

The Child & Adolescent Anxiety SIG Newsletter

Advancing the Science and Practice
of Youth Anxiety

June 2008, Volume 7, Issue 2

Note from SIG Leader

Dear Child and Adolescent Anxiety SIG,

We are so pleased and fortunate to present this Special Issue of our Newsletter, providing an interesting and informative set of articles reviewing the overlap between sleep and anxiety issues in children. We hope to continue to provide the membership with an even greater number of such special newsletter editions in the months and years to come!

As we begin to approach the forthcoming ABCT Conference in Orlando this November, our SIG is hoping to offer the membership some unique learning opportunities, so please monitor our SIG listserv for information about upcoming events. In the meantime, if you are saying asking yourself – What listserv? How do I get to be on that? Well, the first step is to become a Child and Adolescent Anxiety SIG member! In this Newsletter, we have included a New Member/Membership Renewal Form, which you may still complete if you have yet to renew your 2008 SIG membership. Our 2009 Membership Form will be sent out just prior to ABCT in November, but it's not too late to become a member or renew your membership for the remainder of this year.

Also included in this issue is information on two great opportunities to present and be recognized for excellent research related to child and adolescent anxiety disorders. First, we have included the Call for Posters for the Child and Adolescent Anxiety SIG table at this year's ABCT SIG Poster Exposition and Cocktail Reception. Please keep in mind that posters at our table which are first-authored by students will be considered for a \$50 Student Poster Award, presented at the Cocktail Reception. Information regarding the Student Travel Award, which includes a \$200 honorarium and the opportunity to present one's research at the annual SIG meeting, is also included. Past recipients of these awards have included students from a range of academic programs representing a range of child anxiety research topics; we encourage all interested to apply.

Thank you so much for your continued support of our SIG!

Warmest regards,
Jill Ehrenreich, Ph.D.
Leader, Child and Adolescent Anxiety SIG

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Letter from the Newsletter Editors

Aleta Angelosante, Ph.D.
Brian Buzzella, M.A.
Jonathan S. Comer, Ph.D.

Welcome back! We are delighted to bring you the latest CAASIG *Newsletter*. This issue marks the second half of the new format of the *Newsletter* – in which we will provide information on SIG business and special topics of research related to child and adolescent anxiety. The first issue of the year was a post-ABCT wrap-up of conference activities and information. This issue focuses on the overlap of sleep disorders and anxiety in youth.

The overlap between anxiety and sleep disturbance/disorders has been of particular interest to me (AA) since my internship. At a large, urban hospital with no anxiety specialty clinic, I found myself learning an incredible amount about a wide array of topics, and treating patients who had everything and anything *but* anxiety, it seemed. Then I began a rotation in the pediatric sleep clinic and suddenly I felt at ease – here were the anxiety patients! While it would certainly be remiss to say that all of the sleep clinic patients were anxious, many of them were. After internship, when I once again began treating patients in an anxiety specialty clinic, I was struck by how often sleep was a serious concern for my patients and was thankful to have had that sleep clinic training experience. Think about the kids you are treating – how many of them have disturbed sleep? We hope that you find these articles as interesting and clinically useful as we have.

From Dr. Candace Alfano of Children's National Medical Center in Washington, DC (ironically, Dr. Alfano has created an anxiety specialty clinic at CNMC, my former internship site, so I suppose current interns will be able to find anxiety patients somewhere other than the sleep clinic) we have a piece describing the various sleep disorders and when to recommend your patients for a sleep study as well as a case study. Dr. Alice Gregory from The Institute of Psychiatry in London, has provided a piece regarding the research on the comorbidity of anxiety and sleep disturbance in youth.

This issue also includes another installment of the Student's Corner focusing on the internship application process (it's never too early to get a jump on it!). Please keep sending us ideas for topics you would like to see featured in a future issue of the *Newsletter*! We create this newsletter for the benefit and entertainment of SIG members, so be sure to send us your suggestions and comments.

We hope you enjoy this issue! And, of course, have a great summer!

