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Presidential Column

Knowledge of the History of Clinical Psychology: A Partial Antidote Against “Breakthrough-ism”

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

My Emory departmental colleague Ed Craighead, who is one of the few people I know who values the history of clinical psychology at least as much as I do, recently informed me of the following quotation, which is etched into the stones of Norlin Library at the University of Colorado at Boulder: “He who knows only his generation remains a child.” I very much like this quotation (although it should be revised to apply to non-males), and it strikes me as an apt jumping-off point for my latest presidential column, which underscores the relevance of the history of psychology to the current generation of clinical psychology graduate students. In my SSCP presidential address at the Association for Psychological Science meeting in Boston in May of this year, I emphasized the utility of revisiting the history of psychology for those of us in clinical science. Here, I briefly draw upon a few of the points I raised during this talk, albeit with a slightly new twist.

At the risk of painting with an overly broad brush, my distinct impression is that today’s clinical psychology students are just as bright, if not brighter, than we were when we entered graduate school (I began graduate school in clinical psychology at the University of Minnesota in 1982, when a man named Ronald Reagan was president). In most respects, they are better prepared than most of us were, and most of them enter graduate school with many more specialized skills (e.g., brain imaging, autonomic psychophysiology, structured psychiatric interviewing, structural equation modeling) than we did. At the same time, I am also left with the impression that today’s clinical graduate students know less of the history of the discipline of psychopathology than we did – and in fairness, we didn’t know all that much either. Many or most of today’s entering clinical students seem not to know the names Kraepelin, Bleuler, Meyer, Engel, Jaspers, Menninger, Cleckley, Kendell, Meehl, Maher, Gottesman, or a plethora of others. Perhaps more important, they seem not to know much, if anything, about the enduring lessons imparted by these scholars’ work.

The sizeable gaps in our students’ knowledge of the discipline’s history are at least as much our fault as professors as it is theirs. Admittedly fragmentary survey data – we need more such evidence – suggest that many psychology departments are de-emphasizing the history of psychology at both the undergraduate and graduate levels (Benjamin & Baker, 2009; Fuchs & Viney, 2001). Moreover, in many and perhaps most clinical psychology doctoral programs, courses in psychopathology increasingly seem to focus on the description, correlates, and etiology of specific disorders (e.g., schizophrenia, major depression, obsessive-compulsive disorder) without providing students with a deep understanding of the historical, conceptual, and philosophical foundations of the discipline.

Why does any of this matter? As psychologist Mary Henle (1913-2007) observed in an insightful article (Henle, 1976), the history of psychology is critical for several reasons. In particular, knowledge of this history helps to combat the rampant hyperspecialization in our field and affords us a broader perspective that we often miss when insulated in our intellectual silos. In addition, as Henle noted, outsiders to a field can often detect potential shortcomings that insiders cannot, as the former are often free of the intellectual blind spots afflicting the latter. Moreover, as my friend David Baker, who is Margaret Clark Morgan Director of the Archives of the History of American Psychology at the University of Akron, reminded us, “History provides perspective, context, a dose of humility, and it allows us to see the development of our profession in the larger cultural context” (see Chamberlin, 2010).

Baker’s point regarding humility strikes me as especially germane. Over the course of my academic career, I have acquired enough gray hairs and witnessed enough fads come and go to become more than a bit skeptical of highly enthusiastic claims regarding the “next big advance” in psychopathology. Over the years (well, to be more precise, over the decades), I have learned to turn a wary eye to what I term “breakthrough-ism” – the propensity to believe that we are at long last on the verge of the next breakthrough for psychological disorder X, or even more optimistically, for psychopathology in general. Most forms of psychopathology are almost certainly highly multifactorial, and progress toward understanding their etiology is likely to be exceedingly slow, patchy, and incremental (Kendler, 2005; Lilienfeld, Smith, & Watts, 2016).

For example, when I was in graduate school, I “learned” that functional brain imaging, which was then taking its initial baby steps, would soon supplant both clinical neuropsychology and standard methods of diagnosis, such as psychiatric interviewing. I also “learned” that brain imaging would soon afford astonishing new insights into the etiology of mental disorders. We were assured by many that effective treatments, if not cures, were on the horizon. These expansive assertions were echoed by many leaders in the field. For example, in her popular book *The Broken Brain* (1984), eminent psychiatrist Nancy Andreasen wrote that “as they improve and become more accurate, these imaging techniques and other laboratory tests for mental illness will become part of standard medical practice during the coming years, thereby improving the precision of diagnosis” (p. 260). Yet, when we fast-forward three decades, we will discover that with the exception of electroencephalography for some sleep-wake disorders, the DSM-5 (American Psychiatric Association, 2013) does not contain any neurophysiological indicators among its 300+ diagnostic criterion sets. To be

sure, functional brain imaging is a remarkable tool, and it has yielded a number of enormously useful clues to the correlates and causes of psychological disorders. But is not all clear that this technology has generated any genuine breakthroughs in etiology, let alone treatment or prevention (Schwartz, Lilienfeld, Meca, & Sauvigne, 2016). Nor does it appear that any such breakthroughs are imminent.

As we read the pages of today's psychology and psychiatry journals, we will similarly encounter numerous claims regarding the latest ostensible breakthrough in our understanding of mental illness: genotype-by-environment interactions; epigenetics; endophenotypes; precision psychiatry; the microbiome; network models; computational psychiatry; big data; machine learning; oxytocin as the key to disorders of social attachment; and so on. Let me be crystal-clear to avoid misunderstandings and to avoid incurring the wrath of my many friends and colleagues who conduct research in these domains, among others. I view all of these approaches as promising and well worth pursuing; indeed, I have recently co-published empirical articles using one or two them (e.g., network models) myself. I strongly suspect that many of these approaches will contribute to helpful discoveries or at least tantalizing clues concerning the etiology of psychopathology, and a few of them may eventually yield bona fide breakthroughs. My gripe is not with these approaches per se, but rather with their all-too-frequent overhyping by fervent advocates. Such overhyping can lead us as a field to promise far more than we can deliver, in turn leading policy-makers and our fellow scientists in other domains to regard our research endeavors with considerable skepticism (Lilienfeld, 2012).

