Required Narratives for ACEPT Site Information Form

Advanced Therapeutic Solutions for Anxiety

1. Ideal Applicants to Your Program

As an anxiety specialty clinic, the ideal applicants to Advanced Therapeutic Solutions for Anxiety are those interested in gaining experience with exposure and response prevention (ERP) treatments, cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), acceptance-based behavior therapies (ABBT), motivational interviewing (MI), modified parent-child interaction therapy for selective mutism (PCIT-SM), and supportive parenting for anxious childhood emotions (SPACE). In addition, ideal applicants are those who want to work with the child's ecosystem, involving school sessions and psychoeducation with school teams, learning (and then modeling) interventions schools can use in school, and pushing in to school classrooms to help carry over treatment gains into the classroom setting (under live supervision and coaching from their supervisor). Engaging the child's ecosystem also involves training and working with parents, family members, and caregivers (e.g., nanny, grandparents, etc.) to provide psychoeducation on how to recognize anxious-avoidance coping and how to support an approach-coping style instead. Our goal is to help the individual (and families) out of the negative reinforcement cycle of anxious avoidance and move into a positive reinforcement cycle of approach coping so they can live freely and not feel stuck by their phobias.

Most of the cases we treat are children with selective mutism and social phobia. Selective mutism (SM) is a failure to speak in expected situations (e.g., school), even though the individual has the capacity to speak and does speak in other situations (e.g., at home). Individuals with selective mutism are treated at ATSA using a clinic-school-home-community approach, practicing exposures to speaking in hierarchical steps and generalizing across people, places, and activities. Ideal applicants are those who enjoy the rush of taking risks and thinking on their toes as they immerse themselves into exposure therapy with their young kid patients, applying our evidence-based exposure protocol to guide their young patient during exposure tasks and behavioral shaping, and feeling the rush when the child meets their goal as they face their fear of speaking. Once a child begins to talk, sometimes it's like the floodgates open and they show their true selves at school and in public. Ideal applicants are those who enjoy the experience and feel energized by the emotional rewards when applying exposure therapy. Hence, the ideal applicants are those who

can embrace ATSA's "Use Your Brave" motto and feel *comfortable with being uncomfortable* when delivering exposure therapy protocols to children, adolescents, and adults.

Applicants interested in pursuing an APA internship in a child anxiety site are ideal candidates for a practicum at ATSA. Not only will applicants gain a foundation in exposure therapy, they will also gain experience with the rare and often misunderstood condition of selective mutism. Since it is rare to find a provider who specializes in evidenced-based selective mutism treatment, the training offered at ATSA can help boost the applicant's marketability when competing for an internship slot. Those interested in behavioral disorders and PCIT, or hope to gain an APA internship slot at a PCIT training site, are also ideal candidates for ATSA's practicum, as well as those interested in pursuing ERP training with adult populations. Overall, the ATSA practicum experience provides a strong foundation of exposure therapy for anxiety disorders. It is part of ATSA's mission to educate and train budding psychologists in evidence-based treatments, especially treatments for more challenging conditions like selective mutism; therefore, ideal applicants are those who will take their knowledge forward by teaching others as they move on to internship and continue forward on their career path.

2. Supervision Philosophy of Site

We supervise using an integrative developmental model (IDM). We appreciate the model's approach to conceptualize the supervisee across three levels of self/other awareness, motivation, and autonomy. Given that one of the main interventions we teach is a specialized treatment protocol for selective mutism, IDM aligns nicely with our approach of providing live modeling, live coaching, and release of responsibility as the supervisee becomes more autonomous in delivering exposure therapy for an often misunderstood and puzzling condition.

ATSA trainees range from graduate students through professionals; while some may be supervisees with secure identities as therapists and quite autonomous (up to Level 3i) in treating anxiety disorders, many, if not all, are Level 1 supervisees when it comes to treating selective mutism, regardless of their years of experience with ERP, CBT, and ACT/ABBT.

Since little is known about selective mutism and how to effectively treat selective mutism, we find that the integrated developmental approach applies well. We meet for 1:1 supervision weekly, and 1-2x/mo for group supervision. PCIT-SM, ERP, CBT, ACT, and SPACE are the main treatment interventions used, and therefore supervision also follows a similar model, encouraging

supervisees to step out of their comfort zones and to be aware of their thoughts and emotions in the moment during treatment delivery. We train supervisees on how to stay focused in the moment vs. worrying if they are “doing it right” and to rely on their foundational academic knowledge and research to inform their delivery of treatments. Therapy is an art; while clinical research provides the form and structure to use for interventions, one learns the nuances and develops the intuition to analyze and act (instead of react) in the moment through experience. This way of thinking is crucial in exposure therapy, where one can go in with a plan, but never truly know exactly how the exposure session will go, especially working with children and parents. If the patient is not meeting the expected goal for the approach task, the clinician is encouraged to analyze under what condition can the patient meet the goal, or an approximation of the goal, by improvising based on what the patient is giving them. For example, we teach clinicians to apply “yes, and” versus “no, but” to what the patient is giving them, thereby *adding* to what the patient is able to do (instead of going against it), and aligning with the patient to work towards the goal together; if all else fails, go back to where the patient was last successful, recalibrate, and continue shaping from there, while also staying emotionally regulated, confident, and supportive of their patients (and their distressed parents, when working with children). It is because of the improvisation based on what the patient gives you that makes exposure therapy an art.

Supervision follows a structured approach, reviewing each patient (child, adolescent, adult, parents) and what level of exposure they reached in their session, as well as self-evaluation and reflection of how the supervisee feels they are doing with administering the exposure therapy. Are they still relying on the concrete manual/protocol, or are they able to think more abstractly about what is happening and act from there? It is truly a joy to witness trainees develop from novice to skilled as they learn more about themselves, gain a better understanding and empathy for anxious patients, build confidence in recognizing the nuances, use setbacks in the patient’s favor as they tailor treatment, engage in their own personal and professional growth, and ultimately become more autonomous.

3. **Research Opportunities** (if applicable)

We collect data to assess therapy outcome for clinical purposes. Questionnaires we use include:

- La Greca’s Social Anxiety Scale (Self report and Parent report)
- Spence Child Anxiety Scale (Self report and Parent report)

- Selective Mutism Questionnaire (Parent report)
- School Speech Questionnaire (Teacher report)
- Parent Stress Inventory (Parent report)
- Beck Youth Inventory (Self report)
- Family Accommodation Scale (Self report and Parent report)

We also collect observational data during our intensive 5-day group treatment for selective mutism.

We provide prolonged exposure for selective mutism and social anxiety, and collect outcome data for clinical purposes. Treatments range from individual intensive to group intensives. An interesting but yet unexplored area is assessing the treatment effects of intensive treatment vs traditional treatment for selective mutism.

Students interested in using ATSA data for their thesis are welcome to propose their plan. Support can be provided for students to obtain consent from previous or current patients to use their data for research.