Aleta Angelosante (aleta.angelosante@nyumc.org)

Brian Buzzella (bbuzz@bu.edu)

Jonathan Comer (jcomer1@gmail.com)

Newsletter Co-editors

Call for Posters

We are accepting submissions for the upcoming *SIG poster exhibition* at:

**ABCT's 42nd Annual Convention
November 13-16, 2008, Orlando, FL**

All poster submissions should consist of empirical studies related to child and adolescent anxiety etiology, treatment and research.

*Posters first-authored by students will be considered for **The Child and Adolescent Anxiety SIG Poster Award** for excellence in child and adolescent anxiety research, with a \$50 book voucher and certificate to be awarded to the winner.*

The abstract should be formatted in the following manner (on a single 8.5" x 11" sheet): Title of submission at top of page, followed by names and affiliations of the authors (no addresses or Department names please). After skipping one line, type the word "Contact" and list the contact person, their affiliation, full address, telephone, fax number, and e-mail. Below this type the abstract. Do not exceed one page, single-spaced.

Please attach an author's list to each copy of the abstract, containing the name, affiliation, full address, telephone, fax number, and e-mail of each author.

Please email all submissions to:

Jill Ehrenreich, Ph.D., Leader, CAA-SIG
jill.ehrenreich@gmail.com

Deadline for **receipt** of all submissions: July 14, 2008

Sleep Disorders in Children

Candice A. Alfano, Ph.D.
Children's National Medical Center
The George Washington University School of Medicine

The way children sleep affects nearly every aspect of their daytime functioning. For example, extensive empirical data indicate the presence of early sleep disruption to be associated with poor impulse control and inattention, decrements in academic performance, school absenteeism, risk-taking behavior and injury, and behavioral and emotional problems. Health-related outcomes include potentially deleterious effects on cardiovascular, immune and metabolic systems. Thus, while sleep-related problems are extremely common during childhood, they should not be ignored.

Unfortunately, compared to adults, sleep disorders during childhood are poorly studied and described. Defining sleep disorders in children is a more challenging task for a number of reasons including ongoing developmental changes in sleep requirements and habits, caregiver-dictated bedtime schedules and routines, and socio-demographic and cultural variables impacting sleep practices. Also, a majority of children presenting with a sleep complaint meet criteria for a psychiatric disorder or problem. As a result, the proportion of children with a primary sleep disorder without a comorbid psychiatric diagnosis is generally unknown and there currently is no broad consensus on the definition of childhood insomnia.

Despite these challenges, the need for child practitioners to attend to sleep is a critical one. According to the *International Classification of Sleep Disorders (ICSD)*, sleep problems should be considered in terms of their age-appropriateness, severity, chronicity and co-occurring diagnoses. However, mere description of a child's sleep problem can be quite subjective and, in most cases, dependent upon the parents' and child's awareness of and tolerance for the problem. For these reasons, thorough evaluation should include the use of several assessment tools focused on differential diagnosis. Initial assessment at a pediatric sleep clinic typically includes a structured interview aimed at collecting information about a child's medical, developmental, psychiatric and sleep history, as well as familial and environmental factors that may be impacting sleep. In addition, completion of several validated measures of daytime and nighttime behaviors and a sleep diary or sleep log provide a broad understanding of a child's behavior and functioning. Children also may be referred for further medical evaluation (including an overnight polysomnogram) as needed, such as when questions of sleep-disordered breathing or unexplained daytime sleepiness are present.

For a large number of children, sleep problems fall into a broad category of difficulties termed *Behavioral Insomnias of Childhood*. Such sleep problems include chronic difficulty initiating and/or maintaining sleep resulting in excessive daytime fatigue and functional impairment. Insomnia may be associated with physiologic and cognitive (i.e., intrinsic) or environmental and familial (i.e., extrinsic) factors. For example, when a child consistently spends excessive amounts of time awake in bed while experiencing somatic tension and/or worrisome thoughts, a diagnosis of *psychophysiological insomnia* may be appropriate. When a child consistently delays or refuses to go to or stay in bed as a result of inadequate structure or limits within the environment, a diagnosis of *limit setting sleep disorder* may be given.

