of University of Pennsylvania Medicine. He continues to be intrigued by the intersections between philosophy and clinical science.

Join us for...

## SSCP Virtual Clinical Lunch Talks

View the talks online & then join the discussion on the SSCP Listserv.

For February, Dr. Scott Lilienfeld presents  
**"Evidence-Based Practice and Why We Need It: Conceptions and Misconceptions"**

Find the talk here: <https://youtu.be/VFeeFloA-mOA>



# Student Perspective

## Imposter Syndrome, or: How I Learned to Stop Worrying and Love Myself

Joanna Berg, M.A., Emory University

This is a column that I wish someone had handed to me right along with my acceptance letter to grad school.

This column – along with many, many other articles, both peer-reviewed and anecdotal – might have given me a heads-up for what was to come, might have prepared me for my own struggles with depression, and might have helped me navigate the paradoxical attitudes toward self-care that are all too prevalent among both graduate students and their advisors in doctoral psychology programs.

The attitudes I'm talking about are tied to what is known as "impostor syndrome." It's the insidious feeling that you've somehow tricked everyone around you into thinking you are smarter or more capable than you truly are, and that sooner or later your deception will be discovered and you'll be ejected from your program. It's what leads to the persistent sense that we, grad students, are never good enough and never deserving of a break.

Most everyone recognizes that impostor syndrome is a normal part of grad school – and that, itself, is the idea I am challenging here. **It should not be normal to constantly feel like a fraud.** It is true that grad school admissions are cutthroat competitive. Once we are accepted to a program we may feel as though, if we do not live up to certain standards, our advisors will regret extending an offer to us over another (surely smarter and more qualified!) candidate. So we hold ourselves to unreachable expectations and self-flagellate when we don't meet them. When we are constantly working to prove ourselves in this way, stopping for breath is just not an option.

Impostor syndrome creates a vicious cycle. Striving for perfection means inevitable failure (there is always something more we could be doing), which is proof-positive that we're not good enough, which means we have to work even harder and strive for better-than-perfection, and so on. Yet, how often have we asked our patients to challenge their cognitive distortions

about achieving perfection? How often do we stress to our patients that self-care is critically important to one's wellbeing – that it is not a luxury to sleep well, to eat well, or to make time for positive activities? We are so well versed in talking about mental illness with regard to clients and research participants, but have such a very hard time acknowledging it in ourselves.

So, this column is to say: enough is enough. There are thousands of us, and we are training to become experts in mental health, and as it turns out, **we don't need to be miserable to be successful.** In fact, a hasty Google Scholar search confirms the existence of dozens of studies indicating that happiness is not only linked to success, but also appears to engender further success. The happier we are, the more productive and competent we are likely to be in just about every area; the more we are reinforced for productivity, the happier we are likely to be in turn.

In other words, with the appropriate self-application of behavioral principles, that vicious negative cycle can be turned around. This is, of course, easier said than done. (Note: Mentors and advisors, your help is quite appreciated in this endeavor.) One of the key problems with perpetual self- and other-inflicted punishment, as any behaviorist will tell you, is that it violates some of the core tenets of effective consequences. It is disproportionate to the "crime" committed, it is not temporally limited, and it is not directly linked to the behaviors we are trying to decrease. Our internal running commentaries of ruminations and negative self-talk tend to be catastrophic in magnitude – "I'll be kicked out of grad school"; "I'll never match for internship"; "Anything less than an A in this class will mean utter failure." These thoughts are nearly constant, especially once we've gotten into the habit of them (Exhibit A: think back to the last time you talked to a grad student in the midst of qualifying exams), and they tend to be unaffected by reality – existing regardless of whether we have recently underperformed on some project or another.

I will not go into detail about how to change one's thought processes, because behavioral principles are behavioral principles, and they apply to us just as well as to our clients. I will, however, encourage anyone reading this piece to practice the first step: mindfulness of one's thoughts and emotions. (It can be difficult to change thoughts or feelings if you aren't aware of them in the first place.) Take a moment to check in with yourself. What are you thinking? What are you feeling? Identify your thoughts as simply thoughts, and your feelings as simply feelings.

There are other things to be done as well, in addition to practicing cognitive and/or behavioral strategies on ourselves. Unfortunately, checking the facts, which is typically one of the best strategies for changing cognitive distortions, can be somewhat less effective in a setting where the "facts" are that most everyone around you is engaging in the same kinds of thought processes. So ask for fact-checking from people who might have a different perspective, like older grad students who have already survived the hurdles you're trying to jump. During my first year in my program, a fourth-year told me she had failed her qualifying exam the first time she took it. Yet she had passed the second time, and she continued on to successfully defend her dissertation, match with an excellent internship, and graduate the program. Although her example did not entirely alleviate my qualms anxiety, it did help me breathe easier in some of my darker hours, knowing that one failure would not sink my career.

