The Child & Adolescent Anxiety

S I G N e w s l e t t e r

Advancing the Science and Practice of Youth Anxiety *February 2017*

Dear SIG members,

Welcome to the February 2017 issue of the Child Anxiety Special Interest Group (CASIG)! I'd like to thank Dr. Cara Settipani, our outgoing SIG Leader, for her excellent work and the significant amount of personal time that she invested in planning and organizing the successful CASIG events at our 2016 ABCT conference in New York. The events included many excellent presentations, student research, a happy hour, and a panel discussion. These events were relevant, informative, and interesting. I'd also like to thank all of our panel speakers, presenters, and attendees at our events at ABCT last year. I also would like to publicly congratulate Dr. Adam Weissman of The Child and Family Institute (with multiple locations in the New York metropolitan area) who was selected Leader Elect of the CASIG. Dr. Weissman will help us prepare for a great ABCT in San Diego later this year and will become the new leader after the conference. Also, congratulations to Anna Swan for winning our 2016 Student Travel Award (and whose research is spotlighted in the current edition of the newsletter) as well for being selected as the newest co-editor of the newsletter. She joins Dr. Dana Hodkin and Dr. Linda Spiro on the newsletter editing team. And, finally, congratulations to this year's student representatives, Christopher La Lima, Rachel Terry, and Michelle Clementi, who each contributed to this edition of the newsletter.

In this issue, in addition to Anna Swan's award winning research, you'll find a forward thinking article on barriers and future steps for child anxiety therapeutic interventions using technology, an in depth interview with Dr. Ali Mattu of CUCARD in New York City about the use of pop cultural references, stories, and metaphors being integrated into therapy, advice for those of you preparing to apply to clinical internships, and an article on why you should always have a couch in your office made of fine Corinthian leather. Finally, I'd like to thank our new sponsor, Brookline Leather Goods, makers of Fine Corinthian leather.

Please reach out to our newsletter editors for any comments about the newsletter or if you'd like to contribute to future editions. We hope that you enjoy this edition!

Sincerely,

Clark R. Goldstein, Ph.D.

Founder of Growth Psychology and CASIG Leader

If you have suggestions or comments about the newsletter, or if you would like to contribute an article, we would love to hear from you! Please contact one of the newsletter co-editors:

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Happy February! In this issue you'll find…

Features:

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The Power of Using Pop Culture, Stories, and Metaphors in CBT for Children and Adolescents with Anxiety Disorders: An Interview with Ali Mattu, Ph.D.

By Rachel Terry, M.S.

As trainees and emerging professionals in the field of psychology, we are often encouraged to personalize CBT to each client we work with. In an effort to learn more about ways to do so, I sat down with Dr. Ali Mattu, to discuss his experiences integrating pop culture, stories, and metaphors into treatment for individuals impacted by anxiety disorders. Dr. Mattu is a clinical psychologist at the Columbia University Clinic for Anxiety and Related Disorders (CUCARD), where he specializes in the treatment of anxiety and body-focused repetitive behaviors and serves as a coordinator for CUCARD's Launching Emerging Adults Program (LEAP), an innovative family-based treatment designed to help young adults function independently. Outside of his work at CUCARD, Dr. Mattu hosts The Psych Show, a YouTube channel that aims to bring topics in psychology to the general public. Additionally, Dr. Mattu is creator of the award-winning Brain Knows Better blog, where he writes about the psychology of science fiction.

Q: How can integrating meaningful stories, metaphors, and characters from pop culture enhance CBT and treatment in general?

A: One of the challenges about psychology is that we don't get a lot of exposure to it growing up. With biology, for example, I remember making a papier-mâché cell in elementary school and that is the foundational unit of biology. And we learn math very young and that's a foundational set of knowledge for physics. With chemistry too, we create atoms and things like that. We get exposure that starts building basic schemas about what those fields are, and we also get exposure in the media to some of these other fields in science from a very young age. So if you close your eyes you can kind of think of what a biologist does, and what biology is, or with physics

or chemistry or even with medicine—we interact with a lot of health care professionals over the course of our life. Over time these schemas become more elaborate, more complicated, more nuanced over time, and that's without any formal education—that's just grade school and exposure to society.