It is noteworthy that behavioral insomnias commonly co-occur with anxiety in children and treatment planning across settings should include consideration of both problems and associated impairments. The following brief case example highlights some typical sleep problems experienced by anxious youth. This vignette is specifically intended to provide clinicians with an introduction to relevant clinical issues, assessment and treatment approaches.

Case Example:

Brian is a 10 year-old male with a history of problems initiating sleep. Although his bedtime is at 9:00 p.m., Brian is unable to initiate sleep until 10:30 or 11 p.m. at least 5 nights a week (i.e., on school days). Between bedtime and sleep onset Brian lies in bed watching the clock, listening to noises in the house, and "just thinking". He reports being worried about not feeling rested the next day, performing poorly in school and why he is not a "good sleeper". He also frequently goes to his parents' room when he cannot fall asleep to ask for a back rub. Visits to his parents' room occur 3 times a week and last up to 30 minutes. Brian's parents are concerned because he is excessively tired during the daytime and his teachers have reported recent problems with inattention. Brian also has missed several school days this year due to difficulty waking in the morning.

Thorough evaluation at a sleep specialty clinic resulted in a diagnosis of psychophysiological insomnia and a tailored behavioral intervention protocol was subsequently implemented. First, principles of sleep hygiene including use of stimulus control techniques were reviewed, including removing the clock from Brian's bedroom and engaging in a quiet activity (e.g., reading) in a comfortable chair with dim light if unable to initiate sleep in 30 minutes. Brian's parents were instructed to send him back to his room immediately if he came to their bedroom during this time. A white noise machine also was introduced to filter out noises in the house. A temporarily delayed bedtime of 10:00 p.m. was set in order to increase Brian's natural sleep drive and reduce frustration surrounding sleep. He also was prohibited from "sleeping in" on weekends to help regulate his sleep schedule. Lastly, progressive muscle relaxation was demonstrated, practiced and assigned for homework over several sessions to help Brian focus on his body instead of his thoughts at bedtime.

Treatment progress was assessed using a daily sleep log and child and parent report of daytime and nighttime behaviors. Insomnia was significantly reduced within 3 weeks of beginning treatment as measured by a reduction in sleep onset latency and daytime tiredness. Brian also reported a reduction in his nighttime worries, particularly concern regarding his sleep, and feelings of heightened arousal at bedtime.



Associations between Sleep Problems and Anxiety in Youth

Alice M. Gregory, Megan R. Crawford, Jessica E. Holland, & Thomas A. Willis

Goldsmiths College, University of London, UK
and the Institute of Psychiatry, Kings College, London

Most of us are able to recall sleepless nights during periods of heightened anxiety, and the associations between sleep and anxiety are sufficiently well established to be acknowledged in the DSM-IV (American Psychiatric Association, 1994). Indeed, sleep-related difficulties are included in the diagnostic criteria for posttraumatic stress disorder, acute stress disorder and generalized anxiety disorder.

In contrast to the wealth of literature highlighting associations between sleep problems and anxiety in *adults*, less is known about these associations in *children and adolescents*. It is important to understand associations between disorders as there is evidence to suggest that co-occurring difficulties may result in greater impairment than those occurring alone. For example, a study focusing upon depression found that individuals with co-occurring disorders were more likely to demonstrate suicidal behaviour as compared to those with pure depression (Rohde et al., 1991). Furthermore, focusing upon *children* is important as various difficulties, including anxiety, may appear early in life and persist into adulthood (Kim-Cohen et al., 2003). This article summarises some key findings with regards to the associations between sleep problems and anxiety in youth and proposes possible clinical implications of this research.

Sleep problems and anxiety co-occur

Sleep problems have been shown to co-occur with anxiety in youth. One report examined sleep problems in children and adolescents with anxiety disorders (Alfano et al., 2007). The authors revealed that various sleep-related problems (e.g. insomnia, nightmares, overtiredness) were common in children with different types of anxiety - and overall 88% of the participants experienced one or more sleep problem (Alfano et al., 2007; see also Alfano et al., 2006). Conversely, others have focused upon children presenting clinically with insomnia, highlighting the high prevalence of accompanying psychiatric difficulties including anxiety (Ivanenko et al., 2004).

