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SCIENCE FORUM

Addressing the Psychology Internship Crisis: Converging Perspectives of the Psychology Community

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THE PSYCHOLOGY INTERNSHIP IS WIDELY regarded as the capstone clinical experience in doctoral training. Following years of coursework, practicum training, and dissertation research, students complete a year of intensive clinical training in real-world settings before receiving their degrees. The Association of Psychology Postdoctoral and Internship Centers (APPIC) is an educational, nonprofit organization that has coordinated the internship selection process since 1968 (Baker, McCutcheon, & Keilin, 2007). APPIC introduced a computerized matching system in 1999. This system revealed that, from 1999–2012, there was a 79% increase in participants who did not match to a position (APPIC, 2015a). This alarming trend prompted ongoing debates in the field of psy-

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INSTRUCTIONS *for* AUTHORS

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chology about the best way to address the internship imbalance, and eventually led to focused efforts to improve the match rate (e.g., programs aimed at increasing the number of available positions). Although the number of unmatched participants has been declining in more recent years (a decline of 48% was seen from 2012–2015), a total of 436 graduate students were unmatched during the 2015 application cycle (210 from Ph.D. programs and 226 from Psy.D. programs). Further, a considerable number of students withdraw from the match each year: 97 Ph.D. students and 145 Psy.D. students in 2015 (APPIC, 2015a). Consequently, continued efforts to address the internship imbalance are required, and might be bolstered by conducting systematic, empirical investigations of the situation, especially those that consider the perspectives of numerous key stakeholders in the match (e.g., graduate students, training directors).

The consequences of the problematic match rate are difficult to overstate. Students preparing for the match experience unnecessary stress and anxiety, and often spend a substantial amount of time acquiring unnecessary clinical hours, detracting from other aspects of training. Many students also apply to more sites (M = 16.1 applications in 2015; APPIC, 2015b) than is recommended by APPIC (15 sites), which is time-consuming and expensive (APPIC, 2015c) and does not improve one's chances of matching.

Students who fail to match to an internship position experience numerous hardships. Graduation is postponed, which translates into increased debt and modified career plans (Baker et al., 2007). Unmatched students may be faced with paying another year of tuition or looking for alternative employment (if their graduate programs are unable to fund them for an additional year), and there is a financial burden associated with reapplying (Albin, Adams, Walker, & Elwood, 2000). On a more personal level, some students postpone relationships, marriage, and childbearing (Madson, Hasan, Williams-Nickelson, Kettman, & Van Sickle, 2007). Finally, many unmatched students are emotionally devastated by this experience, leading them to question themselves, the principles of the education system, and the profession they seek to enter (Baker et al., 2007; Keilin, Baker, McCutcheon, & Peranson, 2007).

Doctoral training programs and internships are also affected by the match rate. Internship training directors (TDs) and staff review an ever-growing number of applications (Keilin et al., 2007), and directors of clinical training (DCTs) in graduate programs devote more time to mentoring students on the internship application process. In a survey of DCTs of counseling psychology doctoral programs, 32% of respondents considered the time spent in such additional mentorship to be a consequence of the underlying supply and demand problem (Miville, Adams, & Juntunen, 2007). Of note, despite increased faculty time devoted to helping students with the internship process, students report increased dissatisfaction with match results (Miville et al., 2007). Furthermore, DCTs feel pressured to shift the emphasis from research to clinical training in order to ensure that students are competitive applicants (Miville et al.).

Doctoral programs also compromise their standards of what constitutes a high-quality internship (e.g., nonaccredited and/or non-APPIC internship sites) in order to assist their unmatched students and improve their match rates (Keilin et al., 2007). Moreover, graduate programs are

vulnerable to potential lawsuits from students who accuse them of requiring an internship that they are unable to provide, or providing a subpar internship that does not meet licensing requirements (Meyerson, Meyerson, Bolson, & Wilson, 2013).

More generally, the match imbalance is a serious problem for the psychology profession. The current internship process is inherently discriminatory toward nontraditional students, those with caretaking responsibilities, and those with disabilities who may have difficulty working full-time, which raises moral and ethical concerns (Madson et al., 2007). An inadvertent consequence of the imbalance is the establishment of an inferior level of training due to unmatched students often completing unregulated, ad-hoc, or marginal placements (Baker et al., 2007; Keilin, Thorn, Rodolfa, Constantine, & Kaslow, 2000). Of those unmatched applicants who succeed in finding a position, almost 19% accept an unfunded position and over half accept an internship without standard medical benefits (Keilin et al., 2000). These percentages are significantly worse among students who voluntarily withdraw from the match. In addition, despite an improving match rate over the past 3 years, the percentage of students matching to nonaccredited internships has stayed consistent at 25% (APPIC, 2015a). There is also a divide between Ph.D. and Psy.D. programs, with 9.5% of students from the former matching at nonaccredited internship sites, compared to 41% of the latter.

APPIC argues that the field of psychology should be concerned about the consequences students face, and the risks that inadequate training pose to the welfare of the public and the reputation of our profession. These concerns are echoed by faculty members who have become increasingly frustrated as the imbalance continues, and by members of Council of Directors of Clinical Psychology, who argue that the imbalance is a detriment to the development of entry-level professional competency in students (Collins, Callahan, & Klonoff, 2007).

There is ongoing debate about the source of the problematic match rate. The predominant stance is that the internship crisis is a supply-demand issue (i.e., a greater number of applicants than internship positions; Keilin et al., 2000). The number of applicants registered for the match increased by 39% between 1999 and 2012 whereas the number of available internship slots grew by only 22% (APPIC, 2015a). Hatcher (2011) views the internship crisis as a common-pool resource problem; that is, an ever-growing number of graduate programs (288 doctoral programs existed in 2004 vs. 380 in 2014; APA, 2004, 2014a) have unrestricted access to a limited pool of quality internships. This limited resource is further depleted each year, eventually leading to a net loss for all involved. Accordingly, recent efforts to address the imbalance have focused on increasing the number of internship positions, efforts that appear to be paying off. It is promising that, over the span of the last 3 years, 499 internship positions were added while the number of match participants actually decreased by 62 (APPIC, 2015a).

Another perspective is that the ongoing crisis is due to unrestrained growth in doctoral programs (Baker et al., 2007), primarily due to an increasing number of Psy.D. programs. Indeed, applicants from Ph.D. programs increased by 4% from 1999–2007, in comparison to a substantially larger increase of about 45% in applicants from Psy.D. programs (Keilin et al., 2007). Further, Parent and Williamson (2010) found that only 4% of programs (mostly Psy.D.) were responsible for over 30% of unmatched applicants. One of the defining characteristics of these "unequal contributors" was the number of students they sent to the match each year, an average of 46 compared to 7 from all other programs. It is important to note that although there is an oversupply of students relative to internships, this may not be the case with regard to the need for psychologists in the field. Some workforce analysis studies suggest that most psychologists are employed soon after graduation and there is in fact a shortage of psychologists in certain domains (e.g., behavioral health psychologists in community-based health care centers; Lally & Paszkiewicz, 2011). This highlights the continued need for adequate internships both despite and because of increasing numbers of students entering the field.

Proposed Solutions for Addressing the Internship Crisis

Numerous strategies have been proposed to address the internship crisis, the majority of which are aimed at either increasing the number of available internship positions or decreasing the number of internship applicants participating in the match each year. Further, more fundamental changes in the internship process have been debated, such as abolishing the requirement altogether. We now turn to a discussion of these proposed solutions.

Increasing the Number of Internship Positions

Many of the potential solutions involving the development of new internship positions were generated during a meeting of the Council of Chairs of Training Councils (CCTC), which convened in 2008. Specific recommendations included decreasing financial barriers to accreditation, engaging in local and national advocacy to fund internships, and developing a Psychology Internship Development Toolkit to assist institutions in creating and/or expanding internship programs (CCTC, 2010).

The American Psychological Association (APA) passed the Internship Stimulus Package in 2012, which provided $3 million in grant funding over a 3-year period for accredited internships, with the potential for 520 new positions (APA, 2012). The most recent call for proposals was released in July 2014 (APA, 2014b). Of note, APAGS played a key advocacy role in the passing of this package (Wells et al., 2014). The National Council of Schools and Programs of Professional Psychology (NCSPP), as well as the CCTC, have advocated for doctoral programs to develop internship sites (Lally & Paszkiewicz, 2011) and, in a 2011 survey of NCSPP doctoral programs, 87% of responding programs indicated they had contributed to the development of new internships. APPIC has also made substantial efforts to increase the supply of internship positions over the past several years, such as providing mentorship to TDs of new internship programs and consulting with programs developing affiliated internships, among others (Baker et al., 2007). As has been noted, such efforts have led to an increase in the number of available internship slots, yet several hundred students remain unmatched in a given year.

Of note, concentrated efforts to increase external funding available for developing new internship positions (e.g., federal support) are especially important in the context of diminished internal funding available to internship programs. Specifically, in most states, third party payers (e.g., Medicare and Medicaid) do not reimburse for psychology interns' services (CCTC, 2013; Larkin, 2011). Further, clinical psychology internship programs are not eligible for support from Medicare's General Medical Education (GME) program, which funds training in other clinical professions

(Frank, Blevins, & Dimoulas, 2004). Thus, ongoing attention to funding constraints, and the identification of new sources of revenue, will be required to facilitate long-term gains—and prevent future loses—in the number of internship positions available to applicants. For example, some states (e.g., Arkansas) have successfully obtained reimbursement for intern services (APA, 2014c).

