



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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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

Clinical Psychology and the Replication Crisis: Where Have We Been?

Scott O. Lilienfeld, Ph.D., Emory University

Unless you have been living in a cave for the past few years, or have just returned from an extended vacation on Mars, you probably know that the field of psychology has recently been embroiled in a crisis of sorts. Termed the “replication crisis,” it is every bit as much a crisis of confidence as of data. Specifically, many of us have come to doubt the robustness of at least some of the core findings in psychology that we had long taken for granted (Lilienfeld & Waldman, 2017).

The replication crisis is a perfect storm of sorts, reflecting the confluence of several separable but converging trends. First, in 2005, medical epidemiologist John Ioannidis, now at Stanford University, wrote a bombshell article entitled “Why most published research findings are false” (which has been cited over 4500 times as of this writing) in which he conducted simulations that appeared to show that most published results in medicine were very likely to be erroneous or exaggerated (Ioannidis, 2005). Second, six years later, my former undergraduate advisor at Cornell University, Daryl Bem (2011), published an article in the marquis journal in social and personality psychology, *Journal of Personality and Social Psychology*, that purported to find evidence of precognition (one of three ostensible forms of extrasensory perception). Many critics howled in derision, finding Bem’s results to be both highly implausible and based on problematic methodology. Third, the field of psychology was shaken by several cases of egregious but undetected fraud by several prominent researchers, perhaps most notably that of Dutch social psychologist Diederik Stapel (Carey, 2015). Fourth, in an ambitious effort to gauge the magnitude of the reproducibility problem in psychology, University of Virginia psychologist Brian Nosek and his collaborators at the Open Science Collaboration attempted to replicate 100 published studies in social and cognitive psychology. Depending on the metric used, only about 40 percent of the original studies replicated (Open Science Collaboration, 2015). Although this figure does not demonstrate – despite widespread media pronouncements – that the original findings were erroneous, it reminds us that we can no longer take the replicability of our findings for granted.

In response to these developments, there have been numerous calls for reforming our standard ways of doing research business in psychology (Lindsay, Simons, & Lilienfeld, 2016). Despite the enormous impact of the replication crisis on research practices in many domains of psychology, especially social and cognitive psychology, our own field of clinical psychology has remained

largely insulated from these important debates. Articles on the replication crisis in the pages of clinical psychology journals have been few-and-far-between, as have open discussions of this crisis at clinical psychology conferences. Even on the often far-ranging Society for a Science of Clinical Psychology (SSCP) listserv, there has been a surprising dearth of debate concerning the replication crisis and potential remedies for it.

In a recent article that is “in press” at the Association for Psychological Science (APS) journal *Perspectives on Psychological Science* (Tackett et al., in press), we briefly recounted the history of the replication crisis and examined potential reasons for clinical psychology’s virtually wholesale absence from the table with respect to ongoing replicability discussions. For example, we observed that because many of our clinical samples are difficult, expensive, and time-intensive to collect, there is often less of a “culture of replication” in our laboratories compared with those of our colleagues in experimental psychology. In addition, because the bulk of the replication efforts have thus far been directed at social and cognitive psychology, we may assume that replicability problems do not apply to us. This sanguine conclusion seems implausible. For example, a recent survey of 83 widely cited studies in our sister discipline of psychiatry found a comparable rate of nonreplication as Nosek’s team had reported for social and cognitive psychology (Tajika et al., 2015). Specifically, only 40 investigations had been subjected to replication attempts and, out of these 40, only 16 (40%) were deemed to have been successfully replicated.

If anything, there may be reasons to suspect that replicability problems may be even more pronounced in clinical psychology than in social and personality psychology. Our sample sizes are often modest; our samples are often highly heterogeneous; we often rely on psychiatric diagnoses that are themselves heterogeneous; we often test patients whose behavior is unstable across brief periods of time; we often rely on indicators, such as laboratory and functional brain imaging measures, that tend to display only modest levels of test-retest reliability; and so on (Lilienfeld & Treadway, 2016).

Fortunately, there are a host of partial solutions to the replicability challenges confronting our field (Wagenmakers & Dutilh, 2016). First, preregistration of hypotheses and analyses on publicly available websites, such as *AsPredicted.org* and *Open Science*

Foundation, is a crucial step toward enhancing the robustness of our science (indeed, in our own lab at Emory University we are now beginning, albeit belatedly, to routinely preregister all of our hypotheses and analyses, as well as make explicit which analyses are exploratory versus confirmatory). Preregistration is hardly a panacea, but it greatly minimizes the risk of p-hacking (a broad set of post-hoc analytic decisions, such as cherry-picking dependent measures, tossing out outliers, transforming data distributions, pooling or splitting samples, all designed to bring alpha levels below the hallowed threshold of statistical significance, usually .05) and HARKING (hypothesizing after results are known). These deeply problematic practices have been normative in many psychology labs for decades, and transmitted implicitly (and in some cases explicitly) to generations of our graduate students. Second, opening our datasets and stimulus materials to other researchers makes it easier for our peers to determine whether previously published findings can withstand careful scrutiny and are independently replicable. At the APS journal I currently edit, *Clinical Psychological Science*, we have instituted a badge system, modeled after that the other APS empirical journal, *Psychological Science*, which recognizes authors for preregistration, open data, open materials, or all three.

The open science revolution is coming, and it will soon be hitting clinical psychology whether we like or not (I like it, as I view it as a healthy and greatly overdue corrective for our discipline). It is high time for us to begin to reform our modal research practices and to change the way we train our clinical graduate students. At least at our premier journals, the bad old days of p-hacking our way to statistical significance are numbered. That is a very good development. We will soon be in a far better position to gauge which of our discipline's findings to trust.

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Join us in Boston...

SSCP Events at APS

Friday, May 26th

11:00-11:50 AM

SSCP Student Poster Competition

3:00-3:50 PM

Psychological Treatments for the World
Daisy Singla, Vikram Patel

4:00-4:50 PM

SSCP Presidential Address
Scott Lilienfeld

5:00-5:50 PM

SSCP Distinguished Scientist Address
Michelle Craske

5:00-7:00 PM

Student Social (see details in the Student Updates section of this issue)

Diversity Corner

Diversifying SSCP: Survey Results II Gabriela Hurtado, Ph.D.

In the fall of 2016, we conducted a survey of the membership of SSCP. This is the second in a series of columns related to the survey results that will be included in the next few issues of the SSCP newsletter. In this column, we will focus on the composition of the membership as it relates to religiosity. We will then discuss the impact that these results may have for SSCP as an organization.

The results of our survey showed that the majority of SSCP members identified themselves as Non-Religious (46.5%), followed by Christian (30.1%), Jewish (16.4%), Other (3.2%), Buddhist (2.1%), Muslim (1.2%), and Hindu (0.6%). Those participants that endorsed the Other category described themselves as Unitarian Universalist, Spiritual, Catholic, Agnostic, and Deist. In regards to the importance of religion in their lives, members endorsed Not at all (44.8%) most frequently, followed by Not too important (23.4%), Somewhat Important (21.7%), Very Important (9.5%), and Prefer Not to Answer (0.6%).

When compared to the general population, where approximately 22% of individuals identify themselves as non-religious (Pew Research Center, 2014), the numbers presented above bring up an important issue that is not only relevant to our organization, but that is also reflective of the field of psychology as a whole. Does the membership of our field reflect the diversity of groups that make up our society?