So by all means, let us pursue all of these exciting new research avenues with vigor and perhaps even cautious optimism. But let us also recognize that the history of clinical psychology and allied fields (e.g., psychiatry) teaches us that few of them are likely to bear as much fruit as their proponents hope. In this respect, a thoroughgoing knowledge of the history of clinical psychology is a much-needed prescription for humility as well as a partial remedy for the chronic ailment of breakthrough-ism.

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Diversity Corner

Diversity Spotlight: Dr. Nicholas Eaton

Yara Mekawi, M.A., Joya Hampton, M.A., M.Ed., and Adam Bryant Miller, Ph.D.

The SSCP Diversity Committee would like to introduce a new feature for the SSCP newsletter called the “Diversity Spotlight.” The new addition to the newsletter will feature a clinical scientist that does work focused on underrepresented groups. It is our hope that this addition will broaden the way that we think about work centered around diversity in our field. In lieu of our regular diversity column this month, we will showcase our first spotlight from Dr. Nicholas Eaton.



Deemed a rising star in clinical psychology by the Association for Psychological Science, Dr. Nicholas Eaton’s research on the conceptualization and classification of psychopathology, as well as individual and group-level differences in psychopathology has taken the field by storm. A St. Louis native, Dr. Eaton received his BA from Washington University in St. Louis and his PhD from the University of Minnesota, and is now an assistant professor at Stony Brook University. Dr. Eaton is impressive in many ways - he has a remarkable publication record (which includes over 70 journal articles and book chapters published in many high-impact outlets), and a varied knowledge base (for example, he minored in Islamic Studies and Arabic as an undergraduate). Notably, Dr. Eaton’s work stands out in that he specifically examines issues related to diversity in clinical psychology research. In the face of growing interest in mental health disparities (e.g., gender, race/ethnicity, sexual orientation), Dr. Eaton tackles important questions such as, “From where do these disparities emerge?” and “Can a more accurate characterization of psychopathology help us understand these questions better?” We were lucky to sit down with Dr. Eaton to have him answer some of our

questions about doing diversity-related research in clinical psychology...

1. How do you define “diversity” in your research?

My lab takes a very broad view of diversity, including race/ethnicity, gender identity, sexual orientation, religion, age, and so on. Much of our research involves characterizing mental health disparities between populations, with a particular focus on oppressed groups. A good deal of these studies investigate minority stress processes in conjunction with advances in mental disorder classification – for instance, how racial discrimination may have negative associations with multiple mental disorders due to its link with core, transdiagnostic constructs of psychopathology.

2. What are some barriers to studying oppressed minority groups and how do you try to overcome them?

Studying oppressed groups of individuals, particularly groups to which the researchers do not belong, requires a great deal of consultation and collaboration. Through much dialogue and reflection, I have come to realize how scientific investigations can themselves promote and maintain systems of oppression. Even the best-intentioned researcher can do a study that their participants would find stigmatizing and more harmful than beneficial. One solution to this is to break down the artificial barriers and power differentials between the researcher and the community and to recognize that researchers’ communities of interest can provide critical guidance and extremely valuable perspectives. A second suggestion is to take negative feedback in an open and accepting way, rather than acting defensively. It seems that most people who want to study oppressed minority groups do so because of very admirable reasons (e.g., a strong orientation toward social justice); hearing that your work is off-track (or even could be taken as harmful by the populations you study) can be heartbreaking and prompt you to try to justify yourself. When someone criticizes your research efforts and you find yourself wanting to try to convince the person that they are wrong: Stop talking and listen very carefully to what they are saying. You will likely learn something very important.

3. From your research, what are some major themes or lessons learned about LGBT or racial/ethnic minority populations?

A major theme that cuts across different oppressed groups is how their treatment in society is associated with negative outcomes: mental disorder, substance use, suicide, and so on. Life for many of these individuals – and particularly for

individuals who have multiple intersecting oppressed identities – can be extremely difficult across domains. However, despite this adversity, oppressed individuals can also show remarkable resilience in the face of these inequities, highlighting the sources of strength and support from which the oppressed often draw.

4. How do you think your and others' research examining the mental health of oppressed minorities benefits the field of clinical psychology as a whole?

On the most basic level, identification of these disparities is the necessary first step toward their amelioration. Characterizing disparities is critical. To quote the late LGBTQ research pioneer Judy Bradford and others, "If you're not counted, you don't count." and this remains true of today: We are only now starting to get clear estimates of how many LGBTQ people there are, let alone fully documenting their health, wellbeing, and so on. On a deeper level, I believe it is critical to bring, and keep, these issues on the radar of clinical psychology. While clinical psychology includes a good deal of this sort of research, other disciplines do much more, and I believe we should, too.

5. How can the field of clinical psychology do a better job of thinking about issues of cultural, race, ethnicity, gender, sexual orientation, etc. in regard to psychopathology research?

Clinical psychology tends to be insular in some ways, which is a great disadvantage for studying diversity. For instance, Black feminist writers, queer theorists, sociologists, and a multitude of others have identified many of the most critical issues in the study of the oppressed; however, clinical psychology is often quite divorced from these topics, for a number of reasons (with which I do not agree). I made it entirely through graduate school without once hearing the word "intersectionality," for instance. Psychopathologists need to read other perspectives, including those from non-scientific paradigms, to be able to understand the breadth of these issues and where their efforts can be most valuable to individuals and communities.

Awards & Recognition

SSCP Student Poster Award Winners

SSCP holds a student poster competition at each annual meeting of the Association for Psychological Science. This year, we had 70 posters presented by student members, with 3 Award Winners (\$250 prize) and 5 Distinguished Contributions (\$100 prize).