Decreasing the Number of Applicants

Numerous solutions have been proposed for reducing the overall demand for internship positions, many of which include changes at the level of graduate programs. During the CCTC Imbalance Meeting in 2008, members advocated for placing more responsibility on graduate programs to reduce enrollment and create positions for unmatched students (CCTC, 2008). Collins et al. (2007) proposed remediation plans (e.g., reducing class size) for programs with match rates consistently lower than the national average. Stedman, Schoenfeld, Carroll, and Allen (2009) also outlined specific proposals for increasing the accountability of graduate programs, such as putting programs with match rates less than 50% on probation, reducing their entering class size by 20%, and withholding APA accreditation if match rates do not meet or exceed 50% by the second year. Currently, the Commission on Accreditation's (CoA) Guidelines and Principles for Accreditation specify that the CoA will examine any clinical or counseling doctoral program with match rates below 50% (APA CoA, 2013; Meyerson et al., 2013). Nonetheless, Parent and Williamson (2010) suggested that accreditation be contingent upon a match rate of at least 80%, and Meyerson et al. noted that only setting a 100% match rate criterion will lead to amelioration of the crisis.

An additional solution is restraining the development of new programs and the number of students admitted to current programs (Baker et al., 2007; Callahan, Collins, & Klonoff, 2010; Larkin, 2012). Baker et al. (2007) proposed a voluntary restraint system in which all graduate programs reduce the size of incoming classes by 10% for a 3- to 5-year period, which could provide time for the development of longer-term solutions (e.g., workforce analyses, funding for new positions). If this pattern was maintained over time, the internship crisis would be eliminated by 2025 (Larkin, 2012). As noted earlier, however, this must be considered within the context of our need for a greater understanding of supply-demand issues for psychologists in the workforce.

Fundamental Changes to the Internship Requirement

Another solution is to abolish the internship requirement (Miville et al., 2007; Thorp et al., 2005). Miville et al., however, view this option as ineffective and potentially lacking the support of the field. Further, McCutcheon (2011) notes that the immersive, integrative experience provided by an internship leads to higher-order professional competencies. Eliminating this experience may negatively influence students' preparation for the profession, reduce accountability of doctoral programs to properly prepare their students, and ultimately, widen the science-practice gap.

Table 1. Effectiveness and Feasibility of Solutions to the Internship Crisis

Proposed Solution	Effectiveness		Feasibility	
	M(SD)	Rank	*M*(SD)	Rank
Adding fewer students to graduate programs	7.52 (1.87)	1	5.84 (2.44)	5
Increased funding to create additional internship positions (e.g., from the Graduate Psychology Education program)	7.31 (1.97)	2	5.17 (2.01)	8
Development of "in-house" internships created by psychology departments	6.82 (1.95)	3	5.09 (2.03)	9
Elimination of the predoctoral internship requirement altogether	6.63 (3.12)	4	3.61 (2.80)	10
Replacing the internship requirement with a requisite number of clinical hours to be completed predoctorally	6.52 (2.57)	5	5.39 (2.43)	7
Making the accreditation process less expensive and cumbersome for internship sites	6.40 (2.21)	6	5.91 (1.97)	4
Having a Phase II to the match for students who do not match during the initial phase	5.70 (2.09)	7	7.27 (1.73)	1
Making the predoctoral internship requirement a post-doctoral internship, as in medicine	5.66 (2.85)	8	5.63 (2.47)	6
More guidance and supervision at the departmental level for students preparing to apply	5.51 (2.12)	9	6.45 (1.82)	3
Clearer guidelines provided by internship sites explicitly stating what constitutes a competitive applicant	5.22 (2.08)	10	7.26 (1.79)	2

Note. Observed ranges were 1 (strongly disagree) to 9 (strongly agree) for all scales. Rankings do not imply statistically significant differences between scores of each proposed solution.

The Survey

During the height of the imbalance, ongoing discussions between the constituents of the Society for a Science of Clinical Psychology (SSCP; Division 12, Section III of APA) regarding the state of the internship crisis led members of the executive board of SSCP to implement a data-driven approach to assessing the situation. Moreover, they agreed that it was essential to assess the perspectives of a broad range of key stakeholders from the psychological clinical science community (e.g., students, postdoctoral fellows, internship TDs, and graduate program DCTs), with a particular focus on the perspectives of students. Students are arguably the biggest stakeholders in the internship match, despite having the least amount of influence over the process. An Ad Hoc Internship Committee was assembled in 2010 to more closely examine the current state of the internship crisis.

A survey was developed to assess (a) the extent to which the internship imbalance is perceived as a crisis, and (b) the perceived effectiveness and feasibility of possible solutions for addressing the match rate. This pilot survey was launched in November 2010 and was disseminated via multiple professional listservs. Over 600 people responded. Respondents were also asked to provide open-ended comments and propose potential solutions that were not listed which later were used to expand the survey. Further, items about the newly implemented (at the time) Phase II of the match were added. The revised survey (~10-15 minutes) was launched in October 2011 and invitations were sent to major professional listservs, including the Association for Behavioral and Cognitive Therapies (ABCT), the Association for Contextual Behavioral Sciences (ACBS), and SSCP. IRB approval was obtained from the University of Mississippi.

Results

Participant Characteristics

We received 531 responses to the revised survey. The majority of respondents (58.4%) were predoctoral (i.e., graduate students and current interns); however, responses were also received from faculty members in doctoral programs (16.8%), postdoctoral fellows (12.7%), internship supervisors (6.6%), internship TDs (2.8%), and DCTs in graduate doctoral programs (2.8%). The majority of respondents were either currently enrolled in Ph.D. clinical psychology programs or had received their doctorate degrees from such programs (84.8%); however, individuals from Psy.D. (12.7%), counseling (2.0%), school (0.2%), and combined programs also responded to the survey. Several respondents also reported that they had failed to match to an internship, including 19% of postdoctoral fellows, 20% of current interns, and 4% of current graduate students.

Attitudes Toward the Internship Crisis

Respondents were asked to indicate the degree to which they agreed or disagreed with several statements regarding the internship imbalance using a 1 (*strongly disagree*) to 9 (*strongly agree*) Likert scale. In general, the clinical science community views the match rate as a crisis that must be addressed ($M = 8.38$, $SD = 1.37$, Range = 1–9). Very few respondents (3%) disagreed (i.e., responded with a rating less than 5). Respondents generally agreed that the internship application process imposes unreasonable monetary cost to students in the form of application fees, travel costs for interviewing, and costs associated with relocating ($M = 7.48$, $SD = 1.81$, Range = 1–9). There was also general agreement that the current internship application process puts unreasonable pressure on students to log more therapy and assessment hours in order to be competitive for internship ($M = 6.77$, $SD = 2.12$, Range = 1–9). Finally, the majority of respondents agreed that the current internship application and match process takes an unreasonable emotional toll on students ($M = 7.07$, $SD = 2.16$, Range = 1–9).

Qualitative Results

After responding to questions gauging attitudes about the internship imbalance, and prior to answering questions regarding specific solutions, respondents were invited to provide open-ended comments regarding problems they had observed with the current match. Thirty-eight percent of those completing the survey provided comments. We conducted a qualitative content analysis to identify prominent themes emerging from these comments. Many respondents expressed strong negative feelings about the crisis. The current internship process was described as "broken," "a disaster for our profession," "a mentally unhealthy process," "unfair," "shocking," and "ridiculous." One of the most frequently raised concerns was large class sizes of graduate programs, and the need for both APA and doctoral programs to take greater responsibility in governing enrollment. In particular, respondents expressed concern for students of "for-profit" programs (respondents' term) who often acquire substantial financial debt despite the possibility of not obtaining a degree due to failure to match to an internship.

Possible Solutions for Addressing the Internship Crisis

Several potential solutions for addressing the internship crisis were provided (see Table 1), and respondents were asked to provide two ratings for each solution. The first rating was in response to the question, "How effective do you believe this would be for addressing the worsening match rate?" and was made on a Likert scale from 1 (*not at all effective*) to 9 (*extremely effective*). (Of note, although the match rate has actually been improving over the last few years, it was on a downward trajectory at the time of the study.) The second rating was in response to the question, "How feasible do you believe this would be?" and was made on a Likert scale from 1 (*not at all feasible*) to 9 (*extremely feasible*). Respondents could also provide open-ended comments after rating each solution. Mean scores of effectiveness and feasibility are reported in Table 1. Solutions are presented in descending order from most to least effective.

Effectiveness. Participants identified "adding fewer students to graduate programs" as most effective in addressing the internship crisis ($M = 7.52$, $SD = 1.87$), but viewed it as only somewhat feasible ($M = 5.84$, $SD = 2.44$). Open-ended comments demonstrated further endorsement of this solution; however, there was uncertainty about how it would be enforced. Many recognized that APA would need to institute a policy, such as adjusting accreditation guidelines. There was also recognition that this solution would only work if internship positions were not simultaneously minimized due to budget cuts, and if new graduate programs were not established. Many doctoral programs, Ph.D. programs in particular, already limit their class sizes and some suggested that further reduction would have a detrimental impact on quality of training. There was consensus that, if such restrictions were implemented, they should be applied to "for-profit" schools that admit more than 100 students each year and programs with low faculty/student ratios. A secondary benefit of this solution was raised: It may simultaneously address a worsening job placement rate following graduation. Respondents who did

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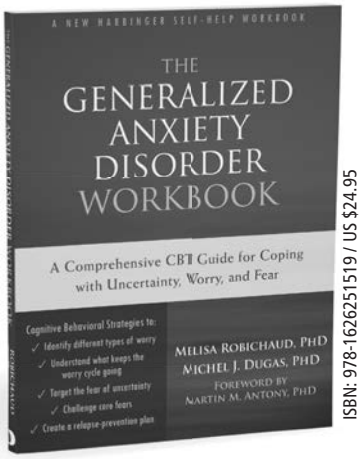

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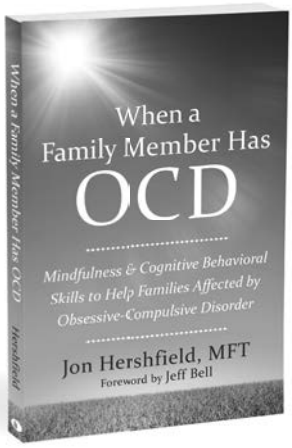