The lack of inclusion and diversity in psychological science and practice has gained attention due to the current affairs in the United States. There has been a lot of public debate recently regarding the relationship between religiosity and science; however, scientists continue to perceive that there is no conflict between religion and science. In fact, psychologists continue to generally support the inclusion of religion as a form of diversity and note that they are open to discussing these topics in academic settings. Unfortunately, research has shown that a large proportion of graduate school programs do not include any training regarding the impact of religiosity in mental health; moreover, psychologists continue to note that they have limited competence regarding issues of religiosity.

Several organizations within our field have made efforts to consider religion as an aspect of diversity in psychological science. SSCP has taken steps, such as the survey presented above, to study the composition of the organization and examine the current status of diversity within the organization. APA has included religion within the definition of diversity in psychology and created guidelines to promote the inclusion of diversity in training programs as part of psychology's

professional-wide competencies. Additionally, APA has grants available for the study of religion and spirituality. Moreover, training programs have incorporated various strategies to increase the competency of students regarding religion, such as expanding the curriculum of multicultural classes and psychological assessment to include religious diversity, and offering religion-related seminars to graduate students. Hage (2006) also proposed that training programs promote self-exploration of religiosity and spirituality through the use of individual and group supervision, such that trainees can discuss the impact that these topics have on their research and/or clinical practice. Due to the limited information available, further exploration is needed to identify how religion and spirituality can be incorporated effectively into the organizations and leadership of psychological science.

There is no short-term solution that will enable us to effectively incorporate diversity into our training programs, research agendas, or clinical practice. Instead, inclusion and diversity is a process for which we must consciously create space within the field of psychology. It is also important to be reminded that the work that we do has an impact on the creation of health and school-related policies, access to care, and the development of effective prevention and intervention efforts that are needed to fulfill the needs within diverse communities; therefore, representation within our field matters. Now more than ever, inclusion and diversity within the field needs to become a priority.

Acknowledgments to Yesel Yoon, Ph.D., Adam Bryant Miller, Ph.D. and Juliette McClendon-Iacovino, M.A. for providing their input for this column.

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Awards & Recognition

Susan Nolen-Hoeksema Early Career Award Winners



Joshua W. Buckholtz, Ph.D is a recipient of the 2017 Susan Nolen-Hoeksema Early Career Award. Dr. Buckholtz is an experimental psychologist and neuroscientist who uses behavioral, genetic, brain imaging, and brain stimulation methods to understand why humans vary so dramatically in their capacity for self-control. His work is focused on identifying distinct brain circuits supporting different kinds of self-control, and understanding how dysfunction in these circuits leads to maladaptive decision-making in drug addiction, aggression, psychopathy, and personality disorders. Dr. Buckholtz is an Associate Professor in the Department of Psychology at Harvard University, is a Network Scholar for the MacArthur Foundation's Research Network on Law and Neuroscience, and serves on the faculty of the Center

for Law, Brain and Behavior at Massachusetts General Hospital. He is grateful for research support from the National Institute on Drug Abuse, the Alfred P. Sloan Foundation, the Brain and Behavior Research Foundation, and the MGH-CLBB.



Aidan Wright, Ph.D is a recipient of the 2017 Susan Nolen-Hoeksema Early Career Award. Dr. Wright completed his PhD in clinical psychology at Penn State University and clinical internship at the Western Psychiatric Institute and Clinic, and is currently an Assistant Professor at the University of Pittsburgh. His work focuses on the interface of personality and psychopathology, with a specific emphasis on the latent structure of personality and psychopathology, long term change and stability in each, and understanding the contextualized dynamic processes that give rise to maladaptive behavior through intensive repeated measurement in naturalistic settings (i.e., ambulatory assessment). He has published over 100 articles and book chapters, and his research is funded by the National Institutes of Health. More information about his work can be

found at his website: www.personalityprocesses.com

Awards & Recognition

Outstanding Student Diversity Research Award Winner



Donte Bernard, M.A. is a fourth year Ph.D. candidate in clinical psychology at the University of North Carolina-Chapel Hill. He earned his B.A. in psychology at Kansas State University and his M.A. in clinical psychology at Chapel Hill. Donte's research investigates the unique race-related factors that may influence the development and maintenance of the impostor phenomenon—feelings of intellectual incompetence—among racial minority youth and emerging adults. Additionally, he is interested in identifying risk and protective factors that may influence the positive psychological development of ethnic and racial minority in the context of racial injustice. His dissertation project will investigate how African American students define and make sense of the impostor phenomenon using a mixed methods approach. Donte's research is supported by a Ford Foundation Predoctoral Fellowship and a National Science Foundation Predoctoral Fellowship.

What drew you to your current research interests?

I believe the best research is “me-search”, or research that you can personally relate to. As such, I am motivated to pursue my particular line of research in light of my own experiences as an African American first generation student. In my opinion, shedding light on the risk and protective factors that influence the lived experiences of African American youth and young adults represents a critical line of research that that often goes unrecognized.

What is one potential step our field can take towards increasing diversity and inclusion in psychological science?

One potential step our field can take is to acknowledge and promote the work done by scholars of underrepresented groups. There is literature to suggest that scholars of color are awarded fewer grants, publications, and faculty positions than that of their White peers. Therefore, if we expect to make progress, we need to have seats at the table.

What is one piece of advice you wish you had gotten before you started graduate school?

Be prepared to be challenged. Not just academically, but psychologically, emotionally, and professionally.

Who have been your mentors or scientific influences?

I truly stand on the shoulders of giants. My current advisor Dr. Enrique Neblett represents arguably my most significant mentor as a burgeoning scholar. However, it is important to acknowledge the notable impacts of other scholars that have shaped who I am today including Dr. Noni-Gaylord Harden, Dr. Maryse Richards, Dr. Shawn Jones, Dr. Ashly Gaskin-Wasson, Dr. Daniel Lee, Dr. Donald Saucier, and Dr. Jessica McManus. It takes a village!

Where do you see your career headed in the future?

As a budding researcher and clinician, I am motivated by my ambitions to pursue a career of bolstering the positive psychological development of racial and ethnic minority adolescents and other underserved groups. Specifically, I aspire to pursue a career within an academic hospital setting that would allow me to conduct research, provide mental health services, and serve as a mentor within communities that desperately need such services.

Outstanding Student Teacher Award Winners



Hannah Raila is a fifth year doctoral student at Yale University. Her research program bridges clinical affective science with innovative approaches in cognitive science – not simply studying them both, but studying the *intersection* of both. She seeks to leverage each of these fields in the service of the other, to bring psychophysical considerations to the study of emotion. More specifically, she studies how emotional experiences are partially maintained by the “diet” of information that we consume as we navigate the world – a diet largely driven by our habits of attention allocation in our environment. She is passionate about teaching and has sought out teaching opportunities both at Yale and as a lecturer at Albertus Magnus College; her favorite course to teach is Abnormal Psychology. Clinically, she has experience providing CBT and DBT, and she is excited to start her internship next year at Weill Cornell Medical Center.

What are your teaching interests and/or teaching philosophy?