2017 Poster Award Winners:

Emma Tanovic, Yale University, *Anticipatory Neural Activity Is Enhanced By Uncertain Threat*

Adrienne Romer, Duke University, *Structural Alterations within Cerebellar Circuitry Are Associated with General Liability for Common Mental Disorders*

Brooke Slawinski, Michigan State University, *The Etiology of Social Aggression*

The 2017 Distinguished Contributions:

Esther Tung, Boston University, *Distinct Risk Profiles in Social Anxiety Disorder*

Nauder Namaky, University of Virginia, *Looking out or Checking out? the Differential Effects of Trait Anxiety and Depression on Frontal Asymmetry during Loss Anticipation*

Lara Moody, Virginia Tech University, *Remote Alcohol Monitoring for Behavioral Interventions: Implementation Intentions As a Strategy to Reduce Drinking*

Aliona Tsypes, Binghamton University, The State University of New York, *Neural Reward Responsiveness in Children with Nonsuicidal Self-Injury*

Abhishek Saxena, Rush University Medical Center, *Neuroplasticity in Neural Networks of Emotion Following Targeted Social Cognition Training*

Lawrence H. Cohen Outstanding Mentor Award

Jonathan Huppert is Full Professor and Chair of the Department of Psychology at The Hebrew University of Jerusalem, Israel, where he holds the Sam and Helen Beber Chair of Clinical Psychology. Dr. Huppert specializes in the nature and treatment of anxiety and related disorders, and has worked on dissemination of CBT throughout Israel and beyond. He conducts research on the processes of cognitive behavioral therapy to better understand its mechanisms. In addition to examining cognitive biases such as interpretation and attentional biases, he also examines factors such as emotion regulation, changes in cognitions and behaviors, and common factors including the therapeutic alliance and the placebo effect. He has been involved in a number of RCTs examining CBT vs. medications or other interventions for OCD, panic disorder, social anxiety disorder, and PTSD. He has published over 100 articles and chapters and speaks frequently at national and international events. He has received multiple sources of funding for his work including from the US National Institute of Mental Health and the Israel Science Foundation. Dr. Huppert is a fellow of the Association for Behavioral and Cognitive Therapies. He was the scientific chair of the 2015 EABCT Congress held in Jerusalem. He was full time faculty at the Center for the Treatment and Study of Anxiety at the University of Pennsylvania School of Medicine from 2000-2007 and has held an adjunct appointment there since 2007.



Awards & Recognition

Outstanding Student Clinician Award



Elana Kagan, Temple University

Elana is a fifth year doctoral candidate in clinical psychology at Temple University. She works in the Child and Adolescent Anxiety Disorders Clinic under the direction of Dr. Phil Kendall. Elana earned her BA in Psychology from Yale University in 2010. Following graduation she worked at the Yale Child Study Center doing in-home therapy with children and families, and then spent two years as a Clinical Research Assistant at Massachusetts General Hospital in the Pediatric Psychopharmacology group. Elana has worked in a number of clinical settings providing care to youth with a wide presentation of clinical disorders. Her research interests include the role of parental factors in the treatment of youth with anxiety disorders. She is currently conducting her dissertation evaluating a new intervention that targets parental accommodation for anxious youth.

What are your clinical interests?

I enjoy working with children and adolescents with a range of clinical presentations. My primary clinical and research interests center on the treatment of anxious youth. I'm particularly interested in the ways that parents can be engaged in treatment to maximize treatment gains, a question that comes from my clinical work and has become central to my research.

Why is this area of clinical work exciting to you? What is the most rewarding part of your clinical experiences thus far?

I love working with children and adolescents because of the creativity required to tailor evidence based treatments to fit the needs of individual youth. In what other job do you get to explain how Hamilton relates to identifying our emotions, play "Vomit go fish" with a child with a vomit phobia, and then walk around wearing silly hats as a social anxiety exposure? Working with children and adolescents also gives me an opportunity to make a significant impact at an age where children are still figuring out who they are and how the world works. It is incredibly rewarding to intersect with people's lives at such an impressionable age.

Who are/have been your mentor(s) or clinical influences?

My most important mentor is my graduate advisor, Dr. Phil Kendall. Dr. Kendall has always been supportive of all my clinical and research goals, and the opportunities presented by being a member of his research lab have been an invaluable part of my training. I have also benefited from the wonderful clinical guidance of my supervisors, both here at Temple and at my external practicums in the community. They are too numerous to name here, but I would not be where I am today without their support and guidance.

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

Seek opportunities to learn wherever you can, not just from supervisors and teachers, but also from your fellow students. Collaborating with my peers on research and clinical work has taught me just as much as my formal classes and supervision.



Shannon Blakey, University of North Carolina at Chapel Hill

Ms. Blakey is a sixth year clinical psychology PhD student at the University of North Carolina at Chapel Hill. Working with Dr. Jonathan Abramowitz, her research centers on the cognitive-behavioral mechanisms involved in the maintenance and treatment of anxiety and related disorders. Ms. Blakey strives to integrate science and practice in her clinical work by translating laboratory research findings to the clinic. She is particularly interested in enhancing treatment outcomes by (a) delivering exposure therapy in a manner consistent with the inhibitory learning model and (b) integrating compatible cognitive-behavioral treatments for co-occurring conditions (e.g., anxiety and depression). Ms. Blakey has authored or co-authored more than 30 journal articles and book chapters and is a regular presenter of symposium talks, posters, and clinical workshops at national and international conferences. Her personal interests include hiking, seeing live music, traveling, and watching Duke's basketball team lose.

Awards & Recognition

Outstanding Student Clinician Award

What are your clinical interests?

My primary clinical interest is delivering exposure-based cognitive-behavioral therapy for anxiety-related disorders. I especially enjoy working with anxious individuals who have co-occurring depression or alcohol/substance abuse. During my graduate training, I gained experience supervising UNC's Anxiety and Stress Disorders practicum trainees and leading clinical workshops at conferences like ABCT and IOCDF. These opportunities helped me discover that I value training therapists in exposure therapy in addition to treating anxious patients myself.

Why is this area of clinical work exciting to you? What is the most rewarding part of your clinical experiences thus far?

I love delivering exposure therapy because of the swift, powerful treatment gains evidenced via objective assessment and behavioral observation. In fact, I am probably more excited than my patients are when they reach the top of their exposure hierarchy! What I find even more rewarding than helping patients overcome their fears, however, is providing clinical supervision. It is difficult to describe the sense of pride and purpose I feel when helping a trainee therapist learn how to conceptualize clinical anxiety according to a transdiagnostic cognitive-behavioral model and confidently deliver prolonged and intense exposure.