Although many studies have focused upon *subjective* reports of sleep problems, a recent report highlighted sleep problems assessed *objectively* in children and adolescents

suffering anxiety disorders (Forbes et al., in press). This study also revealed a methods effect – whereby, perhaps contrary to expectations, there was greater evidence of an association between sleep problems and anxiety when objective measures were employed as compared to when using subjective measures. Indeed, polysomnography revealed that anxious participants had greater sleep latency and more awakenings as compared to depressed and non-clinical participants. However, of these associations, subjective measures only picked up a link between anxiety and sleep latency. In addition to emphasising associations between sleep problems and anxiety in clinical samples, studies focusing upon non-clinical samples have also found links between these difficulties (e.g. Gregory & Eley, 2005) although not all studies have reported a strong link (Gregory et al., 2006).

Overall, cross-sectional studies have demonstrated associations between various sleep problems as well as different types of anxiety assessed in a variety of ways in different types of samples. Our understanding of these associations has been further enriched by longitudinal studies – some of which have confirmed these concurrent associations as well as highlighted the possibility that the strength of the association between sleep problems and anxiety/ depression increases developmentally (Gregory & O'Connor, 2002; Johnson et al., 2000). It is important to point out that these two latter studies focused on a mixed anxiety/ depression phenotype based on the finding that parents find it difficult to differentiate these two difficulties in their children (Achenbach, 1991). This is noteworthy as studies have recently highlighted the possibility that sleep may be associated with anxiety and depression differently. For example, one report indicated that children and adolescents with anxiety disorders experienced more awakenings and demonstrated less slow wave sleep as compared to participants with depression (Forbes et al., in press). Furthermore, analyses of data from a prospective longitudinal study of a birth cohort showed that persistent sleep problems during childhood predicted anxiety disorders but not depression in adulthood (Gregory et al., 2005a). Contrasting results

were obtained by another group who reported that prior insomnia was associated with the subsequent onset of depression and not anxiety in youth (Johnson et al., 2006). A further study found that low consistency in the sleep-wake cycle during childhood was linked to adolescent (but not adult) onset of depression *and* anxiety disorders (Ong et al., 2006). These mixed results underscore the need for further investigation of the associations between sleep problems, anxiety and depression across the lifespan.

Why do sleep problems and anxiety co-occur?

Research investigating hypotheses as to *why* sleep problems are associated with anxiety in children has lagged behind that research describing *how* these difficulties are associated. Twin studies are able to examine reasons for overlap between traits – and have revealed important trends for a number of childhood difficulties. For example, it is now widely accepted that anxiety and depression are genetically similar difficulties, but that their different manifestations may be largely due to environmental differences (Eley & Stevenson, 1999; Thapar & McGuffin, 1997). Although limited, twin research with regards to the overlap between sleep problems and anxiety suggests environmental influences may be particularly important in explaining the overlap between the two difficulties (e.g., Van den Oord et al., 2000). A further twin study attempted to specify factors involved in the association – highlighting a role for maternal depression and family disorganisation (Gregory et al., 2005b). Indeed, it is easy to imagine that families characterised by high levels of disorganisation may lead frantic lifestyles associated with anxiety and may have poor sleep hygiene (including inappropriate levels of light and noise for easy sleep). A host of other ‘environmental factors’ including difficult peer relationships and negative life events have been linked to both sleep problems and anxiety individually and may partially account for the association between the two (Deater-Deckard, 2001; Eley & Stevenson, 2000; Sadeh, 1996; Williams et al., 1996). In addition to specifying genetic and environmental influences upon sleep problems and anxiety, there is a need to understand how these specific influences result in these

difficulties. Indeed, why does having difficulties with peers make children feel both anxious and have sleep problems? One possibility is that genetic and environmental risk factors increase the likelihood of children developing dysfunctional cognitive styles which lead to or exacerbate problems. Indeed, links between certain cognitive styles (e.g. the interpretation of ambiguous information as threatening) and anxiety have been demonstrated in children (Barrett et al., 1996; Creswell et al., 2005); and links between threatening interpretations of ambiguous stimuli as well as biased attention to sleep-related stimuli have been found in adults with sleep difficulties (Jones et al., 2005; Ree et al., 2006). Although there is limited research focused upon the links between cognitive style and sleep problems in children, it has been revealed that certain cognitive styles typically associated with anxiety (e.g. anxiety sensitivity – which refers to fear of the physical symptoms of anxiety) are also associated with sleep problems (Gregory & Eley, 2005).