I once got the great teaching advice that “less is more.” Accordingly, I try to prioritize my top learning goals for the students at both the macro (e.g., across the semester) and micro (e.g., within a single lecture activity) level. It is better to drive home the few concepts that you have deemed most important than to breeze across a lot of information. Part of this entails balancing generalist knowledge with specialist knowledge. Of course, teachers must tailor specialist information for future scientists or clinicians so they can move forward in the field. But many of the students in a course are not going into psychology *per se*. Yet, they may be future policy leaders who make science funding decisions, have family members who would benefit from psychological treatment, or chime in on discussions with friends of psychology-related news. What are the high-level takeaways that I want to make sure those students bring with them into those scenarios?

What do you enjoy most about teaching?

First, I enjoy thinking through ways to most effectively make the information “stick” with the students – whether that be through finding memorable video clips, coming up with compelling discussion or debate topics, or simply structuring lectures in a way that keeps students curious and attentive. It is an exercise in theory of mind (getting in touch with where the students are most likely starting from) as well as a creative endeavor. Second, I enjoy the interpersonal interactions and informal mentoring that occur through conversations with students. The sense of community that exists at most academic institutions fosters a culture of supporting student growth both in and out of the classroom. Coffee chats about professional development and interesting discussions that occur at the end of class are delightful parts of being a teacher.

Who are/have been your mentor(s) or other influences on your teaching?

At this early stage of teaching, a lot of the activities I do in my classroom are borrowed from courses I have taken in undergrad or graduate school where the content was particularly memorable and compelling. If a professor came up with an activity that I am still thinking about 5 years later, chances are it is a good one, and I am going to use it with my own students. I went to undergrad at Dartmouth College, which is often recognized for its quality undergrad teaching, so I feel lucky to have originally been inspired by so many wonderful and dedicated professors there.

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

“The days are long, but the years are short.” Sit down near the beginning of grad school and really think about what you want to get out of it – especially in terms of the things that you may have unique access to or opportunity for while still in school. Do you want to learn a new coding language? Learn a new methodology? Try teaching a course to figure out whether you like it? There will be many demands on your time, so plan ahead to make sure you prioritize learning the things that you really want to learn – and then relentlessly pursue them.

Outstanding Student Teacher Award Winners



Lillian Reuman, M.A. is a fourth year doctoral candidate at the University of North Carolina-Chapel Hill under the mentorship of Dr. Jonathan Abramowitz. Her research (and related clinical interests) focuses on the treatment of obsessive-compulsive and related disorders (OCRDs) across the lifespan, as well as factors that may play a role in the maintenance of these disorders (e.g., symptom accommodation, cognitive biases, uncertainty). She is an instructor for undergraduate courses including Clinical Psychology and Abnormal Psychology. She was previously a teaching assistant for courses including Research Methods, Health Psychology, and Introductory Psychology.

What are your teaching interests and/or teaching philosophy?

I consider both teaching and learning to be lifelong journeys – skills to be continuously developed and honed. My teaching experiences, in conjunction with my roles as a graduate student, therapist, and researcher within the UNC Clinical Psychology program, inform my teaching philosophy. I aim to promote scientific curiosity via a student-centered approach. I expect that students be prepared, respectful active participants in their learning so that they may challenge convention, communicate effectively in written and oral formats, and share their knowledge with others. As a student of psychology, my teaching is informed by fundamental psychological principles rooted in our understanding of group dynamics, individual responsibility, and modeling. My teaching is similarly influenced by my role and values as a therapist. In both clinical work and teaching, I prioritize open communication, appropriate boundaries, the act of challenging assumptions, and collaboration. Priorities from my scientific research extend to my teaching philosophy, as well. I employ evidence-based teaching practices, continually evaluate my effectiveness, and offer parallels between students' assignments and my own academic research whenever possible.

What do you enjoy most about teaching?

I love learning from my students! Each time a student asks a question, I have an opportunity to critically think about an issue from a new perspective. It also strengthens my teaching, as I often modify my materials so that they're more comprehensive for the next semester.

Who are/have been your mentor(s) or other influences on your teaching?

My previous teachers and professors have influenced who I am as a teacher. My grandparents and father were/are college professors, and I've always admired the ways that they supported their students outside of the classroom by attending their students' athletics events or having them over for dinner. At UNC, Dr. Jeannie Loeb has been an amazing, supportive mentor in so many ways. I especially admire her energetic teaching style and thoughtful pedagogical philosophy.

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

If you're considering a career in teaching/academia, seek/gather teaching opportunities whenever possible. Sleep, exercise, and nourish your body... you can't pour from an empty cup!

2017 Varda Shoham Clinical Scientist Training Initiative Winners

Modernizing a Training Clinic to Enhance Patient Monitoring Aaron Heller, Ph.D., University of Miami

This grant will provide funds to facilitate the implementation of technology to integrate science and practice in the Psychological Services Center, the Psychology Department's Training Clinic at the University of Miami in at least three ways: First, with funds from this grant we will purchase tablets so patients can digitally complete weekly questionnaires pertaining to current symptom and top problem severity. These data will be stored longitudinally and will be reviewed by graduate trainees prior to therapy sessions as outcome data. Second, funds from this grant will be used to setup an Ecological Momentary Assessment (EMA) system. While in treatment, adult patients will receive semi daily text message prompts to track current symptom severity in a more intensive longitudinal fashion. And lastly, funds from this grant will be used to purchase state-of-the-art audio recording equipment. This last goal constitutes a more long-range scientific aim of this proposal – which is to determine whether specific acoustic features at intake can predict psychotherapy treatment outcomes. Using high fidelity audio recording equipment, we can identify individual acoustic features associated with affective communication that are aberrant in psychiatric patients. However, there is limited evidence for whether acoustic features can be used to identify who might get better or who might be at-risk to drop out from psychotherapy treatment. A long-term goal of this research is thus to be able to identify, in a community setting, which patients are most likely to improve and which may require additional care due to a heightened likelihood of treatment failure if psychotherapy proceeds as usual.

Using Wikiversity and Wikipedia to Increase Global Access to Evidence-Based Assessment in Psychology

Eric Youngstrom, Ph.D. and Mian-Li Ong, M.A., University of North Carolina-Chapel Hill

The Varda Shoham Grant will fund a student service club that we founded in March 2017 (named Helping Give Away Psychological Science), paying for food and participant incentives for to keep students engaged and expand participation. The funding supports a cadre of student editors coming regularly, leading to substantial increases in engagement and editing productivity as a result. The club will complete the following: (a) build out and complete a set of pages about evidence-based assessment on Wikiversity to provide a training resource and support for practitioners and teachers and to (b) expand the reach by hosting edit-a-thons at UNC, new events at regional universities (Duke and North Carolina State University), and (c) long distance events to further disseminate those resources (examples include Yeshiva University and University of Miami). These meetings will engage new contacts, share skills and resources, and help seed satellite groups that are able to incorporate editing and dissemination into their training programs.

Training Graduate Students in Parent-Child Interaction Therapy (PCIT): An Opportunity to Increase Accessibility of Evidenced-Based Treatment for Families in the Bronx

Greta Doctoroff, Ph.D., Yeshiva University

This project focuses on two goals: 1) to provide increased access to evidence-based treatment for underserved children ages 2 to 7-years-old and their families at her department's training clinic in the Bronx, and 2) to provide access to high-quality training in Parent-Child Interaction Therapy (PCIT) to graduate students. PCIT is a treatment for young children with behavior problems that relies on a parent coaching model through a one-way mirror with bug-in-the-ear technology for the therapist to guide the parent in real time. Dr. Doctoroff is a certified Level I PCIT trainer and has already started a PCIT training program for graduate students within her department. The grant will fund improved technology resources to facilitate treatment and will add to training and quality care by providing additional resources, such as new treatment manuals, training materials, and toys for sessions.