Who are/have been your mentor(s) or clinical influences?

Two of my earliest clinical mentors and professional role models are Joshua Clapp and Tara Waddell Clapp. They not only gave me exceptional training in psychoeducational and diagnostic assessment, but also (and more importantly) inspired me to never quit a job until the job was done—and done well. I also owe much of my clinical identity and competencies to Stacey Daughters and Jessica Magidson. They pushed me out of my clinical “comfort zone” to help me develop in the most supportive way possible. To my first graduate advisor, Brett Deacon, I owe my confidence in delivering prolonged and intense exposure and my ability to discriminate between science and pseudoscience. But I wouldn't be where I am now without my current graduate advisor, Jonathan Abramowitz. His infinite support and mentorship have shaped me to be the scientist-practitioner that I am today, and it was from him that I learned how to conduct a useful functional assessment and convince people to confront the very things they are afraid of! I also credit several experts whose work comprised the foundation of my didactic training: Drs. Barlow, Beck, Clark, Craske, Foa, and Lejuez (and Abramowitz, of course).

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

1. Overcome imposter syndrome. If you are in a graduate program, it is because experts in the field thought highly enough of your academic/research potential to invest in you. The same goes for clinical activities: we are in graduate school to learn, not be perfect from the very beginning. Be humble, but act like you belong to be there.
2. Don't get defensive. I expect to make blunders during therapy, receive manuscript drafts graffitied with track-changes, and field tough questions following a PowerPoint presentation. Learn to love being critiqued. Such feedback is usually constructive feedback if you approach it with the right attitude.
3. Don't be afraid to network. Half of my professional relationships are a result of my approaching experts I wanted to learn from. Don't let shyness prevent you from seeking out and contacting potential supervisors/collaborators to discuss opportunities to work together.
4. Recognize burnout. I did not, and I paid the price for it one long, dark school year. It sounds banal, but prioritize self-care and a work–life balance. Exercise, community service, LARPing, creative arts—make time to engage in activities that are consistent with your personal values!

Clinician Perspective

Intensifying the Therapeutic Frame

David Anderson, Ph.D., Clinical Psychologist and Senior Director, Child Mind Institute

Early on in my graduate training, I remember being fascinated by readings on the frame of psychotherapy- guidelines for what a patient might expect in a therapy session related to factors like session frequency, duration, interaction with the therapist, and office setting. I received a considerable amount of guidance on how to establish expectations, how long a therapy session should last, how to stop and start the session, how to set up the office, how much to self-disclose, and how to process deviations from the established frame with my patients.

At first, my perfectionistic way of coping with graduate student imposter syndrome led me to doggedly pursue firm adherence to any guidelines related to the therapeutic frame. After all, I wanted to be doing it right, and the frame gave me a port of predictability in a storm of uncertainty that was difficult to tolerate at that early stage of my career. If I ended my sessions on time, reflected and explored a question with a patient without self-disclosing, and ensured that my patients consistently attended their weekly appointments, then it felt like therapy. Before I knew how to actually do therapy, at least there was the frame.

Yet as my training progressed, as with many aspects of therapy, the frame became just one consideration related to how a therapy session might be constructed. Particularly when implementing evidence-based interventions with my child and adolescent patients, non-adherence to a strict therapeutic frame appeared to be integral to the success of the intervention. Intervention literature involving a focus on multiple settings, real-world generalization, and modular, unified, or intensive approaches pushed me to question how flexible therapy might need to be in order to facilitate change. Certain of my patients still needed the consistency of a more structured therapeutic frame, but the more I read of Barlow, Chorpita, Eyberg, Kazdin, Kendall, and Weisz- scientists of Olympus in child and adolescent intervention- the more my attachment to the traditional therapeutic frame weakened. Was 45 or 60 minutes really the optimal amount of time for a session? Why meet in the office rather than moving as quickly as possible to real-world situations? Why meet weekly if it seemed like the pace of change could be accelerated with more frequent sessions? Regular, weekly sessions involving just the patient and the therapist might be most convenient from a logistical perspective, but I couldn't help but be intrigued by the possibility that there was a more efficient (and perhaps effective) way to get the job done.

Concurrently, I was fascinated by investigations into the dose-effect relationship in psychotherapy. Early studies suggested that for about 50% of patients, significant symptom improvement tended to occur within the first 8 sessions (Howard et al., 1986), while later studies placed the number closer to 15 to 19 (Hansen & Lambert, 2003). This research

contends that the rate of change in psychotherapy tends to decrease with each session, flat-lining somewhere around 30 sessions (Howard et al., 1986; Stultz et al., 2013). Whether it's placebo, hope for the clinician or treatment, or a sense of novelty aiding the active ingredients of an intervention, a surprising amount of therapeutic change needs to take place within the first few sessions, or clinicians might face ever-decreasing odds of success. In my mind, this literature suggested that therapy was sort of like a car merging onto the highway before stalling on a slight downhill slope - massive and exciting acceleration at the beginning, then gradually slowing to a stop after coasting down the hill.

So rather than wait for what seemed a decidedly non-triumphant point of good-enough therapeutic departure, I've always been interested in anything that would help to combat the prospect of demotivating and diminishing returns in long-term psychotherapy. If there was evidence for any child/adolescent intervention that could both increase the rate of change in symptoms while decreasing the amount of time in treatment, then I wanted to get my hands on it. That's why the part of the therapeutic frame that seemed most exciting to fiddle with was session frequency and duration - more sessions, more hours per day, in a shorter period of time. A child or teen who participates in an intensive intervention might experience a brief but significant disruption to their schedule or school year, but if they could get a similar or superior benefit from treatment in a shorter amount of time, it seems well worth it.