It also bears recognizing that this is a systemic issue, rather than one based on "individual differences." These attitudes are so prevalent that, although it is helpful in the short term to change your own thinking, I would also ask that we as a field start more conversations to change the ways we approach our own mental illnesses. We need to speak more candidly about our depression, anxiety, and other issues. We need to hear from our advisors about their own struggles; we need models of successful coping, not models of perfection. We need accreditation boards to hold our programs accountable for supporting our mental health rather than brushing our difficulties under the rug. And, as we ourselves earn our doctorates, we need to remember where we've been, and pay it forward to the next generations. We have chosen to dedicate our lives to helping others do better – so let's do better ourselves.

**About the Author:** Joanna Berg is a sixth-year PhD student in clinical psychology at Emory University. She is currently completing her clinical internship at Yale University. Her research focuses on the differential contributions of impulsivity and disinhibition to maladaptive behavioral outcomes, including substance abuse, self-harm, and suicidality; her clinical interests focus on the dissemination and implementation of Dialectical Behavior Therapy.

# Clinician Perspective

## A Clinician-Friendly Guide to Incorporating Technology into Evidence-Based Practice

Jenna Carl, Ph.D., Cognitive Behavior Therapy and Science Center

Many psychologists are interested in incorporating technologies, such as CBT or behavioral health digital applications (“apps”), into their clinical practices. And yet, they may hesitate to do so for several reasons (Eonta et al., 2011; McMinn, Bearse, Heyne, Smithberger, & Erb, 2011). They may wonder how integrating technologies into care fits with an evidence-based practice (EBP) model. They may be overwhelmed by the sheer volume of apps and devices, and not know how to select among them. They may be apprehensive about privacy limitations. Or they may be unsure how clients will react to being asked to use technology in therapy. Understandably these questions can be daunting, and many busy psychologists stick with what they know rather than spend the time to research and implement new practices. However, some psychologists have found a way to add technologies to their services with great results. This article aims to illustrate how new technologies can support EBP, how clinicians can overcome barriers to incorporating technologies into their practices, and provides examples of how a handful of innovative clinicians are using technologies to improve their treatment.

One reason clinicians refrain from incorporating new technologies into their services is because of a concern that they are not evidence-based. Indeed, most apps lack sufficient empirical data to be deemed efficacious as stand-alone treatments. However, for the clinician who wishes to apply a true EBP framework, there is ample opportunity for augmenting therapy with technology. The “three-legged stool” of EBP calls for providers to integrate the treatment literature with clinical judgment and client preferences. From this perspective, clinicians are providing the highest quality care when they use their clinical judgment to apply findings from treatment research in a way that is the best fit for the particular client. Thus, if the clinician judges a technology to be consistent with evidence-based principles from the treatment literature and the client’s unique needs and preferences, then utilizing it with the client is fully congruent with EBP. In fact, clinicians may be led astray by aiming to select apps based on the degree of research support in absence of considering whether the components of the app align well with the

client’s treatment targets. For example, a depressed client with prominent insomnia, may benefit more from a less researched app that closely monitors insomnia than the more researched depression app that does not address insomnia. In other words, the most effective technologies will be those that match the client’s particular set of problems or needs.

Clinicians are also intimidated by the multitude of apps available. The good news is several forums for app reviews are emerging, including on the websites of mental health organizations (e.g., <http://www.adaa.org/finding-help/mobile-apps>) and in systematic reviews of apps for different problem areas (e.g., Fairburn & Rothwell, 2015). Sharing and discussing apps with colleagues is another great way of finding them and learning how clinicians are using them. Hopefully, recognizing that clinicians can use their clinical judgment in selecting apps rather than solely relying on the level of research support for an app, may also make the process less daunting. Nevertheless, it is important that clinicians test out apps themselves to make sure they are consistent with evidence-based treatment principles.

Clinicians are also wary of the privacy risks inherent in using technology in treatment. Apps provide varying levels of security and privacy for user data, thus it is important to review the privacy policy of each app before recommending it to clients. Consider what type of data the app collects (e.g., personal health information, geo-location, billing information), whether the data is encrypted, where the data is stored (e.g., on the client’s device, cloud servers), how the data may be used, and whether it may be shared with third parties. For children under 13, clinicians can search for apps which are COPPA compliant, ensuring a higher level of security. But even apps offering enhanced security still have privacy risks, thus it is critical that the clinician understands and discusses these risks with the client before they implement them.