2017 Varda Shoham Clinical Scientist Training Initiative Winners (cont.)

The updated technology resources will improve the training provided to graduate students in evidence-based psychotherapy and support the continued development of the existing PCIT team within the Cognitive Behavior Therapy for Youth practicum at Ferkauf.

Bridging the Research-Practice Gap in Adult Clinical Training **Lisa Starr, Ph.D., University of Rochester**

The clinical psychology program at the University of Rochester will use the Varda Shoham Clinical Science Training Initiative funds (in combination with matching departmental funds) to improve access to training in CBT with adult populations. Specifically, we will hold a workshop in the Unified Protocol (UP) for the Transdiagnostic Treatment of Emotional Disorders. Developed by Dr. David Barlow and colleagues, the UP is a flexible, evidence-based intervention designed to treat cross-cutting aspects of emotional disorders, drawing tools from cognitive, behavioral, and mindfulness-based therapies. This transdiagnostic approach would allow broad applicability across a wide range of clinical problems, allowing our students to apply techniques in a variety of clinical placements. To allow our students to immediately use this UP training, we have partnered with the Rochester Institute of Technology (RIT) counseling center to develop a clinical placement centered on the implementation of UP. Students, faculty, and RIT supervisors, as well as additional supervisors from other local externship sites, will attend the 3-day intensive workshop. Following the training, a portion of students will take on cases at RIT, in which they will be supervised in the implementation of UP. By “training the trainers,” we will increase the reach of the workshop, sustaining its benefits for years to come. This training opportunity will address a significant gap in our doctoral program, benefiting our students and expanding clinical services available in the greater Rochester community.

Updates from 2016 Varda Shoham Training Award Winners

Training Doctoral Students in Methods of Dissemination Susan Orsillo, Ph.D., Suffolk University

Despite research documenting the considerable benefits of evidence-based treatments on psychological functioning, there are still substantial barriers that prevent many individuals in need from receiving high quality mental health care. One factor that can limit the accessibility of evidence-based therapies is a shortage of trained clinicians. Given that most licensed mental health professionals obtain exposure to, and training in, new approaches to treatment through continuing education (CE) programs, some have suggested that CE may be a mechanism by which widespread, cost-effective training in evidence-based practices could be achieved (e.g., Weissman et al., 2006). Unfortunately, to date, there have only been a handful of studies that look at the effectiveness of trainings delivered in this context.

The goal of the current project is to provide students with training and supervision in the design and implementation of research aimed at measuring the effectiveness of CE program promoting evidence-based treatment. As a CE provider, the psychology department at Suffolk University offers colloquia that are typically open both to the university and clinicians in the community. Recently, we have moved toward using this mechanism to offer full day trainings in evidence-based approaches to treatment. This effort has the potential to more widely disseminate evidence-based treatments in the community and to provide our doctoral students with an opportunity to design program evaluations and to co-facilitate trainings.

Funds from the Varda Shoham Innovation in Clinical Science Training Grant have been used both to develop the infrastructure needed to provide this training to our doctoral students and to plan and execute our first effectiveness study. Over the past year, with faculty supervision, doctoral students researched best practices in program development research including methods of developing valid and reliable measures of therapist knowledge and skill. Using a peer-training model, senior students provide didactic and experiential training to junior students in these methods. We have also forged collaborations with state organizations in social work and mental health counseling that will allow us to provide free CE credit to, and examine the effectiveness of our trainings with, a broader group of mental health professionals.

Our first program evaluation assessing the effectiveness of a full-day training in acceptance-based behavioral therapy (ABBT) for generalized anxiety disorder (GAD) and related disorders is scheduled for June 2017. Participants will be licensed psychologists, mental health counselors, and social workers from the community. Two senior students are spearheading the effort, training and supervising 12 junior doctoral students who volunteered to be involved in the project. Their responsibilities include assisting with advertisement, co-facilitating the training (along with Dr. Sue Orsillo who developed the treatment in collaboration with Dr. Liz Roemer), and evaluating outcome data to determine the effectiveness of the training. This will be the first of what we hope will be many projects that will benefit our community by increasing therapist knowledge and skill in evidence-based practices and our students by providing a mentored opportunity to engage in empirically informed methods of dissemination and program evaluation.

Expanding the Training and Implementation of Parent-Child Interaction Therapy (PCIT) in Under-Resourced Settings

**Cara Remnes, Ph.D. and Jennifer Cruz, Ph.D., Morgan Stanley Children's Hospital of New York
Presbyterian – Columbia University Medical Center**

Funds from the SSCP Varda Shoham Clinical Science Training Initiative grant were used to integrate evidence-based practice into our clinical child psychology training program at New York Presbyterian-Columbia University Medical Center (NYP-CUMC) while also improving outcomes for under-resourced youth with disruptive behavior disorders. At NYP-CUMC, there is great demand for effective and efficient treatments for youth behavior problems. Parent-Child Interaction Therapy (PCIT) is a time-limited dyadic treatment approach that reduces behavior problems in youth ages two to eight. In this treatment, parents are coached in the use of behavioral strategies through the use of a one-way mirror and bug-in-the-ear audio device. We were able to expand our reach beyond our proposal to provide intensive training not only for child psychology interns and externs, but also a postdoctoral psychologist, a psychiatry resident, a social work intern and 4 full-time early career psychologists. Further, through collaboration with a Master Trainer, we have been able to invest in our training model and have three

Updates from 2016 Varda Shoham Training Award Winners (cont.)

psychologists pending Trainer Certification so that we can continue to provide PCIT certification for trainees in years to come. By providing the technology to expand our provision of services into our School-Based Teams, we have expanded the reach of this treatment into the community by providing direct care to families and preventative care through Teacher-Child Interaction Therapy (TCIT). This grant has provided the infrastructure and created an ongoing level of training and expertise in this program that will enable us to continue enhancing our training program and to expand this work into home-based intervention and prevention efforts.

Community-Based Implementation of Parent-Child Interaction Therapy for Families Exposed to Domestic Violence

Sarah Taber-Thomas, Ph.D, University of Buffalo

In 2015, the University at Buffalo doctoral program implemented Parent-Child Interaction Therapy (PCIT) at the Psychological Services Center (PSC), our “in-house” training clinic. PCIT is an evidence-based treatment for young children (ages 2.5 to 7) with disruptive behavior problems, as well as families at-risk for child maltreatment (McNeil & Hembree-Kigin, 2010; Zisser & Eyberg, 2010). While training students in EBTs is a central goal of our program, there is also growing recognition of the importance of moving EBTs from university-based to community-based settings, and more importantly, providing emerging psychologists with explicit training in dissemination and implementation methods.

As such, our project proposed to implement PCIT within a domestic violence shelter, with three goals in mind: 1) enhance the accessibility of EBTs for an underserved population, (2) identify barriers and challenges of community-based implementation, and (3) provide students with an ecologically valid implementation of an EBT. In addition, we proposed to train shelter staff in the Child-Adult Relationship Enhancement program (CARE; Gurwitsch et al., 2016). CARE is a trauma-informed model based on the same principles underlying PCIT, and would enable shelter staff to utilize theoretically-grounded and practical behavior management skills (Gurwitsch et al., 2016).