The problem with psychology is that most of the time people don't get exposure to the field until AP Psychology, and that's if the school that you go to is privileged enough to offer that course, or in college if someone is fortunate enough to take an Intro. Psych. class, or alternatively maybe some kids work with a psychologist and get some exposure there. So by the time someone is a young adult and they have the opportunity to get exposure to psychology, their understanding of it and their schemas of the behavioral sciences and the brain are so underdeveloped compared to other sciences and that's because we just haven't invested much in early curriculum for the brain-behavior sciences… On the other hand, when you take the things that people love and think about—the stories that they dream about—the schemas for those things are so well developed and you can use those as a bridge to help people understand concepts in psychology and in cognitive behavioral therapy that are so underdeveloped. It's a way of bridging the material and making it easier to understand, and that's why metaphors and stories are so powerful. We can really benefit from using existing knowledge to make this new knowledge so much easier to understand.

Q: In your clinical work with children and adolescents, how do you approach weaving in meaningful stories, characters, and elements of pop culture into treatment?

A: I think that everything starts with having a really good conceptualization of the person you're working with that goes beyond diagnosis—so what are the mechanisms at play, how did the problems start, how does their family, their culture, their development, how do all of these things contribute to the mechanisms that are getting in the way, and having a really good understanding of which treatment is going to be most effective for them, and feeling confident in that treatment or at least confident in the supervision and training you're getting in that treatment.

And then, from the very first time I meet someone, in my intake, I also make sure to ask pretty early in the interview, "What do you like to do for fun? When no one else is around, how do you like to spend your time?" A lot of times most kids or teens that I work with will say some version of, "I like to watch TV, I like to watch movies, I like to hang out with my friends, and I like to read books." But that's not good enough—I'm not satisfied with that, because we all like those things. So then I move on to questions like, "What are you watching right now?" and if they don't want to talk about it or provide a vague answer, I try to ask questions like, "Well what was the last thing you watched?" or "What was the last video game you played?" Though I try to stay up to date, I might not know exactly what they're referencing, but what's more important, and this speaks to a lot of the literature on culture—we can never fully be culturally competent but we can be culturally responsive, we can always respond to the culture of our patients and not assume what their experience has been and at the same time make an effort to understand what their experience has been, what are their expectations and beliefs. The same is true of the stories that power their imaginations and power their dreams. So when I ask them about a particular area of interest, I'll also ask questions like, "Help me to understand, what is it about it that you love?"

So from the intake I don't just have a conceptualization of their psychopathology and of their family, their culture, and their personality, but I also have a conceptualization of their dreams, of the stories that power their imagination. I need to know that because those are related to their hopes and dreams and who they want to be—their vision of the world. And it doesn't just have to be media or pop culture, maybe it's sports, religion, or something else that is really important to them. I need to know what gives the people I work with meaning and purpose, and what excites them. That is incredibly important information. How I tailor the intervention and how I map treatment onto their existing schemas is through that. It's through knowledge of the things that drive their passions. It might sound like that takes forever and it really doesn't. It's very similar to integrating culture into treatment, you just have to make a genuine effort to try to understand.

And you have to practice what you preach. In my office I really try to have symbols and representations of a wide variety of stuff to show the people I work with that it's okay to talk about this stuff. For example, I have geeky

toys, and I also have a basketball hoop and a football. I want every child, adolescent, and adult that comes into my office to be able to find something there that they identify with and care about because it does make it a little bit easier to have those conversations. It can spark those conversations and it communicates that this stuff is up for grabs. As much as we're going to talk about symptoms, diagnoses, treatment, the three-component model, acceptance, and dialectics, and all of that stuff, we're also going to talk about these other things as well.

Myths and stories are an important part of human civilization. Every culture has had important stories that help us understand morals and expectations and give us hope in times of struggle. For some people, that might be religion. For some people that might be comic books, for some football. It's different and it's really important that we know what it is for the people that we work with. This is just how we've operated for millennia. I think what's different now is that there is a wider diversity of stories and myths in our society than you would have in our past. It was more homogenous in the past, and we don't have as much of that common language as we did before—there's more of a bouquet of options than in the past, but it's still just as important to understand.

Q: Moving beyond the intake session, as you're delving into treatment, what are some recommendations you might have about trying to weave those areas of interest into treatment?