Many lines of research reveal converging effects for more intensive approaches to intervention. Ost and Ollendick's (2017) meta-analysis of the literature related to brief, intensive, and concentrated interventions for anxiety disorders in children indicates similar positive outcomes for intensive and once-weekly CBT approaches, with strong support for intensive approaches for specific phobia and moderate support for intensive approaches for OCD and PTSD. These intensive approaches yielded lower attrition rates while maintaining gains at 12 months post-treatment (Ost & Ollendick, 2017). Graziano and colleagues (2015) tested an intensive approach to Parent-Child Interaction Therapy (PCIT), replacing the standard model of once-weekly sessions with 90-minute sessions each day for 2 weeks. Reduction of externalizing behaviors paralleled that in traditional weekly PCIT. Kurtz and colleagues modified PCIT for children with selective mutism while also developing an intensive, camp-based model of intervention (Carpenter et al., 2014). Summer treatment programs, intensive day camp interventions lasting up to 8 weeks, have an extensive body of literature supporting their effectiveness in addressing ADHD and behavior problems in school-aged children. Recent summer treatment program studies highlight expansion to adolescent populations with ad-

ditional parent training to decrease parent-teen conflict (Sibley et al., 2013) as well as modifications for pre-kindergarten populations with an increased focus on social-emotional and school readiness skills (Graziano et al., 2014).

To be clear, weekly psychotherapy is still great. With most patients, our problem as clinicians is not whether they will get weekly or intensive evidence-based treatment, but whether they will get any treatment at all. For a host of reasons, whether it is convenience, limitations of insurance, or societal norms, our patients and families will often expect to see us once a week. They won't be thinking about their rate of therapeutic change or whether the therapeutic frame is flexible or what the effect sizes associated with the treatment might be. They just want to get better.

But taken together, compelling evidence suggests that weekly psychotherapy for certain diagnostic presentations may be doing child and adolescent patients a disservice, underestimating the pace of therapeutic change that patients are capable of and perhaps losing the opportunity to capitalize on the period of greatest momentum in therapy. I'm never exactly sure what wave of psychotherapy we're currently on, but if we assume that we're in the midst of a well-defined third wave, perhaps the fourth wave will focus not solely on new therapeutic techniques but also on accelerating their application. To be sure, even if intensification is the next stage in therapeutic evolution, strength of science won't be enough to ensure its viability. Its survival will depend on its adaptation toward cost-effectiveness and scalability.

In my work at the Child Mind Institute, that last point has become central to my team's current initiatives, as we push the boundaries of evidence-based practice in the area of intensive behavioral parent training interventions. Within our practice, we're monitoring outcomes for patients who receive standard, weekly behavioral parent training compared to those who complete the entire behavioral parent training curriculum in a week with less frequent follow-up care. We're testing whether a one-day behavioral intensive for relatives, educators, and non-parent caregivers boosts or accelerates outcomes for traditional behavioral parent training protocols. We're also investing our resources in a summer treatment model that attempts to produce similar outcomes to a traditional summer treatment program in half the time.

Overall, we can be emboldened by the emerging strength of evidence for intensive approaches. Yet even as our therapeutic frame has become a lot more flexible, there is still so much work left to do. Evidence-based interventions that push the boundaries of the traditional therapeutic frame to enhance benefits to patients must be made cost-effective, must be integrated into training programs, and must demonstrate superiority to even the same evidence-based interventions administered in shorter or more infrequent doses. Only then will intensive interventions gain the appropriate and requisite footholds for dissemination. In the end, while the traditional therapeutic frame is comfortable and familiar, pushing its boundaries in applying evidence-based interventions will maximize our ability to transform our patients' lives.

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Student Perspective

Keeping the Romance Alive: A Grad Student's Guide to Research

BreAnne A. Danzi, University of Miami

A few weeks ago, an undergraduate came to my office and excitedly informed me that he wanted to do research. I launched into my spiel about the different research projects in our lab that he could get involved with, but was stopped—you see, he wanted to do his own study. He animatedly explained that he wanted to recruit babies and expose them to different stimuli to see how they responded (not something our lab does). Oh and also, he needed this study to be published by next month, in time for his medical school applications.

Although my undergraduate's enthusiasm is to be commended, many of us probably (hopefully) had a more realistic understanding of the research process before entering graduate school. Still, no matter how many hours you logged as an R.A., there was likely some aspect of research that surprised you as a graduate student. It may have been the challenging logistics, the sheer number of confounding variables to contend with in any study of human psychology, or the lengthy timeframe from study conceptualization to implementation to publication.

Many students experience a moment of disillusionment with research at some point during graduate school. For some, this moment passes and they keep calm and carry on. For others, this moment is a crisis: *Oh no! Did I choose the wrong career? What if research isn't for me?*

Below are a few tips for what to do in these moments, and how to keep that same bright-eyed enthusiasm that you had as a new graduate student.

1. Take failures in stride! Given the competitive nature of clinical psychology graduate school admissions, many incoming students have very impressive, high-achieving backgrounds, and may not have much experience with failure. I remember submitting my first primary-authored manuscript and receiving the dreaded "reject without review." I was devastated! *How could the journal editor not like my painstakingly prepared paper? Is my research not good enough?* My mentor wasn't worried: "Just try another journal – your paper will get accepted." She was right: My paper ended up getting published by a journal with a much higher impact factor that was definitely a better fit. The lesson: My mentor's decades of research experience had given her perspective, something that I didn't have yet as a brand new researcher. When you are just starting out, it is easy to get caught up in the ups and downs of research, which is why it is important to be reminded that failure is just part of the process.

2. Structure your environment! It is essential to surround yourself with amazing mentors and colleagues to provide support and guidance as you develop as a researcher. These

people can be a wealth of information and insight that can help your research to move along more effectively, and can also make those long work days much more fun! Just as having the right people around you can make you a better researcher, getting set up with the right stuff can also be helpful – an elaborate day-planner, a coffeepot, or even a comfy chair. My office hallway of clinical child researchers love making creative sticker charts to add some fun and whimsy to checking off our to-do lists and tracking our research milestones. Figure out what brightens your day, and bring it into your research!