Final comment

There has been a recent surge in research examining associations between sleep problems and anxiety in childhood and adolescence. Some tentative implications for clinical practice are proposed. First, the clear association between various types of sleep problems and anxiety suggests that when children present with one type of difficulty it may be worth assessing for the other type. The close association between these difficulties has now been repeatedly emphasised and a recent study highlighted a reduction in sleep-related problems following pharmacological treatment for anxiety in youth (Alfano et al., 2007). Second, the emerging suggestion that sleep problems may be associated with anxiety and depression in different ways underscores the importance of continuing to acknowledge differences between these latter two frequently co-occurring problems. The third implication concerns the familial nature of sleep problems and anxiety. Twin studies have demonstrated that sleep problems and anxiety run in families – and considering the possibility of difficulties in family members of those presenting clinically with these types of difficulties may prove fruitful. Finally, this commentary highlights longitudinal links between the common difficulties sleep problems and anxiety in youth, suggesting that early identification and appropriate response to just one of these two types of difficulties may reap benefits beyond alleviating the symptoms being focused upon. Indeed, aspects of therapies which consider factors related to both sleep problems and anxiety – such as those emphasising the possible importance of family organization – may be particularly valuable.

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STUDENT CORNER**It's Never Too Early To Start Managing Your Anxiety About Internship**

Kaitlin P. Gallo, M.A.

Boston University

Shelly Gonzalez, B.A.

SDSU/UCSD Joint Doctoral Program in Clinical Psychology

Natoshia Raishevich, M.S.

Virginia Polytechnic Institute and State University

As graduate students, thoughts about internship may trigger significant worry. Sure, we can tell ourselves that it's too early to think about internship, but as we all know, avoidance is not the answer. Because we will one day have to apply to internship, we thought it might be helpful to expose ourselves to (so to speak), and to demystify the process of applying for and completing an internship by gathering some accurate information. To that end, we have sought out the wisdom of senior students, those who have survived the process and now feel able to reflect on their experiences. There are many routes one can take to complete internship, therefore, everyone must decide which path best suits their own training goals.

In the first of a series of interviews with those who have successfully applied to (or completed) clinical internships, we spoke with Thomas Cunningham, a doctoral student at Virginia Tech. Thomas has taken a somewhat non-traditional internship route in which he has created his own placement. With a background in organizational behavior management from his undergraduate work at Western Michigan University, Thomas' research focuses on using behavior modification strategies to prevent medical errors in hospitals. He will complete an internship at the National Institute for Occupational Safety and Health (NIOSH) in Cincinnati, where he will continue his career as a behavioral scientist following completion of his Ph.D. Below is a Q and A with Thomas:

Tell us a bit about your background prior to applying for internship.

Prior to applying for internship, I completed three years of clinical practicum, as well as two years of externship work at the university counseling center. My practicum experiences mainly focused on treating adult clients in a community outpatient setting. My externship was specifically focused on group therapy, where I co-led general process and grief/trauma recovery groups for university students.

Can you give a general timeline of the process?

I began my search for sites somewhat later than most, in mid-summer. This list grew and shrank over the months until I sent out applications, and finally ended with a list of 6 sites. In the midst of this process, I also searched for jobs which would possibly serve the purpose of a research-focused internship. This included an application to NIOSH through usajobs.gov for a Ph.D. level research scientist. I also began completing all of the necessary forms and writing the essays in October (again, later than most I believe).

How did a non-traditional internship suit your career goals?