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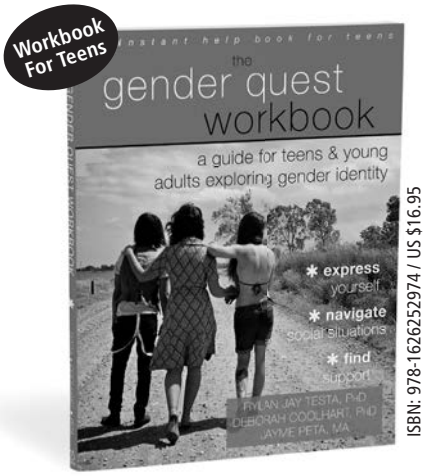

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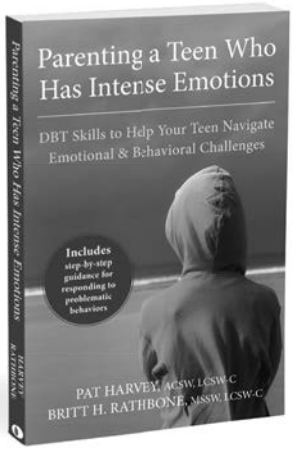

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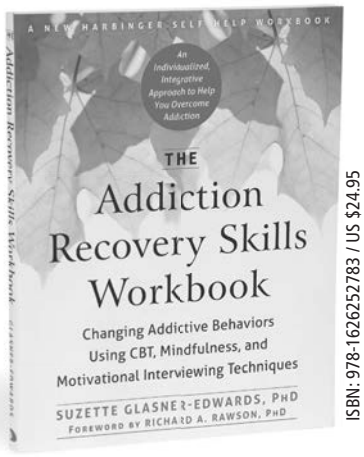

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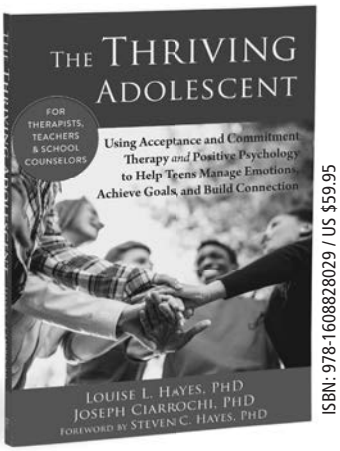

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not endorse this solution pointed out that more clinical psychologists are needed in the field and that this solution "fails to consider the number of clinicians needed to serve populations in need." Further, an important point was raised regarding the efficiency of this solution: It would take at least 5 to 10 years to see a meaningful impact on the current match rate.

The solution identified as the second most effective was "increased funding to create additional internship positions" (M = 7.31, SD = 1.97); this was perceived as somewhat feasible (M = 5.17, SD = 2.01). Comments provided by respondents suggested that creating additional internship sites is the most direct method of addressing the crisis, next to reducing the number of students admitted to graduate programs; however, the crisis would then inevitably shift to later career stages. Indeed, concerns regarding recent graduates facing difficulty securing postdoctoral positions were raised. Also, in order for this solution to be effective, there must be simultaneous restrictions on graduate program class sizes. Although there is increasing demand for mental health care, funding is required to create new, and maintain existing, predoctoral and postdoctoral positions. State funding could help to promote growth of new internship sites given that wages are considerably less for interns compared to postdoctoral or established clinicians; however, given state governments deficits, this may not be feasible. Finally, with up to 900 students not matching in either Phase I or II in a given year (APPIC, 2015a), increasing the number of internship sites would not fully address the concern as it is not feasible to develop this many positions in a timely manner.

Feasibility. Not surprising given its recent implementation, "having a Phase II to the match" was ranked as most feasible (M = 7.27, SD =1.73), but was viewed as only moderately effective (M = 5.70, SD = 2.09). Open-ended comments suggest that not everyone was aware of Phase II despite its implementation prior to survey administration. The general consensus was that Phase II does not appear to be helpful in addressing the internship imbalance. Although it helps to fill internship positions that did not secure an intern during the first round, there are still a substantial number of students who do not match due to an insufficient number of positions.

Viewed as equally feasible, "clearer guidelines provided by internship sites explicitly stating what constitutes a competitive applicant" (M = 7.26, SD = 1.79) was viewed as only moderately effective (M = 5.22, SD = 2.08). Respondents questioned the degree to which such guidelines would actually be considered by students during the application process and the degree to which this information would impact decisions about where to apply. Students apply to sites for multiple reasons, fit being only one consideration, although arguably the most important. Some internship TDs and supervisors indicated that they already include detailed criteria for their sites, but it does not consistently result in applicants who fit the criteria well. The general consensus was that it may be helpful for applicants to have clearer guidelines, but it will have minimal impact on the overall internship crisis.

It is noteworthy that perspectives regarding eliminating the internship requirement altogether—deemed the least feasible (M = 3.61, SD = 2.80), but a potentially effective solution (M = 6.63, SD = 3.12)—were generally split, and numerous responses and opinions were generated in response to this solution. There was consensus among respondents that this would be effective in addressing the internship crisis, but that there would be additional consequences that make this an undesirable option, including: (a) compromising the quality of patient care and competence of practicing psychologists, (b) undermining the employment value that organizations ascribe to psychologists and the credibility of the profession, and (c) students missing out on breadth and depth of training opportunities provided during the internship year. These are important considerations, as a supervised internship serves as a gatekeeper for the profession and protection for the public. In addition, a major barrier to this solution is that state licensing laws require an internship, and statewide changes would therefore likewise need to be implemented. If the internship requirement was eliminated, alternative options might include requiring a certain number of practicum hours prior to graduation or, more generally, requiring a total number of prelicensure hours. Additionally, postdoctoral positions could be expanded to include more extensive clinical training, and this could be governed by state licensing boards.

New solutions generated by respondents. At the end of the survey, respondents could list additional solutions and approximately 10% of respondents shared ideas. Many of the responses involved enthusiastic endorsement of the previously rated solutions; however, novel solutions were also generated, including: (a) a separate match process and unique internship sites for Psy.D. and Ph.D. students, (b) taxing programs a set amount per student enrolled in a program to fund new internship sites, (c) internship cycles that last 6 months instead of a full year to accommodate twice the number of interns, and (d) national news exposure informing the general public of the problem and better informing prospective graduate students of the realities of the profession.

Informed Consent During Graduate Admissions

As noted earlier, one of the concerns raised about the internship crisis is that doctoral programs may be at risk for lawsuits from students who accuse them of not being able to provide one of the requirements for the doctoral degree. Notably, the majority of graduate students responding to this survey (62%) reported that no one explained to them during graduate school interviews that a predoctoral internship is not guaranteed. Of current interns, 84% reported that this was not explained to them during their graduate school interviews, and 60% of postdoctoral scholars reported that they had not been informed. In contrast, 92% of DCTs and 70% of faculty reported that prospective graduate students are informed of the possibility of not matching to a predoctoral internship while interviewing at their graduate programs.

Discussion

Hundreds of psychology doctoral students fail to match to an internship each year, and results of our survey indicate that a range of key stakeholders from the psychology community view this as a crisis. There was consensus that the best possible solution to the internship crisis would involve a combination of restricting the number of students enrolling in graduate programs and creating new internship positions. Smaller-scale changes to the application process (e.g., clearer guidelines by internship sites) were viewed as feasible but relatively ineffective and certainly not sufficient. It is important to note that the landscape of the internship imbalance has evolved since this survey was administered. Indeed, some of the solutions that were endorsed by respondents (e.g., creating additional internship positions) have since been implemented (e.g., APA Internship Stimulus Package). Specifically, while the number of participants registering for the match increased by only 48 from 2011 to

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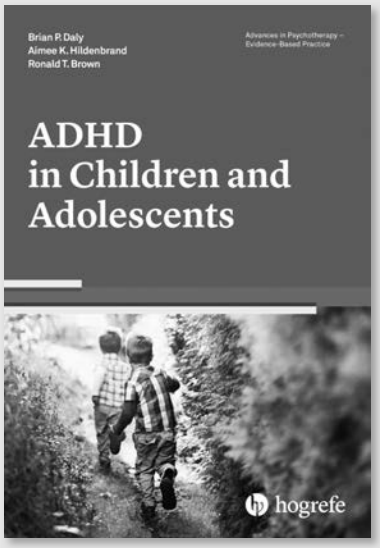

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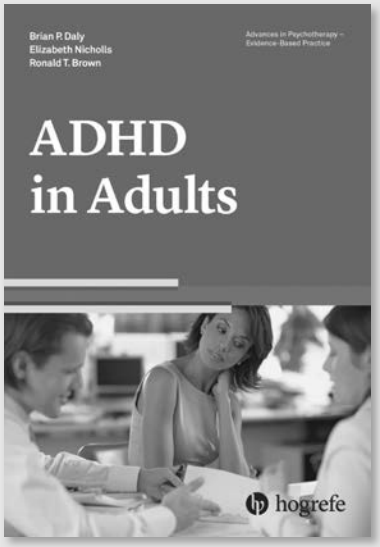

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Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that emerges during childhood. However, it is now well recognized that ADHD frequently persists over the lifespan and well into adulthood. Although ADHD is typically first identified during the childhood years, the presentation of symptoms may differ considerably between adults and children. Without appropriate symptom management, ADHD can significantly interfere with academic, emotional, social, and work functioning.
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2015, 535 more positions were offered at the latter time point (APPIC, 2015a). This may have contributed to the match rate improving from 79% to 89% during this time; however, the imbalance is far from resolved, and the sustainability of observed gains has yet to be determined.

While the situation has undeniably improved, we believe that the internship imbalance still constitutes a crisis that requires ongoing attention. The 2015 process left 436 graduate students unmatched, another 242 withdrew from the match, and 853 students matched to nonaccredited internship sites (APPIC, 2015a). It is unclear whether the recent growth in positions will continue, and/or if match participation will need to be further curbed in order for the field to see lasting change. Thus, additional solutions must be considered in order to further remediate the imbalance for long-term and sustainable change, and to minimize the ongoing detrimental impact of the imbalance on students who are currently navigating this process. Indeed, it is notable that survey respondents endorsed "adding fewer students to graduate programs" as more effective than creating additional internship positions, acknowledging that increasing the number of internship positions will only have a sustainable effect if both APA and doctoral programs take greater responsibility in governing enrollment in graduate programs.