A: It's always a collaborative process for me. That's one of the beauties of CBT—it's a very transparent treatment…Whatever cognitive behavioral treatment you are applying, all of our treatments are transparent, they always begin with psychoeducation, we always make it very clear how it's going to work. It's always a collaborative process with CBT and that's how this works too. The way I do it is I weave it in throughout treatment. So let's say I'm treating depression and let's say I'm doing behavioral activation and the kid is really into Disney movies. So I have Baymax in my office, who comes from *Big Hero 6*, a story about two brothers and [spoiler alert] one of the brothers is killed early on and the other brother really does fall into a state of depression. The character Baymax—this sort of robot type of assistant—really engages in behavioral activation and helps that other brother who is

mourning this loss engage his social support network. What a beautiful story that has such a strong parallel with what we are doing in treatment.

Or let's say I'm working with a kid who maybe has struggled with trauma and really also loves Batman. You know the whole Batman family of characters, Batman, Robin, Batgirl, Barbara Gordon who then goes on to become Oracle, they are all linked by experiences of trauma and also experiences of post-traumatic growth. So I'll often talk to kids who I work with, if they have this interest, to help them understand that it is possible to grow from traumatic experiences, just like Batman did. So from psychoeducation, to learning skills, to exposure or whatever it is that we're doing, these areas of interest can be woven throughout. And again, the whole idea is that I am asking them to develop a new way of understanding, to build up schemas that have never been created before, so we have to map that on with something that they do know.

Another example of it is in psychoeducation, if someone has a lot of experience with sports, I'll say, "I'm the coach, you're the athlete. I know this treatment. I know the skills. I know the drills. I know how to help you practice. You know what though? I could never step foot on the field on game day. This is a partnership and collaboration. I'm going to help you. I also need you to be really actively involved because I can coach you, but I can't play the game for you." That right there that completely shifts a lot of the perspective they have about therapy. The perspective and story that is in pop culture about therapy is that you are going to climb a mountain to this wise elder person and they are going to bestow wisdom upon you and that new insight is going to now change everything for you. That's not how CBT works. It is much more similar to practicing a sport or having music lessons. You have to practice.

So we find the things that kids naturally do on their own, have experience with, and every step of the way it's integrated throughout. It's not like I have a session and think "now let's talk about pop culture!" it's woven throughout. And again, it's the exact same way as what we need to do with culture. It has to be woven throughout. It's not just a one moment thing. It's a core part of treatment that is woven throughout.

Q: Are there any characters or stories related to anxiety that often resonate with the kids you work with?

A: So many! And this is one of the really fun things about being a child therapist—a lot of times our homework is to stay up to date in pop culture, which can make things really fun. There are so many stories that resonate. *Harry Potter* is a big go-to that has done really well for me in the early 2000's. What's cool about *Harry Potter* is that you have a lot of young adults now who grew up on *Harry Potter* and it's a core, fundamental story for so many. Just like for a lot of adults who grew up in the '70s, *Star Wars* was a big cultural moment. And I think for my generation it was more *Lord of The Rings*, it was a really core cultural moment.

What's cool about *Harry Potter* is that there are stories about trauma, and there's also this really interesting experience related to anxiety: In the middle of the series Voldemort is invading Harry's mind and trying to take control of his mind. And Harry has to learn *occlumency*, which is a way of strengthening his mind against these thoughts. It's such a great parallel for OCD. What's cool about this too is that Daniel Radcliffe, the actor who played Harry Potter, has been very public about his own experience with OCD and getting treatment for it, and that always surprises a lot of kids that I work with. If they like Harry Potter, I'll weave that in. And Daniel Radcliffe has been such a wonderful person in carrying the flag of Harry Potter and being Harry Potter for the community so to hear that he struggled with OCD is really meaningful for a lot of kids. We are going to learn your own *occlumency*, just like Harry practiced "defense against the dark arts." And then there's the whole idea of a *patronus* in Harry Potter. In Prisoner of Azkaban, they have to learn how to create these *patronuses* against *bogarts*, which sort of represent your deepest darkest fears, and it takes a lot of practice, it's difficult, and Harry has to go through that process over and over again. He's basically doing exposure! He's learning how to be in situations that are so difficult for him.

A lot of the analogies I use in treatment come from sci-fi because that's what I know really well. For example, there's this wonderful quote from *Doctor Who* that I absolutely love. In an episode called "Listen," The Doctor encounters this kid who's really afraid of monsters under his bed and he says this thing to the kid that I love:

> Let me tell you about scared. Your heart is beating so hard I can feel it through your hands. There's so much blood and oxygen pumping

> through your brain it's like rocket fuel. Right now you could run faster and you can fight harder. You can jump higher than ever in your life and you are so alert it's like you can slow down time. What's wrong with scared? Scared is a superpower! Your superpower! There is danger in this room. And guess what? It's you.