I am most interested in large-scale behavior change for health and safety improvement, and there really are not many (if any) viable options for traditional internships which help me meet this goal. The non-traditional internship I was able to get is exactly the kind of work I want to be doing, and I don't have to go through several steps (i.e. internship, postdoc, etc.) over several years to get the position I want. While this non-traditional internship does count toward my degree fulfillment, it is essentially a Ph.D. entry-level position with excellent pay and no need to reapply after the internship year is completed.

How did you research the opportunity for a non-traditional internship?

I found this internship opportunity through the professional society I belong to – the OBM network. I proceeded with submitting my application while making it very clear that I would need them to make an agreement to create an internship position for me. There is some complexity in getting a non-traditional internship approved, and part of the trick is to be sure that the position you are seeking is understood to be an intern position, with all of the necessary agreements for supervision and training opportunities.

What kinds of questions were you asked on interviews?

With NIOSH, the questions I was asked focused mainly on my research experience. They were interested in what kind of research I had done, and what I was interested in researching in my work with them. They also included a 1-hour presentation in my interview day, which was similar to a faculty candidate colloquium, where I presented my entire body of research to a group of about 30 people. Questions asked also included things such as what are my long-term career goals, and why am I interested in a career with NIOSH.

What tips do you have for other applicants?

My advice to other applicant is to have a clear understanding of what they want for their careers and be willing to be creative to make that happen. The traditional internship application process seems to me to very much limit what people will consider possible. By thinking outside of the box and exploring more than only what APPIC offers, I was able to find a position which many would have thought I could only obtain after I had completed my degree. Don't rule out options beyond what has already been done before. If you can take control of the process and tell people what you want, I think you can carve out your own niche that perhaps fits better with your career goals than the status quo.

2007 Student Travel Award

The SIG Student Travel Award will recognize excellence in student research in the field of child and adolescent anxiety disorders. Any graduate student or postdoctoral fellow who has completed or is in the process of completing an empirical study related to the assessment, treatment, or phenomenology of youth anxiety disorders is eligible for the award.

The award winner will receive an award certificate, a \$200 award, and will give a 20 minute presentation of their research at the Annual CAA SIG meeting held at the ABCT conference in Philadelphia, PA (Nov. 15-18).

To apply, please submit your curriculum vita and a 1-2 page (single spaced) description of your study (including brief intro, methods, and results).

Submission Deadline is July 31, 2007.

Recipient will be notified by August 30, 2007.

Award Amount: \$200

Requirements: ABCT membership, CAA SIG membership, graduate or postdoctoral student

Send applications to: Shelly Gonzalez at arg001@ucsd.edu

Submission Deadline: July 31, 2008



See you in Orlando!!
November 2008



Child and Adolescent Anxiety

Special Interest Group

2008 New Member/Membership Renewal Form

Association for Behavioral and Cognitive Therapies

Name: _____
 Title: _____ Degree _____
 Address: _____

 Phone: _____
 Fax: _____
 Email: _____
 Web Page: _____

Membership Status (check one):

Professional _____ Student _____
 \$10 (US funds) \$5 (US funds)
 for one year for one year

**Fees received after 12-31-08, will be subject to a \$5 late fee.

Are you an AABT member or student member?

YES _____ Note: You must be an ABCT member to join the Child and Adolescent Anxiety SIG.
 NO _____

Would you like to join the Child and Adolescent Anxiety SIG Listserv:

YES _____ (make sure email address is included above)
 NO _____

To initiate your membership:

1. Email this form to: Ellen Flannery-Schroeder at: efschroeder@uri.edu

Then:

Send a check or money order (in US funds), payable to Child and Adolescent Anxiety SIG,
 to : Ellen Flannery-Schroeder, Ph.D., Department of Psychology, University of Rhode Island, 10
 Chafee Road, Suite 8, Kingston, RI 02881 e-mail: efschroeder@uri.edu

OR

Use Paypal in 5 easy steps:

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2. Login to your account.
3. Click on the "Send Money" tab.
4. Enter childanxietysig@yahoo.com as the recipient's e-mail address.
5. Enter the amount and currency type, then hit "Continue."
6. Enter credit card information, review, and hit "Send Money."