Interestingly, solutions with the potential to produce more expedited progress and long-term improvement by incorporating larger, structural changes (e.g., eliminating the internship requirement altogether) were not widely endorsed by respondents and raised significant concerns. Miville et al. (2007) expressed their reservations about abolishing the internship, noting the potential lack of support by professionals in the field. Results of our survey corroborate this concern. While clinical psychology professionals acknowledge that there is not an easy and straightforward solution for effectively solving the internship crisis, they are reluctant to make any large-scale modifications to the current system.

The majority of graduate students reported that they had not been informed that an internship is not guaranteed when they were interviewing for graduate school, yet DCTs and faculty reported routinely informing students of the possibility of not matching to an internship. This is concerning, and highlights the importance of enhanced transparency (e.g., requiring doctoral programs to publicly report match rates; APA CoA, 2013). During the 2008 Imbalance meeting (CCTC, 2008), those in attendance agreed that "truth in advertising" is necessary to best inform students of this issue. Nonetheless, it is not yet clear how this will be systematically implemented into current practices, or how this could be governed to ensure compliance.

A limitation of the present study is that the sample consisted primarily of graduate students or graduates of Ph.D. clinical psychology programs, limiting the generalizability of the results. Individuals from Psy.D., counseling, school, and combined programs (who responded to the survey but in smaller numbers than those from Ph.D. clinical psychology programs) may have differing views based on their unique experiences. Future assessment of the views of stakeholders from a wider range of training modalities is necessary.

It is also noteworthy that the survey responses reported in this article were collected during 2011–2012, yet perspectives of the psychology community may have changed since the survey was administered due to the ever-evolving nature of this problem. Nonetheless, the present report provides a snapshot of perspectives during the height of the internship imbalance. The solutions that were most strongly endorsed (i.e., restricting the number of students enrolling in graduate programs and creating new internship positions) have since been implemented in various capacities, providing us with the opportunity to observe the effectiveness of those efforts. As we review above, there has been a measurable shift in the imbalance, and the current trend seems to point toward enduring improvement. It is conceivable that recent progress is attributable, at least in part, to efforts consistent with the common-pool resource paradigm (Hatcher, 2011; Lally & Paszkiewicz, 2011). Nonetheless, it is unclear to what extent those efforts have directly affected the match, whether recent gains will be sustainable, and the extent to which qualified students are able to depend on the match process to secure adequate internship training. We propose that it will be important to continue tapping into the collective wisdom of the larger psychology community in order to monitor changing perspectives and generate novel solutions to the problem.

Conclusions

This article highlights both the gravity and complexity of the internship crisis, and emphasizes that there is not an easy or efficient solution. Solutions that are most likely to be supported by the psychology community (e.g., limiting student enrollment in graduate programs, creating new internship positions) require considerable effort, resources, and collaboration, and take time to implement. Most likely, a combination of numerous solutions is required to produce sustainable change in the imbalance. In the meantime, hundreds of students continue to suffer, and immediate attention to their needs is required (e.g., a less cumbersome and financially burdensome internship application process, more support and transparency from graduate training programs). The effectiveness of any solution, including short-term resolutions, will require the collaboration and cooperation of those invested in the use of the match system. The psychology community must focus its attention on enhancing the quality of benchmarks for training and licensure and facilitating a multiorganizational governance system to address the current crisis (Hatcher, 2011). Such a structure has the potential to bring together key stakeholders to develop a system that provides an effective and stable solution to the crisis.

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ACCESS & EQUITY

Behavioral Consultation Within a Psychiatric Hospital Setting

Michael J. Moravecek, *Whiting Forensic Division, Connecticut Valley Hospital*

IT IS CURRENTLY QUITE COMMON for psychologists to provide mental health services in conjunction with a multidisciplinary treatment team (American Psychological Association [APA], 2013; Miller & Swartz, 1990). Multidisciplinary teams are often made up of a variety of different service providers, including psychiatrists, physician assistants, nurses, dieticians, social workers, and many others, all of whom have different training, skill sets, and experiences. Within these teams, psychologists can fulfill a number of different roles when sharing experience, assisting in treatment, and providing leadership. Consultation is one way that psychologists can interact with other treatment providers within a multidisciplinary team in order to improve quality of care. Psychologists' expertise in clinical, communication, behavioral, and systems issues makes them especially suited to providing consultation to multidisciplinary treatment teams (APA, 2013). This is especially true in cases where patients present with complex difficulties that cannot be addressed effectively by a single discipline and that result in administrative, systems, and bureaucratic issues that affect the delivery of care.

Consultation by psychologists can take a number of forms that include psychological assessment services, neuropsychological consultation, and behavioral consultation, depending on the needs of the treatment team and the skills of the psychologist providing the consultation. Behavioral consultation involves collaborating with a consultee (such as a teacher, parent, or treatment team) in order to effect a change in the behavior of a patient, student, or even the treatment providers themselves (Hagermoser Sanetti & Kratochwill, 2008). Behavioral consultation, and behavioral interventions in general, involve a number of steps including identifying and defining the problem behavior, analyzing the factors influencing the behavior (including reviewing data related to its frequency and severity), implementing the intervention, and measuring the outcome of the intervention (Hagermoser Sanetti & Kratochwill, 2008). Some specific and structured models of behavioral consultation and report writing have been identified in the literature (e.g., Brinkman, Segool, Pham, & Carlson, 2007) and many of these models have specifically addressed communicating recommendations and assessing the effectiveness of interventions. Ensuring that interventions are implemented effectively and measuring adherence to the correct implementation of the intervention (treatment integrity) have been identified as key elements to effective behavioral consultation (Hagermoser Sanetti & Kratochwill, 2008). In fact, treatment integrity has been identified as an important element in measuring the effectiveness of a number of treatment modalities, and research in recent years has investigated this issue and its impact on treatment outcomes (e.g., Perepletchikova, Treat, & Kazdin, 2007; Wilkinson, 2007).

Behavioral consultation can occur in a variety of settings, including inpatient hospitals, outpatient clinics, forensic services, and schools. Much of the current research in the practice of behavioral consultation has focused on school systems (e.g., Mueller & Nkosi, 2007; Parker, Skinner, & Booher, 2010; Truscott et al., 2012) since addressing student behavioral issues in the classroom can often be a significant and readily identifiable barrier to successful learning. However, inpatient psychiatric hospitals, especially those run by state agencies that tend to treat patients whose cases are usually quiet complex and do so on a longer term basis, are settings where behavioral consultation can also have a significant impact. Despite this, research regarding the effectiveness of behavioral consultation in these settings is currently relatively sparse. There are some barriers to implementing behavioral techniques with multidisciplinary treatment teams in inpatient psychiatric hospitals, such as the power differentials between practitioners of different disciplines (Miller & Swartz, 1990). However, behavioral consultation in inpatient psychiatric hospitals could be a vehicle for integrating services, identifying measureable outcomes for behaviors, and overcoming systems barriers to change if implemented correctly and effectively.

The Behavioral Intervention Service

Connecticut Valley Hospital (CVH) is Connecticut's public hospital for treatment of people with severe mental illness, providing general psychiatric, addictions, and forensic services (State of Connecticut, 2014). CVH is capable of treating over 500 patients at any one time and provides a wide array of services by different disciplines based on individual patient needs. As the only public psychiatric hospital in Connecticut, CVH typically provides care to patients with complex clinical presentations, significant behavioral difficulties, and limited community resources. Patients referred to and admitted by CVH are typically those who have been treated at a lower level of care and had difficulties. In addition, due to the complex needs of the patients at CVH, the length of stay is usually longer than that of a private psychiatric hospital and can include admissions of several years for the most compromised patients or those whose forensic and legal issues necessitate prolonged periods of observation and support.

While the majority of patients at CVH respond to the standard treatment methodologies employed by the treatment teams on individual units, there is a small percentage of patients whose response to treatment is less than optimal, whose level of dangerousness is not successfully mitigated by traditional treatment approaches, who are unable to function successfully outside the hospital setting, or whose complex clinical presentation is not adequately conceptualized by treatment teams. The treatment difficulties presented by these patients have been addressed in a number of ways by the staff and administration at CVH to include hiring outside consultants, case conferences that involve outside treatment providers, and referring these patients to specialized treatment centers in other areas or states, to name only a few. In addition to these interventions, in the interest of broadening the resources available to treatment teams within the hospital, improving quality of care provided to patients, and decreasing the risk of violence within the hospital, CVH developed, organized, and implemented a specialized internal consulting team, Behavioral Inter-

vention Service (BIS), focused on behavioral treatment planning.

The CVH BIS was created in order to address the needs of the most challenging and complex patients admitted to the hospital. While housed on the hospital grounds, the BIS is not assigned to any particular hospital unit or division and operates mostly autonomously throughout the hospital. Made up of psychologists as well as master's-level developmental specialists, the BIS conducts functional behavioral analyses, develops Positive Behavioral Support Plans (PBSP) and provides consultation to units throughout CVH's General Psychiatry, Addictions and Forensic Divisions. Referrals to the BIS are made by individual treatment teams who present the identified patient's case to a PBSP seminar attended by members of the BIS, an outside behavioral consultant and members of the treatment team. Once a case has been referred, the case is either rejected or accepted for behavioral intervention. Cases may be rejected for behavioral services for a number of reasons, such as the patient having a diagnosis of dementia or other limiting factor that would make it difficult for them to learn new behaviors or if the patient is diagnosed with antisocial personality disorder, in which case a patient might actually get worse with the use of a behavioral approach focused on positive reinforcement (Harris & Rice, 2006; Hatchett, 2015). If a case is rejected, a reason and feedback are provided to the treatment team regarding the factors limiting behavioral intervention. If a case is accepted, the BIS works with the team to develop either a full or abbreviated PBSP tailored to the individual patient's needs. Other options that include more brief, less detailed interventions are also possible outcomes of a referral depending on the patient's and treatment team's specific needs.