In this one quote there's psychoeducation to anxiety and there's a reframing: this is a natural response that helps you in these situations, it's your superpower. I love that.

There are so many stories that we can draw from, and we can also draw from history. One thing that I use with a lot of parents, particularly with parents of young adults who are helping them try to launch, I say: You and I together, we're basically creating an Apollo program. We're trying to launch your child. We want them to get to the moon, to get to college, functioning, and to live independently. How did NASA do that? I really like to ask them the question socratically, and they often say something like, "Well there's the Apollo mission." So I ask them, "So how did the Apollo mission work?" And they'll say something like, "Well you know they did a bunch of small launches, and they were testing things along the way, they got input." And so I'll ask them, "Okay so they didn't just do one launch and had them go straight to the moon?" And they'll say, "No, that would be dumb!" Okay, why? "Because a lot of things could go wrong and things aren't tested." So I'll say, "Okay, so do a series of things, figure out how they go, and then you push a little bit farther. So that's basically Vygotsky's principle of zone of proximal development, of scaffolding—you want to find that area that's just above what someone can do on their own and provide them with support. And as they master that you have them do more, and more and more. So when you're raising a kid, especially one who might be struggling with anxiety, it's not about assuming that after high school everything is going to be fine, but we need to push them in small ways that are increasingly more difficult and challenging, see how they do, just how NASA did, you launch into orbit, then you orbit the planet, then you go a little bit farther and farther, and then you orbit the moon—that's like visiting college—and then you test everything out and you have them stay overnight somewhere and then you see how that goes and then push them to stay a little bit further and things like that. So sometimes it's about weaving in history.

…And it doesn't just have to be pop culture and stories. The analogies you use can come from everyday life. For example, when talking about sleep with patients. Sleep is something we so poorly value in society. I'll often talk to parents and kids and ask them, "How do you charge your smartphone?" and the kid will usually say, "What do you mean?" and I'll go on to ask, "Well what do you do?" and the kid will say, "When the battery is low, I plug it in and when it's done charging I take it out. So I'll say, "You really make sure that your phone is fully charged before you go out for the day"…and the dots start to connect. And I'll ask them, "So what happens if you don't charge your phone all the way? And they'll say something like, "I get into trouble in the middle of the day… I can't do this, I cant do that." And so then we talk about what some of the consequences are if you don't charge your body up for the whole day, and how you need to take care of your mind and body just like how you charge your cell phone.

Another example that comes from everyday life is the idea of introducing new patients to therapy. I'll often say, "Therapy is like taking a cab. If you don't give the driver a goal, a destination, you're never going to get anywhere." So that sort of speaks to the idea that this is a very goal-directed, active process that we're going to work on together.

With video games, there's this concept in most video games right now that you can just sort of power through and finish the game or you can go off on these side quests. And so when I'm talking to teens and kids about video games and especially if video games might be becoming a problem in their lives, I will try to say something like, I want video games to be a 'power up' for you, something that helps you and adds to your life, like the mushroom in *Mario Bros.* that makes you bigger and stronger, I don't want it to be a side quest that takes you away from your main mission. I don't want video games to be a side quest that take you away from your school, your work, your friends, your family. I don't want you to get lost in that so that you never end up finishing the game. So we talk about how we can make it more of a power up rather than a side quest…and it's okay every now and then to get lost in the side quest, we all do, but we want to make sure it's mostly a power-up for you.

There are so many ways in which all of this works. I was recently working with a young adult and was trying to get him more engaged in treatment

using motivational interviewing. He didn't want to talk to me much about treatment but he was really open to talking to me about the new *Star Wars* film that was about to come out. We started talking about the characters, about why he loves Luke Skywalker so much, and then that led into the idea of the hero's journey and the myth of heroes, and I eventually tied that into what I wanted to talk about with motivational interviewing. I explained to him, "You're on Tatooine waiting for your hero's journey to begin, and how do we help you to move forward on it." And we talked about how his actions right now weren't consistent with his value of becoming a hero in his own life.