Over the spring and summer semesters of 2016, 4 graduate students were trained in PCIT by Dr. Taber-Thomas, and most began providing services to families at the PSC. In addition, Dr. Taber-Thomas attended a training in the CARE model, focused on learning how to train others. We then reached out to local shelters in an effort to identify a community partner. Unfortunately, after much consideration, it was determined that the nature of this project would not be the ideal fit for the shelter setting. Specifically, concerns were raised regarding security, given multiple students would be coming and going to the shelter’s confidential location, as well as feasibility, given that in our community’s shelter, most families remain very short-term.

In the fall of 2016, Dr. Taber-Thomas identified an alternative local partner - a residential substance abuse treatment facility for pregnant and parenting women with children. Because children and mothers reside *together* at the facility, the setting provides an ideal context for offering PCIT. Moreover, researchers have demonstrated that parental substance abuse is linked to child maltreatment (e.g., Hanson et al. 2006), increased disruptive behaviors in children (e.g., Hussong et al., 2008), and disruptions in parent-child attachment (Child Welfare Information Gateway, 2014); all issues that can be targeted directly by PCIT. Finally, because the CARE model is trauma-informed, designed to complement ongoing therapy services, and most staff have frequent contact with the children, the program director expressed an explicit interest in training the entire staff in the CARE model.

To date, the SSCP award was used to purchase a “PCIT To-Go” kit, which includes all toys, assessment measures, and necessary equipment to be able to transport PCIT to the residential facility. In addition, the grant covered expenses associated with receiving and being able to provide training in the CARE model. Dr. Taber-Thomas has met several times with the program director in order to develop a plan for implementation. At present, Dr. Taber-Thomas and 3 graduate students are scheduled to begin training all 30 staff in the CARE model in May 2017. Starting in the summer of 2017 one graduate student who has already demonstrated proficiency in PCIT with a standard outpatient population, will begin offering PCIT services. Moving forward, Dr. Taber-Thomas will meet regularly with students engaged in this project to discuss implementation challenges, develop strategies to overcome barriers, and enhance their understanding of how to bridge the science and practice gap. It is anticipated that we will develop this project into a formal ongoing practicum experience for students, and will track treatment outcome so that we can monitor the success of our efforts over time.

Updates from 2016 Varda Shoham Training Award Winners (cont.)

Integrating Empirically-Supported Treatment into a Boot Camp Program for At-risk Youth Joye Anestis, Ph.D. and Nora Charles, Ph.D., The University of Southern Mississippi

The University of Southern Mississippi's (USM) clinical psychology doctoral program is committed to integrating the science of clinical psychology into clinical practice. The project we proposed for the Varda Shoham Clinical Science Training Grant involved (1) providing our doctoral students with expert training in an empirically-supported intervention (Dialectical Behavior Therapy) and (2) implementing this intervention in the training clinic and local community agencies. USM is located in the city of Hattiesburg, which has a population of approximately 47,000 (60% non-White) and a median household income of \$24,409. The three-county area surrounding Hattiesburg is classified as a Medically Underserved Area as well as a Mental Health Professional Shortage Area (US DHHS, 2016). Individuals in this area face health care disparities related to being members of racial/ethnic minority groups, having low SES, and living in a rural area. USM's students and faculty are among the few sources for empirically-supported mental health services in our area, so we were eager for our students and training clinic to develop the capability to provide DBT-informed interventions.

The funds from this award were used to partially cover the costs of a two-day DBT training workshop on our campus in the fall of 2016. The training was led by Laura Meyers, PhD, ABPP, a VA national trainer in DBT and certified clinician by the DBT-Linehan Board of Certification, and Jacqueline Wright Holland, LICSW, an experienced DBT clinician and trainer within the VA system. Thirty-six graduate students and faculty attended this training, along with nine psychologists and social workers who provide supervision for our graduate students at their community placements. Feedback during and after the training indicated that it was well-received by all attendees.

Following the training, students and faculty supervisors in our training clinic were prepared to implement DBT-informed treatment with clients. Specifically, adolescent and adult clients can receive DBT-informed individual sessions, and we offer a weekly DBT-informed skills training group for adult clients that is led by three doctoral students. Additionally, the PIs are currently supervising the implementation of two DBT for Adolescents (DBT-A) skills training groups at a local residential boot camp for at-risk adolescents aged 16-19 years old. Youth at the facility were screened for symptoms of borderline personality disorder and suicidal ideation near the beginning of their enrollment in the boot camp. Those who reported elevated levels of these symptoms ($n = 18$) were approached about their interest in joining a weekly counseling group. All youth who qualified assented to participate in the intervention group. Youth completed measures of DBT-relevant constructs (i.e., distress tolerance, emotion regulation, mindfulness) prior to beginning the skills groups and will be re-tested again at the end to examine change in specific skills. The intervention protocol developed for this implementation is a 12-week program that incorporates skills related to distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness. So far, the youth appear to be tolerating the treatment well, and they are experiencing success implementing their skills. We will use information from their post-test measures, a formal intervention evaluation measure, and feedback from the graduate student leaders to determine any adjustments that should be made for future iterations of the intervention.

The benefits of this project have included: providing graduate students, faculty, and community providers with expert training in DBT; providing students with hands-on experience integrating clinical science into practice; increasing access to evidence-based treatments in an underserved community; and providing opportunities for faculty and students to present and publish research about integrating DBT techniques into practice at community agencies.

Clinical Science Early Career Path

Ellen Driessen, Ph.D., Vrije Universiteit Amsterdam

In the final year of high school, the last chapter of our biology book covered the nervous system. I was very excited to learn about how our brain works and quite disappointed that biology classes ended just when things started to get really interesting. That's when I decided to study psychology. I did so at the University of Amsterdam (UvA), Netherlands, and my curiosity was instantly rewarded during the first year's course in biological psychology. However, I also found the clinical psychology courses surprisingly interesting. The development of psychopathology fascinated me and I was struck by how people could behave in ways that seem so odd, yet are quite understandable when one considers their psychological background. Luckily, UvA provided me a scholarship to complete an additional master's program, so I didn't have to choose and took both the clinical psychology and the clinical neuropsychology program.

During the course of the latter, it became increasingly apparent that the work of a clinical neuropsychologist in the Netherlands mainly consists of conducting neuropsychological assessments. The work of a clinical psychologist seemed more diverse and therefore more interesting to me, so I aimed at pursuing this career path. However, in my final year at university, I started a job as a student-assistant for one of the Ph.D. candidates at the clinical psychology department, who conducted a randomized clinical trial (RCT) comparing different interventions for people with burn-outs, and learned firsthand what it was like to do research. I had always found the idea of obtaining a Ph.D. appealing, but I thought the process would involve four years of reading in a dark office cut off from the living world. I now found out that the work of a Ph.D. student was not necessarily like that and could include project management, diagnostic interviewing, and sometimes even conducting therapy.

Thus, after graduating, I decided to apply for a Ph.D. program (unlike in some other countries, a Ph.D. program in Holland is a job with even a decent salary). One vacancy I found was for conducting an RCT comparing the efficacy of short-term psychodynamic therapy (STPP) and cognitive-behavioral therapy (CBT) for depression. When I read the application, I remember thinking: "Why are they studying that anyway? It is clear that CBT for depression is efficacious and psychodynamic therapy is not", which is what was thought at university. This was also what I sort of asked during the job interview, and the supervisors Pim Cuijpers, Jack Dekker, and Rien Van found that a refreshing perspective to balance the research team that mainly consisted of psychodynamically-oriented psychiatrists.