The main intervention of the BIS's consultation service is the PBSP. These plans involve a number of elements that summarize relevant patient history, provide a functional analysis (which includes an antecedent analysis and a comprehensive case formulation including cognitive, developmental, and psychiatric functioning), recommend interventions, and identify procedures for evaluating progress. Each plan is highly individualized and focused on one or two discreet behaviors of concern (such as aggression, self-harm, etc.) that are most pressing for the patient and the treatment team at the time of the referral. The BIS works with the patient and treatment team through records review, interviews (with the team, patient, family, and community providers), and participation in treatment planning meetings to develop a PBSP. Once the plan has been developed, the BIS provides a written copy of the plan for the patient's medical record, arranges for formal training regarding key elements of the interventions with staff, and periodically meets with the treatment team and patient to review progress. Data are collected for each plan to track the progress of the interventions and these data are summarized for both the patient and treatment team. The periodic reviews by the BIS of the implementation of the plans are designed to monitor treatment integrity, obtain feedback from the patient and treatment team regarding the plan, and service as a basis for modifying the plan or initiating new interventions as needed throughout the life of the PBSP. This process seeks to actively involve the treatment team and the patient in a long-term treatment planning and behavioral intervention process that quantitatively

tracks progress, is responsive to the challenges and successes of the initial interventions, and provides support and expertise to the treatment team.

The BIS's PBSPs include a number of interventions and certain elements are specifically included to ensure treatment integrity. Staff training is a key aspect of this process. Obtaining recommendations from outside consultants is a common practice in clinical settings that deal with complex cases. However, implementing consultant recommendations so that they are actively utilized by treatment providers to improve quality of care can be difficult. In order to address this issue, members of the BIS, after developing a plan, conduct training sessions that include both an educational and role-playing component. These trainings give the staff members who will be implementing the plan a chance to ask questions, an opportunity to practice the intervention as it is planned to be implemented, and a chance to receive feedback on their performance. This process is fully documented so that the hospital knows who was trained and helps ensure that staff are accountable for the implementation of the intervention.

In addition to staff training, the BIS provides data analysis to monitor patient progress and provides feedback to treatment teams as to the effectiveness of the implemented interventions. Collecting quantitative data that can be used to track or infer progress in treatment has been shown to be an important aspect of clinical care and behavioral interventions specifically (see LaVigna & Willis, 2012). The BIS ensures that both patients and treatment teams receive feedback in the form of graphic representations of treatment progress for each individual behavior of concern. These graphs are used to encourage the consultee (the patient and treatment team), modify the behavioral plan if needed, and make treatment planning discussions more specific and concrete.

The BIS also provides ongoing consultation in order to increase the flexibility of the PBSPs and to ensure that both the patients and the treatment teams continue to participate in the treatment planning process. This ongoing consultation model is different from the traditional technique of providing consultative feedback at a specific point in time and then leaving it up to the consultee to implement the recommendations. The BIS is actively involved with the treatment teams they consult with for months or years to determine the effectiveness of the interventions and to adjust the PBSP as needed during changes in the patient's condition. This results in a flexible treatment model that allows the patients and the treatment teams to collaborate with and provide feedback to the consultants on a continual basis. This long-term involvement also affords numerous opportunities for the BIS to teach behavioral concepts and skills to treatment team members, providing staff members with skills that can be used to improve treatment for future patients.

The BIS provides a number of benefits to the patients and staff of CVH. One significant benefit is that this service provides expertise in behavioral techniques, such as functional behavioral analysis, to treatment teams who may have little previous experience with or training in these empirically validated treatment techniques. In addition, since the BIS is fully integrated in the CVH system, but operates autonomously within that system, the members of the BIS are familiar with administrative and systems issues within the hospital and are able to work with administration to overcome difficulties in a way that outside consultants may have difficulty doing.

Conclusions

The CVH BIS is a relatively novel approach to providing support that focuses on behavioral interventions to treatment teams within a public inpatient psychiatric hospital. The interventions provided by the BIS involve a variety of interventions that require intensive functional behavioral analysis. The BIS works with treatment teams to develop PBSPs, but their intervention goes beyond the initial analysis and plan development. The BIS provides staff training to support treatment integrity, data analysis to monitor patient progress, and ongoing consultation services that continually refine the PBSP to maximize the plan's effectiveness. The BIS is also fully integrated with CVH and the State of Connecticut's Department of Mental Health and Addiction Services (DMHAS), decreasing the hospital's reliance on as-needed, case-specific consultation by outside providers who may not be familiar with, invested in, or able to effectively interact with the systems and administration issues that predominate the public psychiatric hospital setting. We feel that this model is an effective and relatively low-cost way to provide behavioral expertise and apply behavioral treatment principles in a setting where these techniques are desperately needed, but where specific training in these techniques does not predominate.

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LETTER TO THE EDITOR

Response to the Special Issue [*tBT*, Vol. 38, Issue 7]

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WE ARE WRITING IN RESPONSE to *tBT*'s special issue on "The Biomedical Model of Psychological Problems" (Deacon & McKay, 2015). As members of the Executive Steering Committee for ABCT's Neurocognitive Therapies/Translational Research Special Interest Group (SIG), we congratulate the editors and authors for highlighting some of the controversies in what has become the dominant perspective in the field. This issue helps to start a long-overdue dialogue within the ABCT community on the role of neuroscience and biomedical research overall.

In embracing neuroscience, we note that many of the sentiments expressed in the special issue are essential: first and foremost, that reductionism of any kind (biological or otherwise) is not helpful for understanding the complexities of psychological dysfunction and human suffering. Of course, we hope that our colleagues—in particular, students and trainees at an early career stage—who have an interest in integrative research utilizing neurocognitive and biological methods will understand that reductionism is not embraced by the many in our society who actually do this work. Rather, like our colleagues who contributed to this issue, we are interested in integrative formulations in which no scientifically supported perspective is excluded. A reader new to this discussion could take from the issue the perspective that neuroscience (or biomedical research overall) is not such a discipline, and for those readers, we will spend a few moments on the view from the trenches.

A refrain in the special issue is the notion that a biomedical model, emphasizing the brain and other biological mechanisms *in isolation from* psychological constructs, has come to dominate the mental health landscape. While it is easy to see how biological reductionism can be inferred from widely circulated language (for example, the language contained in NIMH's current Strategic Plan, in which mental disorders are described as "brain disorders"), it is noteworthy that from the perspective of those who do some of this work, eliminative biological reductionism is almost always a mischaracterization of the point of view being expressed when "brain disorders" are invoked. In particular, there is a danger of conflating a "biomedical model" (and relevant brain measures) with psychopharmacological approaches. Pharmacological approaches are historically rooted in biological models and their intersection with psychology has often been tangential. However, this communication is improving and is not representative of current biopsychosocial models pervading both the pharmacological and cognitive neuroscience communities. Advances in both psychology and psychiatry have allowed us to move away from an either/or, "biologically based psychiatry versus psychology" approach. Indeed, the emphasis in today's translational research environment is on integration of information obtained across multiple levels of analysis, from molecules and genes, to brain networks, to the thoughts, feelings, and experiences that uniquely define human experience (Mohlman, Deckersbach, & Weissman, 2015). Thus, we feel that our best hope of understanding and ameliorating psychological distress—the mission that all of ABCT is committed to—is to attend to the "big picture" in all its complexity, including neurobiology.

The special issue also highlights that neuroimaging and other neuroscience methods widely applied to psychological disorders are correlational and therefore limited in their ability to reveal causal mechanisms of psychopathology. Neuroimaging studies are indeed correlational (as is much of clinical psychology research), but because they reveal insights about an organ system whose organization is fairly well preserved across species, they allow for unprecedented translation to animal studies, where causal hypotheses are readily tested through experimental manipulation, and where a more fine-grained analysis of molecular and cellular structures is possible. In addition, neuroimaging findings generate causal hypotheses that can be tested in humans. For example, cognitive neuroscience is beginning to utilize experimental tools including "neurofeedback" (a form of biofeedback that provides operant conditioning of brain function), cognitive training paradigms to modulate or remediate brain function through practice, and neuromodulation approaches such as transcranial direct current stimulation (tDCS), transcranial magnetic stimulation (TMS), and deep brain stimulation (DBS). Such approaches not only enable experimental manipulation of brain function in humans to test causal hypotheses, they open up new potential avenues for treatment development, including both behavioral and somatic/pharmacological options.

Our own research, and that of many of our colleagues, shows the integrative potential of combining neuroscience with traditional methods in order to optimize psychological treatments like CBT, creating synergistic treatment combinations and personalization of treatment prescriptions. Specific examples include: fine-tuning the timing of exposure work to take advantage of memory consolidation and reconsolidation mechanisms, revealed through animal neuroscience research, in order to harness more durable forms of fear extinction (Rothbaum et al., 2012; Schiller, Kanen, LeDoux, Monfils, & Phelps, 2013); use of pharmacological agents such as D-cycloserine in conjunction with exposure to enhance extinction learning mechanisms (Ressler et al., 2004); understanding how cognitive biases work in a way that leads to novel interventions that combine cognitive interventions with noninvasive brain stimulation (De Raedt, Vanderhasselt, & Baeken, 2015); and use of

neuroimaging biomarkers to achieve unprecedented levels of precision in predicting individual patient outcomes following CBT (Doehrmann et al., 2013; Siegle et al., 2012). These are just a few examples of an ongoing and iterative process of discovery in which neuroscience and clinical psychological science inform one another and create avenues for continuing to improve on the valuable tools psychologists already have at their disposal.

We enthusiastically welcome any of the contributors to the special issue, as well as any readers who find the topic engaging, to attend our SIG meeting which occurs annually at the ABCT convention. The meeting will serve as a useful launching point for ABCT members from all backgrounds to learn more about the possibilities our SIG members envision for translational and neurocognitive research and to engage in an open dialogue around these issues. We hope and expect that ABCT will continue to be a place where individuals utilizing diverse methodologies can learn from one another, united in the goal of relieving the suffering caused by psychological conditions.