The list can be endless, but what it takes is a willingness to hear and understand the other person and also a willingness on your own to try and understand what they're interested in. It doesn't mean that necessarily you have to spend hours watching or learning the material. You need to do a little of that, but what's more important is really listening and trying to understand why these things resonate for the people you work with. Again, like what we would do with culture. You might not share the same religion or same beliefs as the patient but it's so important to find a way to weave those elements into treatment because it is a fundamental way that the person understands the world. If we don't take advantage of the stories and the ways in which our patients understand and relate to the world, it makes the work we do so much harder, but if we do, it makes it a whole heck of a lot easier.

What metaphors related to characters, pop culture, sports, etc. have you found helpful in your clinical work? Feel free to send them to *rachel.terry@icloud.com* ***and we can feature examples from our CAASIG members in the next newsletter!***

Functional Outcomes of Youths Treated for Anxiety Disorders: Results from CAMELS

Anna J. Swan[1], Philip C. Kendall[1], Thomas Olino[1], & The CAMELS Team[2-]

Background and Rational. Anxiety disorders are common mental health disorders affecting youth (Costello, Egger, & Angold, 2005). Coupled with high prevalence rates, youth anxiety disorders are associated with global and domain-specific impairment that, when left untreated, can extend into adulthood (Swan & Kendall, 2016). Although some studies have examined impairment in global and domain-specific functioning immediately following treatment, the longer-term impact of efficacious treatment on functional outcomes as youth transition into adulthood is limited, particularly for youth treated with medication.

Prior to the Child/Adolescent Anxiety Multimodal Study (CAMS; Walkup et al., 2008), several RCTs comparing medication versus placebo in the treatment of youth with generalized anxiety disorder (GAD), social phobia (SoP), and/or separation anxiety disorder (SAD) found these medications to be efficacious (Reinblatt & Riddle, 2007). However, there have been no long-term follow-ups. In contrast, several studies have assessed the long-term outcomes (i.e., >5 years) of youth treated with CBT (Barrett, Duffy, Dadds, & Rapee, 2001; Beidel, Turner, & Young, 2006; Benjamin, Harrison, Settipani, Brodman, & Kendall, 2013; Garcia-Lopez et al., 2006; Kendall, Safford, Flannery-Schroeder, & Webb, 2004), and a single study examined outcomes following combined treatment with CBT and SRT using data from the Child/Adolescent Anxiety Multimodal Extended Long-term Study (CAMELS), a naturalistic follow-up study of CAMS participants (Ginsburg et al., 2014). Of these, only three report an initial look at functional outcomes. Moreover, all > 5 year follow-up studies assessed distal outcomes at only one time-point, which does not allow for examination of the trajectories of change over time. To date, no studies have examined domain-specific functional outcomes for youth initially treated for anxiety with medication.

This report presents preliminary results from CAMELS, a follow-up study of CAMS participants. Participants were assessed annually by an independent evaluator across a 5 year follow-up window (2011 – 2015), and completed an average of 3.1 assessments. The study examines global

(overall impairment, life satisfaction) and domain specific (social, familial, educational, occupational, legal) functional outcomes associated with the four CAMS treatment conditions (1. CBT; 2. sertraline: SRT, 3. CBT and SRT: COMB, and 4. Placebo). *Response* status (whether or not participants were determined to be "much improved" or "very much improved" by an Independent Evaluator), *remission* status (whether or not participants no longer met criteria for any study-entry anxiety disorder), and treatment type were examined as predictors of functional outcomes. We hypothesized that responders and remitters would report improved functional outcomes. The impact of treatment condition was exploratory.

Data analytic approach. A multilevel modeling (MLM) framework was used to estimate linear growth models for the following functional outcome variables: (1) global functioning, as measured by the *Global Assessment of Functioning* and *Children's Global Assessment Scale* (GAF, Endicott, 1976; CGAS, Shaffer et al., 1983), (2) life satisfaction as measured by the *Quality of Life Enjoyment and Satisfaction Questionnaires* (Q-LES-Q; Endicott, Nee, Yang, & Wohlberg, 2006), and (3) overall and domain-specific impairment as measured by the *Health of the Nation Outcome Scales* (HoNOS**;** Gowers et al., 1999). Legal functioning was evaluated using a form developed for the CAMELS study which assesses legal history including arrests and convictions.