So, in June 2006, I started my Ph.D. combined at Vrije Universiteit Amsterdam's section of clinical psychology and Arkin Mental Health Care Institute. For the first year or so, I focused on coordinating the RCT's data collection, enjoying working with several research assistants to include the 341 participants needed for our non-inferiority trial. In the Netherlands, a dissertation basically is a collection of (at least) four first-author papers, a couple of which need to be published. As the RCT's data collection lasted several years, I needed to start getting some articles out to complete my thesis in time. With Pim Cuijpers (alias "Mister Meta-analysis") as one of my supervisors, it seemed logical to start doing a meta-analysis to summarize the literature concerning the efficacy of STPP for depression. This turned out to be a very valuable learning experience (not in the least in what an enormous amount of work it is to conduct such a study). It turned out that STPP was more efficacious than I had thought, though the quality of evidence was not optimal, which was probably underlying my former university's perspective.

Notwithstanding the amount of work, the RCT's data collection still wasn't completed by the time the meta-analysis was submitted for publication, so I needed some other manuscripts to work on. Also, Ph.D. candidates at our department were expected to go on a working visit abroad to experience another lab. Pim Cuijpers got in touch with Steve Hollon at Vanderbilt University and suggested I would go there, which I did. Around that same time, Steve had initiated a project with Claudi Bockting and Erick Turner aimed at examining publication bias in NIH-funded psychotherapy for depression RCTs. Erick Turner had just published his study in the *New England Journal of Medicine* showing that the effects of antidepressant medication are overestimated in the published literature due to selective publication of positive results. They wondered whether that might also be the case for psychotherapy, hypothesizing that publication bias would be less of an issue due to smaller financial incentives in this field. They asked me to work with them, which I happily accepted and I very much enjoyed working on this interesting project that included tracking down investigators and requesting their unpublished data for inclusion in our meta-analyses. Our hypothesis ended up to be proven wrong; publication bias appeared to be as much of a problem in the psychotherapy literature as it is in the antidepressant medication literature.

Getting back from this inspiring visit to Nashville, an opportunity to do more clinical work arose, when our

department started collaborating with a large mental health care institute in Amsterdam to bridge the gap between science and practice. This collaboration included a yearly position for one Ph.D. candidate of our department in the clinical training program to become a Dutch licensed psychologist, practicing at the mental health care institute. Unlike the U.S., where a clinical psychology Ph.D. program includes a clinical internship, a clinical psychology Ph.D. in Holland consists of conducting research only, usually without any clinical training. Given my clinical interest, I had always hoped one day to be able to do more clinical work and I was very lucky to be offered one of these positions. So, for the next four years I combined clinical practice with completing my dissertation.

Then, six years after we had started, our RCT's data collection was finally completed. My former university's perspective proved wrong when we found STPP non-inferior to CBT in the reduction of depressive symptoms during treatment. However, we were also disappointed to find that less than one-fourth of the patients in our sample had their depression in remission after 22 weeks of manualized treatments by trained therapists. In the absence of overall treatment differences, we wondered whether there might be subgroups of patients who might benefit more from one of the treatments than the other. Post-hoc analyses indicated that this might be the case. Patients with low anxiety levels appeared to benefit more from STPP. This was also the case for severely depressed patients receiving psychotherapy and antidepressant medication who reported a duration of the depressive episode of one year or longer, while we found CBT more efficacious for such patients reporting a duration shorter than one year. The article describing these analyses was the final chapter of my dissertation.

So, the conclusion of my thesis was that although we have efficacious treatments for depression, not all patients benefit adequately from treatment and the efficacy of depression treatment needs to be improved. I believe better knowledge about treatment moderators can be an important way to do so. In fact, I think on one of the main challenges in the field of depression treatment research is to learn which treatment works for whom, to guide treatment selection for individual patients. As with my biology book in high school, the most interesting stuff appeared to be in the final chapter of my thesis. And as with my choice of study, I hoped to answer the remaining questions in the next phase, in this case a post-doc position. I was lucky enough to be offered such a position at Vrije Universiteit Amsterdam, where I could continue my line of research, now focusing on identifying moderators of depression treatments efficacy.

To do so, I currently work on an individual participant data meta-analysis to examine which patients benefit

specifically from psychodynamic psychotherapy for depression. For this project, we are requesting the patient-level datasets of the 63 studies included in the 'conventional' meta-analysis that I conducted as part of my dissertation. We combine these datasets in one large database to examine treatment moderators with sufficient statistical power. I also collaborate intensively with Rob DeRubeis' lab at University of Pennsylvania on an exciting project in which we aim to adjust their *Personalized Advantage Index* approach to select the optimal treatment for individual patients for use in such individual patient data meta-analyses. I hope that these lines of research can eventually contribute to more efficient use of treatments for depression, thereby reducing the tremendous disease burden depressive disorders cause to both patients and society.

About the Author:

Ellen Driessen graduated cum laude from University of Amsterdam, the Netherlands, in both the clinical psychology and clinical neuropsychology master's programs. She obtained her Ph.D. (cum laude) from Vrije Universiteit Amsterdam for the dissertation *Short-term psychotherapy for depression: Broadening the field of efficacy research*. Ellen now works as a post-doctoral research associate at Vrije Universiteit Amsterdam's section of clinical psychology. Her research focuses on the efficacy of psychotherapies for depression and their moderators.

Student Perspective

So You Want to be Inclusive

Juliette M. Iacovino, M.A., Washington University in St. Louis

I've forgotten where I heard this expression, but I think it sums up my thoughts on the *inclusion* part of "Diversity and Inclusion" very nicely, so excuse me for not citing my source. The expression goes, "Diversity is like being invited to the party; inclusion is being asked to dance."

Just because we fill our psychology departments with people from diverse backgrounds, does not mean that we are being inclusive.

When I think of inclusion gone right, I think of my preschool-aged son's classroom. We live in a school district with excellent school-based therapy services for children with special needs. Students of varying development are all integrated into the same classroom. My son has a behavior therapist who is by his side for 45 minutes a day while he is in class with his peers so that he can participate in a way that is most conducive to his learning. About half the students in his class have some kind of in-class therapy during the week. The classroom environment is also structured in a way that supports both typically developing students and students with special needs. Everyone's needs are met and no one's learning is disrupted. This is inclusion.

When I reflect on what I consider inclusion, I think of times that I have felt safe to express my own thoughts, beliefs, and feelings. I know the word "safe space" is derided in some circles nowadays, but this is what I'm talking about. Being in an environment where I feel I can speak up; where people will not dismiss my opinion just because it comes from me; where people will not become instantly defensive to my comments; where I will not develop a reputation as "angry" or "pushy" because I speak up. And when I wrack my brain to find some examples of spaces like this, well... I kind of come up empty. I have felt like this in small settings, with one or two other people of color. Of course I've felt this one on one, almost always with another person of color. I have usually felt this with my graduate advisor and in clinical supervision. But, unfortunately, I have never felt this in a classroom, in a lab meeting, or at an informal student gathering.