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LETTER TO THE EDITOR

Response to Lacasse and Leo (2015)

Ronald W. Pies, *SUNY Upstate Medical University*

FOR THE PAST 33 YEARS as a psychiatrist, teacher, and writer, I have advocated a comprehensive, "biopsychosocial" model of mental illness and its treatment. Indeed, my 1994 textbook was titled *Clinical Manual of Psychiatric Diagnosis and Treatment: A Biopsychosocial Approach*. There is overwhelming evidence that biological and genetic factors contribute to the risk of developing some psychiatric disorders, including but not limited to major depressive disorder (MDD) (Gold et al., 2015); however, psychological, social, and cultural factors are also involved in the genesis of many psychiatric disorders, including MDD (Compton & Shim, 2015). Hence, a purely "chemical imbalance theory" of depression or any mental disorder is simplistic, incomplete, and unhelpful when it implies that psychosocial factors are unimportant.

Unfortunately, in recent years, antipsychiatry bloggers have argued that "psychiatry"—in some broad, institutional sense—has promoted a "chemical imbalance theory" of mental illness in general. I have argued that there has been no such general "theory" propounded by academic psychiatrists, psychiatric textbooks, or official psychiatric organizations, such as the American Psychiatric Association. I stand by that claim. On the other hand, most psychiatrists would acknowledge that the biogenic amine *hypothesis* of affective disorders (Schildkraut & Kety, 2015) has indeed led many physicians to use the unfortunate, shorthand expression "chemical imbalance" to explain how antidepressants may work. I have repeatedly pointed out that this expression, even if intended to reduce the stigma associated with psychiatric illness, is still misleading (Pies, 2011; Pies, 2014a). I have also acknowledged that in the 1990s, there was an overemphasis on the role of serotonin in the etiology of depression (Pies, 2015b).

Unfortunately, the article by Drs. Lacasse and Leo (2015) in the October special issue of *the Behavior Therapist* (Deacon & McKay, 2015) misrepresents my views in the matter of the so-called "chemical imbalance theory" (CIT) and insinuates that I have acted in bad faith, owing to alleged "conflicts of interest." These aspersions seem based, in part, on the false claim that I consider use of the chemical imbalance metaphor as merely "a little white lie"; and on the equally false claim that I was "paid to help [drug companies] promote their products." Specifically:

- Lacasse and Leo (2015) mistakenly imply that I either originated, or endorse, the phrase "little white lie" in reference to the CIT. In truth, I have never applied that expression to, for example, a clinician's telling a patient, "Your emotional problem is due simply

to a chemical imbalance." I would regard such a statement as simplistic and reductionistic, and would never shrug it off—as Lacasse and Leo imply—as "a little white lie." Lacasse and Leo may have made an innocent mistake in attributing this expression to me, owing to two online versions of my "Nuances" article (2014a, 2014b). However, had they investigated carefully, they would have seen that it was journalist Robert Whitaker who first employed the "little white lie" expression in the context of the CIT (Levine, 2014), and that my subsequent use of that phrase (Pies, 2014b) was in reference to Whitaker's comments in his interview with Bruce E. Levine. Unfortunately, in the *Medscape* version of my "Nuances" paper—which originally appeared in *Psychiatric Times* (Pies, 2014a)—I did not put Whitaker's phrase in quotes, for which omission I take responsibility. However, I could easily have cleared up any confusion on this point, had Drs. Lacasse and Leo discussed the matter with me, before writing their article.

- Citing papers I co-authored in 2003 and 2005—in which I disclosed having received occasional speaking honoraria from three pharmaceutical companies—as well as my consulting work with the medical communications company Apothecom (2001–2006), Lacasse and Leo assert that ". . . he [Pies] was paid to help [drug companies] promote their products at the time [their drug] advertisements were running" (p. 209). *Lacasse and Leo reach this conclusion without any direct knowledge of formal arrangements or agreements I may have negotiated in the years 2003–2005, or at any other time.*

Let me be clear: never, in any lecture I delivered that was underwritten by a pharmaceutical company, did I ever agree to "promote" a particular product; nor did I ever use slides or material provided by such companies, or have any personal contact with anyone representing the sponsoring company. I estimate that, in toto, I delivered 5 to 6 lectures, over a 30-year period, that were underwritten to some extent by pharmaceutical companies—with which I had no ongoing financial relationships.

As for my part-time consulting role with Apothecom, all stipends came solely from Apothecom and were paid to me on an ad hoc (hourly) basis. At no time did I agree to "promote" any drug company's product, nor was I induced or expected to do so by anyone at Apothecom. Of course, I am aware that "conflicts of interest" may sometimes arise inadvertently, even when physicians are not conscious of them, and I have written extensively on this issue (Pies, 2013). Furthermore, by 2007, when I became Editor-in-Chief of *Psychiatric Times* (2007–2010), I no longer accepted any lecture invitations (e.g., from various hospitals) that were supported by pharmaceutical companies.

As for Lacasse and Leo's (2015) allegation that I ". . . didn't speak out on the chemical imbalance issue decades ago" (p. 209)—for example, with an op-ed in the *New York Times*—there is a straightforward explanation for this. In my more than 30 years in psychiatry, I never once heard any of my colleagues or teachers propound a simplistic "chemical imbalance theory" of mental illness—or even of depression. I began addressing this issue in 2011, as I became increasingly aware of antipsychiatry bloggers using the "chemical imbalance" canard as a cudgel against psychiatry.

More substantively: Lacasse and Leo's (2015) article ignores the critical distinction between a *hypothesis* and a *theory—the* latter being an integrated constellation of validated hypotheses (Understanding Science, 2015). Specifically, they fail to distinguish between the biogenic amine *hypothesis* of affective illness (which was indeed propounded by some psychiatrists, on good evidence) and a general, comprehensive *theory* that "mental illness is caused by a chemical imbalance"—which has never been the position of any professional psychiatric organization, or of most academic psychiatrists. Lacasse and Leo's confusion is highlighted in their quite unconvincing Table 2 (p. 211), which cites precisely 9 psychiatrists (out of over 36,000 in the U.S.!) who refer in some fashion to a "chemical imbalance," chiefly in the context of *depression*; or with respect to an antidepressant's putative *mechanism of action*—not as a causal theory of "mental illness" in general.

Moreover, Lacasse and Leo's (2015) paper obscures the difference between a putative *mechanism of action of a drug* (e.g., serotonin reuptake inhibition) and a *causal theory of mental illness* (the focus of my writings). To say that a drug "corrects a chemical imbalance"—as, indeed, some psychiatrists have stated—is not to claim that the illness being treated is caused by that imbalance. Many drugs work via mechanisms that are helpful for symptoms of a disease without addressing or reversing the numerous (and often unknown) "causes" of that disease. For example, beta blockers are used to treat some cardiac arrhythmias, but nobody infers from this that the arrhythmia is *caused* by a deficiency of beta-receptor blockade. (Nor, for that matter, do cardiologists routinely explain to patients the mechanism of action of the medications they prescribe.) Of note: the most recent publicly available information from the American Psychiatric Association does not use the expression "chemical imbalance" in discussing risk factors for depression or the rationale for antidepressant treatment (What Is Depression, 2015).

Finally: If there is anything resembling an "official" psychiatric position on the causes of mental disorders, it is the 1978 statement from the American Psychiatric Association—which, unlike off-hand comments from one or another former APA president, was *approved by the APA Board of Trustees,* and is available online to this day:

> "Psychiatric disorders result from the complex interaction of physical, psychological, and social factors and treatment may be directed toward any or all three of these areas."

And this is precisely what most of my academic colleagues and I have been teaching—and telling our patients—for the past three decades (Pies, 2015a).

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LETTER TO THE EDITOR

Response to Lacasse and Leo (2015)

Daniel J. Carlat, *Tufts University School of Medicine*

IN THEIR RECENT ARTICLE, Drs. Lacasse and Leo (2015) continue an important discussion about the use of overly simplistic explanations of antidepressant actions. They argue that drug companies have used such explanations to market their drugs, and that psychiatrists have often been complicit—or at least silent—partners in this promotional technique.

In one section of the article, they accuse me of making deceptive statements to my patients about how antidepressants work. I deny this accusation. In talking to patients I simplify neurobiological concepts, using a shorthand to describe, in a simplistic way, some common theories of mental illness. I do this to enhance the placebo effect—which accounts for a significant portion of the overall effectiveness of antidepressants. Two of the most crucial components of the placebo effect are fostering positive expectations of success and reinforcing the medical ritual of pill-taking (Kaptchuk et al., 2010; Leuchter, 2014). In order to augment my patients' response to antidepressants, I will say something like, "This is a very effective medication, you should take this pill every morning, and you will begin to feel better within a couple of weeks." If a patient asks me how the medication works, I will respond with, "We're not completely sure, but it has something to do with increasing levels of neurotransmitters like serotonin or norepinephrine—basically, these pills rebalance certain chemicals in the brain."

There is nothing deceptive about such statements. While we don't understand exactly what serotonin's role is, we have some educated hypotheses. A recent review of serotonin and depression identifies 14 known serotonin receptor subtypes. When antidepressants bind to these receptors, a variety of chemical processes unfold, affecting levels of dopamine, norepinephrine, acetylcholine, cortisol—and yes, serotonin. While it isn't clear exactly how these chemical cascades alleviate depression or anxiety, it is clear that effective antidepressants exert their actions via shifts in the brain's biochemical milieu—and that serotonin is one of the central players in the drama (Kohler et al., 2015).

The authors, unfortunately, do not seem to be interested in scientific evidence. In their role as the serotonin thought police, they brook no uncertainty: the serotonin theory is discredited, full stop. To support this conviction, they refer to a table entitled, "Evidence the Chemical Imbalance Theory of Depression Is Not Valid: Selected Quotations" (p. 210). But the table presents no "evidence" as we normally think of the term. Instead, it is a list of 12 statements made by various psychiatrists reflecting their personal opinions about the chemical imbalance theory. But just because smart people say something doesn't make it true. If it did, then their Table 2, "Promotion of the Chemical Imbalance Theory of Depression as Valid: Selected Quotations" (p. 211) would be an effective refutation of their entire article.