MLM allows for the analysis of systematic changes in longitudinal data over time and permits the examination of intra-individual and inter-individual differences in change. Within this framework, change over time is estimated using: (1) initial levels at the starting point of the growth curve (growth intercept); and (2) the slope of the growth curve and the rate of change over time (linear slope). To accommodate repeated measures for individuals in real time, analysis type was specified as TWOLEVEL and RANDOM in Mplus. Separate models were fit for each continuous outcome variable.

To test the impact of treatment outcomes and treatment condition, we computed a conditional growth model for each functional outcome. Sex, ethnicity, SES, CAMS Site, CAMS baseline severity (CGI-S), CAMS baseline functioning (CGAS), treatment outcome (response/remission status), and treatment condition dummy-coded with the placebo condition as the reference group were entered as time invariant predictor variables. Given that functional outcomes are tied to developmental stage, age at first

CAMELS assessment was also entered as a time invariant predictor. Mental health service utilization (ADIS supplemental services form), years since CAMS randomization, and time were entered as time-varying predictor variables. Time was coded so that the intercepts of participants' growth curves reflected their estimated scores at the first CAMELS assessment. Treatment outcome (response/remission status) and treatment condition were examined as predictors of the intercept and linear slope for individual functional outcomes.

Results. Both treatment responders and treatment remitters demonstrated better global functioning, decreased overall impairment, and enhanced life satisfaction at their first follow-up (growth curve mean intercept). Treatment remission, but not response, predicted decreased domain-specific impairment (better social relationships, more self-care/independence, higher academic functioning) at the growth curve mean intercept. Randomization to the CBT condition, compared to placebo, predicted the linear slope of growth curves modeling overall impairment, life satisfaction, and impairment in academic functioning and competencies of daily living: results suggest improved functional trajectories for participants randomized to CBT compared to placebo in these areas. Acute treatment outcome and condition did not predict legal outcomes, occupational outcomes, or family life.

Conclusion. Positive early intervention outcomes are associated with improved overall functioning, and life satisfaction an average of 6.5 years posttreatment. Anxiety disorder remission, a stricter definition of treatment outcome than response status, is associated with decreased impairment in specific domains (social relationships, academic functioning, self-care/independence). Treatment type differentially predicted some functional trajectories. Findings support the positive impact of pediatric anxiety treatment on functioning during adolescence and emerging adulthood.

Technology-based Interventions for Child Anxiety: Barriers and Next Steps

**Written by Christopher La Lima, M.A.*

While efficacious and empirically supported treatments for child anxiety disorders exist, there are a number of systematic barriers limiting access to such care. Geographical limitations such as living in rural or remote regions can restrict access to mental healthcare (Comer & Barlow, 2014). Furthermore, the undertreatment of low base-rate disorders (e.g. chronic tic disorders, trichotillomania, selective mutism) requiring specialized interventions is not adequately addressed in the American healthcare system. Specialized treatment services are typically confined to metropolitan regions with large populations (Comer & Barlow, 2014).

Technology-based interventions have the ability to increase access to care for a broader population (Kendall et al., 2011; Khanna & Kendall, 2010). Limited but growing research highlights the potential for effective internet-based interventions for child anxiety disorders. In particular, telemental health interventions that leverage videoteleconferencing (VTC) to deliver real-time services are on the rise. Comer et al. (2014) conducted a case series utilizing VTC methods to deliver real-time cognitive-behavioral therapy centering on exposure and response prevention to treat early-onset OCD (i.e. onset < age 9). All five participants, ages four to eight, showed OCD symptom reductions and global severity improvements from pre- to posttreatment. Additionally, all participants showed at least partial diagnostic response, and 60% no longer met diagnostic criteria for OCD at posttreatment.

Comer, et al. (2016) then conducted the first randomized evaluation of Internet-delivered treatment versus supported clinic-based treatment for early-onset OCD. In this pilot RCT, they compared VTC-delivered, family-based cognitive-behavioral therapy (FB-CBT) versus clinic-based FB-CBT (N = 22). Participants in both conditions showed improvement in the areas of symptom reduction and family accommodation. Between 60% and 80% of participants showed clinically significant responder statuses as assessed by the Clinical Global Impressions-Improvement Scale (score of 1 or 2), the Children's Yale-Brown Obsessive Compulsive Scale ("subclinical"/"mild" range; i.e., score ≤15), and the Anxiety Disorders Interview Schedule for DSM-IV, child and parent versions (not diagnosed with OCD) at

posttreatment and at follow-up. No significant differences were found between conditions on clinical significance responder statuses. Additionally, treatment retention, engagement, alliance, and satisfaction were high across conditions.