Being able to use technologies within an evidence-based practice framework, affords clinicians many novel assessment and intervention tools. Fur-

ther it allows them to function as innovative scientist-practitioners who are forming hypotheses about potential mechanisms (e.g., core beliefs, lack of reinforcers, etc.) underlying the client's problems, and selecting targeted assessment or intervention tools that will optimize the client's treatment outcomes. Clinicians should be encouraged to think creatively about how and what technologies, from the most basic to the most sophisticated, may benefit their particular client. Below I provide a handful of examples from innovative psychologists that illustrate the potential for enhancing evidence-based practice with technology.

Carol Friedland, Ph.D., in NY, has clients with chronic anxiety set their phones to vibrate every 30 minutes as a cue to take one slow, conscious breath that facilitates tension-reduction and present-focused attention, intervention objectives associated with decreasing anxiety. Jennifer Lish, Ph.D., in MA, uses text messaging with adolescent OCD clients to conduct imaginal exposure and response prevention (ERP) between sessions. Rebecca Shingleton, M.A., in NY, sends text messages as between session motivational reminders for clients with eating disorders. Yvette Tazeau, Ph.D., in CA and Robert Reiner, Ph.D., in NY, utilize mobile virtual reality goggles that sync with smart phones to provide a range of exposure content for their clients. Additionally, many clinicians are augmenting their therapy with smart phone apps for assessment of specific treatment targets or skill practice. There are apps for phones and/or wearable devices that facilitate ecological momentary assessment of therapy targets, such as mood, anxiety, eating, exercise, sleep, or impulsive behaviors, as well as apps that assess therapeutic alliance. Mark McGinn, Ph.D., in OR, uses an app he co-developed that collects client feedback at each therapy session and charts these data so the therapist may make modifications to improve the alliance and outcomes. And then there are apps that provide access to intervention content or techniques, such as PTSD apps that provide personalized stress management tools and prolonged exposure recordings or suicide prevention apps that connect clients with crisis intervention resources when they are feeling at risk. Innovative clinicians are integrating a wide range of smart phone apps into therapy, searching broadly to find apps suited to specific client needs. Dr. Tazeau, who uses a variety of apps in her therapy, describes examples such as using an app tracking menstrual cycles for adolescent girls who have anxiety associated with menstruation and an audiovisual timer app for children with developmental difficulties that need help building internalized time-management skills.

These examples from innovative, early adopters highlight the potential for enhancing evidence-based practice through the integration of new technologies. Moreover, such clinicians report an overwhelmingly positive response from their clients to the idea of using technology in treatment. The integration of technology into mental health practices is barreling forward. If you are a clinician who has been interested yet apprehensive about incorporating technologies into your practice I encourage you to face your fears while exercising your good clinical judgment. There is much to gain!

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# Update from Student Representatives

**Andrea Niles, M.A., University of California, Los Angeles**  
**Jessica Hamilton, M.A., Temple University**

As your student representatives, we would like to take this opportunity to update you on a couple opportunities and resources for our members:

**SSCP Internship Hotel Match-Up** - The SSCP Internship Hotel Match-Up had a successful first year! This resource, available for those applying to internship, allows students to complete a request for dates and locations for which they would like to share a hotel. Students can then find other students with requests for the same date and location and contact them to make hotel arrangements. This year, we had 113 entries into the database, which included 51 individuals and 65 cities. We are going to collect feedback from students about their experience with the match-up, so look for an email with a survey link in the next few weeks. Your feedback will help us improve this resource for future years.

**Outstanding Student Clinician Award** - SSCP is accepting nominations for the Outstanding SSCP Student Clinician Award. This award is intended to recognize outstanding graduate students who are providing exceptional contributions to the field of clinical psychology through their clinical work. One student will be selected based upon his/her interest, dedication, and exceptional performance in clinical work. Selected students will be featured in the Outstanding SSCP Student section of the SSCP Newsletter. Applications must be received by March 1, 2016. Please see the SSCP website for details on how to apply (<http://www.sscpweb.org/page-18132>).

**SSCP Student Poster Award Competition at APS Convention** - The 2016 SSCP Student Poster Award Competition will take place at the APS Annual Convention, May 26-29, 2016 – Chicago. Come by the poster session at APS (check the program for location and time) to see this year's competitors!

**Become More Involved in SSCP** - Looking to get more involved in SSCP? Let us know! We have an open position for communications manager and are hoping to expand our network of campus representatives. This could be a great opportunity to become more involved in SSCP. More information will be sent out shortly, but please email Jessica or Andrea if you are interested.

## Contact Us!

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

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