3. Have a few plates spinning! Being involved in several projects, either within your own lab or through collaborations, is a great way to keep research feeling fresh. This strategy allows you to work on studies that are in different stages, and allows you to shift gears if you are feeling a bit stuck with a particular study. Having eggs in more than one basket can help with feelings of stress when you run into roadblocks with your research. Involvement in multiple projects also allows you to explore different areas of interest, learn new methodologies, and network with other researchers.

4. Sell, sell, sell! Many graduate students can get hung up on the limitations of their research. This is understandable. You spend a lot of time running up against those limitations, thinking about them, and trying to figure out how to fix them. This becomes a problem when asking about a student's research elicits a disheartened lament about all the problems in their study. It is certainly important to be transparent about limitations in research, but it is also up to you to sell your research. Even if you feel a bit preoccupied by the things that are going wrong, consider what's going right and talk about your successes. And who knows? If those pesky cognitive-behavioral principles are to be believed, focusing on and talking about your successes might actually change how you feel about your research!

5. Have fun and recognize the positives! Although aspects of research may be frustrating at times, there are also parts that are pretty great. Conference travel can be an excellent way to refocus on the "big picture" parts of research and to relieve stress. We get to travel to fun places, get to know other researchers, and share our ideas with people interested in similar things as us. In addition to taking part in the fun aspects of research, it is equally important to learn to identify successes when they do come – that lengthy "revise and resubmit" may inspire a jolt of panic at all the work you are going to have to do, but it is a victory! Make sure to celebrate it as such.

Some students may weather the ups and downs of research in graduate school and then thoughtfully decide that research just isn't for them. That's okay too! Whether you decide to pursue a research career, become a consumer of research by providing evidence-based clinical services, or choose another path, this process allowed you to become better-informed—about research and perhaps about yourself too!

About the Author:

BreAnne Danzi is a fifth-year Ph.D. student in Clinical Child Psychology at the University of Miami, working with Annette La Greca, Ph.D. Her research interests are in the area of child trauma. Her line of research focuses on improving the diagnostic conceptualization of PTSD to be developmentally-appropriate for children. For her dissertation, she is investigating genetic vulnerability for PTSD in trauma-exposed children.

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Q&A

Navigating Internship as a Research-Oriented Clinical Psychology Student

Andrew D. Peckham, Ph.D., McLean Hospital & Jessica Hamilton, Ph.D. Temple University

Between July and September of 2017, more than 3,500 students will begin the challenging and exciting experience of beginning their clinical internships. Internship entails a number of challenges, including learning new clinical skills, developing new relationships with mentors, colleagues, and training directors, and for many, relocation to a new region of the country. For research-oriented clinical psychology students, the transition to internship comes with the added challenge of maintaining research productivity while undergoing full-time clinical training.

Fortunately, there are many internship sites that provide research-friendly opportunities such as dedicated time to work on scholarly projects, mentorship from research-oriented clinical psychologists, and opportunities for new research collaborations during the internship year. The match process allows research-oriented students to identify and apply to sites that openly allow for such opportunities alongside clinical training, and there are a number of resources (such as the APPIC website and individual program brochures) that allow students to select sites that will maximize their research potential. Yet, even interns at “research-friendly” internship sites often struggle to find the right balance between internship training responsibilities and their ongoing academic pursuits.

Below, we provide the results of a series of interviews with current and former research-oriented interns from internship programs located in the Northeast and Midwest. While this is by no means a representative sample of all research-oriented psychology interns, the perspectives they offer represent some common themes and pieces of advice that we hope will be helpful for new interns to hear.

1. How would you recommend interns balance their clinical, research, and personal/life responsibilities?

Intern: Set small research-related goals for yourself that you think will be manageable given your intern schedule. If possible, ask around and choose the rotations that are less demanding if you have a particularly stressful research-related deadline or project you’d like to be working on. However, I would say to keep in mind that this is a demanding clinical year, and you will likely not be able to be as productive as you would like! Also—a huge thing I would recommend if possible is to have your dissertation defended. If possible, try to submit for publication as many of the ongoing projects from graduation school prior to going on internship. It becomes hard to balance old projects with new projects, especially with the limited time!

Intern: I found it important to carve out specific times or activities that I enjoy for each week. For example, putting a fun community activity on my calendar for the weekend to make sure I got out of the house, rather than just lounging

in PJs all day feeling guilty about research work! It was also important to me to leave as much of my work “at work” as I could, even if that meant staying a little later to finish up rather than bringing work home with me.

Intern: This is an exciting and challenging year. Regardless of how much research you want to do (or have done in the past), remember that it is a clinical year even at the most research-oriented sites. I definitely expected to have more research time on internship than I do. However, that is not because of the grueling clinical hours, but rather prioritization of my personal life in a very busy year! It was really important to me to explore my new city, build solid friendships with my fellow interns and postdocs, and maintain my connections with family and friends living farther away. I would say that flexibility is key—and that you should focus on what is important to you and accept that it will change based on the time of year, deadlines, and whatever life throws at you. The biggest thing for me is to remember that this year is a unique balancing act and it does not necessarily reflect anything more than that!

2. What have you learned about yourself from internship?

Intern: I had some unique clinical experiences prior to internship, but the ability to try working with new types of presenting difficulties, in different settings, and with different therapy modalities has made me really appreciate clinical work! I found that I really enjoy working with clients in intensive outpatient programs, for example. On the flip side, I’ve also learned that I have a very hard time saying no, especially when I’m being asked to do things by multiple different people in different domains (clinical work, research, administrative), so that has been a challenge.

Intern: The internship year confirmed and intensified my desire for a research career, which has been helpful in clarifying my training goals for post-doctoral training and beyond. In addition, my internship provided many opportunities to work with diverse and varied clinical populations, which further opened my eyes to what I do and do not enjoy about clinical work as well as new populations I might be interested in conducting research with in the future.

Intern: I have learned that I know way more than I thought I did prior to coming on internship! I have also learned to be more reliant on and confident in my own decision-making skills. In graduate school I had a really supportive mentor who I would run most decisions by. I still have her guidance, but have had to learn to make more decisions on my own. It’s unsettling but with practice and time I’m learning to navigate this better.

Intern: I have learned that it really is possible to balance clinical and research responsibilities in the same

career. So often in graduate school, it seemed like clinical work and research were completely different parts of my life, but I've learned from internship that it is possible to have both of these roles fully complement each other.