In addition to the treatment of early onset OCD, Dr. Comer and colleagues conducted a randomized non-inferiority trial examining the use of VTC methods to deliver Parent-Child Interaction Therapy (PCIT) as compared to standard clinic-based PCIT (N=40) (Comer, et al., manuscript). In this study, participants were children ages three to five years with disruptive behavior disorders and their caregiver(s). Internet-delivered Parent-Child Interaction Therapy (I-PCIT) was conducted using webcams and parent-worn Bluetooth earpieces. The authors found I-PCIT to have significant effects on children's symptoms, overall functioning, and burden to parents, with large-to-very-large effect sizes at posttreatment and a 6-month follow-up. Both treatments were also associated with positive engagement, treatment retention, and very high treatment satisfaction.

Comer et al. (2012) previously examined the preliminary feasibility and efficacy of an anxiety-based modification of PCIT (The CALM Program; Coaching Approach behavior and Leading by Modeling) for treating children ages three to eight diagnosed with separation anxiety disorder, social anxiety disorder, generalized anxiety disorder, and/or specific phobias (N = 9). In this study, approximately 80% of participants completed all treatment sessions. All treatment completers were considered global treatment responders, with all but one showing full diagnostic improvements, and all but one showing meaningful functional improvements. Dr. Comer and colleagues are currently conducting a waitlist-controlled randomized trial evaluating Internet-delivered CALM (I-CALM), drawing on VTC to remotely deliver CALM to families in their homes and coach parents in real time in how to be an exposure therapist for their young child.

Although there is research support for technology-based treatments being effective and acceptable, there are significant barriers to furthering this research and integrating such interventions into the American healthcare system. In a recent paper, Chou, Bry, and Comer (in press) discuss barriers to the broad dissemination and implementation of technology-enhanced treatments. While the task of incorporating technology-enhanced interventions into routine care is faced with many of the same obstacles as with other evidence-based practices (e.g. implementation complexity,

organizational support and readiness, and policy-related factors), these innovations raise new challenges (Chou, Bry, and Comer).

While the use of technology is intended to increase access to care, a portion of targeted consumers do not have adequate technological accessibility (Chou, Bry, & Comer, in press). Additionally, Chou, Bry, and Comer emphasize considering timelines for research and application, and being cautious about investing extensive time and resources into specific technologies or platforms that may soon be outdated. They promote collaborations with industry and "staying ahead of the curve" to better adapt to evolving technologies.

Clinically, there currently are limited guidelines for how to handle situations involving risk (e.g. therapist witnesses child maltreatment in the home during a VTC session) while providing remote treatment. For this reason, high-risk participants have been largely excluded from proof-of-concept research to date on technology-enhanced treatments. Additionally, as the consumer-base for services expands, there is an increased need for emphasis on cultural competency and culturally sensitive training (Chou, Bry, & Comer, in press).

Regarding legislative barriers to adoption and implementation, licensed clinicians in most states are typically not authorized to practice across state lines. In a brief phone interview with Dr. Comer, he noted that although policy-makers do not appear to be moving towards national licensure, some states particularly underserved by mental health care are adopting new policies increasing licensure reciprocity with other states. Lastly, current federal funding in clinical psychology prioritizes research examining conceptual mechanisms underlying treatment effects and biological treatment targets over the dissemination and implementation of technology-enhanced treatments. Therefore, investigators developing technology-enhanced interventions will need to be creative in order to fund their valuable work (Chou, Bry, & Comer, in press).

While the dissemination and implementation of technology-enhanced interventions raises new challenges, it has the potential to increase access to care and address some of the gaps in our current mental healthcare system. In order to address barriers to these efforts, Chou, Bry, and Comer (in press) argue that continued adoption and systematic incorporation of perspectives from key stakeholders throughout all stages of the development process are crucial for moving towards improved population-level impact.

Students' Corner: How to Proactively Prepare for the Internship Application Process

Michelle Clementi, M.A.[1] & Carolyn Spiro, M.S.[2]

In your first few years of graduate school, internship may seem too far off to focus on. You're juggling so many responsibilities that it's difficult to think about the future. However, you can complete a number of manageable first steps early in graduate school to strengthen you as an applicant, and make the process easier and more streamlined.