Lost in their polemic is the fact that as mental health clinicians, we are fortunate to be able to offer very effective treatments—both psychotherapeutic and psychopharmacologic—for our patients. There is much we don't understand, and we can do better. But mean-spirited attacks on colleagues are not going to help further the field.

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LETTER TO THE EDITOR

Response to Daniel Carlat (2015) and Ronald Pies (2015)

Jeffrey R. Lacasse, *Florida State University*

Jonathan Leo, *Lincoln Memorial University–deBusk College of Osteopathic Medicine*

Response to Daniel Carlat (2015)

In our recent article (Lacasse & Leo, 2015), we transcribed public statements made by Dr. Carlat on National Public Radio (NPR). Dr. Carlat disclosed that he used content similar to the Zoloft marketing campaign (Lacasse, 2005) to explain antidepressants to patients:

> I'll often say something like the way Zoloft works, is, it increases the level of serotonin in your brain (or synapses, neurons), and, presumably, the reason you're depressed or anxious is that you have some sort of a deficiency. And I say that [chuckles] not because I really believe it . . . I think I say that because patients want to know something . . . . They certainly don't want to know that a psychiatrist essentially has no idea how these medications work. (Davies, 2010)

Despite Dr. Carlat's allegation, we are not the serotonin thought police, ticketing offenders that violate our sensibilities. But, we don't believe we're alone in thinking it's objectionable to tell patients something you don't believe yourself. To say things like this publicly and not expect criticism seems naïve. We are not cherry-picking here, as Dr. Carlat has a history of such disclosures:

> While it is true that most of our drugs affect neurotransmitters in various ways, when psychiatrists start using what I call neurobabble, beware, because we rarely know what we are talking about. I fall into this habit with patients all the time. When I find myself using phrases like "chemical imbalance" and "serotonin deficiency," it is usually because I'm trying to convince a reluctant patient to take a medication . . . (Carlat, 2010, p. 75; see pp. 74–83 for published content similar to that reported in the NPR interview)

We don't think scientific truth is so flexible, and disagree with shaping it for purposes convenient to the prescriber (e.g., to get patients to take medication, or to reassure the patient of the prescriber's expert knowledge). Dr. Carlat also writes that he boosts the placebo effect by telling patients that SSRIs are "a very effective medication" (Carlat, 2015; this issue, p. 262). Fournier et al. (2010) demonstrated a Number-Needed-to-Treat (NNT) of 11 for severely depressed patients. In other words, when prescribing to 11 severely depressed patients, a prescriber would expect 1 to have an impressive short-term response as compared to placebo. Given the existence of such data, we question the accuracy of claiming that antidepressants are "very effective" (see also Weitz et al., 2015).

Response to Ronald Pies (2015)

On the "Little White Lie" of Chemical Imbalance

In his reply, Dr. Pies (2015; this issue) states that he does not endorse calling the chemical imbalance a "little white lie," and that he was referencing Mr. Robert Whitaker when he used this phrase. We take his word on this, appreciate that he acknowledges his editorial error, and apologize for the confusion. We are glad that we and Dr. Pies have this opportunity to correct the record.[1] We note that a correction has been made to Dr. Pies' original article as of November 4, 2015 (Pies, 2014).

On Promotion of Psychiatric Drugs

Like many, we believe that academic psychiatrists have been too closely aligned with the pharmaceutical companies (e.g., Healy, 2004). In our article, we hypothesized, as we had before (Lacasse & Leo, 2009), that the flow of money from drug companies to academic psychiatry might be partially responsible for the resounding silence in academia regarding misleading advertising of psychiatric drugs. Dr. Pies had himself argued that pharmaceutical companies were responsible for spreading the chemical imbalance metaphor. While we agreed that this was part of the problem (Lacasse & Leo, 2005), we saw some irony in the fact that he had received funding from GlaxoSmithKline, among the worst offenders in our opinion when it came to misleading consumer advertising. We never accused Dr. Pies of acting in bad faith, and in fact wrote, "We want to be clear that we are not accusing Dr. Pies of anything" and that entanglements with drug companies aren't "uncommon among academic psychiatrists, and some would say it was par for the course in the 2000s" (Lacasse & Leo, 2015, p. 209). However, Dr. Pies strongly objects to our assertion that he has been involved in the promotion of psychiatric drugs, and so we will reluctantly respond.

How Psychiatric Drugs Are Promoted

As background, it is useful to understand the strategies that pharmaceutical companies use to promote[2] their products. They often contract with "medical communications companies," which specialize in "publication planning" and employ medical writers who contribute to (or even author or co-author) peer-reviewed articles (Lacasse & Leo, 2010), usually with academics listed as authors on the byline

[1] In his 2014 article, Dr. Pies begins a paragraph by citing an interview of Mr. Robert Whitaker (Levine, 2014; Pies, 2014). Dr. Pies then writes about the "antipsychiatry movement." In these sentences there are no quotations and no citations; they consist of Dr. Pies' own interpretations. He mentions chemical imbalance, writing that "by promoting this little white lie…" Mr. Whitaker had used quotation marks around the phrase as editorial comment, but Dr. Pies did not. Without quotation marks or citation, we took this as we did his other writing in this section, as his opinion (we aren't the first to do so; see Hickey, 2014). We reproduced the entire quotation from Dr. Pies in a footnote, commenting on this exact issue (Lacasse & Leo, 2015, p. 209). A correction to the article (Pies, 2014) was made in November of 2015, after our article was published. Rather than clarifying where the phrase "little white lie" came from, Dr. Pies removed it and replaced it with "simplistic formulation." Interestingly, Mr. Whitaker did not characterize chemical imbalance as "simplistic" (Levine, 2014).

(Sismondo, 2009; Sismondo & Doucet, 2010). Unrestricted educational grants are another strategy used by pharmaceutical companies, as they are ". . . a well-established tool that all of the major pharmaceutical manufacturers use to disseminate information to the medical community. . . . The off-label promotion risk of educational grants appears to pose the greatest threat to the Federal health care programs and beneficiaries, but it is also the most difficult to demonstrate conclusively"[3] (U.S. Senate Committee on Finance, 2007). Nonetheless, the legal complaint against GlaxoSmithKline for illegal marketing of drugs like Paxil and Lamictal (which was eventually settled for 3 billion dollars; Department of Justice, 2012) described the following:

> GSK's [GlaxoSmithKline's] extremely aggressive off-label marketing campaigns for Lamictal included spending large sums of money in the form of unrestricted grants, membership on advisory boards and speaker's fees on physicians and researchers who served as "national thought leaders." (*United States of America v. GlaxoSmithKline*, 2012)

Certainly many professors believe they are being hired to share their expert opinion, but in the eyes of pharmaceutical and medical communications companies, academics are clearly being paid because their opinions are helpful in the promotion of the drug company's product.[4] At the risk of stating the obvious, from the companies' point of view, it would make no sense to pay psychiatrists or medical writers if they didn't have positive things to say about the product. From their point of view, the ideal academic would be someone who believes that grants, payments, or the assistance of medical writers have no effect on their objectivity. In fact, academics receiving funding from drug companies or proxies may be genuinely unaware that they have been retained because their opinions have promotional value (e.g., Carlat, 2007). We do not believe that academics agree to just say anything the companies want in return for compensation, and we never asserted that Dr. Pies was a "hired gun." We share the views of Dr. David Healy (2012), who argues that pharmaceutical companies seek out academics who already share their views.

Our Clarification

First of all, our statements were not based on any direct or firsthand knowledge of any verbal or written agreement that Dr. Pies had with Apothecom, or any other corporate entity. We were trying to be brief, and so we wrote that Dr. Pies "fails to mention that he was paid to help them [drug companies] promote their products" (Lacasse & Leo, 2015, p. 209). In retrospect, we could have written more clearly and specifically, and we therefore correct this section to read as follows:

Dr. Pies blames the drug companies for running misleading advertisements about chemical imbalance, belatedly admits he should have done something sooner, but fails to mention his involvement with the pharmaceutical industry. In 2005, he disclosed that "he has consulted for an independent medical education company that involves work with pharmaceutical company clients" (Pies & Rogers, 2005).[5] As of 2003, Dr. Pies disclosed that he was a recipient of "ad hoc stipends from Abbott, Jannsen, GlaxosmithKline, and other pharmaceutical or related corporate entities" (Chaudron & Pies, 2003, p. 1284). In this same 2003 article, Dr. Pies disclosed that he was a consultant for Apothecom (Chaudron & Pies, 2003), a medical communications agency listed in the Top-100 agencies by Medical Marketing and Media (Frank, 2015). The Apothecom website boasts that they are a "communications powerhouse" employing "130 scientific storytellers" and that they do "scientific branding . . . publications planning, delivery and maximizing . . ." (Apothecom.com, 2015). Dr. Pies reports working with Apothecom from 2001–2006 (Pies, 2015). As of 2003, Apothecom listed the pharmaceutical companies Abbott, Sepracor, and GlaxosmithKline among their clients (Lieberman, 2003).

From 2002–2006, Dr. Pies was author or co-author of articles funded through unrestricted educational grants from GlaxoSmithKline (makers of the anticonvulsant drug Lamictal). These include an article entitled "The 'Softer' End of the Bipolar Spectrum" (Pies, 2002a); a 2002 article on combining lithium with anticonvulsants such as Lamictal in bipolar disorder (Pies, 2002b); a review article on "Matching the Bipolar Patient and the Mood Stabilizer" (Gelenberg & Pies, 2003); a 2003 article on postpartum psychosis and bipolar disorder stating that Lamictal ". . . also not FDA-approved for treatment of bipolar disorder, does appear especially useful for bipolar depression" (Chaudron & Pies, 2003, p. 1289);[6] a review article focused on treatment of bipolar disorder with co-occurring substance use (Albenese & Pies, 2004); and a 2006 article recommending Lamictal for use in maintenance treatment of bipolar disorder (Marken & Pies, 2006). Another 2006 article funded by GlaxoSmithKline stated that "lamotrigine [Lamictal] may also have benefits in borderline personality disorder" (MacKinnon & Pies, 2006, p. 8), with the co-authors disclosing that "The authors of this paper do not have any commercial associations that might pose a conflict of interest in connection with this manuscript" (MacKinnon & Pies, 2006, p. 1). Dr. Pies was also co-author of a review article on treatments for insomnia which highlights the potential benefits of Lunesta, and acknowledges the assistance of Sepracor, Inc. (makers of Lunesta) in the preparation of the manuscript (Winkelman & Pies, 2005);[7] and co-author of a 2007 article on insomnia in which the authors acknowledge "that they received compensation from Sepracor for services they pro-

[2]The Oxford Dictionary defines promote as "...Further the progress of (something, especially a cause, venture or aim); support or actively encourage... Give publicity to (a product, organization, or venture) so as to increase sales or public awareness...". The word "promotion" by itself does not imply that the information is biased, inaccurate or deceptive, nor is it intrinsically negative. Products can be honestly and enthusiastically promoted. This point may have been overlooked by some readers of our original article. Sismondo (2009) describes a balance between marketing and science among publication planners.