3. How have your own expectations shifted over the course of the year, in terms of your expectations about how much research you expect to get done during internship?

Intern: I think overall my expectations haven't shifted much. In fact I may have had more time than expected to do research. But it takes flexibility - using a couple hours here or there rather than expecting to have half a day.

Intern: Although the internship program I attended is primarily clinical, there was an emphasis on and time dedicated to research. At the beginning of internship, all interns were required to set research goals for the year, which helped set my expectations for the year. Overall, my expectations were met or exceeded in terms of how much research I expected to get done during internship.

Intern: Manage your expectations about how much research you can get done during internship! While it is certainly possible to stay productive, there is no way around the fact that you will have fewer hours in the day to work on research. This is a fact that deserves some radical acceptance at first, followed by strategic planning. Once I accepted that there is less time for me to devote to research than I would like, I found that it was easier to pick a few specific projects to focus on.

4. What advice would you give to new interns about settling into a new place, institution, and/or position?

Intern: I think I have a few pieces of advice: 1) Give yourself some time to settle in! If you can move to your internship site's city before the start of internship, do it. It's stressful to start a new full-time position regardless, but it's more stressful when your whole apartment is in boxes and you don't know how to get to the grocery store! 2) Ask for clarification (from all supervisors - research, clinical, training directors) about expectations up front. It's much easier to have those conversations when you're starting a new rotation or working with a new mentor than it is to address miscommunications later on. 3) Don't sign up for too many projects, patients, etc. right away - it's easy to feel like a kid in a candy store with a lot of new opportunities in front of you, but it's much easier to add something a month in than it is to stop doing something you've already agreed to. 4) Recognize that you're new, and that just because things have always been done a certain way in your previous experiences doesn't mean that will necessarily fly at the new place. Also remember that people may have very different opinions than you (about certain theoretical orientations, for example), especially if you're starting at an institution or in a city that's very different from the one where you did your training. Acknowledge the experience and expertise of those around you!

Intern: Enjoy and explore! I found that my internship

mentors have been much more likely to encourage me to spend my free time pursuing activities that bring me pleasure and adventure. This exploration led me to feel much more enmeshed in the larger community of my city than I felt in graduate school.

Intern: Try to find those supportive people, whether it be friends, family, or mentors, especially if you are moving somewhere new. For me, building a supportive network has been the most significant piece of adjusting to a new place, job, home, and people.

5. What advice would you have for navigating different research mentors (including current and past advisors)?

Intern: I think it's helpful to have a conversation with your graduate advisor before you go on internship about what their expectations are for you (and what your expectations are for them) during the internship year. Do they want you to write up your dissertation into a manuscript? Do they want you to be Skype-meeting with them weekly? Do you want to be meeting with them a lot when maybe they would prefer to be in less frequent contact? Will you have any responsibilities to your old lab? I think that, if you've had that conversation before internship starts, you're in a better position to set up reasonable expectations with your internship research mentor. I also think that my earlier advice (don't sign up for too much too early) applies here - it's better to set limited, reasonable goals for yourself with your internship research mentor and then be pleasantly surprised by being able to take on more later than it is to say you can do 5 projects but only deliver on 2!

Intern: Broadening your research network is both amazing and challenging. Specifying your training goals to your mentorship team is essential as well as making explicit the role you see each mentor playing in achieving those goals. Putting things in writing always helps.

Intern: Your new mentor will undoubtedly be different from your grad school mentor, who you have now known for 5-6 years, at least. So, it takes some time to adjust to a new mentor's style and personality. If a meeting doesn't quite go how you wanted it to, take some time to reflect on how your learned interactional style in these meetings might contribute to any miscommunications. Problem solve about how you might structure the interaction or approach your mentor differently so that you can have a more productive and clear meeting. That being said, from the outset make sure to ask around about the mentor's style and personality prior to making any commitments--it is stressful to have a difficult mentor, especially during internship!

Intern: Don't over-extend yourself. It's good to make some new connections, and keep the old ones in good shape, but don't promise too much. It's easy to get excited and agree to lots of different projects, but you have to protect your time and be realistic. Most mentors understand that. Importantly, be honest about your time up front.

6. How would you have approached this year differently

knowing what you know now?

Intern: I think I would have set clearer plans for myself about how to balance my own research projects with the clinical work. Even when I've had rotations with relatively lower clinical workloads, it's just very mentally taxing to be working clinically all day, and then try to "switch" your brain to a more research-focused line of thought. I might have done better with research productivity if I'd set specific goals for myself on a weekly basis, with the hope of staying more on track.

Intern: I would have approached the internship year with more purpose from the very beginning. Because I was initially ambivalent regarding the value of a purely clinical year, my approach was to let experiences come to me rather than specifically seeking out certain experiences. This year has made me re-evaluate that approach and led me to be more explicit in my goals for post-doctoral training.

Intern: In retrospect, I would have given myself "permission" to take more time off from the clinic to work on research projects earlier in the year. I was surprised at the amount of vacation time and "professional" days off that my internship site allows, and once I learned how easy it was to ask for a day off to work on writing, I took advantage of that opportunity. I would have approached my training director about taking time off for research earlier in the year if I had been more confident about making this request.

7. How did you decide the next steps in your career? What advice would you give for people in their internship trying to figure out the next steps?

Intern: I was pretty sure going into internship that I wanted a career focused on research. I think if people are unsure, it's good to think - "could I do this full-time?" or "do I actually miss research?" Because for me, I missed research quite a bit, and I knew that while internship was a good training experience, it wasn't what I wanted to do for my career. I also relied significantly on supervisors for career advice - I highly recommend getting multiple different opinions and perspectives.

Intern: I decided on the next steps of my career based on balancing my long-term career goals with my personal/family goals. I recommend that future interns consider the setting, location, and fit of their next step (e.g., postdoc) as it could provide opportunities for future employment.