My experiences as a woman of color in academia have included being asked by an academic advisor if I was really sure I could handle majoring in biology (I ended up switching my major); being present for the use of a racial epithet by a professor during class (it was part of a story, but still); being singled out as the arbiter of

Black hair (during a treatment planning meeting for a research study); and being excluded from research opportunities that other graduate students were offered. I've seen one black student mistaken for *the other* black student in our department. I've been told we don't want to increase student diversity at the expense of student quality. This is not even counting all of the negative experiences I had in elementary, middle and high school, dating back to when a little girl dropped my hand and said "Ew, black!" during dance class when I was 4 years old.

All of the experiences I mention here were driven by progressive, culturally aware individuals. These were people in positions of authority, and (white) people who *do research to better the lives of minorities*. And, let's be clear, I have at times been insensitive to individuals with marginalized identities. For example, I once mis-gendered a fellow student. And my response to their correcting me could have been more humble and inclusive.

My point is: We *all* have to do better. And when we mess up, we *have to own it*. I can tell you, as a woman of color who actively discusses issues around race, it is *the worst* when someone (especially from a majority group) gets defensive when they are criticized for being insensitive or are encouraged to do something differently. Not only is it frustrating, but it actively shuts down the discussion and creates an unsafe environment for everyone involved. We have to be open to hearing different perspectives and we have to be comfortable not always arguing our side.

We also have to make sure that the environments we work in are inclusive. I wrote about this in a recent book chapter, and this was beautifully discussed in a recent article by Dr. Aline Geronimus and colleagues. Ask yourself this: Is there a wall in your department or University that is filled with white, male faces? Sure, it's great to show the long line of inspirational department chairs and college presidents, but what message are we sending with that wall? How can we fill that wall with more inclusive images? How can we use that wall to make everyone feel like they are truly a part of our department? You might be saying, "Well Juliette, it's just a fact that these were our department chairs. They have given so much to building this department and making it what it is today and we want to honor them." Yes. This is true. But if we honestly, truly, deeply

want to be inclusive, we are going to have to re-think and re-imagine some of our long-held truths. And if we can't think of anything more inclusive to replace those images, well, then, we have a lot more work to do than maybe we thought.

At the end of the day, it is up to us to decide whether we are willing to do the work that is necessary to not just fill our departments with a wider range of identities, but to actually create environments where those identities are part of the everyday fabric. Where the default perspective is not Western, white, cis-gendered, male, heterosexual, judeo-Christian (or maybe non-religious), upper-middle class. *Where there is no default perspective*. Where people visit our department and think, "Wow, I really belong here," instead of, "Well, at least it's not as racist/sexist/homophobic/classist/ableist as those other departments."

If this is what you want, use your campus resources to better understand inclusion and how to get there. Most colleges and universities have a diversity and inclusion office, or at least some kind of on-campus initiative to improve diversity and inclusion. While these structures may have their own shortcomings, it's a good place to start. And I'm looking at those of you from majority groups. People from marginalized backgrounds often do a disparate burden of diversity and inclusion work. We need allies from privileged groups to contribute more. And if you're already doing this work, great! Find out how you can do more, whether by taking a closer look at your own biases, or joining your department's diversity committee (or at least attending their events), or taking on more formal roles within your University or workplace.

Our departments and our students are going to get more diverse every year. The best departments, the ones that will have the most satisfied, productive and innovative people, will be the ones where we all have a seat at the table.

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About the Author:

Juliette M. Iacovino, M.A. is a doctoral candidate and Chancellor's Graduate Fellow at Washington University in St. Louis. She studies psychosocial factors associated with racial inequities in physical and mental health. She is currently working with Dr. Tom Oltmanns on a longitudinal community-based study of personality, aging and health (SPAN study). She has published research in top journals, including the *Journal of Abnormal Psychology* and *Journal of Personality*. She was the recipient of a National Research Service Award from the NIH to study the influence of personality and stressful life events on racial health inequities in the SPAN sample. She was the first recipient of the Outstanding Student Diversity Research Award from SSCP in 2016 and was inducted into the Edward A. Bouchet Graduate Honor Society in 2014. This summer, she will start her clinical internship at the Massachusetts Mental Health Center/Harvard Medical School/Beth Israel Deaconess Medical Center in Boston.

Clinician Perspective

The EST Diet

Jonathan Hoffman, Ph.D., ABPP, Neurobehavioral Institute

When clinicians select EST (Empirically Supported Treatments) from the menu of possible psychological interventions for their clients, clearly, it's the science-based "heathy choice." Sort of like choosing the green salad, not the buffalo wings. But, like all "diets," it has its challenges.

There's no doubt EST are good—no, **great**—for my clients' psychological health. I'm the Clinical Director of a treatment center that provides EST such as exposure-based interventions for obsessive compulsive disorder (OCD) and anxiety disorders, and trains post-doctoral residents in them—licensed since 1986. But, confidentially speaking, I must admit to some lapses. Maybe some clinician colleagues will relate, academic colleagues will be understanding, and those with a foot in each area can do both.

First, why is this relevant? For clinicians, it's because they want to benefit their clients by providing EST in the most efficacious way. It's germane for researchers because the effectiveness of the EST they develop and study depends on how they are implemented by clinicians.

The aim here is to examine some of the "fidelity" challenges for clinical practitioners in adhering to EST by likening it to those inherent in following a healthy nutritional "diet," even with the best intentions. Let's call it the "EST Diet." What is the EST Diet? It's the one where clinicians are asked to eschew non-EST like they were "Death by Chocolate" desserts for a weight watcher.

In practice, however, fidelity to EST isn't an absolute. In general, clinicians are "ESTish" and this may help explain science-practice disconnect, i.e. when research is "lost in translation" in clinical applications. IMHO, master clinicians use EST artfully by turning principles and methodologies into dynamic "clinical recipes"; they do not have a mechanical or humorless "cookbook mentality." In other words, they follow the spirit not the letter of the EST Diet. It's about balancing art and science. Think of it like any diet: the chances of long-term success are diminished by skewing toward being either too restrictive or too loose—the former increases the likelihood of cravings followed by bingeing, the latter, well, just won't cut it to produce the desired results. "By-the book" clinicians who rely extensively on worksheets and manualized protocols might do well to mind the "art," those who "improvise in the kitchen" too cavalierly

might need to stay more mindful of the "science," lest their creativity dilutes EST's "active ingredients," rendering them inert.

Influence in therapy is bi-directional, of course: Clients affect how clinicians stay true to the EST Diet, like a tempting display of "Late-night Bites" on already stuffed wedding guests. Might many clients prefer the "buffalo wings" of "insights" and "tangential but interesting commentary" to the "green salad" of EST? You betcha! Just look at their facial expressions and body language if you serve up a "juicy" observation, insight, or these days, a "funny political reference" as opposed to a nasty exposure! Clinicians who fail to recognize this process are likely at higher risk for "EST drift."

Clinicians are hardly immune to our own cognitive errors. Nor counter-transference (even though this doesn't exist, wink, wink). Practitioners are well advised to periodically re-read findings regarding actuarial versus clinical predictions to remind themselves of the limitations of their own therapizing "instincts." Food dieters are subject to self-defeating cognitions such as, "One donut, and that's it!"; do scientifically oriented practitioners ever think, "How much could one little analytic interpretation hurt?"