[3]One reason that it so difficult to demonstrate this conclusively, as the Senate notes, is because in many cases the money trail is complicated and difficult to sort out from the outside.

[4]Like our original article and the rest of this response, this paragraph reports our academic opinion on these issues.

[5]This is seemingly Apothecom, but Dr. Pies did not disclose the name of the company.

[6]Ghaemi, Shirzadi, and Filkowski (2008) examined GlaxoSmithKline's unpublished negative studies and wrote: "[Lamictal] has very limited, if any, efficacy in acute bipolar depression and rapid-cycling bipolar disorder, areas in which practicing clinicians, as well as some academic leaders, have supported its use."

[7]In an Op-Ed in the *New York Times*, Dr. Daniel Carlat critiqued an arguably similar article as a form of pharmaceutical company marketing (Carlat, 2006).

vided in support of the development of this manuscript" (Roth, Roehers, & Pies, 2007, p. 77). Several of the above-listed articles acknowledge editorial assistance and/or content contribution from medical writers without listing their company affiliation or who paid them for their work; the online resume of one such medical writer lists Apothecom as her employer at the time. Dr. Pies wrote that his relationship with Apothecom took place from 2001–2006 (Pies, 2015). In 7 of the 8 journal publications discussed above, Dr. Pies does not disclose a relationship with Apothecom.

Discussion

While we are pleased to make these clarifications, we think the primary issue remains the use of the chemical imbalance metaphor in clinical interactions with vulnerable patients. We find Dr. Pies' arguments unconvincing, and it is obvious to us that the chemical imbalance theory was indeed embraced by the field of psychiatry (Whitaker, 2015), and that the explanation is still used by prescribers to this day. We have wondered what has motivated Dr. Pies' shifting positions and arguments on this topic (Lacasse & Leo, 2015; Whitaker, 2015), and in his reply, we think he gave an answer. Dr. Pies writes, "I began addressing this issue in 2011, as I became increasingly aware of antipsychiatry bloggers using the 'chemical imbalance' canard as a cudgel against psychiatry" (Pies, 2015, this issue, p. 261). We think this is useful context to guide interpretation of his arguments. Dr. Pies is apparently defending his guild against outside attack (Whitaker, 2015; Whitaker & Cosgrove, 2015). Read as a sustained, political defense of his profession, we think his writings on chemical imbalance make perfect sense.

We are not part of this guild, so we have a different point of view. We think these issues are deeply important, not because psychiatry is under attack, but because we believe many depressed and anxious patients have been hurt by being told that they have a chemical imbalance in their brain that is corrected by psychiatric medication. We think calling this "misleading" is an understatement—and that learning now that chemical imbalance is only a metaphor (Lacasse & Leo, 2006) could well be traumatic. This is true both for the prescribers who were taught to use this metaphor, as well as for the patients who heard it from their physicians and believed it to be a scientific fact. As anyone who has dealt with trauma knows, the first step is to acknowledge what happened. Insisting that it never occurred, or was less severe than perceived, or was unsanctioned by authorities, will inevitably cause negative reactions—especially so when these claims are not quite true.

We think it is in the best interests of the psychiatric profession to look closely at how the chemical imbalance metaphor has been used over the last 25 years. This is no easy task (Tavris & Aronson, 2008). It requires putting ego aside, listening carefully rather then lecturing, and a willingness to be open-minded and nondefensive. Rather than obfuscating the issue, or demonizing those delivering the bad news as "antipsychiatry," the profession will eventually need to admit that patients were misinformed and harm was done. Once this step is taken, perhaps psychiatry can recapture the public's trust and move forward.

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Voluntary Contributors

On behalf of ABCT, President Jonathan S. Abramowitz warmly thanks all who have generously supported our mission with a voluntary personal donation in 2015.

Anne Marie Albano
P. Michael Apolito
John Grebe
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Tom Olson
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call for Continuing Education Sessions

50th Annual Convention | October 27–30, 2016 | New York

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at www.abct.org.

Workshops and Mini Workshops

Workshops cover concerns of the practitioner/educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than FOUR presenters.

Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention.
Please limit to no more than FOUR presenters.

When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

Barbara Kamholz, *Workshop Committee Chair*
workshops@abct.org

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.
Please limit to no more than FOUR presenters.

Lauren Weinstock, *Institute Committee Chair*
institutes@abct.org

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday.

Sarah Kertz, *Master Clinician Seminar Committee Chair*
masterclinicianseminars@abct.org

DEADLINE *for Submission : February 1, 2016*

2016

Call *for* Award Nominations

to be presented at the 50th Annual Convention in New York City

The ABCT Awards and Recognition Committee, chaired by Katherine J. W. Baucom, Ph.D., of the University of Utah, is pleased to announce the 2016 awards program. Nominations are requested in all categories listed below. **Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below**. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Past recipients of this award include David H. Barlow, G. Alan Marlatt, Antonette M. Zeiss, Alan E. Kazdin, Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, and David M. Clark. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

Outstanding Contribution by an Individual for Education/Training

Awarded to members of ABCT in good standing who have provided significant contributions toward educating and training cognitive and behavioral practitioners. Past recipients of this award include Gerald Davison, Leo Reyna, Harold Leitenberg, Marvin Goldfried, Philip Kendall, and Patricia Resick. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Educator/Trainer" in your subject heading. Also, mail a hard copy of your submission to ABCT, Educator/Trainer, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. Previous recipients of this award are Richard Heimberg, G. Terence Wilson, Richard J. McNally, Mitchell J. Prinstein, and Bethany Teachman. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Mentor" in your subject heading. Also, mail a hard copy of your submission to ABCT, Outstanding Mentor, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

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Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, Vikram Patel, and Benedict Carey. Applications should include a nomination form (available at www.abct.org/awards), three letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to awards.abct@gmail.com. Include "Distinguished Friend to BT" in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. This award includes a cash prize to support travel to the ABCT Annual Meeting and to sponsor participation in a clinical treatment workshop.
Eligibility requirements are as follows: 1) Candidates must be active members of ABCT, 2) New/Early Career Professionals within the first 5 years of receiving his or her doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care.
Applicants should submit: Nominating Cover Letter, CV, Personal Statement up to three pages (statements exceeding 3 pages will not be reviewed), and 2 to 3 supporting letters. Application materials should be emailed as one pdf document to Awards.ABCT@gmail.com. Include candidate's last name and "Albano Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Anne Marie Albano Early Career Award, 305 Seventh Ave., New York, NY 10001.

This award is made possible by a generous donation to ABCT. A family who benefitted from CBT and knows of Dr. Albano's work expressed wanting to see others benefit from CBT and CBT-trained therapists.

Nomination Deadline: March 1, 2016

Student Dissertation Awards

- Virginia A. Roswell Student Dissertation Award
- Leonard Krasner Student Dissertation Award
- John R. Z. Abela Student Dissertation Award

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2015. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents. Self-nominations are accepted or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the nomination materials (including letter of recommendation) as one pdf document to awards.abct@gmail.com. Include candidate's last name and "Student Dissertation Award" in the subject line. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001. **Nomination deadline:** March 1, 2016

Nominations for the following award are solicited from members of the ABCT governance:

Outstanding Service to ABCT

Please complete the nomination form found online at www.abct.org/awards/. Then e-mail the completed form and associated materials as one pdf document to awards.abct@gmail.com. Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.
Nomination deadline: March 1, 2016

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ABCT's ***Find a CBT Therapist*** *schooled in cognitive and behavioral techniques. In addition to standard search capabilities (name, location, and area of expertise), ABCT's Find a CBT Therapist offers a range of advanced search capabilities, enabling the user to take a Symptom Checklist, review specialties, link to self-help books, and search for therapists based on insurance accepted.*

We urge you to sign up for the ***Expanded Find a CBT Therapist*** *(an extra $50 per year). With this addition, potential clients will see what insurance you accept, your practice philosophy, your website, and other practice particulars.*

To sign up for the Expanded Find a CBT Therapist, click on the **Renew/Join ABCT** *icon on the right-hand side of the home page; then click on the PDF "2016 Membership Application." You will find the Expanded Find a CBT Therapist form on p. 6.*

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CBT Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.

2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.

3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Barbara Kamholz at barbara.kamholz2@va.gov and include "Medical Educator Directory" in the subject line.

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this listing serve strictly in a volunteer capacity.

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"In sexual minority young adults, there remains a significant gap in understanding the experience of anxiety beyond social phobia and the role of concealment."

Cohen et al.
Behavior Therapy
doi:10.1016/j.beth.2015.09.006

archive

"If we wish to rehabilitate individuals, then we have to modify not only the person but also his relevant environment. Even more important, we have to modify the behavior of the mental health professionals themselves. Rehabilitation and behavior change are not the sole domain of any one individual or any one profession. We are all on the same spaceship."

—John M. Atthowe, Jr.
"Behavior Innovation and Persistence"
In Franks & Wilson (Eds.) (1974),
Annual Review of Behavior Therapy
New York: Brunner/Mazel

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Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2016, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send form to: Christopher Martell, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001 (fax: 212-647-1865)