1. ***Track your hours.*** This seems obvious, but it's so easy to put off entering hours and then forget. This can easily lead to either over-reporting or under-reporting your hours later on and/or providing inaccurate reports of patient demographics and assessment and intervention types. Time tracking programs, like Time2Track, make tracking hours simple, and can help you identify possible holes in your application/training you may want to fill. Preparing your internship applications is a lot of work (and falls on top of many other responsibilities like dissertation and practicum/externship) - taking a couple minutes after each day of clinical work to track your hours is worth the effort. Your future self will thank you!
2. ***Save de-identified reports***. Some internship sites request testing reports or case summaries as supplemental application materials. Save reports that demonstrate your ability to conceptualize cases or to interpret multiple assessment measures and provide recommendations. When the time comes to choose a writing sample to submit with your application, you don't want to have to strain to recall certain cases or names or dig through old files and medical records—especially if you no longer have access to records at an external practicum site.
3. ***Maintain strong professional relationships***. As an early graduate student it may feel as if you *just* asked for recommendation letters from your undergraduate mentors; however, you'll need completely different letters for internship applications. You'll want letters from clinical supervisors who can speak to your character and clinical skills, and who are happy to provide their endorsement for you as an applicant. Maintain professional relationships with previous supervisors—not only for when you need a recommendation letter, but also for their advice and mentoring regarding clinical training and

career paths that you may not get from mentors in your university setting.

4. ***Seek out opportunities for networking.*** Along with maintaining strong relationships with your direct supervisors, it can be helpful to expand your professional network to connect with supervisors and trainees at various sites. Attending professional conferences, such as ABCT, allows you to build both your personal and professional connections and can help you to get a sense of the training offered by different sites. Since the ABCT conference tends to fall toward the middle/end of the internship application season, it is most helpful to attend the internship workshops the year *before* you plan to apply. While it may seem overwhelming or intimidating, the internship workshops and the "Meet and Greet" are important ways to learn about programs and hear about the training experiences directly from current interns.
5. ***Seek diverse externship experiences***. It's easy to get caught up in the number of clinical hours you're acquiring as your training progresses. However, it's important to remember the value of quality over quantity. Rather than focusing on hours, seek out experiences with a range of populations, settings, theoretical orientations, and types of assessment and intervention. This will help you determine your future training goals and what types of internship sites you want to apply to when the time comes.
6. ***Think beyond clinical experiences.*** Many sites want to see that applicants demonstrate strengths beyond their clinical skills. Strong leadership skills and engagement in professional and community service will help you stand out from other applicants. Some internship sites also value trainees who maintain a good work-life balance. Self-care is so important in the work that we do, and internship sites may ask about this during interviews. Don't forget that your hobbies and other aspects of your personal life shouldn't fall by the wayside as you juggle your professional responsibilities—make time for that weekly yoga class or whatever it is that you love!

Although the process may seem daunting or far off, following these tips can save you a few headaches when application time rolls around. There is a light at the end of the tunnel, and preparing early (and saving up some airline and hotel points!) can help make that light seem at least a little closer.

Renewing Your Child Anxiety SIG Membership

Do you need to renew your child anxiety SIG membership? If so, please follow the below instructions to pay your annual dues for the new academic year. If you have any questions about your current status, please contact Kendra Read at Kendra.read@gmail.com

1) Visit the SIG website: www.childanxietysig.com

2) Click on the "JOIN" link.

3) Complete the membership renewal form if your affiliation or contact information has changed.

4) Follow the dues payment instructions below:
Please send a check or money order in US funds, payable to Child and Adolescent Anxiety SIG, to:

Anthony Puliafico Ph.D.
155 White Plains Road, Suite 200
Tarrytown, NY 10591

OR Use **Paypal** in 5 easy steps:

1. Go to www.paypal.com. To complete the following steps, you must be a registered PayPal member. If you aren't registered already, follow their directions to "Sign Up," then continue with the following steps:

2. Login to your account.

3. Click on the "Send Money" tab.

4. Enter **childanxietysig@yahoo.com** as the recipient's email address.

5. Enter the amount ($10 for Students and $20 for Professionals) and currency type, then hit "Continue."

6. Enter credit card information, review, and hit "Send Money."