Another issue for the EST Diet is that it necessitates discomfort, hence avoidance behaviors; and that includes us clinicians, not just clients. Think of EST for panic disorder or OCD. Creating distress, no matter how well its rationale is understood intellectually, may be particularly difficult for newer clinicians, who might tend to be dismayed by human suffering. When EST involves exposures that necessitate "inflicting pain for the client's own good," even in the short-term, some natural balking can occur. In our training program, we often find our postdocs inadvertently providing reassurances, verbally as well as nonverbally, when, for example, asking a contamination-phobic client to put their hand near a toilet. Embracing the need to engender discomfort in clients and themselves is key for clinicians on the EST Diet!

Ah, boredom, the bane of many a dieter. It should not be surprising if "novelty-seeking" might impede the EST Diet. EST are so darn effective, such as for panic disorder or OCD, that sooner or later, it's routine. If you've been in practice for any length of time, you almost can't help but become proficient in decoding even the most

unusual clinical presentations. For instance, knowing the core cognitive distortions in OCD, e.g. “intolerance of uncertainty” to the extent they’re automatic thoughts doesn’t exactly keep it fresh. Placed in this context, the “craving” to stray from EST is comprehensible. Every reasonable diet allows for some flexibility, “cheating,” if you will, to address ennui. In this respect clinicians need not feel excessively guilty if they “digress,” nor researchers or clinical supervisors act like “EST kitchen police.” On the other hand, it behooves clinicians who are committed to EST to think of themselves like a great chef who must “create” their signature dish for the thousandth time, with pride! Moreover, EST were not developed to entertain clinicians. No, they most assuredly were not!

Fidelity to EST is also subject to the “interpretive bias” problem. As human beings, we are built to seek “meaning,” even if it’s not there; in some respects, much of the history of human belief systems might well be called “the story of apophenia.”¹ Even the most well-trained clinicians will never be exempt from the natural propensity to attribute meaning to random patterns and portents in their clients’ behaviors. This is especially bound to occur with “interesting” ones.

EST are developed under watchful eyes, like food preparation in an openly viewed restaurant kitchen. Who’s watching in the privacy of most clinical practices? That’s right, no one. I’d reckon that, in private practice, EST protocols are followed more when a resident or colleague is in the room, or in a group versus individual format. Why? More witnesses (just kidding). But in most private practice settings we’re banking on the honor system of clinicians’ self-monitoring, for better or worse. I suppose a similar question might be raised regarding monetary considerations. What **do** we know about the relationship between fidelity to EST and transactional variables?

There is also “ego” (ETTDE²). What pilot doesn’t think they can’t fly the plane better than the autopilot, especially if the autopilot’s a standardized clinical treatment manual? Also, following any prescribed path, even one as salubrious as EST, means giving up a degree of control and autonomy. We all know how much your typical independent practitioner loves doing that!

Another reason why staying on the EST Diet is hard in practice is sheer fatigue—especially toward the end of a full roster of clients. The prime hours for scheduling therapy often being evening ones doesn’t help. That’s why an arduous traineeship can pay off later in terms

of one’s clinical stamina. Are clinicians less likely to get out of the office and “go in vivo” in implementing EST with later-down-schedule clients? Perhaps. When do actual dieters lapse? Often late at night when exhaustion compromises their judgment. Might increasing difficulty following the EST Diet toward the end of a busy day suggest a clinician needs a vacation?

Which brings me to another point. Wouldn’t many of us clinicians and researchers benefit from putting EST into action in our own lives (I’m assuming sometimes we don’t practice what we preach)? I know it helps when I do. The rewards of doing this will manifest in our medical and psychological health, quality of relationships, and capacity to deal with stress. And, certainly, if we’re physically fit and well-balanced psychologically, as well as happy and social, how could this **not** indirectly be good for those we treat? Which reminds me: A piece I wrote for the public a while back emphasized the importance of finding a healthy work-life balance; given my lifestyle, or lack of one at that time to be more accurate, my wife rolled her eyes and referenced my hypocrisy most bluntly. So, I recommend that clinicians bring EST into their daily lives as much as possible. Friends and family will thank you, and it’s very likely your clients will notice too, even if they can’t quite put a finger on what’s changed and ask things like, “did you get a new hairstyle?”

Certainly, responsible clinicians should try to follow the EST Diet. But fidelity to EST will always be imperfect, which is important for researchers to take into consideration. Occasionally, we clinicians are going to order “Death by Chocolate.” Or buffalo wings.

About the Author:

Jonathan Hoffman, Ph.D., ABPP is the Co-founder and Clinical Director of the Neurobehavioral Institute (NBI) in Weston, South Florida. He thanks Drs. Dean McKay and Katia Moritz for their helpful suggestions in preparing this article.

1 The term “apophenia” refers to our tendency to perceive meaning in random patterns of information.

2 An acronym for “Even Though This Doesn’t Exist.”

Updates from Student Representatives

Jessica Hamilton, M.A., Temple University
Kelly Knowles, B.A., Vanderbilt University

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

Conference and Networking Events

Please join us at the **APS Annual Convention** from **May 25-28, 2017** in Boston. There will be two events to meet with other SSCP students and faculty.

SSCP Student Poster Competition will be held on May 26th from 11:00-11:50AM. It is a great opportunity to view science conducted by your peers and meet with other student members!

Student Social: You're invited to join us for the third annual SSCP Student Social at APS on Friday, May 26th from 5pm to 7pm at Lir on Boylston. There will be free food and drink vouchers, and you do NOT need to be an SSCP Student Member to attend (so bring your friends!).

Lir on Boylston is a 5 minute walk from the conference hotel (Sheraton Boston). The address is 903 Boylston St, Boston, MA 02115. If you would like to walk over to the venue with a group of other students, a group will meet in the Sheraton lobby at 5pm. There will be lots of free food and drinks, and you will have the opportunity to network with more advanced members of SSCP. All are welcome to attend (including students, postdocs, and those interested in joining SSCP).

Please take a minute to RSVP here: <https://goo.gl/forms/A9wdyCipkJM2qIEB3>

We hope to see you there!

Student Award Announcements and Opportunities

Congratulations to the winners of the SSCP Student Outstanding Clinician Award

The award committee has completed its review of applications, and was very impressed by the large number of phenomenal, truly exceptional candidates and their remarkably advanced contributions to clinical psychology. We are very pleased to announce the two winners of the SSCP Student Outstanding Clinician Award (featured in the next newsletter)!

Shannon Blakey

Advisor: Jon Abramowitz, Ph.D.

University: University of North Carolina-Chapel Hill

Elana Kagan

Advisor: Phil Kendall, Ph.D.

University: Temple University

Professional Resources

SSCP Student Initiatives – Please visit our website for a full list of our initiatives (below). We are currently working on several new initiatives, including expanding SSCP student membership to international communities, expanding SSCP social networking beyond APS and ABCT conferences, and developing a series of video webinars on “hot topics” for professional development (e.g., how to interact with the media, integrating research and policy).

As we continue to develop and launch our student initiatives, we would love to hear how we can best represent your interests. Please complete the survey: <https://goo.gl/forms/P29UblOnEoTu5rsE3>

SSCP Student Resources – For more information on updated student resources and initiatives, please see our website: <http://sscpstudent.blogspot.com/>

SSCP Student Listserv – Please email Evan Kleiman (ekleiman@fas.harvard.edu) to be added to the student listserv. The listserv is a great resource for job, research, award, and training opportunities!

Contact Us!

We would love to hear from you with any suggestions, comments, questions, or concerns regarding SSCP student membership or resources for students, so feel free to email us! If interested in sharing ideas, please also visit our website under student initiatives and complete the “What else can we do to help?” form.

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