Intern: So much of the internship year can be thought of as "networking" for postdoc, particularly if you are able to stay at the same institution. So don't be afraid to set up meetings with researchers at your internship site and ask about ways to get involved with their team, even if you may not have the bandwidth to join their team right away. Go to lab meetings, go to grand rounds or other talks, and see if there are people at your internship institution that might be a good fit for your next steps. It's also never too early to start looking into postdoc options. It's a remarkably fast turnaround between starting internship and applying to postdoc positions, so be sure to set aside time early in the year to think about what your next steps might be.

8. Any other advice that would you give to new interns?

Intern: Take the clinical opportunities available to you, even if you don't intend to pursue clinical work as a primary career! First, you might find you really like certain kinds of work, which can inform your career plans or at a minimum where you want to focus your hours for postdoctoral requirements. Second, even clinical work in populations that didn't seem relevant to my research has helped me develop new hypotheses and new ideas that will benefit me in research in the future. Third, it's the last chance you get to be fully focused on your own training!

Intern: Be open to new experiences, but also remember that you can't do it all! Prioritize what is important to you - it's okay to politely decline an offer (clinical/research). Also, remember that this is your training, so you should not hesitate to experience it fully and make it what you want/need!

Intern: Don't be afraid to (respectfully) rock the boat a little. At many internship sites, you are coming in for only 12 months to work with people who may have been working there for decades. Be open to learn from people who do things a little differently than your training, but also don't be afraid to speak up if you see ways to make improvements in the way things are done. As clinical scientists, we have a lot of training in evidence-based practices, and it's important to share that knowledge broadly.

Summary: The interviews in this column represent what many people who have completed internship understand: that despite the stress and challenges associated with this year of clinical training, it is absolutely possible to make progress on your research, to learn new clinical skills, and even to enjoy yourself all at the same time. While everyone's experiences are different, there is also remarkable consistency across these interviews: many interns would agree that managing expectations about your ability to get research done during internship is important, but that internship includes many chances to elevate your research career. We believe that managing this dialectic is essential to staying happy, healthy, and productive during this exciting time.

About the Authors:

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Jessica Hamilton is a postdoctoral scholar on a T32-funded fellowship in the Department of Psychiatry at the University of Pittsburgh.

Updates from Student Representatives

Jessica Hamilton, Ph.D., Temple University

Kelly Knowles, M.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.

Networking Event

Attending ABCT? Come to the SSCP Student and Postdoc Happy Hour on **Friday, November 17th from 4-6PM!** We are very pleased to announce the second annual SSCP Student Social at the ABCT conference, and our first time extending the invite to postdocs! So gather up your friends (students and postdocs) and join us for a wonderful time to network and socialize in sunny San Diego at the Half Door Brewing Company (<http://www.halfdoorbrewing.com>). Light appetizers and the first drink (beer, wine, cocktail, non-alcoholic beverages) are compliments of SSCP. Look for an email on the SSCP Student and Main Listserv for more information and to RSVP for the Social! Faculty interested in mingling with students and postdocs are also welcome to attend.

Student Award Announcements and Opportunities

SSCP Dissertation Grant Awards - These awards are intended to both recognize and support students who have already received approval for their dissertation project. Accordingly, in addition to the evaluation of the proposal as a whole, we will also consider what additional sources of funding have been received in the context of the overall estimated cost of the project. Awards will be in the amount of \$500. It is anticipated that up to 5 grants will be funded. Eligibility requirements and application instructions are listed on the main SSCP website: www.sscpweb.org/Grants-&Awards. Applications must be received by November 15, 2017.

SSCP Student Outstanding Teacher Award - This award is intended to recognize outstanding graduate students who are providing exceptional contributions to the field of clinical psychology through their teaching. Students will be selected based upon their dedication to, creativity in, and excellence in teaching in the area of clinical science (this can include experience as a teaching assistant). Applications must be received by December 1, 2017. Complete guidelines and the cover sheet can be found on the student website: <http://sscpstudent.blogspot.com/p/student-awards.html>. Students may be nominated by their advisor or a faculty member for whom they have TAed, or may self-nominate. Please send nomination packages to Kelly Knowles and Jessica Hamilton at sscpstudent@gmail.com. Only graduate students (including students on internship) will be considered for this round of nominations. Graduate students must be student members of SSCP. The annual student membership fee in SSCP is \$15. The membership application form can be downloaded or submitted on-line at: <http://sscpweb.org/Membership>

SSCP Student Poster Award Competition at APS Convention - The 2018 SSCP Student Poster Award Competition will take place at the APS Annual Convention, May 24-27, 2018 in San Francisco, CA. If you would like to have your poster considered for the award, select 'SSCP Poster' in the first step after you select poster and start new submission. Those receiving the top award receive \$200, and winners of the "Distinguished Contributions" Award receive \$100. The SSCP poster submission can deal with any area within scientific clinical psychology. The research and analyses presented in the poster submission must be completed. Please be sure to provide enough relevant detail in the summary so that reviewers can adequately judge the originality of the study, the soundness of the theoretical rationale and design, the quality of the analyses, the appropriateness of the conclusions, and so on. Complete submissions include a brief 50 word abstract and up to a 500 word summary of the work. Deadline for poster submissions is 1/31/2018. Please follow the link for a complete call for submissions: <http://www.psychologicalscience.org/conventions/annual/speakers>

Internship Resources

SSCP Internship Hotel Match-Up – We are excited to announce that the SSCP Internship Hotel Match-Up will be available to students again this year! The SSCP Internship Hotel Match-Up will allow interested students to complete a request for each date and location 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 in order to make hotel arrangements. Look for an email on the SSCP Student Listserv with more information on this new money-saving resource and a link to sign-up!

SSCP Internship Q&A– Three panelists generously responded to student questions about the internship process, including two directors and one student. Please see the full Q&A on our student website.

Student Perspective:

<https://sscpstudent.blogspot.com/2016/10/the-intern-process-student-perspective-q.html>

The Director's Guide:

<https://sscpstudent.blogspot.com/2016/10/internship-process-internship-site.html>

SSCP Postdoctoral Guide - Check this out if you are looking for research-oriented postdocs!

<https://sscpstudent.blogspot.com/2017/09/an-applicants-guide-to-research.html>

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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